Urology Services Inquiry

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

28 April 2022

Dear Madam,

**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 USI

**Anne Donnelly**
Solicitor to the Urology Services Inquiry

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

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

# Chair's Notice

## [No 10 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:** **Mairead McAlinden**
**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.**

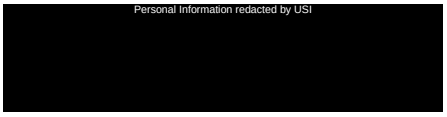
**APPLICATION TO VARY OR REVOKE THE NOTICE**

**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: 


**Christine Smith QC**

Chair of Urology Services Inquiry

Urology Services Inquiry

**SCHEDULE**

**[No 10 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, 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 2009 to 2015.

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 Directors - the Inquiry understand these to have been Patrick Loughran and John Simpson;
    (iv) The Directors of Acute Service – the inquiry understands these to have been Gillian Rankin and Debbie Burns;

(v) The Director of Human Resources and relevant Human Resources personnel – (please name)

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

(vii) The Associate Medical Directors - the inquiry understands this to have been Eamon Mackle (Surgery) and Charlie McAlister (Anaesthetics)

(viii) The Clinical Directors, the inquiry understands this to have been Robin Brown and Sam Hall;

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

(x) The consultant urologists in post.

(xi) The Nurse Managers – the inquiry understands this to have been Shirley Tedford and Gillian Henry.

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, Colm Donaghy, or your successor, Paula Clark, 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

**UROLOGY SERVICES INQUIRY**

**USI Ref:** Notice 10 of 2021
**Date of Notice:** 28 April 2022

**Witness Statement of: Mairead McAlinden**

I, Mairead McAlinden, will say as follows:-

**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.**

1.1 My response to this question is in the form of a very brief overview as I believe that my detailed responses from Question 4 onward fully set out all of my relevant involvement in matters within the Inquiries Terms of Reference.

1.2 By way of context, I worked for the Southern Health & Social Care Trust (SHSCT) since its establishment on 1 April 2007, my roles are outlined in my response to Question 5. I was appointed Acting Chief Executive in September 2009 and appointed substantively to that post in November 2010.

1.3 During my tenure as Chief Executive of SHSCT, the Trust was a large and complex organisation providing a wide range of health and social care services (hospital, community and primary care) to a population of c363,000 people from across the Southern area of Northern Ireland and beyond. SHSCT had accountability for the

effective expenditure of c£600m funds allocated for the delivery of services and employed c14,000 staff.

1.4 I resigned from the post of SHSCT Chief Executive on 31 March 2015 to take up a post as Chief Executive of Torbay & South Devon Foundation Trust on 1 April 2015 and relocated to Devon at that time. I retired from the NHS in July 2018 and since then have worked as an Independent Management Consultant, primarily in the Devon NHS.

1.5 I have had no employed role in Health and Social Care services in Northern Ireland since April 2015, my only contact being as part of the Expert Panel appointed by the Health Minister to review the configuration of health and social care services in Northern Ireland, as referred to in my response to Question 5.

1.6 It is in that context, and to the best of my recollection having requested and reviewed documents provided by the SHSCT Public Inquiry Team, I have made best efforts to answer honestly and as fully as possible the questions in this S21 notice, given the passage of over 7 years since I left the Trust. I had no knowledge of, or involvement in, specific issues of concern regarding Urology Services in SHSCT after I left the Trust in March 2015.

1.7 I wish to advise the Public Inquiry that my father, [redacted], was a patient of Mr O'Brien's until his retirement from SHSCT. The SHSCT and Public Inquiry have written to my father to advise that his treatment and care while a patient of the SHSCT Urology Service has been considered in a lookback review by the Trust. In a personal capacity, given my father's health conditions and frailty, I have accompanied my father as his carer to some of his appointments with Mr O'Brien and also spoke with Mr O'Brien on the telephone during periods of Covid lockdown regarding his treatment and care. I can confirm that no issues of work-related clinical concern regarding the urology service were discussed in this personal contact.

Urology Services Inquiry

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 Other than the documents requested by me and provided by the SHSCT Public Inquiry Team and those publicly available on the Trust's website, which are referenced in my responses, I have no documents in my custody relating to the Terms of Reference of the Urology Review.

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.**

3.1 As directed in this question, all my responses to the questions asked in this notice refer to my tenure as Chief Executive of SHSCT. I have only referred to my previous role as Director of Performance & Reform in SHSCT where specifically relevant to the question asked. I have attempted to confirm postholders as requested

and have referred to the names of any SHSCT staff with whom I have spoken to inform my response to the 124 questions in this notice. Where relevant, I have referred and referenced documents I have requested from the SHSCT Public Inquiry (PI) Team and reviewed same to inform the accuracy of my responses.

**Your Position(s) within the SHSCT**

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

4.1 I have a BA Honours degree in Business Studies and a Certificate in Health Services Management. I do not have any professional qualifications. I have worked in NI HPSS since 1982 in a variety of roles, none of them clinical.

4.2 Prior to commencing employment with SHSCT, I held the following roles:

- Regional Director for Integrated Care & Treatment Services (ICATS) - part-time secondment from Southern Health & Social Services Board to DHSSPS Service Delivery Unit 1 June 2006 – 31 December 2006
- Director of Planning & Performance Management, Southern Health & Social Services Board 1 February 2002 – 30 November 2006.
- Primary Care Commissioning Manager (Armagh Primary Care Commissioning Pilot), Southern Health & Social Care Board 1 June 1999 – 31 October 2002.
- Senior Planner, Southern Health & Social Care Board 1 October 1995 – 31 May 1999.
- Trust Information Manager Craigavon & Banbridge Community Trust 1 April 1994 – 30 September 1995.

4.3 Prior to these roles I held a number of managerial and administrative posts in HPSS within the Southern area from 1 June 1983 and can provide further details of these posts if required.

**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 Director of Performance and Reform/Deputy Chief Executive from 1 December 2006 to 31 August 2009: In this post I was responsible for the delivery of strategic and operational planning and performance management in the Trust, and led the planning, capital, estates and ICT functions within the Trust. As Deputy Chief Executive I was accountable for driving the Trust's performance. I have reviewed my job description for this role *located in S21 10 of 2022 Attachments, 1. Chief Executive MAIREAD McALINDEN JD* and I can confirm its accuracy in terms of duties and responsibilities.

5.2 Interim Chief Executive 1 September 2009 and appointed permanently to the post of Chief Executive SHSCT in November 2010, reporting to the Trust Board and accountable to the Trust Board through to the Minister for Health. My duties and responsibilities were to lead 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, Social Services & Public Safety (DHSSPS), and of the Trust's Commissioner, the Health & Social Care Board (HSCB).

5.3 As the Accountable Officer for the Trust, I was accountable to Trust Board, DHSSPS and HSCB and ultimately the Minister for the performance and governance of the Trust and held overall responsibility for the management and performance of the Trust. The full roles and responsibilities of my tenure as Chief Executive of SHSCT are summarised in the Chief Executive Job Description *located in S21 10 of 2022 Attachments, 1. Chief Executive MAIREAD McALINDEN JD*. I have reviewed my job description for this role and I can confirm its accuracy in terms of duties and responsibilities.

5.4 As advised in paragraph 1.4 of my response to Question 1, I left the SHSCT on 31 March 2015 to take up post as Chief Executive of Torbay & South Devon NHS Foundation Trust. This required relocation to England and since that date I have had little or no contact with the HPSS in Northern Ireland, apart from participating, at Simon Hamilton the then the Northern Ireland Health Minister's request, in an expert panel to review the configuration of HSC services in Northern Ireland. I was appointed to the expert panel under the clinical leadership of Dr Rafael Bengoa in early 2016 and the panel delivered its report 'Systems not Structures' in October 2016. Since that time I

have had no input to health and social care in Northern Ireland other than in a voluntary capacity as Chair of the Trustee Board of incredABLE, a voluntary organisation providing services for children and young adults in the southern area of Northern Ireland.

**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 Director of Performance and Reform/Deputy Chief Executive from 1 December 2006 to 31 August 2009. In this post I reported to the then Trust Chief Executive, Colm Donaghy. I was responsible for the delivery of strategic and operational planning and performance management in the Trust, and led the planning, capital, Estates and ICT functions within the Trust. My role and responsibilities are summarised in my Job Description for this post *located in S21 10 of 2022 Attachments, 1. Chief Executive MAIREAD McALINDEN JD.*

6.2 As Director of Performance & Reform the following staff reported to me:

- Debbie Burns – Assistant Director for Performance and Service Improvement (subsequently this post was split with Paula Clarke, appointed in March 2008, who took lead responsibility for corporate performance and service development)
- Siobhan Hanna – Assistant Director for Informatics
- Alan Metcalfe – Assistant Director for Estate Services
- Martin Kelly – Assistant Director for Planning

6.3 As Acting Chief Executive from 1 September 2009 and substantive Chief Executive from November 2010 until I left March 2015, I was Accountable Officer for SHSCT, accountable to Trust Board (through the Chair of the Trust), Department of Health and Personal Social Services (DSPPSNI) though the DHSSPSNI Permanent Secretary and to the Health and Social Care Board (HSCB) through its Chief Executive, and ultimately to the NI Minister for Health and Social Care and my responsibilities are detailed in paragraph 5.2 of my response to Question 5. During my tenure these posts were held by:

- Mrs Ann Balmer, Chair of SHSCT Board 1 September 2009 – 31 January 2011

- Mrs Elizabeth Mahood, Acting Chair 1 February 2011 until March 2011.
- Mrs Roberta Brownlee, appointed Chair of SHSCT Board in March 2011 and was still in post as Chair when I left as Chief Executive.
- Mr John Compton, Chief Executive of HSCB until March 2014 and his successor Mrs Valerie Watts.
- Dr Andrew McCormick, Permanent Secretary DHSSPSNI until June 2014
- Richard Pengelly, Permanent Secretary DHSSPSNI 2014 until I left the SHSCT.

6.4 As Chief Executive and Accountable Officer I was responsible to the above individuals for the performance and governance of the SHSCT in the delivery of high quality care. Following my appointment to my role as Acting Chief Executive of SHSCT on 1 September 2009, I received a letter on 24th September 2009 from the then Permanent Secretary of DHSSPS, Dr Andrew McCormick, setting out my responsibilities as Accounting Officer for the Trust. These included:

- Paragraph 6: Responsible to the Board and accountable to the Assembly for the Trust's use of resources (for the purposes for which they were voted by the Assembly)
- Delivering the standards expected of the Trust as set out in Box 3.1 of Chapter 3 of Managing Public Money Northern Ireland

6.5 As Chief Executive I had line management responsibility for the following Directors in the Senior Management Team (SMT):

- Dr Patrick Loughran, in post as Medical Director when I took up post in September 2010 until July 2011
- Dr John Simpson, Medical Director from 1 August 2011, still in post when I left the Trust in March 2015.
- Mr Francis Rice, Director of Nursing & AHPs and Operational Director for Mental Health & Learning Disability, in post when I took up post in September 2010 and still in post when I left the Trust. Mr Rice had [redacted] leave due to [redacted] and during this time his Operational Director duties for Mental Health & Learning Disability services were covered by Mr Miceal Crilly and his role as

Director of Nursing & AHPs was covered by Mrs Angela McVeigh, Director of Older People & Primary Care.

- Mrs Joy Youart, Interim Director of Acute Services when I took up post until January 2010.
- Dr Gillian Rankin, Director of Acute Services January 2010 until March 2013
- Mrs Deborah Burns, Director of Acute Services March 2013 and still in post when I left the Trust.
- Mr Brian Dornan, Director of Children & Young People's Services and Director for Social Care when I took up post in September 2009 until his retirement in 2009.
- Mr Paul Morgan appointed Acting Director of Children & Young People's Services and Director for Social Care in December 2009, appointed substantively to this post in March 2011 and was in post when I left the Trust.
- Mr Stephen McNally, Acting Director of Finance from September 2009 and substantively appointed to this post in January 2011, and was still in post when I left the Trust.
- Mr Kieran Donaghy, in post as Director of Human Resources and Organisational Development when I was appointed Acting Chief Executive in September 2009 and was still in post when I left the Trust.
- Mrs Paula Clarke, appointed as Acting Director of Performance and Reform to replace me on my appointment as Acting Chief Executive in September 2009, and appointed substantively to this post in March 2011. Paula Clarke was appointed Deputy Chief Executive in January 2015 and took up post as Acting Chief Executive when I left the Trust.

6.6 In addition to the above Directors, I also line managed:

- The Board Secretary, Mrs Jennifer Holmes, until she left the Trust in March 2011. This post was replaced by a Board Assurance Manager, Mrs Sandra Judt who was appointed in May 2012 and reported to the Chair of the Trust Board.
- Mrs Deborah Burns, Assistant Director for Clinical & Social Care Governance until February 2013, succeeded by Mrs Margaret Marshall who was in post until I left the Trust.

**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 of the Southern HSC Trust, I carried overall organisational responsibility for the operation and governance of all services provided. In March 2010 and with the support of the SMT and Board I commissioned a Trust-wide review of Clinical and Social Care Governance arrangements (CSCG) with the remit to critically appraise the Trust's current operational and assurance systems as related to clinical and social care governance, including processes, capacity, capability and outcomes from the current CSCG system and to ensure roles and responsibilities were clear and defined. The Terms of Reference for this Review were approved by the Trust's Governance Committee on 7th September 2010 under Agenda Item 6 *[2. 20100907 Approved Governance Committee Minutes located in S21 10 of 2022 Attachments]* and the consultation version of 'A System of Trust' is available was circulated to affected staff. *[3. A System of Trust – CSCG Review located in S21 10 of 2022 Attachments].*

7.2 This document clearly defines how I as Chief Executive discharged my responsibility for the operation and governance of Urology Services through delegation to the following Directors and Assistant Directors who reported to me *(3. A System of Trust – CSCG Review Section 2 located in S21 10 of 2022 Attachments):*

- The Director of Acute Services who was responsible for performance against Departmental targets such as waiting times for care and for reporting, actioning (ie learning from and mitigating risk), managing and monitoring patient and client safety and quality of care. This includes the management of incidents, complaints and risk registers, and accountability for implementing appropriate clinical audit and monitoring and reporting against agreed clinical indicators and agreed safety standards. The Directors of Acute Services during my tenure as Chief Executive were as listed in paragraph 6.5 of my response to Question 6.
- Professional Executives (Medical Director/Responsible Officer, Director of Nursing and AHP Services and Director of Social Work) who were responsible for provision of expert professional advice, audit and consultancy, monitoring and reporting the standard of the relevant registered workforce (medical, nursing, social work and

AHP), provide independent assurance on compliance with workforce standards and a corporate alert function, providing expertise advice and assurance on training and development and an adequately skilled workforce.

- The Medical Director had a specific role as Responsible Officer under the Medical Profession (Responsible Officers) Regulations (Northern Ireland) which came into force in 2010. DHSSPS issued 'Confidence in Care: guidance on the role of responsible officers for doctors and employers' in February 2011. This guidance set out in paragraph 63 two principal processes for which the Medical Director as Responsible Officer had prime responsibility:
  - Processes that will underpin the retention of doctors' licences (revalidation).
  - Processes underpinning referral of doctors to the GMC in those cases where there are doubts concerning fitness to practice.

  This placed significant responsibility on the Medical Director in relation to the conduct, safety and competence of the medical workforce and requires the Medical Director to review the Trust's Clinical Indicators relating to outcomes for patients, to identify any issues arising that relate to variation in individual medical performance/practice and to ensure the Trust addresses such issues. During my tenure in SHSCT the Medical Director reported under this responsibility by regular Medical Director reports to Governance Committee under the Agenda Item on 'Professional Governance Reports' and to Trust Board.

7.3 The Professional Executive Directors relevant to Urology Services during my tenure as Chief Executive are referenced in paragraph 6.5 of my response to Question 6.

7.4 The implementation of these new clinical and social care governance structures also brought the function of 'Corporate Co-ordination and Overview' under my responsibility as Chief Executive. This was in practice a central point for co-ordination with Operational Directors responsible and accountable for implementation and included:

- Co-ordination of standards, guidelines, NICE, Safety Alert Broadcasts, RQIA recommendations/reviews and regional and national reviews.

- Monitoring and reporting of complaints, incidents, risk, audit, clinical indicators, patient safety and learning systems.

During my tenure as Chief Executive, this function was undertaken by the Assistant Director for Clinical & Social Care Governance from 1 April 2011, and postholders during my tenure are referenced in paragraph 6.6 of my response to Question 6.

**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, the roles of the Directors and Assistant Directors, the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Services or with any other role which had governance responsibility.**

8.1 My role and responsibilities are outlined in my response to Question 7 above, including the delegated responsibilities to Directors for operational delivery, professional oversight and governance. This ensured no overlap or ambiguity in roles and responsibilities.

8.2 In relation to Associate Medical Directors and Clinical Directors, these postholders reported to the Director of Acute Services on operational and governance matters, and to the Medical Director in relation to their professional accountabilities (such as appraisal and revalidation).

8.3 The Assistant Director reported to the Director of Acute Services and the Head of Urology Services reported to that Assistant Director.

**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 As Chief Executive I held a weekly Senior Management Team meeting and had regular (monthly) individual meetings with each Director including the Medical Director to discuss their objectives and to allow time to raise and discuss any concerns.

9.2 In addition to these formal meetings I had regular, sometimes daily, informal contact with Directors and my leadership style was such that they were encouraged to come to me with any concerns.

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

10.1 As Chief Executive, I had no line management of clinical staff other than the Medical Director and Director of Nursing & AHPs. However I had a schedule of visits to services to ensure that I was visible and accessible to staff, with an 'open door' policy that encouraged staff to approach me with concerns and I regularly took the opportunity for informal discussion during leadership walks and other visits to services. A list of my visits to front line services was shared at each Trust Board meeting.

10.2 Regarding engagement with medical staff, during my tenure as Chief Executive I regularly attended:

- Medical Forum meetings
- Medical Staff Committees at Craigavon and Daisy Hill Hospitals
- Chairing of Medical Job Planning meetings (see my response to Question 91)

10.3 I also attended, as far as possible, the monthly Joint Negotiation & Consultation Forum with Trade Union Representatives, including RCN and other professions, which was co-chaired by the Director of Human Resources and Organisational Development, then Kieran Donaghy, and the nominated Chair from the Trade Unions.

10.4 In all these meetings and formal and informal contact with clinical staff, I made it very clear that I was approachable and would listen to any concerns brought to my attention. As an example of concerns raised with me, I refer to the Confidential Trust Board meeting minutes of 29 August 2013 Agenda item 6ii) *[4. 20130829 Confidential Minutes located in located in S21 10 of 2022 Attachments],* which reflect a detailed discussion on the clinical concerns of stepping down the Trust's Isolation Ward which had been raised with me by the Clinical Director of Infection Prevention & Control.

**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 2009 to 2015**.

11.1 As Chief Executive I chaired the weekly Senior Management Team (SMT) which was substituted with a SMT Governance meetings once per month, both these meetings were formally minuted. These meetings were attended by all Directors and typically lasted 3 hours.

11.2 I met with the Chair of the Board, Mrs Ann Balmer from my appointment as Acting Chief Executive and then Mrs Roberta Brownlee from her appointment as Chair in March 2011, informally at least weekly. I had monthly formal meetings with the Trust Chair, and a formal annual performance review which I detail in my response to Question 69.

11.3 As Chief Executive, myself and the Chair of the Board (Mrs Ann Balmer and then Mrs Roberta Brownlee from March 2011 until I left post in March 2015) met with the DHSSPSNI Permanent Secretary (Dr Andrew McCormick and from 2014 Mr Richard Pengelly) in formal meetings twice yearly:

- Mid-Year Accountability Meeting
- Year End Accountability Meeting

11.4 The minutes and outcomes of these meetings were discussed at Trust Board. As evidence I have reproduced below an extract from the minutes of the Trust Board of 25 August 2011 *[5. 20110825 TB Public Minutes located in S21 10 of 2022 Attachments]* under Agenda Item 4 Chief Executive Business:

> *The Chief Executive advised members that it had been a busy summer and reported on business as follows: Accountability Review Meeting with DHSSPS: The Chief Executive advised that the Trust's end of year accountability review meeting was held on 28 July 2011 and attended by the full SMT and Chair. This meeting is a key element of the Department's accountability arrangements for Trusts and covered the full range of governance and performance issue. The Trust's SIC 2010/11 was discussed in detail including Priority 1 Internal Audit findings, however there was agreement that pragmatic approaches should be taken where cost outweighed potential risk, etc. The Departmental comments*

*on the SIC will be brought to the next meeting of the Trust's Audit Committee. The minutes of the Accountability meeting, when received, will be brought to the Governance Committee for discussion. Other issues raised included the Trust's plans for Bowel Screening, Business Continuity Plans, procurement issues and compliance with safety alerts and guidelines. The [Health & Social Care Board] provided analysis of performance which was generally positive. The Trust shared the Corporate Risk Register to highlight the range of risks being managed and identified where regional commissioner/policy support was required. Concerns on the number (58) and complexity of standards and guidelines received Jan- June '11 and the need for improved coordination was also raised by the Trust. The Chair expressed her gratitude to the Chief Executive and Senior Management Team and commended the quality outcome and performance of all involved in the Accountability Review Meeting. She added that their commitment and responsiveness was evident.*

11.5 In addition, there were regular (quarterly) performance review meetings with Health & Social Board (HSCB) as the Trust's commissioner of services. These were chaired by the HSCB Chief Executive and attended by me as SHSCT Chief Executive with relevant Directors and/or their senior staff.

11.6 I held individual meetings with Directors which were usually monthly and typically lasted 1.5 to 2 hours, these were not formally minuted although I made informal notes of any actions agreed and concerns raised to follow those up. I have not personally retained these written notes and have not been provided with any such written notes by the Trust. I would doubt they would be retained by the Trust after this period of time.

11.7 Given the passage of time since I left SHSCT, I cannot recall any specific significant governance concerns raised in these meetings about the quality and safety of urology services. The relevant minutes I understand are available but, in the case of SMT minutes are c300 sets of minutes, some which have been provided to me but not specifically those that referenced urology services so I have not yet reviewed these due to lack of time. Should specific minutes referencing urology services be provided

I will review and notify the Inquiry of any additions or revisions to my response to questions in this statement.

**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 As Chief Executive and Accounting Officer of SHSCT, I have responsibility for the review of the effectiveness of the Trust's system of internal governance. I was required to sign the Trust's Annual Report and Accounts each year, taking accountability for the accuracy of its content. This document included a Governance Statement that reflected my responsibility for maintaining a sound system of internal governance.

12.2 I have reviewed the Annual Report for year ended 31 March 2015 *[6. ANNUAL_REPORT_AND_ACCOUNTS_2014-15 located in S21 10 of 2022 Attachments]* which was the last year of my tenure as SHSCT Chief Executive. Section 2 of this document describes the Trust's compliance with Corporate Governance Best Practice. Section 3 describes the Governance Framework of the Trust, and references the Board Sub-Committees, which were chaired by Non-Executive Directors and have clear lines of reporting and accountability to Trust Board and minutes of these meetings were presented at Trust Board public meetings, with the Chair of the Committee highlighting any specific issues for the attention of the Board.

12.3 This included the Governance Committee (the overarching strategic Committee responsible for providing assurance to the Trust Board on all aspects of governance except financial governance (which was under the Audit Committee) and performance (which was reported directly to Trust Board. The Governance Committee is comprised all Non-Executive Directors and attended by the Chief Executive, all Directors, the Director of Pharmacy and the Assistant Director of Clinical & Social Care Governance.

12.4 The Governance Committee regularly considers the effectiveness of the Trust's governance arrangements and has a schedule of reporting in place. The key areas

reported at meeting are in line with this. In 2014/15 Assurance Reports were received from lead Directors in relation to their areas of responsibility (see responsibilities defined in A System of Trust referred to below). At this Committee, adverse incidents, serious adverse incidents, complaints and corporate risks are presented and reviewed. Reports and findings from external bodies/agencies (including the Trust's regulators) are presented and discussed, particularly those that indicated practice was below acceptable level, and areas of risk are considered, and assurance sought from myself and the relevant Directors that action plans were in place to address recommendations of these reports and that such plans were being effectively implemented. Where such assurance could not be provided, the Governance Committee ensures that these are appropriately escalated to Trust Board.

12.5 During my tenure, Governance Committee minutes were presented to Trust Board by the Non-Executive Chair of the Committee for review and approval and the Committee Chair was required to raise any matters of concern, thus ensuring that Trust Board was informed of the issues discussed and could exercise a 'check and challenge' function on the matters recorded in each set of minutes.

12.6 The Trust Board Chair and I met each Board Committee Chair after each Committee meeting to discuss the work of their Committee and provide an opportunity to raise any concerns.

12.7 The Governance Committee reviews the Corporate Risk Register at each meeting and ensures that risks outside the Trust's ability to solely manage are escalated to Trust Board and beyond. During 2014/15, the Trust Board instructed me, as Chief Executive, to escalate a number of such risks to the Trust's Commissioner, the Health & Social Care Board (HSCB), including the need for recurring investment to address capacity gaps affecting performance against Ministerial targets and in relation to Medicines Management in domiciliary care.

12.8 Section 4 of the Annual Report for year ended 31 March 2015 referred to in paragraph 12.2 describes the Trust's processes for Business Planning and Risk Management, including performance monitoring requirements.

12.9 The Trust Board operated via an annual Board calendar of meetings and agenda topics. Each Board agenda comprised of:

- Strategic Issues
- Patient & Client Safety and Quality
- Director reports on Operational Matters, including performance, finance and workforce information.
- Statutory Annual Reports

12.10 The Executive Professional Board members (Medical, Nursing & AHP and Social Work) ensure executive challenge as these posts are designed to give independent professional assurance to Trust Board.

12.11 Time was also allocated at each meeting for the Board to reflect on innovative practice in relation to quality improvement and invitations were extended to staff and service users to present same and so the Board could hear their experiences of care.

12.12 A systematic approach is taken within the Trust to ensure that the governance systems on which the Trust relies are challenged and tested. The Board Assurance Framework (BAF) is a statutory requirement for the Trust and is an integral part of the Trust's Governance arrangements, sitting alongside the Corporate Risk Register. The process for compiling the BAF is described in Section 7 of the Annual Report for year ended 31 March 2015 and the sources of external assurance and system validation which include the Regulation & Quality Improvement Authority (RQIA), Internal and External Auditors, Royal Colleges and Professional Councils.

12.13 Controls Assurance Standards (CAS) provide structured assurance on how risks are effectively managed. Substantive compliance is required across all 22 standards. Where risks are outside the Trust's ability to solely manage, these are escalated to Trust Board and beyond. Compliance with Controls Assurance Standards provide an important assurance to the Board, and Governance Committee and Audit Committee review compliance with CASs. A summary of the Trust's substantive compliance with the 22 Control Assurance Standards in 2014/15 is included on Page 63 of the Annual Report, including the core standards that are subject to independent audit (HSC Internal Audit is a function independent of the

Trust). Both the Governance (subject to verification by HSC Internal Audit at the time of this Annual Report) and Risk Management Controls Assurance Standards were assessed as compliant.

12.14 Sources of independent assurance are listed in Section 8 of the Annual Report, including Internal Audit, and a list of the areas that Internal Audit reviewed in 2014/15 are listed on page 65 and 66 of the Annual Report. The 2014/15 internal audits specific to the Trust's governance are listed, including:

- Risk Management, with a Satisfactory level of assurance, and
- Governance including Board Effectiveness, again with a Satisfactory level of assurance.

12.15 In her annual report in the SHSCT Annual Report for year ended 31 March 2015 referred to in paragraph 12.2, the Head of Internal Audit (which provides an audit function independent of the Trust] reported that SHSCT had a satisfactory system of internal control designed to meet the Trust's objectives.

12.16 I ensured that Trust Board was appraised of current performance against the applicable standards of clinical care and safety (as that applies to waiting time/access standards as set by the Trust's commissioner the Health & Social Care Board) through the monthly Board Performance Report. This was brought through to the Annual Report for year ended 31 March 2015 referred to in paragraph 12.2. Under 'New Control Issues in 2014/15' on page 79 of this Annual Report, I refer to Elective Care where there were a number of specialty areas with capacity gaps where no allocation for additional activity was provided in Quarters 3 and 4 of that year. This resulted in increased access times as at March 2015 with demand in excess of the capacity of these specialty areas and backlogs accrued. I indicate that this position will deteriorate further if no funding is made available in 2015/16 for areas with agreed capacity gaps.

12.17 To ensure Trust Board was properly appraised on both serious concerns and the Trust's compliance with performance against current standards of clinical care and safety (as that applies to the quality and safety of care as opposed to waiting time standards of care), as Acting Chief Executive from 1 September 2009, I commissioned a Trust-wide review of the Clinical and Social Care Governance arrangements in the Trust in March 2010, as detailed in my response to Question 7.

12.18 The recommendation of this Review and the subsequent changes to implement same set out how the Trust Board and Governance Committee would be appraised on matters of serious concern and adherence to applicable standards for clinical care and safety.

12.19 I was assured as Chief Executive and, though the implementation of this Review was able to assure Trust Board, that the clinical governance systems in place during my tenure were adequate. This included a revised suite of Reports to Governance Committee and Trust Board as detailed in the Schedule of Reporting to Governance Committee 2014/15 *[7. 2014-2015 Schedule of Reporting to Governance Committee located in S21 10 of 2022 Attachments]* and includes:

- Incident and Complaints Management Report and Update on Ombudsman Cases
- Serious Adverse Incident Report
- Corporate Risk Register
- Professional Governance Reports from the Medical Director (with included Health Care Acquired Infection, Patient Safety Interventions, Medical Workforce and Litigation), the Executive Director of Nursing & AHPs and the Executive Director of Social Work.
- Accountability Report for Standards and Guidelines
- Annual Mortality Review

12.20 I have reviewed a sample of the minutes of the Governance Committees between May 2011 and December 2012 and can confirm that the Clinical Governance reports to Governance Committee included:

- The Corporate Risk Register, the most recent version following the monthly update and review at SMT Governance meetings.
- Report on Incident and Complaints Management presented by the Assistant Director for Clinical and Social Care Governance (AD CSCG – Debbie Burns for this period) who reported independently to me as Chief Executive on 'fitness for purpose' of Clinical & Social Care Governance arrangements in the SHSCT.
- A quarterly report on Serious Adverse Incidents, presented by the Assistant Director for Clinical & Social Care Governance.

- Accountability Report on Trust compliance with Standards & Guidelines, presented by the Assistant Director for Clinical & Social Care Governance twice per year.
- The recommendations and action plans from service or functional reviews and inspections by the Regulation & Quality Improvement Authority (RQIA) and other inspection bodies.
- Professional Governance Reports from the relevant Executive Director on their areas of professional responsibility and Trust leadership of functions:
    - Medical Director Report (medical workforce including medical appraisal, revalidation, Trust Lead for Infection Prevention and Control)
    - Social Work and Social Care (Lead Director for Social Work)
    - Nursing and AHP Workforce and competence (Lead Director for Nursing and AHPs)

12.21 I ensured the Board was assured on the Trust's compliance on standards and guidelines through the Accountability Report for Standards and Guidelines (referenced above) which went to the Governance Committee twice yearly. I have reviewed an example of this report for 01 January 2012 to 30 April 2012 *[8. 20120514 Briefing for ST End Year Strategic Review and Accountability meeting S and G report located in S21 10 of 2022 Attachments].* Page 3 of this report refers to the new SHSCT processes for the management of standards and guidelines and the creation of a Trust Standards & Guidelines Prioritisation and Risk Review Group, with the aim of ensuring that the Trust had in place a systematic and integrated approach for the implementation, monitoring and assurance of clinical standards and guidelines. The Terms of Reference of this Group are detailed in Appendix 1 and an algorithm for communication and approval processes is included in Appendix 2, with a risk assessment proforma to include the outcomes/decisions of the Group included in Appendix 3.

- The first meeting of this Group was in April 2012 and the Group was chaired by the Assistant Director for Clinical & Social Care Governance who reported to me as Chief Executive.
- The report details that in this period the Trust received 57 new standards and guidelines from DHSSPS or other external agencies, and Table 1 provides a summary by title, agency, and relevance to the Directorates in the Trust.

- Of these 57, 28 were issued with a requirement to provide a response on assurance to the Health and Social Care Board within a specified time period. The report provides the level of compliance assessed with an accompanying action plan outlining the work required to achieve full compliance status, which was required to be sent to Director and SMT for approval

12.22 On matters of serious concern, as Chief Executive it was my practice to informally advise the Trust Chair on any serious concerns as soon as they arose. I ensured that myself or the relevant Director brought any such matters to the Trust Board's attention at the earliest possible stage of being alerted to these concerns, either under the confidential section of Trust Board meetings or the confidential section of Governance Committee, thus ensuring the Chair and Trust Board members were kept fully informed of any significant concerns affecting the Trust. Updates on these concerns would be provided at subsequent meetings as appropriate.

12.23 I have requested and received from the SHSCT PI Team the Trust Board minutes, Trust Board Confidential Minutes and Governance Committee minutes of during my five and a half years in tenure as Chief Executive, and I have reviewed these as they provide strong evidence of this practice. Examples include alerting the Board to the regional incident of pseudomonas as referred to in my response to Question 30, and my verbal update on several recent Serious Adverse Incidents to Confidential Governance Committee on 18 January 2011 under Item 4 Any Other Business *[9. 20101207 (20110118) Confidential Governance Committee minutes located in S21 10 of 2022 Attachments].*

12.24 I further ensured that the Board was consistently appraised on both serious concerns and adherence to the current standards by:

- The clarification of governance roles in 'A System of Trust' and the clear responsibility on the relevant Directors to provide assurance on compliance with current standards to SMT, Governance and Trust Board on their areas of responsibility, to report any issues of concern in these meetings, and to bring forward action plans for the reduction and mitigation of risk.
- Examples of how this happened in practice are recorded in the Schedule of Reporting to Trust Board for 2014/15 *[7. 2014-2015 Schedule of Reporting to*

*Governance Committee located in S21 10 of 2022 Attachments]* which was my last year as Chief Executive with SHSCT. This list is not exhaustive, as issues were raised under Any Other Business and in Trust Board Confidential Section.

- The regular reports to Trust Board under the Agenda Section on Patient and Client Safety and Quality of Care included:
    - Medical Director's Report (monthly)
    - Health Care Acquired Infection report by Medical Director (monthly)
    - GMC Trainee Survey presented to Trust Board meeting 27November 2014
    - Director of Nursing & AHP report: Nursing Quality Indicators 14 June 2014
    - Update on Key Nursing and Midwifery Governance activity, Workforce Development and Training; report by Director of Nursing & AHPs 25th Sept '14
    - Report on compliance of AHPs with Core Professional Specific AHP Quality Indicators; report by Director of Nursing & AHPs October '13
    - Trust Annual Quality Report 2013/14; Medical Director and Director of Performance & Reform on 23 October 2014.
- A monthly Performance Report was presented at each Trust Board meeting which highlighted areas of compliance and flagged service that were not compliant with the Commissioner's Priority for Action Targets (including performance against waiting times for Inpatient, Outpatient, Diagnostic services), with analysis of cause and actions to address.
- All minutes of Mid-Year and Year End Accountability meetings went to Governance Committee and Trust Board.
- The Annual Report and Statement of Internal Control was considered and approved by the Board each year.
- Board Assurance Reports to Trust Board, with a year-end report on compliance with Control Assurance Standards, including the 3 core standards which included Governance and Risk Management which were independently verified by Independent Audit.
- The reports to Governance Committee are detailed above.

Again, this list is not exhaustive, as many issues arose that required specific briefing and reporting to Trust Board.

12.25 While no system is perfect, I believe the clinical governance systems in place during my tenure as Chief Executive were robust (as evidenced by annual independent audit of the Controls Assurance Standards for Governance and Risk Management) and fit for purpose.

12.26 As further assurance, I refer to the Trust's Annual Report for 2014/5, referenced in paragraph 12.2, and the reference on page 57 to a Serious Adverse Incident Lookback Exercise commissioned by the Minister for Health in April 2014. The Minister instructed all Trusts in Northern Ireland to undertake a number of actions to review all Serious Adverse Incidents reported between January 2009 and December 2014 and to provide information for each case as regards to patient/client involvement, statutory requirement to inform the Coroner, and appropriate referral of the case to other agencies. The information provided by SHSCT as part of this Lookback Exercise was independently quality assured by our regulator, the Regional Quality & Improvement Agency (RQIA) and no areas of concern had been highlighted to the Trust at the time of the Annual Report being finalised.

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

13.1 During my tenure as Chief Executive, the Trust Board oversaw the performance of the Trust against Ministerial standards. A monthly Performance Report was compiled by the Director of Performance and Reform, which detailed the performance of Trust services against the performance targets set by DHSSPS, highlighting those services performing well and those who were not meeting these targets. This monthly report was scrutinised by the Senior Management Team, which I chaired, and then was presented at each meeting of Trust Board (usually monthly) for scrutiny and challenge to myself as Chief Executive and the relevant Directors.

13.2 I have requested and received from the SHSCT PI Team a selection of Board Performance Reports during my tenure and have reviewed same to remind myself of the reported content on the Trust's performance. As an example I refer to reported

performance for February 2015 in the March 2015 Board Performance Report *[10. 20150326 Performance Report a located in S21 10 of 2022 Attachments].* Page 16 and 16 of this Report specifically analyse outpatient performance against commissioner targets, and the action to address underperformance.

13.3 In addition to this formal monthly report, there was a variety of ways in the Board was appraised of individuals or services that were performing well. These included:

- Under 'Chair's Business' or 'Any Other Business', myself and other Directors would have provided the Chair with information on any significant external recognition of staff or services, including awards, feedback from visits by DHSSPS officials and Health Minister, external experts, etc.
- The annual Trust Excellence Awards
- The annual Quality Improvement Forum
- The outcome of inspections by external regulators such as Regulation, Quality & Improvement Authority (RQIA), action plans to address any recommendations from these inspections would have been discussed and challenged initially at Governance Committee and then at Trust Board if necessary.

**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 On my appointment as Interim Chief Executive on 1 September 2009 I was required to attend comprehensive training on my responsibilities as Accounting Officer and to the best of my recollection I attended:

- CEF Public Accountability & Governance 12 October 2009
- Public Accountability and Governance for Accounting Officers 9 December 2009.

14.2 During my tenure as Chief Executive I attended many meetings and events to keep myself appraised of aspects of clinical governance, patient care and safety or any other risk factors relevant to the Trust's operational functioning. As an example, the Public Health Agency and DHSSPS organised a PEWS (Physiology Early Warning Scores) Workshop for Trust Chief Executives, Lead Clinicians and Governance

Officers on 5 October 2011, which I attended and co-chaired with Dr Michael McBride, Chief Medical Officer, DHSSPSNI.

**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 During my tenure as Chief Executive, I worked closely with the Chair of the Board, the Board Assurance Manager and the Assistant Director of Clinical and Social Care Governance to ensure the Senior Management Team, Governance Committee and Board members (Executive and Non-Executive) were kept up to date on clinical governance best practice by:

1. Regular briefings on topical issues of good clinical governance and the sharing of national and regional Inquiry reports at SMT, Governance Committee and Trust Board – examples being the two reports on the findings and recommendations from Mid Staffordshire Inquiry which triggered the Review of Clinical & Social Governance referred to in my response to Question 7.

   While too many to list in this document, I have provided below a sample of the reports to Governance Committee May 2011 – February 2013:

   - The report into Governance Concerns at the Western Health and Social Care Trust, the Public Inquiry into the outbreak of C Difficile in the Northern Health & Social Services Trust discussed at Governance Committee meeting 10 May 2011 *[11. 20110510 Approved Governance Committee minutes located in S21 10 of 2022 Attachments].*
   - The Dental Hospital Inquiry discussed on 6 September 2011 *[12. 20110906 Approved Governance Committee minutes located in S21 10 of 2022 Attachments].*
   - The Francis Inquiry Report, discussed at Governance Committee on 5 February 2013 *[13. 20130205 Approved Governance Committee minutes located in S21 10 of 2022 Attachments].*

2. Trust Board Workshops regularly included presentation and discussion on topical issues of clinical governance for learning. If required, examples of same during my tenure can be requested from Sandra Judt, Board Assurance Manager.

**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 In addition to the sharing of findings and recommendations from regional and national reviews, benchmarking the Trust against these recommendations, and presenting these to either Governance Committee or Trust Board, the findings and recommendations of Root Cause Analysis (RCA) Reports from significant incidents within the Trust were shared through Governance Committee, together with an action plan to address such recommendations. Examples of this practice can be evidenced through Governance Committee minutes. I cannot recall any RCAs or Significant Adverse Incidents specifically relating to Urology during my tenure as Chief Executive.

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

17.1 It was not a requirement of my role as Chief Executive that I undertook continuing professional development as this is a requirement of clinical staff. Please see my response to Question 14 in relation to training when I took up post as Acting Chief Executive in 2009 and ongoing.

**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 From May 2010 the responsibility for the management of Serious Adverse Incidents (SAIs) transferred from the Department of Health, Social Services and Public Safety (DHSSPS) to the Health and Social Care Board (HSCB) working jointly with the Public Health Agency (PHA) and collaboratively with the Regulation Quality Improvement Authority (RQIA). Learning reports were published twice a year and I

have reviewed an example of such a report for April – September 2011, when the HSCB received 145 SAIs *[14. Edition-01-SAI-Learning-Report-April-September-2011 located in S21 10 of 2022 Attachments]*

18.2 In this Learning report, Early Warning Scores is given as a current learning example (page 7). Early Warning Scores provide an early clinical alert of patient deterioration, and the Regional SAI Group felt that good practice needed to be reinforced as a number of SAIs had been associated with a failure to recognise a deteriorating patient. The Public Health Agency and DHSSPS organised a PEWS (Physiology Early Warning Scores) Workshop for Trust Chief Executives, Lead Clinicians and Governance Officers, which I attended and co-chaired with Dr Michael McBride, Chief Medical Officer, DHSSPSNI (programme for workshop on page 18 of report).

18.3 This report also confirms that in April 2010 the HSCB issued a procedure for 'Reporting and Follow up of Serious Adverse incidents' which set out the procedure of reporting, managing, investigating and reviewing of all SAIs during the course of business of an HSC organisation such as the SHSCT and required full implementation by 1 May 2010. This included:

- Regional reporting system to HSCB for all SAIs.
- The nomination of a Designated Review Officer (DRO) to review and scrutinse reports.
- Regional SAI Group meeting held on a bi-monthly basis to consider reports, identify learning and agree actions.
- Escalation process in respect of:
    - Deadlines for Investigation Reports
    - Assurances for action being taken by Trusts following the investigation.

To the best of my recollection, the SHSCT was compliant with this regional SAI procedure during my tenure.

18.4 In addition to the above process, Trust Chief Executives met monthly with the Chief Executive of the Health and Social Care Board (the commissioner of health and social care in Northern Ireland) and there were twice-yearly individual Trust

performance review meetings with DHSSPS (Mid-year Accountability Review and Year End Accountability Review), where specific issues of clinical governance assurance were required.

18.5 There were many ways of sharing good practice in Northern Ireland, with awards ceremonies hosted by Royal College of Nursing and others. Within the Southern Trust, an annual awards ceremony (Trust Excellence Awards) was held to recognise good practice and outstanding contributions by teams and staff.

18.6 During my tenure as Chief Executive of SHSCT, I believe there was a strong emphasis on robust sharing of information within Health and Social Care in Northern Ireland to assist in maintaining and enhancing clinical governance and overall patient care.

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

19.1 While no system is perfect, during my tenure as Chief Executive at SHSCT I believed the risk management arrangements were fit for purpose. I took further actions to assure myself and the Board that this was the case including the Trust-wide Review of Clinical and Social Care Governance referred to in my response to Question 7.

19.2 This included a review of risk management and the implementation of a defined risk management process. The Trust's Risk Management Strategy 2014 *[15. 201809 Risk Management Strategy, located in S21 10 of 2022 Attachments]* sets out that process. This described the process of corporate and Directorate risk management in place and the risk management process be taken forward by the Directorate Governance Co-ordinators and service teams under the relevant Director. A Directorate monthly Governance Forum, chaired by the Operational Director, was part of this process and was a key point for input by the members of the Executive Director teams to provide expert professional advice and guidance as well as a performance management role in relation to seeking assurance on workforce standards and an acceptable level of compliance with quality and safety indicators.

19.3 From this point forward, I was assured that the Trust at every level was aware of and support to have a mechanism for detection, prevention and contingency for risk and have a resolved position as to acceptable levels of risk which can be borne and those which should not. This was further underpinned by updated Risk Management Policy and procedures.

19.4 I refer to my response to Question 12 and the reference to the Controls Assurance Standards in Northern Ireland which were required to be annually reviewed and reported in the Trust's Annual Report, with 3 of the core Controls Assurance Standards (CAS) requiring to be independently reviewed by Internal Audit, namely Financial Management, Governance and Risk Management. I have confirmed that in the Annual Report for 2015/16 the Risk Assurance CAS was assessed as compliant and was independently assessed by Internal Audit and given a Satisfactory level of assurance.

19.5 I have reviewed the Trust's Annual Report and Accounts for year ended 31 March 2015 *[6. ANNUAL_REPORT_AND_ACCOUNTS_2014-15, located in S21 10 of 2022 Attachments ]* assured myself that the Core Controls Assurance Standards for Governance and Risk Management were independently audited and assessed. In reviewing this documentation and other sources provided by the SHSCT PI Team, I can confirm compliance levels for Risk Management Controls Assurance Standards in the following years.

- 2009/10 – substantive compliance (achieved for all 22 Control Assurance Standards)
- 2014/15 – substantive compliance (achieved for all 22 Control Assurance Standards)
- To the best of my recollection the intervening Annual Reports also confirmed substantive compliance for all 22 Control Assurance Standards

19.6 In addition to depending on the systems put in place to implement the Review, the Chair of the Trust Board, Roberta Brownlee, had instigated a process for Leadership Walks for Non-Executive Directors with a specific proforma to be completed following the event which captured any staff concerns about quality and safety and a check that staff knew how to raise concerns. These reports were shared

with me and I followed up with the relevant Director to provide a response on any concerns raised. An example of such a Leadership Walk for the Thorndale Unit (Urology) in May 2012 is included/has been provided [*16. 20120719 E Chairs Visit to In CAH and Thorndale CAH A located in S21 10 of 2022 Attachments].*

- Section 10 captures understanding of when and how to report an incident/error, which confirmed a good understanding by staff.
- Section 11 captures staff feedback on any concerns of staff on areas of risk.
- Section 12 asks about the timeliness of response when risks are escalated, in this example there were no concern.
- Section 13 asks about the staff getting support to manage the risks they are accountable for, in this example that was confirmed with no issues raised.

19.7 I also undertook a schedule of visits to front line services which were reported to Trust Board at each meeting.

**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 I believe there was extensive training, including in the Trust's induction and mandatory training in respect of the right and responsibility of staff at all levels to raise and report incidents. This is referred to in the Trust's Incident Management Procedure October 2014 *[17. 2014001 SHSCT Incident Management Procedure located in S21 10 of 2022 Attachments]* which sets out the roles and responsibilities for incident reporting at all levels in the Trust and provides the procedure for the identifying and reporting of incidents by all staff. I also believe that the Trust Board and Senior Management Team modelled and promoted this culture. There was ongoing work to promote the reporting and recording of incidents and investment (such as in DATIX an electronic web-based reporting system) to make it easier for staff to report incidents and that these would be properly escalated and addressed.

20.2 I recall one specific event that prompted a Trust Board discussion on how staff were supported to complain and raise concerns. This was where a member of staff (allegedly) approached the Nolan Show raising concerns about the reading of radiology reports by Emergency Department administrative staff. This was fully and openly discussed at a Trust Board meeting on 24 February 2011 *[18. 20110224 TB Public Minutes located in S21 10 of 2022 Attachments]* with clinical leaders from Radiology and the Emergency Department in attendance and providing assurance to Trust Board that these anonymous concerns had been fully investigated and found to be without basis in fact.

20.3 In this meeting Board members also discussed the importance of learning from this event, with work agreed to improve the channels of communication for all staff to raise concerns. A staff briefing on raising concerns was included in the next staff e-brief. The Trust's Whistleblowing Policy was discussed and some amendments were agreed including a nominated Non-Executive Director as a named contact for staff to raise concerns, which was to be included in the revision of this policy in early 2011.

20.4 I believe the Trust Board and Senior Management Team were fully aware of the importance of encouraging the reporting of incidents and concerns and demonstrated their appetite to address the learning from incidents through Governance Committee and Trust Board discussions.

**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 In my response to Question 12 in paragraph 12.11 I have referred to the time allocated at Board meetings to reflect on innovative practice in relation to quality improvement. In paragraphs 12.3 and 12.4 of this response I have also referred to the role and function of the Trust's Governance Committee as the overarching Board Sub-Committee responsible for providing assurance to the Board on all matters of governance (with the exception of financial governance which was the role of the Audit Committee) and the reports to Governance Committee in relation to same.

21.2 The clinical and social care governance information presented to Governance Committee and Trust Board, as detailed in paragraph 12.19 and 12.20 of my response

to Question 12, included recognition of good practice and recommendations for action and improvement which reflected a continued focus on learning throughout the Trust's services.

21.3 The Chairman and I made a concerted effort to celebrate the services and functions of the Trust that were working well and the recognition and commendation of staff and services that were recognised as innovative and providing excellent quality of care. This included recognition at Trust Board meetings of regional and national awards to Trust staff and services, regular presentations by staff to highlight innovation and best practice, and the recognition of this in reports to Governance Committee and Trust Board.

21.4 Examples are included in my response to Question 13 and include:

- Annual Trust Quality Improvement Forum
- Annual Trust Excellence Awards
- Sponsoring staff applications for, and attendance at, Regional and National Awards such as the Lean Academy and RCN Nurse of the Year Awards
- Staff presentations to Trust Board.

**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 During my tenure as Chief Executive at SHSCT I believed the safety and quality monitoring systems were fit for purpose, and I took further actions to assure myself and the Board that this was the case. This included the Review of Clinical & Social Care Governance 'A System of Trust' which I refer to in paragraph 7.1 of my response to Question 7.

22.2 In terms of the specifics of quality and safety monitoring systems I refer to the system of monitoring and reporting to Trust Board and Governance Committee as described in my response to Question 12. There was an extensive suite of indicators of patient safety and quality monitored and reported by the Medical Director as Lead Director for Infection Prevention & Control, oversight of patient safety indicators and initiatives, and benchmarking and reporting the Trust's clinical quality outcomes.

22.3 In signing the Annual Report and Accounts each year of my tenure (as referred to in Question 12) I confirmed that to the best of my knowledge that governance systems such as for quality and safety were effective.

22.4 I found the benchmarking of the Trust's outcomes against Northern Ireland and National averages to be particularly helpful, such as the Medical Director's report on clinical indicators and presentations by Trust staff such as that given to the Trust Board on 29 April 2010 Agenda item 5iv) *[19. 20100429 TB Public minutes located in S21 10 of 2022 Attachments]* on Clinical Indicators for Cardiology and Clinical Governance within the SHSCT Cardiology Department and presented by Dr David McNeaney, SHSCT Consultant Cardiologist.

22.5 As further external assurance, SHSCT invested in membership of Comparative Health Knowledge Systems (CHKS) which was an organisation that facilitated external benchmarking of hospital-based safety and quality data against a UK peer group of like hospitals for its members and provided annual reporting on a range of key performance indicators including efficiency and safety measure and quarterly reporting on mortality.

22.6 The outcomes of the SHSCT's performance in this national benchmarking were reported to Trust Board through a range of reports, including the Medical Director's report on Patient Safety. Through this process, which included performance against a balance of access and quality metrics, the SHSCT was assessed under a range of over 20 indicators (clinical effectiveness, health outcomes, efficiency, patient experience and quality of care) as being in the Top 40 Hospitals in the UK during my tenure as Chief Executive (CHKS Top 40 Hospital for 5 years running up to 2016).

22.7 This approach to benchmarking enabled the Trust to assess its outcomes of clinical safety and quality against peer group services in other Trusts across the UK,

promoting the identification of areas for improvement and giving Trust Board recognition where services were performing well. I believe this approach encouraged staff to provide the best possible care within the resources they had available, understanding how they compared against their peers and taking learning on how to innovate and improve.

22.8 Systems that were improved during my tenure as Chief Executive included:

- A redesign of the Trust's Morbidity and Mortality (M&M) process, which is traditionally doctors only came together to discuss and learn from clinical outcomes and deaths, making this a wider meeting to include nurses and other clinical staff and refocusing on 'lessons learned' and discussions about how to reduce the risk of poor clinical outcomes and avoidable deaths through improvements to patient safety. This new approach was completed and presented to Governance Committee on 6 December 2011 *[20. 20111206 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* as one of the key changes under the Review of Clinical & Social Care Governance referred to in paragraph 7.1 of my response to Question 7.
- A Review of the Trust's Litigation system to ensure closer links with operational services and improved sharing of information on learning from the findings and outcomes of Litigation cases against the Trust.

22.9 Within the Southern Trust, an annual Excellence Awards ceremony was held to recognise good practice and outstanding contributions by teams and staff, which was judged by Board members and allowed them to meet with those nominated and learn about their work.

22.10 In terms of direct observations and conversations with clinical staff on the ground I had a schedule of visits to front line services which were reported to Trust Board at every meeting and any issues followed up with the relevant Director. In my response to Question 10, I have referred to my engagement with medical staff and Trade Union representatives and the meetings I attended. The Chair of the Trust Board, Roberta Brownlee, also instigated a process of direct observations via Leadership Walks by Non-Executive Directors with a specific proforma to be completed following the event which captured any staff concerns about quality and

safety and a check that staff knew how to raise concerns. This was shared with me after each Leadership Walk. I discussed any issues or concerns raised with the relevant Director and reported their feedback and actions to the Chair. A specific example of issues discussed with staff in a Leadership Walk in urology services is referenced in paragraph 19.6 of my response to Question 19.

22.11 As the Senior Leadership Team, Directors also had a schedule of visits to front line services across the Trust to speak with staff about the challenges and successes in delivering their service.

22.12 The Trust's Annual Quality Improvement Forum and Annual Excellence Awards also provided a vehicle for discussions with staff on their successes and challenges.

**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 During my tenure as Chief Executive of SHSCT, I had the following time dedicated to discussing governance issues:

- At the weekly SMT meeting which lasted 3 to 4 hours, governance was a key part of our weekly discussions and once a month the SMT meeting was focused solely on Governance (SMT Governance monthly meeting lasted 3-4 hours). All Governance Committee papers came to SMT Governance quarterly for check and challenge before issue.
- A regular meeting with the Trust Board Chair to discuss the management and performance of the Trust, including any significant governance issues she needed to be made aware of.
- The Board's Governance Committee was quarterly and could last over 5 hours, and all Directors attended to present their specific governance reports.
- I held monthly individual meetings with each Director for 1 – 2 hours, and governance issues would have taken up at least half this time.
- Trust Board was held monthly, usually lasting 4 – 5 hours with usually 2 hours on governance issues.

- Trust Board workshops were held every 2 – 3 months and strategic governance issues would be presented and discussed for awareness, learning and debate as to the Trust's position.

23.2 I would estimate from memory and as conservative estimate I spent up to two days per week talking to my Senior Management Team, DHSSPS and HSCB and Trust Board about governance issues, more if this included financial governance.

**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 Staff generally raised issues of clinical governance through discussion at Directorate Governance Forums and/or used the Trust processes (incident reporting, whistleblowing, etc). I also picked up issues directly from staff who raised these with me on my visits to services and staff teams, in writing or in informal conversation as I tried my best to be visible within the Trust. Where any significant concerns were raised during my visits to Trust services and teams, I would follow up with the relevant Director and, if relevant, the Assistant Director of Clinical & Social Care Governance to ensure any concerns were addressed.

24.2 I have given an example of my response to a concern raised informally with me in paragraph 35.4 of my response to Question 35, which details the response generated by informal concerns being raised with me by the Trust's Infection Prevention & Control Clinical Director about the proposed closure of the Trust's isolation ward.

**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.**

I have referred to the Trust's systems and processes to assess compliance with clinical governance standards and my process of oversight in my response to Question 12. Key examples include

- The monthly SMT review of the Corporate Risk Register and the discussions on escalation or de-escalation of risks from Directorate Risk Registers, an example being the review of the Corporate Risk Register presented to the Governance Committee on 9 September 2014 *[21. 20140909 CRR a located in S21 10 of 2022 Attachments]* which had been reviewed at SMT three times since the last Governance Committee and listed the new and revised corporate risks within the Trust.
- Serious Adverse Incident reports.
- The Accountability Report on the Trust's Compliance with Standards & Guidelines.
- The schedule of internal audits within the Trust.
- The compliance with the Control Assurance Standards for Governance and Risk Management.

**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 have referred to the Trust's systems and processes to assess compliance with clinical governance standards and the process through which issues of significant concern pass through the corporate clinical governance structures in my response to Question 12.

26.2 I have provided a specific example of where there were clinical quality and safety concerns in respect of urology in paragraph 97.2(1) of my response to Question 97, and have described the process whereby this was initially identified by the Medical Director, who led professional discussions with the clinicians involved, an escalation to the Chief Executive when the changes needed could not be promptly resolved, an action plan by the Director of Acute Services to implement the necessary change in

service, and alerts and assurance on the progress of change to Trust Board and Governance Committee.

26.3 I have provided a further example of the response to a concern raised informally with me in paragraph 35.4 of my response to Question 35, which details the response generated by patient safety concerns being raised by the Trust's Infection Prevention & Control Clinical Director about the proposed closure of the Trust's isolation ward.

**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 In respect of my role as Chief Executive, my engagement with the Trust Board can be summarised as:

- Regular meetings with the Chair, formal and informal.
- Attendance at Board Sub-Committees including Governance Committee
- Trust Board meetings
- Board Development workshops

27.2 Outside these formal meetings, I had informal contact with non-Executive Directors of the Trust Board on a regular basis, and with Executive Directors through SMT and individual meetings as described in my response to Question 9.

**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 During my tenure as Chief Executive, I held overall organisational responsibility for clinical governance and patient safety. My response to Question 12 describes the governance arrangements at Board level and in paragraph 12.4 the role of the Governance Committee.

28.2 Paragraph 7.2 of my response to Question 7 describes the specific operational and professional governance responsibilities of Directors I managed as follows:

- Operational Directors, including the Director of Acute Services, were responsible for performance against Departmental targets such as waiting times for care and for reporting, actioning (ie learning from and mitigating risk), managing and monitoring patient and client safety and quality of care. This includes the management of incidents, complaints and risk registers, and accountability for implementing appropriate clinical audit and monitoring and reporting against agreed clinical indicators and agreed safety standards. The Directors of Acute Services during my tenure as Chief Executive are listed in my response to Question 7.
- Professional Executive Directors (Medical Director/Responsible Officer, Director of Nursing and AHP Services and Director of Social Work) who were responsible for provision of expert professional advice, audit and consultancy, monitoring and reporting the standard of the relevant registered workforce (medical, nursing, social work and AHP), provide independent assurance on compliance with workforce standards and a corporate alert function, providing expertise advice and assurance on training and development and an adequately skilled workforce. The Professional Executive Directors during my tenure as Chief Executive are listed in my response to Question 7.

28.3 The implementation of the above Review brought the Corporate function of Clinical and Social Care Governance Co-ordination and Overview under my responsibility as Chief Executive. This was in practice a central point for co-ordination with Operational Directors responsible and accountable for implementation and included:

- Co-ordination of standards, guidelines, NICE, Safety Alert Broadcasts, RQIA recommendations/reviews and regional and national reviews.
- Monitoring and reporting of complaints, incidents, risk, audit, clinical indicators, patient safety and learning systems.

28.4 During the tenure of my post as Chief Executive, the Board Assurance Manager role was undertaken by:

- Mrs Jennifer Holmes, Board Secretary with responsibility for Board Assurance, in post until 31 March 2010 and reporting to me as Chief Executive. Mrs Holmes' Job Description is available *[22. Employment Info for SJ and JH located in S21 10 of 2022 Attachments]*
- Mrs Sandra Judt, Board Assurance Manager, appointed substantively in May 2012 and reporting to Trust Board Chair. Mrs Judt was still in post until I left the Trust on 31 March 2015. Mrs Judt's Job Description is available *[22. Employment Info for SJ and JH located in S21 10 of 2022 Attachments]*

**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 refer to my response to Question 12 for the context of governance arrangements within SHSCT, with the key governance reports that provided an overview of clinical governance assurance and any issues in paragraphs 12.19 and 12.10, these reports would be the usual route for alerting the Governance Committee and Board of any problems regarding clinical governance.

29.2 During my tenure as Chief Executive of SHSCT, when I was made aware of any significant issues of concern, in respect of clinical governance or other issues, that were of an urgent nature I reported this to the Chair of the Board either directly by phone or appointment or in our regular meeting. As necessary, and as agreed with the Chair, either the lead Director or I as Chief Executive would brief Trust Board or Governance Committee (whichever soonest).

29.3 I believe the mechanisms for alerting the Board to governance problems were robust during my tenure, and these were further strengthened as an outcome of the Review of Clinical and Social Care Governance previously referenced under Question 7.

**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 In a Trust of the size and complexity of SHSCT, it was a constant focus of my tenure as Chief Executive to ensure services were being safely delivered. To me that was the 'bottom line' and an absolute requirement despite the many financial and workforce challenges facing the Trust.

30.2 To give an example of a specific challenge in relation to service safety, I have included the Trust Chronology of Events within the SHSCT *[23. 20120226 Pseudomonas – Trust Chronology of events Timeline – updated 3feb2012 located in S21 10 of 2022 Attachments]* in relation to a regional pseudomonas infection incident resulting in colonization of babies in Neonatal Units in Northern Ireland, including the SHSCT. The chronology of events describes the leadership of myself as Chief Executive and that of my Medical Director who was my designated Lead Director for Infection Control, and the many meetings we attended with staff to ensure this risk was being effectively managed, and evidence of investment sought from HSCB *[24. 20130829 E and IPT SHSCT Pseudomonas 5 Aug 13 A located in S21 10 of 2022 Attachments]* to address this risk.

30.3 It was my practice as Chief Executive to get actively involved and be visible to staff when such significant incidents occurred, attending or chairing meetings to demonstrate leadership and Board support to affected staff, and proactively ensuring they had the resources they needed to do their job well.

30.4 I regularly updated the Chair and Trust Board on such significant issues. I have requested and been provided by the SHSCT PI Team the minutes of the relevant meeting of Trust Board and Governance Committee where Pseudomonas was discussed, which I have reviewed to provide assurance that both Trust Board and Governance Committee were kept well informed about this incident and the Trust's response to it. These are summarised below:

- The minutes of the Governance Committee on 7 February 2012 *[25. 20120207 Approved Governance Committee minutes located in S21 10 of 2022 Attachments],* under Agenda Item 4: Infection Control – Pseudomonas Update, I referred members to communications in their papers from the Chief Medical Officer in relation to water sources and the potential risk to patients issued since 15th September 2010. I drew members' attention to the Trust's written responses to

these circulars and advices and noted that these evidence that the content of these were fully considered and appropriately responded to. I provided members with a timeline of recent events:

- 27.1.2012 - Telephone call from Dr Harper and receipt of PHA interim advice
- 28.1.2012 – Incident Control Team established
- Further CMO guidance received 3.2.2012
- All actions on PHA interim advice completed
- The Trust continues to work with the Public Health Agency and the Chief Medical Officer's office and proactive measures are in place.

I confirmed that whilst no babies in the neonatal unit at Craigavon Area Hospital were infected with pseudomonas, three babies have been colonized. In this meeting Dr Simpson, Medical Director, said that:

> *"the speed and flexibility with which the Trust responded to Pseudomonas is to be commended. He advised that the Regulation & Quality Improvement Agency (RQIA) would be undertaking an independent review of the incidents of Pseudomonas in Northern Ireland.*

In this meeting I paid tribute to the commitment and hard work by all staff involved across both sites and advised that a progress update will be given at Trust Board meeting on 1st March 2012. Under Agenda Item 5 of this same meeting: Corporate Risk Register (CRR) I reported that the Corporate Risk Register was last reviewed and updated at the SMT Governance meeting on 25th January 2012. I confirmed that risk issues in relation to pseudomonas would be fully considered at the next SMT review of the CRR.

- The minutes of Trust Board on 1 March 2012 *[26. 20120301 TB Public Minutes located in S21 10 of 2022 Attachments]* provide evidence that I updated the Board as follows under Agenda Item 4: Chief Executive Business:

> *Pseudomonas: Mrs McAlinden updated members on the current position. She advised that there have been no new colonisations since those swabbed on 20th January 2012. The Trust's Incident Control Team has now been formally stood down and any outstanding actions will be taken forward within the Trust's*

*HCAI structures. The work of the Internal Review Team is ongoing and recently attended a round table discussion to finalise the documentation required for the RQIA Review. Mrs McAlinden acknowledged the efforts of those involved in compiling the documentation and particularly thanked Mrs McVeigh and Mr Graham for their input. Mrs McAlinden advised of Professor Troop's visit to the Trust the previous day which included a visit to the Neonatal Unit in Craigavon Area Hospital. Part of the discussion had focused on the HCAI culture within the Trust and how staff raise concerns on infection control issues. Mr Graham stated that Professor Troop was impressed with the Trust's HCAI culture and the Chairman paid tribute to the Chief Executive and Directors for their leadership in this regard.*

The Chair of the Governance Committee, Dr Mullen Non-Executive Director, in presenting the minutes of the Governance Committee meeting of 6 December 2011, advised the Trust Board that assurance had been received on the Trust's management of Legionella in water systems and provided verbal feedback on the Governance Committee held on 7 February 2012 *[25. 20120207 Approved Governance Committee minutes].* He advised that the key issues discussed included Pseudomonas and the potential infection risk from water sources.

- At the Governance Committee meeting on 15 May 2012 *[27. 20120515 Approved Governance Committee minutes]* I presented the Corporate Risk Register which had been reviewed by the Senior Management Team and updated on 2 May 2012. The following extract from the minutes details the level of discussion:

  *Mrs Mahood, Non-Executive Director, referred to the moderate status of the risk associated with water borne pathogens and sought assurance that sufficient actions were being taken to mitigate this risk. Mrs Clarke, Director of Performance & Reform and the lead Director for Estates, advised that following a rigorous risk assessment, a range of actions have been identified, some of which will be ongoing.*

  At this same meeting, under Agenda Item 11 (RQIA Reviews – Status Update), Committee Members discussed the update in their papers on the Regulation & Quality Improvement Agency (RQIA) Reviews, including the Independent Review

of Pseudomonas and the Trust's associated review of the Pseudomonas Action Plan (Appendix 1) which recorded a position as 'green' (acceptable) against 9 of the RQIA recommendations as at 5th April 2012.

- The minutes of Governance Committee on 15 May 2012 *[27. 20120515 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* and the Confidential Meeting of Trust Board on the same day *[28. 20120515 Confidential minutes located in S21 10 of 2022 Attachments]* evidences my briefings on pseudomonas, the review of the Corporate Risk Register to include this risk, and follow up actions through the appointment of an internal review team, including a Non-Executive Director for independent assurance to the Trust Board, to assess the Trust's response to the regional pseudomonas incident and to identify any learning. The Review Team concluded that the Trust's response was timely and effective, and the proactive approach adopted by senior management, clinical teams and support services was to be commended.
- At Trust Board on 14 June 2012 *[29. 20120614 TB Public Minutes located in S21 10 of 2022 Attachments]* Dr Simpson updated the Board under the Medical Director Report: Infection Control update on the Regulation & Quality Improvement Agency's (RQIA) Independent Review of Pseudomonas.

  *Dr Simpson advised that Trust representatives had met with the RQIA Pseudomonas Review Team on 16th May 2012 to discuss items under the second phase of the review. The Trust has confirmed compliance with all relevant recommendations from the first phase of the review and issued a range of best practice guidelines to call clinical staff bases on the learning.*

30.5 The learning from this incident resulted in the establishment of Standard & Guidelines Prioritisation and Risk Review Group, as referred to in paragraph 12.21 of my response to Question 12, to ensure a systematic and integrated approach to the implementation, monitoring and assurance of standards and guidelines, with any constraints limiting the Trust's ability to comply being highlighted. This was subsequently implemented through the Standards & Guidelines Report to Governance Committee, and I have referenced an example of this report in paragraph 12.21 of my response to Question 12.

**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 As detailed in my response to Question 7, in March 2010 I commissioned a Trust-wide review of Clinical and Social Care Governance (CSCG) with the remit to critically appraise the Trust's current operational and assurance systems for clinical and social care governance, including processes, capacity, capability and outcomes from the current system.

31.2 Triggers for the review included:

- An internal review of the assurance mechanisms for CSCG which recommended structural change, including the appointment of a Head of Governance, to improve co-ordination and assurance mechanisms.
- Concerns and issues raised through engagement with professional teams about the effectiveness of the Trust's current CSCG systems and processes, and their understanding and ownership of same.
- The Trust's desire to ensure that recommendations and learning from independent inquiries relating to CSCG issues, such as the Mid Staffordshire NHS Foundation Trust Inquiry, should be assessed and acted upon.

31.3 During the latter half of 2009, a diagnostic was undertaken in the Trust to benchmark the Trust's systems of care against the initial Mid Staffordshire Report (2009) which detailed at a very operational level what had actually occurred in that organisation. This diagnostic was presented to Governance Committee and found that, although there were no major operational issues related to patient safety and quality of care, a number of significant system and organisational issues were emerging, including:

- The (Mid Staffordshire) Trust's ability to capture and report issues of safety and quality of care in a systematic and timely way.
- At service team level, a lack of understanding of the roles and responsibilities for clinical and social care governance within the (Mid Staffordshire) Trust resulting in

a lack of confidence and ownership of their role, combined with a lack of capacity to respond to the increasing CSCG agenda.

- The respective roles and responsibilities for the provision of professional guidance and advice to the (Mid Staffordshire) organisation and the responsibility and accountability for the delivery of safe and quality care and workforce standards were not clear.
- A lack of a proactive, co-ordinated approach across Directorates and the (mid Staffordshire) Trust as a whole to the identification and management of safety and quality concerns.

31.4 During this diagnostic phase, the second Mid Staffordshire Report (2010) was issued which provided an in-depth analysis of the underlying organisational and structural causes of the quality and safety issued experienced in that Trust (Mid Staffordshire). These included:

- Poor and overly complex structures for CSCG which had little clinical engagement or support, and which did not provide SMT and Trust Board of Mid Staffordshire with robust and timely information on compliance with safety and quality standards.
- The lack of effective systems to inform the SMT and Trust Board of Mid Staffordshire of safety issues, service or workforce risk.

31.5 Key governance principles were subsequently discussed and agreed by the SHSCT Senior Management Team and approved by the Trust Board, including:

- Effective decision making as close to the point of service delivery as possible.
- Clarity of responsibility and clear lines of accountability.
- Agreement and understanding of the 'Professional' Executive role and responsibilities.
- The operational management of services carries the responsibility and accountability for the safety and quality of those services and of the workforce delivering the care, supported by the Executive Directors in relation to professional workforce matters.
- Clear arrangements for shared learning across the Trust.
- Effective organisational intelligence must be available both corporately and at all levels in the Trust.

- These principles were underpinned by a continued commitment to a culture of openness, transparency and fairness.

The outcome of this phase of the Review was an agreement to three core components of CSCG which is included on Page 8 of the Review document 'A System of Trust' *[3. A System of Trust – CSCG Review located in S21 10 of 2022 Attachments].* Following a period of consultation with staff affected by the proposed changes, the Review recommendations were implemented in 2011.

31.6 To aid my recollection I have requested from the SHSCT PI Team and re-read the findings and recommendations of this Review *[3. A System of Trust – review of CSCG located in S21 10 of 2022 Attachments]* which were approved by Governance Committee in September 2010, and the recommended changes included:

- Clarity and understanding of the Professional Executive Functions and accountabilities of the Medical Director, Director of Nursing and AHPs and Director of Social Work.
- Clarity and understanding of the Operational Directors' accountabilities for reporting, actioning, managing and monitoring patient and client safety and quality of care, including the reporting and management of incidents, complaints and risk registers.
- The establishment of Directorate Governance Fora.
- The replacement of the then paper based system of recording and then transfer to a remote information management system (Datix) was replaced by a web-based version of Datix which was to be available on clinical desktops for immediate capturing and follow-up of incidents, complaints and risk. An assurance update and presentation on the implementation of the Datix Web system was subsequently given at the Governance Committee meeting on 4 December 2012 *[30. 20121204 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* under Agenda Item 5 detailing the establishment of a Datix Web Project Group and referencing the use of Datix Web to improve the recording of incidents of inpatient falls as one of 4 Clinical Improvement Projects.
- Strengthened links between the Litigation team and operational teams to support operational action and learning of lessons on issues arising from Litigation.

Subsequently at the Governance Committee meeting of 4 December 2012 *[30. 20121204 Approved Governance Committee minutes located in S21 10 of 2022 Attachments*] Dr Simpson, under Agenda Item 8 Medical Director Report, confirmed that a Litigation reporting system is being developed as part of the relationship between himself, Governance Leads and Service Directors to ensure that lessons from litigation have been shared and embedded within the Trust.

- Each operational Director was resourced with an additional Band 8 member of staff to assist with their CSCG responsibilities.
- The roles of Associate Medical Directors, Assistant Directors and Heads of Service were strengthened in terms of the roles and accountabilities for CSCG.
- A Corporate Coordinating Function was established under myself as Chief Executive, specifically to provide corporate intelligence and oversight in relation to trends, exceptions, and Trust-wide issues arising from non-compliance with standards of care, incidents, complaints, risk and audit. This also included a single corporate point of receipt, compliance testing and action planning for all standards, guidelines, NICE, Safety Alert Broadcasts, RQIA recommendation/reviews and Regional and National reviews. This function was led by a Senior Manager (Assistant Director for Clinical and Social Care Governance) who was line managed by me as Chief Executive to ensure the ability to act corporately and independently, and provide, through me as CX, arbitration in cases of non-compliance or dispute.
- The establishment of a Governance Working Group in 2012, chaired by the Assistant Director of Clinical and Social Care Governance, with 45 members from across the Trust including clinicians, management, Litigation and Human Resources bringing together all Directorates, professions and expertise in the Trust to plan, implement and monitor Clinical and Social Care Governance issues.

31.7 These changes ensured that SMT Governance and Governance Committee, and ultimately Trust Board, were provided with the capacity to focus on strategic and operational direction of clinical and social care governance based on good intelligence and sound information, and focused on critical issues, organisational risks and decisions making on clinical and social care governance issues. I believe these changes also raised awareness of individual and collective responsibility and

accountability for good clinical and social care governance as a mechanism to ensure patient safety and quality of care.

**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 From my recollection of my tenure as Chief Executive at SHSCT, there was a significant emphasis on clinical and social care governance and the quality and safety of care for patients and clients, with at least 30% of the time of Trust Board dedicated to this under a standard Agenda Item on Patient/Client Safety and Quality.

32.2 The Board Governance Committee, which was a sub-committee of the Board as described in my response to Question 12, met quarterly and sought assurance on behalf of the Board that care quality and patient safety concerns were appropriately actioned and addressed as far as possible within the resources available to the Trust.

**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, it was my experience while in post as Chief Executive that the Board was deeply committed to quality and safety of care and, despite the financial challenges of SHSCT and the wider HPSS at that time, prioritised resources where there was a known risk to quality and safety of care.

**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 To the best of my recollection, during my tenure as Chief Executive of SHSCT I had no knowledge or personal experience of matters regarding clinical governance and patient safety not being properly dealt with by the Trust or Trust Board, and these matters were prioritised within the constraints of the resources available to the Trust.

34.2 I personally considered clinical and social care governance and the safety of patients and clients as a key priority as did the Chair and Trust Board.

**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 During my tenure as Chief Executive, I found the key challenges in learning the lessons from clinical and governance safety issues to be:

- Competing priorities set for the Trust (such as Ministerial time targets to see new outpatient referrals v's the accountability for safe care in seeing review patients within the designated clinical timescales).
- The challenges of securing funding for, and then recruiting, the workforce needed to ensure the Trust had sufficient capacity to meet the population demand.
- The financial resources available to the Trust, and the annual savings targets imposed on what was the relatively efficient service provided in the Southern Trust.
- The funding allocations from the Trust's Commissioner, the Health & Social Care Board (HSCB), often came very late in the year, creating difficulties in spending this money effectively. As an example, in the minutes of Trust Board of 25 March 2010 *[31. 20100325 TB Public Minutes located in S21 10 of 2022 Attachments],* the discussion under Agenda Item 7 on the Trust Performance Report referred to the delays in securing recurring funding (for inpatient/day case, outpatient and diagnostics access targets) presenting a risk as non-recurring solutions have to be kept in place longer than anticipated, and that the HSCB had acknowledged that particular specialist areas will not meet the access targets but should not exceed 17 weeks. This referred to Urology, as well as Endoscopy, Orthopaedics and MRI services within the Trust. This was a ongoing challenge, and was escalated by the Trust Board as follows:
    - At the Trust Board in April 2012 *[26. 20120301 TB Public Minutes located in S21 10 of 2022 Attachments],* under Matters Arising: Performance against Elective Care Waiting Time Targets I confirmed that I had actioned the

Board's instruction to me at the previous Board meeting and had written to the Chief Executive of HSCB expressing the Board's concern at the lack of recurrent solutions to address capacity gaps. The Chairman advised that Mr Dean Sullivan, Director of Commissioning, Health and Social Care Board, would be attending the Trust Board meeting on 14th June 2012 to update on issues.

- At the Trust Board meeting on 29 May 2014 *[32. 20140529 TB Public Minutes located in S21 10 of 2022 Attachments]* The Chair of the Board undertook to raise Board members' concerns in relation to the continuing lack of clarity on the Trust's financial allocation for 2014/15.

35.2 Despite these and many other challenges there was a real commitment within the Trust Board and SMT to deliver the best possible care and to a culture of learning lessons to improve the care we provided as a Trust, and the minutes of each Trust Board attests to that.

35.3 Staff were communicated with and involved in leading and delivering the improvement of services to improve quality of care and patient safety.

35.4 I give as an example the Trust's approach to Infection Prevention and Control, the plan to reduce Healthcare Acquired Infections such as C Difficile and MRSA within the Trust's hospitals, the audits of IPC practice by staff, and the measurable impact of reduced rates of infection. This work was led by the Medical Director and reported to Governance Committee and Trust Board, with a Trust Infection Control Group chaired by the Medical Director. The IPC Team were awarded the Best Innovation in the Information and Technology Category of the 2010 Health & Social Care Innovations Awards for the development of an electronic dashboard to monitor infection control performance as recognised at the Trust Board Meeting in April 2010 *[19. 20100429 TB Public Minutes located in S21 10 of 2022 Attachments].* I do not have access to the Trust's records of the work of the Infection Prevention and Control Group to provide minutes and presentations.

**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 Please see my response to Question 15 and 18.

**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 I recall many significant Board discussion on balancing the respective risks of financial 'break even' and the delivery of timely access to care. I believe there was a formal 'risk appetite' discussion and annual assessment. Evidence of same should be requested from the Board Assurance Manager, Sandra Judt, as I do not have access to these documents.

37.2 I would describe the Trust's appetite for risk as being appropriate in relation to assuring patient and client safety, which at times impacted negatively on the operational and financial performance of the Trust. and the approach to balancing risk in relation to quality and safety, operational performance and finance. Trust Board and Governance Committee minutes demonstrate relevant examples including:

- The stated Trust position to close or cease services if they were considered unsafe.
- The decision to address outpatient backlogs before this became a Departmental/Commissioner Priority for Action.
- The decision to cease a programme of IV fluids and antibiotics provided by the Trust's Urology Service, as described in my response to Question 97.

37.3 The Trust's Risk Management Policy Statement, set out on page 5 of the Risk Management Strategy *[15. 201809 Risk Management Strategy located in S21 10 of 2022 Attachments]* reflects the Board's proactive approach to risk management in order to:

- Bring about the continual improvement in the care and services the Trust provides.
- Enhance the services and efficient management of Trust resources
- Comply with public and statutory duties placed upon the Trust

**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's approach to assuring high standards of professional practice is described in Process 10 on page 30 of the Trust's Review of Clinical and Social Care Governance *[3. System of Trust – CSCG Review located in S21 10 of 2022 Attachments].* The process for managing poor professional performance and conduct in the medical workforce is included in Appendix 3 on pages 49 – 57 of this document. For nurses, AHPs and social workers, managing poor professional performance is on page 58, and for all employees on page 59 of this document.

38.2 As evidence of high standards of professional supervision of AHP practice, I refer to the minutes of Trust Board of 28 January 2010 *[36. 20100128 TB Public minutes located in S21 10 of 2022 Attachments]* under Any Other Business where:

> *Members were advised that on 19th January 2010, the "Leading Effective Supervision for AHPs in the Southern Health & Social Care Trust" was shortlisted as one of the finalists by the adjudication panel of the Advancing Health Care Awards at the Department of Health, London.*

38.3 Trust guidelines for Handling Concerns about Doctors' and Dentists' Performance were updated in September 2010 *[33. 20100915 Guidelines for Handling Concerns about Doctors located in S21 10 of 2022 Attachments].*

38.4 The assurance to the Board included Professional Governance Reports to Governance Committee by the Directors with accountability for the competence of the professional workforce of the Trust, including:

- Reports from the Medical Director which included information on medical appraisal, revalidation, and the outcome of Serious Adverse Incidents that required referral to General Medical Council (GMC)
- Board Reports from the Director of Nursing and AHPs that gave assurance on the training, supervision and competency of those staff.

38.5 High standards of practice for the Trust's non-registered workforce, which included managers without a clinical or social work qualification or no longer practicing as such, were assessed through the Trust's general appraisal process.

**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 During my tenure, the designated Lead Professional Director for medical appraisal and revalidation was the Medical Director, and for Nurses and AHPs the designated lead was the Director of Nursing and AHPs. Their roles are defined in paragraph 7.2 of my response to Question 7.

39.2 I was assured by these Professional Directors that there were appropriate policies and procedures in place, and that the system was working well through their discussions with me as their line manager and their assurance reporting to SMT, Governance Committee and Trust Board. These reports have been referenced in paragraph 38.4 of my response to Question 38.

**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 I refer to my response to Question 37. This was a recurring discussion at Trust Board meetings, with appropriate Board scrutiny and challenge to ensure that, as Chief Executive, I and my Directors were appropriately assessing the balance of financial and operational/clinical risk and providing a full analysis of same as appropriate to the complexity of decisions sought at Trust Board.

40.2 As an illustrative example of the Trust Board's detailed discussions and decisions about committing funding at financial risk to seek to reduce clinical risk, I refer to Trust Board minutes of 23 October 2014 *[34. 20141023 TB Public Minutes located in S21 10 of 2022 Attachments]* where under Agenda 10ii) there was a Board decision to address clinical waiting time risks as detailed in the following extract:

*Mrs Clarke drew members' attention to the key areas of risk predominantly with respect to elective access standards. She noted that performance against this target has become increasingly challenging, particularly in the Acute Services Directorate. Mrs Burns referred to the deteriorating position in access times and stated that priority continues to be directed to the most clinically urgent work as a first call, however there are a number of areas where the potential risks have escalated. Members considered a short briefing paper which outlines four risk areas: Symptomatic Breast Clinics; CT; Endoscopy and T&O and discussed the proposed options/actions. After a detailed discussion, members agreed to create additional capacity for routine patients in CT, Endoscopy and Symptomatic Breast Clinics, at financial risk, for one month in the first instance. Mrs McAlinden undertook to the write to the Chief Executive, Health and Social Care Board, to advise of this decision. The Chair asked about the Speciality risks of Urology and Dermatology to which Mrs Burns advised that Urology remains a risk related to access times. She spoke of a new service model developed by the clinical and service team proposed to be implemented on 1 December 2014.*

**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 As I have not been employed by SHSCT since March 2015 I do not have any personal notes relating to discussions on problems with Urology Services at such meetings. I have requested and been provided with minutes of key meetings by the SHSCT PI Team from Trust records and I understand these will be provided to the Inquiry. As far as possible I have referenced relevant meetings in my responses to Inquiry Questions in this statement.

41.2 I have requested the Trust's PI Team to provide me with any specific minutes where I was in attendance at a meeting when problems with urology services were discussed. Weekly Senior Management Team minutes during my tenure total over 300 sets of minutes and I have been advised by the SHSCT PI Team that it is not

possible to search these minutes for specific reference to urology at the time of submitting this witness statement. If provided in this way I will review same and revise my response to this question.

41.3 I have been provided with Governance Committee and Trust Board minutes for my tenure (c50 Trust Board minutes, c50 Confidential Trust Board minutes and c20 Governance Committee minutes) and (as far as possible) have reviewed these for specific references to problems with urology services. I have included some relevant references from these minutes in my responses in this witness statement. For example, I have referred to Trust Board briefings and discussions on Outpatient Backlogs in my response to Question 54.

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

To the best of my recollection, it was my experience that the Trust Board of the SHSCT operated efficiently and effectively during my tenure as Chief Executive. The assurances provided in the Trust's Annual Report 2014/15 as referred to paragraphs 12.12 to 12.15 in my response to Question 12 provides evidence that this was the case.

**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 During my tenure as Chief Executive of SHSCT, it was my experience that the Trust Board, collectively and individually, had a strong motivation to address concerns regarding governance and clinical and patient safety. This mirrored the strong commitment of myself as Chief Executive and my Senior Management Team to being a well-led Trust with good systems of governance and the safety of our patients and clients at the heart of all we did.

43.2 While I do not recall any specific Board discussions on the safety of urology services, other than those referred to in my response to Question 97, I have no doubt that if these were drawn to the attention of myself or to the Board, they would be appropriately dealt with within the resources available to the Trust.

43.3 The Board had a process for following up where there were concerns raised and an action plan provided by the relevant Director as to how these would be dealt with, generally through either a 'Matter Arising' at a following Board Meeting, a delegation to the appropriate Board sub-committee to oversee the completion of actions and report back to the Board, or a specific review was proposed, discussed and approved.

43.4 I believe that Board meetings were conducted in an open and transparent manner, public meetings were advertised in advance, members of the public, staff and others were encouraged to attend and the Board meetings circulated throughout the geography of the Trust to be accessible to our population and staff. The Board Agenda, minutes and reports were made publicly available on the Trust's website, these reports included the performance and governance reports.

43.5 My experience during my tenure as Chief Executive of SHSCT was that the Board had an appropriately high level of 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 During my tenure as CX of the Southern Trust, I had a formal annual evaluation with the Chair of the Trust under a formalised Individual Performance Review (IPR) process based on a set of objectives that were set in the previous April and with face to face monthly performance reviews at scheduled meetings. My personal objectives were clearly linked to the delivery of the Trust's Corporate Objectives.

44.2 An illustrative example is my IPR documentation for the year 2010/11 *[35. 2010 11 IPR Chief Executive located in S21 10 of 2022 Attachments]* which records my key objectives for the coming year, the action required and notes on my attainment of these objectives. This IPR details my objectives under each of the Trust's Corporate

Objectives. Under Corporate Objective 1 (Providing Safe, High Quality Care) the Chair had set me 3 specific personal objectives:

1. Ongoing implementation of the Trust's 5 Year Strategic Plan 'Changing for the Better'.
2. Delivery of Ministerial/Priorities for Action (PfA) standards and targets.
3. Improved Clinical and Social Care Governance arrangements to ensure patient and client safety.

On behalf of the Board, the Chair would assess my attainment against each objective and make a recommendation to the Trust's Remuneration Committee on this assessment. I believe, but cannot recall specifically, that this assessment was also shared with the Permanent Secretary DHSSPS.

44.3 In addition, the Chair and myself as Chief Executive had 2 formal meetings per year with the Permanent Secretary DHSSPS (mid-year and year end accountability meetings) as referenced in paragraph 11.3 of my response to Question 11.

**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 It is my recollection that budgets at Trust, Directorate and service level would be adjusted with any additional allocations bid for and secured from our commissioner the Health & Social Care Board (HSCB). Proposals for additional funding required the completion of a specific investment template mandated by HSCB.

45.2 In completing the investment template, issues such as service capacity to deliver access targets, compliance with any new standards of care and any specific clinical risk would be identified to support the bid. Service Teams would be supported to complete these templates by the Planning and Financial leads aligned to their Directorate.

45.3 All bids for additional funding were authorised by the Director accountable for that service and considered for approval by SMT before submission to HSCB.

45.4 As this process was onerous and did not always have a guaranteed outcome of agreed investment, where the service need was pressing there would have been a discussion either at SMT or Trust Board in relation to proceeding at financial risk. The service risks that justified such action were usually already on either the Directorate or Corporate Risk Register, using the methodology set out in the Trust's Risk Management Strategy *[15. 201809 Risk Management Strategy located in S21 10 of 2022 Attachments]* and the Risk Acceptance Framework in Section 5 of this document (which describes what level of risk is held at what level in the Trust) would be well understood by SMT and Trust Board. For ease of reference this is reproduced below:

> *Definition of Acceptable Risk: As a guide the Trust considers green (low and medium) risks to be acceptable (as defined by the risk rating matrix, Figure 6). This definition is to be used as a guide only and managers are encouraged to take action on green and yellow (low and very low) risks identified particularly when these risks can be easily eliminated or reduced.*
>
> *Definition of Unacceptable Risk: The Trust considers all amber (high) and red (extreme) risks to be unacceptable (as defined by the risk rating matrix, Figure 6). Managers are expected to take immediate action on amber (high) and red (extreme) risks identified and document action taken.*
>
> *Definition of Significant Risk: Those red (extreme) risks, which have been identified as potentially threatening the achievement of the Trust's objectives or represent significant gaps in controls/assurances are escalated by the SMT Governance to the Board Assurance Framework.*

45.5 Examples of Trust investment at financial risk include in areas such as waiting list initiatives, outpatient backlog clearance, and investment in unfunded additional posts such as for the locum consultant in Urology referred to in my response (in 3rd bullet point) to Question 46 below.

45.6 The Trust was required to produce an annual Trust Delivery Plan setting out how the required targets and standards would be delivered in the coming year. This included how the savings plans required of the Trust would be delivered, and proposals for the delivery of savings plans went through a similar process, having to

be stratified for risk and impact and requiring approval at Director, SMT and Trust Board before submission.

**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 I refer to my response to Question 45 to describe the process as I recall it during my tenure. Specific examples from the documents provided to me by the SHSCT PI Team include:

- Trust Board 28 January 2010 *[36. 20100128 TB Public Minutes located in S21 10 of 2022 Attachments].* Under Agenda 5(v) Recurrent Investment for Elective Care

  *Mrs Clarke (Director of Performance & Reform) circulated and spoke to a briefing note which provided members with an update on current progress in relation to negotiations with the Commissioner on recurrent investment for elective care. To date, the Trust has secured recurrent investment of £1.3m into ENT services (£590k); Pain management services (£185k) and AHP services (£555k). In addition, the Trust expects to secure a further £0.75m into Gynaecology and Neurology services. Negotiations continue as regards investment into other services, namely Endoscopy; Ophthalmology and Orthopaedics. With the degree of funding sought for these services being approximately £2.6m, negotiations are considering the potential options to make best use of the available funding against this requirement.*
- Trust Board 28 January 2010 *[36. Ref 20100128 TB Public Minutes] located in S21 10 of 2022 Attachments]* under Agenda Item on Operational Performance 7i) Performance Report (ST 204/10) Mrs Clarke presented the report summarising the Trust's performance in December 2009. The quarterly supplementary report on PfA targets for the quarter ending 31 December 2009 is also included. Mrs Clarke stated that:

  *the Trust continues to perform well against the majority of the targets. She noted a continued improvement against the diagnostic reporting and timely hospital discharge targets and added that the Trust continues to achieve a high performance in terms of cancer referrals and an improved performance in*

*mental health referrals. The risk areas remain as in previous months and are detailed in the report. Mrs Clarke highlighted that a number of risk areas relate to the need for investment as identified in item 5v) above*

- Governance Committee 6 September 2011 [ref 20110906] under Agenda Item 12 Outpatient Backlog – Progress Report, where the Director of Acute Services, [Dr Rankin] advised of the appointment of a locum urology consultant to commence in October 2011, which would have incurred a financial risk.

**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 To the best of my recollection, the Trust had an annual planning process which was 'bottom up' within each Directorate, and supported by aligned Heads of Planning and Finance, which enabled the development of specific service development proposals for funding in relation to risk. Risk would have been assessed using the Trust's Risk Management Framework.

47.2 This planning process would have been adapted in relation to the requirements set by the Trust's Commissioner (Health & Social Care Board) for development of the Trust's annual Trust Delivery Plan, which would have applied to all Trusts in Northern Ireland.

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

48.1 Each year the DHSSPS issued its Ministerial Priorities for Action and the Trust's Commissioner (Health & Social Care Board - HSCB) would have translated those targets into commissioning intent which shaped the content of the Trust's annual Trust Delivery Plan. This would have been standard in all Trusts in Northern Ireland. This would have included the management of risk within the funding to be made available by HSCB.

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

49.1 Please see my response to Question 48. At all levels of the Trust, risks were assessed under the Risk Management system as set out in Section 4 of the Trust's Risk Management Strategy *[15. 201809 Risk Management Strategy located in S21 10 of 2022 Attachments]* and only escalated to the Corporate Risk Register (CRR) where they could not be managed within the resources of the service or Directorate concerned.

49.2 The CRR was scrutinized and reviewed monthly by the Senior Management Team and risks were assessed using the methodology and grading in the Trust's Risk Management Strategy referenced above. The CRR was presented by me at each Governance Committee for discussion and as part of the Board Assurance Framework that was considered bi-annually at Trust Board.

49.3 I believe that there was a high degree of awareness of the Trust's most significant risks. The annual draft Trust Delivery Plan, which set the funding allocation for Directorate services, was subject to scrutiny by SMT and Trust Board before submission for approval by our commissioner, the Health & Social Care Board.

**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 While the Regional Urology Review was completed in March 2009, the final report was not endorsed by the Minister for Health until 31 March 2010. The Team South Urology development was critical to the Trust in addressing long standing capacity challenges resulting in the under-delivery against Commissioner access targets. In 2009 the then Director of Acute Service (Joy Youart) had undertaken an

internal Trust Review of Urology Services. This is reflected in the Trust Board minutes 24 September 2009 under Agenda Item 6 *[Ref 20090924 TB Public minutes].* Paula Clarke (Acting Director of Performance & Reform) drew members' attention to performance risk areas, including the Inpatient/Daycase Access target. The Interim Director of Acute Services, Joy Youart, advised the Board that she had undertaken a Trust review of urology services that had highlighted a capacity gap, and that this was a regional issue across the services in Northern Ireland. She stated that a Regional Review of Urology Services was underway.

50.2 As Chief Executive I was ultimately accountable for the safety, quality and performance of all Trust services. I had strategic-level involvement in the establishment of 'Team South' and carried overall accountability for discharging the Trust's responsibilities in this regard. The operational responsibility would have sat with the Director of Acute Services, Dr Gillian Rankin until March 2013 succeeded by Mrs Debbie Burns who was in post when I left SHSCT. They were supported in the development of the existing Trust urology service into Team South Urology by the planning and service improvement staff led by the Director of Performance and Reform (then Paula Clarke) and the finance staff led by the Director of Finance (then Stephen McNally) that were aligned to the Acute Care Directorate.

50.3 Because of the importance of this development for the Trust and indeed the region, I recall attending a few of the planning meetings for Team South Urology. As Chief Executive I wanted to support Dr Rankin and to provide assurance to the urology clinical team that the Trust would support them to deliver the challenging ask of expanding the catchment population to include Fermanagh while at the same time delivering a significant improvement in patient access waiting times through not only additional investment but also significant service reform to improve efficiency. This assumed efficiency was 'locked in' to the commissioner's capacity modelling for each of the three Urology Teams. From information requested and received from the SHSCT PI Team I can confirm that I attended (as a minimum) the following meetings:

- Urology pre meeting on 2 April 2014 *[38. 20140402 Diary Urology Pre Meeting located in S21 10 of 2022 Attachments]* (which could possibly have been for the following meeting on 29 May 2014)

- I believe I attended a meeting regarding the Urology Stocktake narrative with Mark Fordham on 29 May 2014 *[39. 20140510 E for diary Urology Review Stocktake located in S21 10 of 2022 Attachments],* however as there was a clash with a Board Workshop I cannot definitely confirm this.
- A meeting on 18 August 2014 where the Urology Team presented a sustainability proposal. *[40. 20140731 E re urology modernisation meeting located in S21 10 of 2022 Attachments].* I emailed Debbie Burns following this evening meeting *[41 20140819 E Urology Sustainability Proposal located in S21 10 of 2022 Attachments]* asking her to pass on my appreciation to the Urology Team for the amount of discussion, debate and analysis that went into this work and the commitment to a different approach to the twinned problems of demand management and best use of clinical expertise. This email referred to a meeting on 1 September 2014 which I hoped to attend, but I can see no record that I did actually attend.

I do not have any personal notes or access to any written notes of these meetings.

50.4 I have requested from the SHSCT PI Team and have reviewed a letter dated 27 April 2010 from Hugh Mullen, Director of Performance Management and Service Improvement of the Trust's Commissioner the Health & Social Care Board (HSCB) *[42. HM700-ltr to Trust Directors of Acute re urology review implementation located in S21 10 of 2022 Attachments]* and addressed to Trust Directors of Acute Services to refresh my memory on the detail of the commissioning of Team South Urology. This letter refers to meetings already held with the other Urology Teams (East and North) and that the SHSCT was required to submit an Implementation Plan for same which would include the current population demand from the southern area and expanded capacity to include new population demand from Fermanagh, increasing the catchment population for urology services to be provided by SHSCT via 'Team South' to c410,000. The letter also refers to the establishment of an overarching (regional) Implementation Project Board to be held in July 2010.

50.5 Mr Mullen's letter referenced in paragraph 50.4 summarises the approved recommendations of the Regional Urology Review in Appendix 1, and the estimated costs – by Team – for the implementation of these recommendations. The total

investment in urology across Northern Ireland was £3,511,853 less funding previously allocated to Team East of £637,076 leaving a remainder of £2,874,777. Of this the total for Team South was £1,195,264, with none of that funding having previously been allocated to SHSCT.

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

51.1 I have requested and received from SHSCT PI Team a copy of the Team South Implementation Plan v0.3 revised as at 9 November 2010 *[43. Team South Implementation Plan v0.3 located in S21 10 of 2022 Attachments]* which I have reviewed to refresh my memory given the passage of time.

51.2 As Chief Executive I would not be aware of specific performance indicators for each service in the Trust, this would be an operational matter. I would only be aware of those that are reported through the Trust's monthly Performance report to SMT and Trust Board.

51.3 On reviewing the Implementation plan, there is a significant focus on efficiency indicators (outpatient new to review ratios, day case rates, etc. The performance indicators for the Urology Service, as reported to SMT and Trust Board in the monthly Trust Performance Report, were based on the Minister's Priorities for Action for DHSSPS (PSA 18 Deliver high quality health and social services). Specifically in relation to waiting times for hospital services, in 2010-11 these were that no patient will wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 17 weeks for inpatient or day case treatment.

51.4 The Health & Social Care Board, the Trust's commissioner, in their commissioning plan for 2010-11 stated their commissioning intention to ensure that waiting times for assessment remain at 9 weeks (first outpatient appointments) and that waiting times for treatment are kept as short as resources will allow, with a specific target that the majority of inpatients and day cases are treated within 13 weeks and no patient waits longer than 36 weeks for treatment. A further target was set for review patients, in that they should be seen in a more timely fashion and from March 2010 all reviews should be completed within the clinically indicated time. In relation to cancer, the HSCB targets for Trusts were that 98% of cancer patients commence treatment

within 31 days of the decision to treat, and 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.

**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 In April 2008 until I became Chief Executive (acting Chief Executive from 1 September 2009) I was the Director of Performance & Reform in SHSCT and would have had responsibility for assurance that IEAP was properly implemented. The delivery of the IEAP protocol would have been the responsibility of the Director of Acute Services.

52.2 I have spoken with Mrs Lesley Leeman, currently Acting Director of Performance & Reform at SHSCT and in April 2008 my Assistant Director, to refresh my recollection in responding to this question. Mrs Leeman confirmed that IEAP was largely implemented from 2006 in SHSCT, with the 2008 protocol changing little other than the introduction of a 'Red Flag' categorisation for outpatient referrals in addition to 'Routine' and 'Urgent'.

52.3 While Mrs Leeman and Mrs Louise Devlin undertook the communication with staff on the 2006 guidance, she advised that the updated 2008 Protocol was communicated to administrative and management staff through a presentation to staff *[44. Integrated Elective Access Protocol (IEAP) Awareness presentation Oct 2008 located in S21 10 of 2022 Attachments]* by Operational Service Leads within the Acute Services Directorate which was updated from Mrs Leeman's original presentation in 2006. In 2008 Acute Services was under the leadership of Mrs Joy Youart as Interim Director of Acute Services. I have no information available to me as to what specific staff this communication was with.

52.4 As the Director of Performance and Reform I had a specific responsibility for independently providing assurance on the Trust's performance to Trust Board each month, including assurance that the IEAP Protocol was being properly implemented within the Trust. To provide that assurance in relation to IEAP, I requested an independent review of operational processes within the Trust be carried by the

DHSSPSNI Service Delivery Unit (SDU) to ensure consistent and standard processes were in place across the elective pathway from referral to admission, including diagnostic services.

52.5 This review 'SHSCT Elective Systems Pathway Review' was led by Michelle Irvine, Programme Director (Elective Access Reform, Service Delivery Unit, DHSSPSNI) and was undertaken by a small team from the Service Delivery Unit (SDU) who spent two weeks on a number of the Trust sites. A copy of the Review document is included in an email from Mrs Siobhan Hanna to Mrs Anita Carroll, Assistant Director Acute Services, dated 24 February 2009 *[20090224-E Referral and Booking Centre located in Relevant to PIT/Evidence Added or Renamed 19 01 2022/Evidence no 77/No 77 – Mairead McAlinden]*. During their site visits, a number of Trust staff were consulted on existing practice, including booking clerks, medical secretaries, health records clerks, clinical and technical staff, supervisors, managers and consultants. The report was received in July 2008 and, in Section 2: Approach, it was confirmed that Trust policies and procedures were made available to and examined by the SDU review team and that the team was welcomed into the Trust with open access to clinical and administrative areas, management teams and information sources.

52.6 This Review made 127 recommendations, with the only recommendations specific to urology being with regard to urodynamics (recommendations 105 – 118). At the time of this review, the Trust was nearing the end of a period of consultation on a proposed move to a single site for outpatient registration, referral management and booking, with a view to centralising these functions in a Trust-wide Referral & Booking Centre on the Craigavon Hospital site. I recall that this consultation came under my responsibility as Director for Performance & Reform and was led on my behalf by Mrs Siobhan Hanna, my Assistant Director for Informatics.

52.7 The SHSCT PI Team have provided me with records which confirm that this change to centralise outpatient appointments was discussed at the Medical Staff Committee for Daisy Hill Hospital on 28 November 2008 with a presentation given by Mrs Hanna which is included in an email from Mrs Hanna to Mrs Anita Carroll, Assistant Director Acute Services, dated 24 February 2009 *[20090224-E Referral and*

*Booking Centre located in Relevant to PIT/Evidence Added or Renamed 19 01 2022/Evidence no 77/No 77 – Mairead McAlinden].* This email includes an electronic copy of the SDU Review above and confirms that this document had been provided to Assistant Directors of Acute Services in July 2008. This email also confirms that Mrs Hanna and Dr Catherine Weaver, the then Head of Health Records, had engaged with a number of clinicians on the actual administrative processes involved in booking, including electronic referrals, triage turnaround and appointments no longer being booked by secretaries and would see this element of the consultation through to the end.

52.8 The list of consultants provided as an attachment to Mrs Hanna's email confirmed that there was a meeting with the urology consultants (Mr O'Brien, Mr Young, Mr Mahmood, locum consultant Mr Vincent Keo and Mr Rodgers who I believe was a staff grade doctor).

52.9 This email defined a list of consultation issues with consultants which would not be undertaken by Informatics and which was required to be undertaken by Assistant Directors in Acute Services to maximise the efficiency of the Referral and Booking Centre. These included agreeing the Trust Policy for patients that 'Did Not Attend/Could Not Attend' and the process for booking appointments across sites, reviewing the outpatient capacity across sites, review of outpatient clinic templates in terms of new slots, number of review slots and time allocated for each, agree and implement 'pooled lists'.

52.10 I have spoken with Mrs Hanna, who was then my Assistant Director for Informatics, to refresh my recollection of the implementation of these recommendations, and she has reminded me of a memo I sent at this time (while Director of Performance & Reform) referring to a number of meetings that had been held to take forward the recommended actions from the Review, and identifying 3 critical and underpinning areas for action to reform the outpatient service in line with the recommendations of the Review:

1. Review/reform of outpatient capacity templates, for action by Simon Gibson, Assistant Director of Acute Services and Mrs Louise Devlin, to be supported by

Mrs Debbie Burns, who was at that time my Assistant Director for Service Improvement.

2. Establishing agreed 'rules' for management of outpatient referrals, for action by Simon Gibson and Eamon Mackle, the then Associate Medical Director for Surgery.
3. Establishment of Central Referrals and Booking Centre at Craigavon Area Hospital by January 2009, for action by Siobhan Hanna, my then Assistant Director for Informatics and Dr Catherine Weaver, Head of Health Records, in liaison with Louise Devlin.

52.11 Responsibility for the operational management of the Central Referrals and Booking Centre at Craigavon Area Hospital transferred from the Siobhan Hanna to Anita Carroll, Assistant Director to the Director of Acute Services, in 2009.

52.12 I moved from my post of Director of Performance & Reform on 1 September 2009 to the post of Interim Chief Executive in the SHSCT (subsequently appointed as Chief Executive), and at that time Paula Clarke took on responsibility for this role.

**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 The operational management and governance of Urology Services was led by the Director of Acute Services, supported as required by the Professional Directors for medical, nursing and AHPs and by aligned Human Resources, Finance, Planning and Reform/Improvement experts from each of these Directorates. The monitoring of IEAP process timeline and timescales was an operational responsibility overseen by the operational Director of that service. In the case of Urology that was the Director of Acute Services.

53.2 In terms of oversight, if and when IEAP process timelines impacted on the management and governance of Urology Services, this would initially be managed at an operational level and only if significant would that be escalated to SMT and/or Trust Board through the monthly Board Performance Report or respective Professional Executive reports.

53.3 I have requested and received from the SHSCT PI Team a range of Board Performance Reports for each year of my tenure. I have reviewed a sample of these reports, and I refer to the Board Performance Report which went to Trust Board meeting on 26 March 2015 *[10. 20150326 Performance Report a located in S21 10 of 2022 Attachments].* In the coversheet for this report, in the section 'Senior Management Challenge' there is specific assurance sought and received on the adherence to the IEAP process, in particular strict chronological management. This chronological management was based on categorisation of urgency (routine, urgent and 'red flag' which indicated a risk of cancer) though consultant triage of outpatient referrals. I do not believe any Director during my tenure would have given this assurance to SMT or Trust Board if they were aware of systemic failings in this regard.

53.4 As Chief Executive, the only specific concern relating to the application of IEAP in urology that I was aware of is referenced in my response in paragraph 97.2 (3) to Question 97. A key strategic focus of Trust Board was the actions needed to improve patient waiting/access times in line with the targets set for the Trust by HSCB as our commissioner, and to address the outpatient backlog review as a patient safety issue.

**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?**

54.1 As Chief Executive, while I was not directly involved in the development of this plan, I was very aware of the wider issue of outpatient review backlogs in the Trust and, through discussion at SMT and Trust Board, Trust resources were prioritised to address this backlog action plan. Trust performance against the reduction in Outpatient Backlogs was reported each month in the Board Performance Report and regularly discussed at SMT and Trust Board.

54.2 I have requested from SHSCT PI Team and have been provided with the revised version of the SHSCT Team South Implementation Plan V0.3 revised 9

November 2010 *[43. Reference Team South Implementation Plan v0.3 located in S21 10 of 2022 Attachments].* I have reviewed this document in order to respond to this question to the best of my recollection. This document on page 7 refers to a substantial backlog of patients awaiting review at consultant led clinics and that the Trust has submitted a plan to deal with this backlog and implementation of this plan is in progress.

54.3 Outpatient Reviews were not a HSCB Commissioning Plan target for Trusts during my tenure as Chief Executive but as a Trust, SHSCT took early and ongoing action to address review backlogs due to clinical concerns raised about patients waiting beyond their clinical indicated date for an outpatient review. The Board Performance Report referred to in paragraph 53.3 above includes on Page 18 a summary of performance and actions relating to Outpatient Backlog management, which would include urology, as follows:

> *Comments:*
> *Of the 20,608 patients waiting for review appointments beyond their clinically indicated date:*
> • *36% (7455) of these are waiting in excess of 6-months;*
> • *24% (4958) of these are waiting between 3 – 6 months; and*
> • *40% (8195) waiting less than 3-months.*
> *Focus on the longest waiters, with validation and additional capacity created via internal funding initiatives, has seen the cohort of patients waiting over 6 months decrease by over 1500 from December to February as per the red line on the chart.*
> *Action to Address:*
> • *Arrangements in place to minimise risk and ensure reviews with high clinical priority take place in accordance with the clinically indicated timescale;*
> • *Discussion paper submitted to HSCB and SLCG to highlight ongoing issues (July);*
> • *Trust has sought engagement with Primary Care via the SLCG [NB this refers to the Southern Locality Commissioning Group, a Locality arm of the Health &*

*Social Care Board] to consider potential solutions in the absence of additional funding options to address backlog;*

- *Trust has commenced a validation programme to review patients waiting beyond their clinically indicated date. This plan includes both data and patient validation. This has been funded by Trust until March 2015; and*
- *Funding has in additional been provided by the Trust to provide addition capacity for patients waiting beyond their clinically indicated date. This temporary additional capacity will be directed towards the longest waiting review patients over the next three months.*

54.4 In terms of direct involvement, during my tenure the development of the Backlog Plan was led on the Trust's behalf by Dr Gillian Rankin and then Debbie Burns as the Trust's Director of Acute Services.

**II. How was it implemented, reviewed and its effectiveness assessed?**

54.5 The Implementation of Backlog Action Plan was led by the Director of Acute Services, and regular performance reports brought to SMT and to Trust Board as part of the monthly Board Performance Report, as demonstrated in paragraph 54.3 above.

54.6 In reviewing Governance Committee Minutes for 10 May 2011 *[11. 20110510 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* Agenda Item 14 reflects Dr Rankin's Report on action to address Outpatient Review Backlogs, referencing funding secured from the Trust's Commissioner (Health and Social Care Board) and the clarification to all staff the Trust's approach to outpatient reviews. At this meeting Dr Rankin advised of progress in reducing the backlog across 5 specialties as follows:

- 2008 Backlog reduced from c2,000 to 344
- 2009 Backlog reduced from c7,000 to 2,000

54.7 In reviewing Governance Committee Minutes for 6 September 2011 *[12. 20110906 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* Agenda Item 12 reflects an update report from Dr Rankin on ongoing action to address Outpatient Review Backlogs and provided a snapshot of the position

at the end of August 2011, the action being taken by each specialty to reduce backlogs and advising of an internal Trust targets set as follows:

- By end of 2011, the 2010 Outpatient Backlog will have been triaged/seen/discharged
- By end of March 2012, the 2011 Outpatient Backlog will have been triaged/seen/discharged

Dr Rankin referred to specific action for urology, in that a locum consultant had been appointed to commence October 2011. She referred to a range of actions to prevent backlogs recurring and to action underway by the Trust's Commissioner (Health and Social Care Board) to review capacity for each acute specialty in Northern Ireland and the intention to only provide funding for capacity gaps against targets set by them for New to Review Outpatient ratios.

54.8 At Trust Board in August 2011 *[5. 20110825 TB Public minutes located in S21 10 of 2022 Attachments]* under the agenda item on Operational Performance i) Performance Report (ST 326/11), Mrs Clarke presented the Trust's Corporate Performance Dashboard for July 2011 which supplements the Corporate Performance Management Report. Mrs Clarke guided members through the dashboard, highlighting the main areas. Members noted the trends, analysis and narrative update on key performance indicators of particular interest. Members noted that improvements have been made regarding Outpatient Review Backlog.

III. What was your role, if any, in that process?

Please see my response to I and II above.

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?

54.9 During my tenure I believe every reasonable effort was made to address the outpatient backlog in urology given the specific Commissioner priorities for waiting times for new outpatient appointments, and there is evidence of success in doing so above. However the underlying gap between the capacity of urology services and the population demand placed upon this service made it very difficult to maintain. As advised in paragraph 54.3 above, Outpatient Reviews were not a HSCB

Commissioning Plan target for Trusts during my tenure as Chief Executive, and HSCB did not provide recurrent funding to address timely outpatient reviews.

**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 It was my role as Chief Executive with responsibility for providing Trust Board and Governance Committee with an oversight of Clinical & Social Care Governance (though the Assistant Director for Clinical & Social Care Governance) and operational performance (through the Director of Performance & Reform.

55.2 I believe that, supported by the evidence I have included in my response to Question 54, the issues of outpatient backlogs within SHSCT were being actively managed within the constraints of funding and workforce, and that this issue was prioritised for funding by the SMT and Trust Board on the advice of myself as Chief Executive and the Director of Acute Services.

55.3 Please see my response to Question 54 providing evidence that the Outpatient Backlog plan was discussed at Governance Committee with performance reporting through the monthly performance report to Trust Board. The risk of the Outpatient Backlog was also a constant on the Trust's Corporate Risk Register, for example the Corporate Risk Register *[45. 20130910 CRR located in S21 10 of 2022 Attachments]* presented to Governance Committee on 10 September 2013 provided an update on the management of the Backlog risk and an agreement with Health and Social Care Board to address review consequences of new in-house additional capacity being delivered in 2013/14. For ease of reference I have reproduced the wording below:

> *Outpatient Review Backlog*
>
> • *Whilst significant reduction in volume of review backlog achieved initially in the number of routine waits in Q3 and 4 of 2011/12, there has been an increasing trend in 2012/13 as the system continues to bring in significant volumes of in-house additional new patients to meet access targets.*

- *Trust anticipates a rolling backlog in reviews until recurrent demand/ capacity gaps have been addressed.*

- *Of the total waits, 88% of those waiting have been waiting from 1 April 2012.*

- *The largest volumes of waits are in Urology and ENT with the longest waits in Urology.*

- *Work continues to cleanse lists and Specialist Nurses are working with relevant consultants to screen urgent reviews and longest waiters*

- *Whilst some funding has been provided in 2012/13 to address review backlog, capacity to put in the place the additional capacity required is limited by availability in specialties that have capacity gaps and require to utilise capacity to maintain access times for new referrals also.*

- *Health and Social Care Board has agreed funding to address review consequences of new in-house additional capacity being delivered in 2013/14.*

55.4 The implementation of Team South Urology in relation to the performance of urology was regularly discussed at Trust Board meetings in the context of the monthly Board Performance Report. For example, at the Trust Board of 25 August 2011 *[5. 20110825 TB Public minutes located in S21 10 of 2022 Attachments],* Dr Rankin undertook to explain the cancer performance in relation to Urology Services. She advised that:

> *the Trust is continuously aiming to improve services and the longer waits are decreasing in numbers, however, there is a capacity issue in terms of prioritisation of referrals. Dr Rankin added that the Trust is waiting on written confirmation on funding to recruit 2 additional consultants with 2 additional specialised nurses which should dramatically improve compliance with the cancer pathway.*

**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 As Chief Executive, I had an overview, scrutiny and challenge role in relation to the Team South Implementation Plan though the updates provided to SMT and Trust Board. I have requested and received from the SHSCT PI Team the revised Team South Implementation Plan *[43. Team South Implementation Plan v0.3 located in S21 10 of 2022 Attachments]* which I have reviewed to inform my response to this question.

56.2 The key issue was the capacity of the current staffing of SHSCT Urology Team at that time to deliver the demand modelled for 'Team South' for the catchment population of the Southern area (where there was a recognised capacity gap to meet this population demand) and additional capacity needed to meet the demand from the Fermanagh population.

56.3 The SHSCT Commissioner (Health and Social Care Board/HSCB) allocated funding of £1.223m to SHSCT to expand the Urology Team's capacity by 2 consultants and associated staff to meet the Team South capacity gap. The Trust's proposals for this investment are detailed in the Investment Proposal Template sent to Lyn Donnelly in December 2011 *[46. 20120320 E urology review revenue case A2 located in S21 10 of 2022 Attachments].* The Trust proposed a range of Options with a preferred Option 2 that this would enable annual levels of service expected by HSCB of:

- 3,948 new outpatient appointments
- 5,405 review appointments
- 5,585 inpatient/day cases

56.4 This proposal states that this investment would facilitate a sustainable service model for Team South urology, alongside planned reform initiatives such as the introduction of one stop assessment for cancer patients, but that additional recurrent investment of £147,470 would be required to deliver the full model in Option 2. The risks of this proposal as assessed by the Trust were flagged to the Commissioner in this proposal (page 16) and were identified as:

- Inability to recruit consultant urologists
- Inability to appoint other key staff
- Activity projections not being achieved.

The Trust proposal highlights the plans to mitigate these risks, including readvertising posts when new consultants qualify.

56.5 Mrs Heather Trouton, Assistant Director of Acute Services, Surgery & Elective Care was appointed as Lead for Implementation of the Team South Implementation Plan under the line management of Dr Gillian Rankin, then Director of Acute Services.

56.6 As Chief Executive at that time, I was aware of the recruitment challenges for the additional Consultant Urology posts and was kept updated by Dr Rankin on the significant work to address these recruitment challenges.

56.7 I do not have the exact detail of the timeline for implementation of the Team South Plan and any issues that arose. I would suggest that this information would be more accurately provided by Mrs Trouton and/or Dr Rankin. As Chief Executive, I would have monitored the impact of the Team South implementation plan through the Trust monthly Performance Reports to Trust Board.

**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 It is my view as Chief Executive that all possible actions were taken to adequately staff the urology department/Team South during my tenure as Chief Executive, including the appointment of locum Consultants and a focused recruitment campaign to recruit the staff for Team South. I refer to my responses to Questions 54 (I) and 56 for detail.

**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.**

58.1 I refer to my response to Questions 56 and 57.

**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 The Regional Review of Urology *[47. 20120320 Urology Review Final Report A located in S21 10 of 2022 Attachments]* recommended a 5 wte consultant model for Team South Urology (I believe there were 3 substantive consultants in post in SHSCT), and the appointment of additional nurse specialists.

59.2 I have spoken with Martina Corrigan, the then Head of Service for Urology, and she has confirmed that the consultant urology complement and recruitment was as follows:

- Mr Aiden O'Brien and Mr Michael Young in place as substantive consultant urologists.
- Mr Tony Glackin in place from 2012 as 3rd consultant (I believe replacing Mr Mahmood as 3rd substantive consultant). I do not have access to any information on the gap between Mr Mahmood leaving SHST and Mr Glackin commencing.
- Two additional consultants were appointed as the 4th and 5th consultants in 2013 but left shortly after appointment (I believe to take up Consultant Urology posts in the Belfast Trust who were also recruiting at that time).
- Mr Mark Haynes and Mr John O'Donoghue were appointed in 2014 as the 4th and 5th consultant urologists for Team South. I do not have access to any information on the gap between the 2013 consultant appointments leaving SHST and Mr Haynes and Mr O'Donoghue commencing.

59.3 As Chief Executive, I would have been aware of the impact on Urology access performance through the monthly Board Performance Reports.

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

While no impact on governance was alerted to me, I was very aware of the consultant recruitment challenges on the performance of the Team South urology service as alerted to me and to Trust Board through the monthly Performance Report as referenced in my responses to earlier questions, for example in paragraph 55.4.

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

As Chief Executive I would not be aware of such changes other than as reported to me as significant by the Director of Acute Services, Dr Gillian Rankin. I believe Dr Rankin could provide the most accurate response to this question.

**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 During my tenure as Chief Executive of the SHSCT, I held overall responsibility for the governance of the Trust and this did not change during my tenure. The only relevant change in my line management responsibilities for governance was as a consequence of the implementation of the Trust's Review of Clinical and Social Care Governance implemented in 2011 when the function of Corporate Coordination and Overview of Clinical and Social Care Governance came under my management responsibility, and the Assistant Director for Clinical and Social Care Governance reported to me as Chief Executive.

62.2 The Assistant Director led a small team to manage corporate (Trust-level) coordination of standards and guidelines, monitoring and performance reporting of complaints, incidents, risk, audit, clinical indicators, patient safety and learning systems.

62.3 As referenced in my response to Question 7, the Director of Acute Services was responsible to me for the performance and governance of acute hospital services, including urology, for reporting, actioning (ie learning from and mitigating risk), managing and monitoring patient and client safety and quality of care. This includes the management of incidents, complaints and risk registers, and accountability to me for implementing appropriate clinical audit and monitoring and reporting against agreed clinical indicators and agreed safety standards.

**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 As Chief Executive, I would not have been aware of the detail of administrative support to the urology service as this would have been an operational matter under the responsibility of the Director of Acute Services with escalation to me as Chief Executive and to SMT if there were significant concerns. I have no recollection of such escalation.

**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 As Chief Executive, I would not have been aware of this level of operational detail, and would have expected the Director of Acute Services to have raised any significant concerns with me or at SMT/SMT Governance meetings. I have no recollection of any such issues being raised.

**65. Were there 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 During my tenure as Chief Executive, I do not recall any concerns on this matter being raised with me. I have requested any relevant emails from the SHSCT PI Team and reviewed any provided to me which reference urology for the period of my tenure. I cannot identify any emails where such a concern was raised with me.

65.2 When a concern was raised with me informally by staff, it was my usual approach to email the relevant Director to inform them and request a response.

65.3 I would consider that the most appropriate person to whom such a concern would be raised would be the Head of Service responsible for urology services, during my tenure this was Mrs Martina Corrigan.

**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.**

66.1 I have no recollection of, nor have I been provided with any record of, urology services administrative staff raising any concerns directly with me during my tenure as Chief Executive.

**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 As Chief Executive, I would not have been involved in the day to day running of the Urology Unit, which came under the operational responsibility of the Director of Acute Services.

67.2 I have spoken on 27 May 2022 to Mrs Martina Corrigan, Head of Service for Urology during my tenure as Chief Executive of SHSCT. Mrs Corrigan confirmed with me that she was appointed to the new role of Head of Service with responsibility for urology services in September 2009 and continued in that post during my tenure as Chief Executive SHSCT.

67.3 She also confirmed that she reported to Mrs Heather Trouton as Assistant Director for Acute Services, who reported to the Director of Acute Services (see my response to Question 7 for the postholders of the Director of Acute Services during my tenure).

67.4 Mrs Corrigan also confirmed that the Associate Medical Director for Urology was Mr Eamon Mackle, and the Clinical Lead was Mr Michael Young. The Lead Nurse was Shirley Telford. These clinical staff would have reported to the Director of Acute Services on operational matters including patient safety, with professional links to the Medical Director and Director of Nursing & AHPs. The postholders for these Professional Executive roles is included in my response to Question 7.

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

68.1 During my tenure as Chief Executive I was responsible for undertaking staff performance reviews for the Trust Directors and latterly the Assistant Director for Clinical and Social Care Governance.

**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 Please see my response to Question 44.

**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.**

70.1 During my tenure as Chief Executive, I was accountable for the totality of Trust services, which included a wide range of hospital, community and primary care services provided by c14,000 staff, serving a population of c370,000 and managing expenditure in the region of £550 million.

70.2 I give this context to illustrate that I did not have regular operational contact with staff in the urology unit. The line management arrangements within the Trust placed that operational responsibility under the Director of Acute Services and, for appraisal and revalidation of Medical Staff on the Medical Director as Responsible Officer.

**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.**

I refer to my response to Question 70, in my role as Chief Executive I did not have any regular scheduled meetings with Urology staff/services.

**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 During the five and a half years I was Chief Executive of SHSCT, I made a considerable effort to be visible to staff and when meeting them would have had informal discussions about their work and concerns. I have no recollection of, nor have I been able to access any Trust records which indicate that, urology staff informally raised specific concerns about patient care and safety and/or governance concerns with me.

72.2 I would strongly encourage and expect that any such concerns would be raised through the normal line management processes, and if staff were not comfortable to do so the Trust had some independent system for raising concerns as referred to in my response to Question 20.

**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 refer to my response to Question 70, in my role as Chief Executive I did not have any regular contact with Urology staff/services. To the best of my recollection I believe the urology team and their Head of Service Martina Corrigan worked well together.

73.2 My response to Question 19 refers to the independent assurance provided by Leadership Walks by Trust Non-Executive Directors. An example of such a Leadership Walk for the Thorndale Unit (Urology) in May 2012 is included/has been provided *[48. 20120719 E Chairs Visit to 1N CAH and Thorndale Unit CAH A located in S21 10 of 2022 Attachments]:*

- Section 10 captures understanding of when and how to report an incident/error, which confirmed a good understanding by staff.
- Section 11 captures staff feedback on any concerns of staff on areas of risk.

- Section 12 asks about the timeliness of response when risks are escalated, in this example there were no concern.
- Section 13 asks about the staff getting support to manage the risks they are accountable for, in this example that was confirmed with no issues raised.

**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 During my tenure as Chief Executive of the SHSCT, I held overall responsibility for the governance of the Trust, including the management of complaints, and this did not change during my tenure. In my response to Question 7, I referred to the clarification of roles and responsibilities for clinical and social care governance following the implementation of the Trust's review of clinical and social care governance *[3. A System of Trust – CSCG Review located in S21 10 of 2022 Attachments].* This included complaints, which is outlined as Process 1: Complaints on page 22 of this document. Complaints of any nature can be raised by staff and their representatives, service users and their representatives, other public body or independent organisation. Staff can made a complaint through a variety of routes including the Trust's Complaints Policy *[50. Policy for the Management of Complaints 2013 located in S21 10 of 2022 Attachments]* or by raising a concern through the Incident Management process *[19. 2014 SHSCT Incident Management Procedure located in S21 10 of 2022 Attachments]*

74.2 The Trust also made a number of additional avenues available to staff to raise a complaint or concern regarding clinical governance. These included the Trust's Whistleblowing Policy *[Your Right to Raise a Concern (Whistleblowing) Regional HSC Framework located in Relevant to HR, Reference 2i],* their Trade Union representatives, and via their professional supervision and appraisal meetings.

74.3 There were specific processes for managing poor professional performance and conduct which might arise from a complaint which are also detailed in the 'A

System of Trust' document in pages 49 to 59. Under this process for managing poor professional performance and conduct, a flow chart setting out the steps for the screening process is included in Appendix 3 pages 49 to 57 and details that an issue of concern (ie conduct, health and/or clinical performance) be raised with the relevant Clinical Manager, and that the Clinical Manager/Operational Director informs the:

- Chief Executive
- Medical Director
- Human Resources Department
- Practitioner

It was my responsibility as Chief Executive to appoint an Oversight Group, usually comprising the Medical Director/Responsible Officer and Director of Human Resources and Organisational Development. This guidance reflects the Trust's Guidelines for Handling Concerns about Doctors' and Dentists' Performance of 16 September 2010 *[33. 20100915 Guidelines for Handling Concerns about Doctors located in S21 10 of 2022 Attachments]* which was based on Maintaining High Professional Standards in the Modern HPSS A framework for the handling of concerns about doctors and dentists in the HPSS as issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005.

74.4 The process for managing poor professional performance for Nurses, AHPs and Social Workers is also included in page 58 the A System of Trust document referenced above.

74.5 I have no recollection or can find any evidence in the information requested and provided to me by the SHSCT PI Team that I was advised that any member of the Urology Team was subject to these processes during my tenure.

74.6 Following approval and implementation of the Review of Clinical & Social Care Governance *[3. A System of Trust – CSCG Review located in S21 10 of 2022 Attachments]* the Operational Directors were responsible for performance against Departmental targets such as waiting times for care and for reporting, actioning (ie learning from and mitigating risk), managing and monitoring patient and client safety and quality of care. This includes the management of incidents, complaints and risk

registers, and accountability for implementing appropriate clinical audit and monitoring and reporting against agreed clinical indicators and agreed safety standards.

74.7 In my answer to Question 7 I have detailed the Directors of Acute Services who were in post during my tenure as Chief Executive.

74.8 Following approval and implementation of the Review of Clinical & Social Care Governance [3. A System of Trust – CSCG Review *located in S21 10 of 2022 Attachments*] the roles of Professional Executives (Medical Director/Responsible Officer, Director of Nursing and AHP Services and Director of Social Work) were defined as responsible for provision of expert professional advice, audit and consultancy, monitoring and reporting the standard of the relevant registered workforce (medical, nursing, social work and AHP), provide independent assurance on compliance with workforce standards and a corporate alert function, providing expertise advice and assurance on training and development and an adequately skilled workforce.

74.9 In my response to Question 7 I have detailed the Medical Directors and Directors of Nursing and AHPs who were in post during my tenure as Chief Executive.

74.10 The implementation of these clinical and social care governance structures also brought the function of 'Corporate Co-ordination and Overview' under my responsibility as Chief Executive. This was in practice a central point for co-ordination with Operational Directors responsible and accountable for implementation and included:

- Co-ordination of standards, guidelines, NICE, Safety Alert Broadcasts, RQIA recommendations/reviews and regional and national reviews.
- Monitoring and reporting of complaints, incidents, risk, audit, clinical indicators, patient safety and learning systems.

74.11 This function was undertaken on my behalf by the Assistant Director for Clinical & Social Care Governance, and the postholders during my tenure as Chief Executive, are listed in paragraph 6.6 of my response to Question 6.

74.12 The process for handling complaints, as referred to in paragraph 74.1, ensured all complaints were captured through a central point under the Assistant Director of

Clinical & Social Care Governance's remit. These were largely dealt with at operational level, but a number of complaints would come directly to the Chief Executive's Office, normally from elected representatives on behalf of their constituents. While these complaints would be managed in the same way, I responded personally to those addressed to me. As an example, I received MLA representation on behalf a patient awaiting a urology procedure *[49. 20130827-E Mr* Personal Infor *located in S21 10 of 2022 Attachments]* which was recorded by the central complaints point referred to above, and the response coordinated by the Acute Services Complaints manager in liaison with the Head of Urology Services.

**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 I refer to my response to Question 7 and the clarification of specific roles following the Review of Clinical and Social Care Governance *[3. A System of Trust – CSCG Review located in S21 10 of 2022 Attachments]*

**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 refer to my response to Question 7, setting out how the different aspects of clinical governance were clearly allocated to the Directors in my Senior Management Team following the implementation of the internal Review of Clinical & Social Care Governance 'A System of Trust' *[3. A System of Trust – CSCG Review located in S21 10 of 2022 Attachments].* I believe these roles were clearly set out and well communicated within the senior team and across the Trust. I am not aware of any issues caused.

**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 As Chief Executive, I believed that there were robust policies and guidelines in place that encouraged and supported staff to raise concerns or complaints either directly or through the Trust's Whistleblowing policy *[Your Right to Raise a Concern (Whistleblowing) Regional HSC Framework located in Relevant to HR, Reference 2i]* which specifically gave assurances in paragraph 16 that "If a member of staff has honest and reasonable suspicions about issues of malpractice/wrongdoing and raises these concerns through the channels outlined in the policy, they will be protected from any disciplinary action and victimisation, (e.g. dismissal or any action short of dismissal such as being demoted or overlooked for promotion) simply because they have raised a concern under this policy". However the example I provided in paragraph 20.2 and 20.3 of my response to Question 20 demonstrates that no system is perfect.

**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 Please refer to my responses to Question 7, paragraph 28.2 of Question 28 and to Question 67 for detail of clinical governance responsibilities in SHSCT and the day to day running of the urology unit.

78.2 During my tenure as Chief Executive of SHSCB I directly managed:

- The Director for Human Resources and Organisation (Mr Kieran Donaghy)
- The Medical Director (Dr Patrick Loughan and then Dr John Simpson)
- The Director of Acute Services (successively Mrs Joy Youart, Dr Gillian Rankin, Mrs Deborah Burns) who managed the Assistant Directors of Acute services.

78.3 The Director of Acute Services was responsible for performance against Departmental targets such as waiting times for care and for reporting, actioning (ie learning from and mitigating risk), managing and monitoring patient and client safety and quality of care. This includes the management of incidents, complaints and risk registers, and accountability for implementing appropriate clinical audit and monitoring and reporting against agreed clinical indicators and agreed safety standards.

78.4 Professional Executives (Medical Director/Responsible Officer, Director of Nursing and AHP Services and Director of Social Work) were responsible for provision of expert professional advice, audit and consultancy, monitoring and reporting the standard of the relevant registered workforce (medical, nursing, social work and AHP), provide independent assurance on compliance with workforce standards and a corporate alert function, providing expertise advice and assurance on training and development and an adequately skilled workforce. As Responsible Officer, the Medical Director has a specific responsibility for revalidation of the medical workforce, and a professional role in setting the clinical indicators of safety and quality for the Trust and providing independent assurance to the Board on performance against same.

78.5 The implementation of these clinical and social care governance structures also brought the function of 'Corporate Co-ordination and Overview' under my responsibility as Chief Executive. This was in practice a central point for co-ordination with Operational Directors responsible and accountable for implementation and included:

- Co-ordination of standards, guidelines, NICE, Safety Alert Broadcasts, RQIA recommendations/reviews and regional and national reviews.
- Monitoring and reporting of complaints, incidents, risk, audit, clinical indicators, patient safety and learning systems.

The postholders of the Assistant Director of Clinical & Social Care Governance during my tenure were Mrs Debbie Burns followed by Mrs Margaret Marshall.

78.6 The operational management of the Urology Unit is included in my response to Question 67.

**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 During my tenure as Chief Executive in SHSCT, the clinical governance arrangements in the Urology Department were the responsibility of the Director of Acute Services with support and input from the Professional Executive Directors (Medical Director and Director of Nursing and APHs) who were the Executive Profession Directors for this clinical workforce. Please see my response to Question 7 for detail, and the Medical Director had a specific role as Responsible Officer as described in paragraph 7.2 of my response.

79.2 To respond accurately on the specific issue of the management of governance in the Urology Department, I have spoken with Martina Corrigan on 27 May 2022, and she confirmed with me that:

- A regular Mortality & Morbidity (M&M) meeting was held for the Surgical Division of Acute Service which included and was attended by consultant urologists. There was a requirement on all individual consultants that they were to attend at least 66% of these meetings. Mrs Corrigan confirmed that minutes of and any learning from M&M meetings were shared with all consultants, staff grade doctors and the Medical Director.
- Any issues arising from M&M meetings would be discussed at the Medical Forum chaired by the Medical Director and attended by Associate Medical Directors.
- On the 2nd Friday of each month the Director of Acute Services held a Directorate Governance meeting attended by Associate Medical Directors and Assistant Directors which reviewed SAIs, complaints, and any significant learning from M&M meetings.
- The Assistant Directors for Acute Services then mirrored the content of this Governance meeting in their areas of responsibility.

79.3 As relevant to my role, I assured myself that this was being done properly by reviewing and checking/challenging the suite of reports that were compiled for Governance Committee and Trust Board. Specific examples include papers that were presented to the following meetings:

- Governance Committee 10 May 2011 *[11. 20110510 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* under Agenda Item 5, the Medical Director referred to a Review of Mortality & Morbidity Meetings that was underway, under Agenda Item 8 the Report on Incidents and Complaints was presented, and under Agenda Item 10 the Medical Director updated on Medical Appraisals and Revalidation.
- Governance Committee 6 December 2011 *[20. 20111206 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* under Agenda Item 8 the Medical Director presented the Mortality Report, the Medical Appraisal Annual Report 2009 (advising that 98% of consultants had completed their appraisal) and confirmed that the review of Mortality & Morbidity Meetings had been completed.
- Governance Committee 15 March 2012 *[27. 20120515 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* under Agenda Item 9 a report on compliance with Standards & Guidelines Jan – March 2012 was presented.
- At all Trust Board meetings, the monthly Board Performance Report was presented and discussed in terms of variance against Commissioner targets and standards.

**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 Please see my response to Question 79.

**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 During my tenure as Chief Executive, the responsibility for the delivery of performance and activity metrics clearly sat with the operational Director, in the case of urology this was the Director of Acute Services.

81.2 The responsibility to provide an oversight of performance and activity metrics to myself, the Senior Management Team and Trust Board through a monthly Performance Report sat with the Director of Performance and Reform, during my tenure this was Paula Clarke.

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?

Urology Services were specifically referred to in the monthly Board Performance Reports when there was variation in performance against access or Trust targets, as an example in my response to Question 54. Patient risk and safety was reported under a range of reports to Trust Board and Governance Committee, as referred to in my response to Question 12, and any significant issues and risks highlighted.

**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 Please see my response in paragraph 12.19 to Question 12. As well as the Incidents & Complaints Management Report referred to in my response, concerns could also be raised by external bodies such as the Trust's Commissioner (as was the case in my response to Question 97 as described in paragraph 97.2 (1)) by the annual survey of Junior Doctors through the Specialty Programme Reviews such as that for Urology in *2014 [51. 20141015 Speciality Programme Review of Urology for the ST A2 located in S21 10 of 2022 Attachments],* and by inspections of regulators such as Regulation & Quality Improvement Agency (RQIA) and professional bodies for the medical workforce.

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

84.1 As previously explained, I do not have direct access to Trust records and therefore cannot give an accurate answer to this question.

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

85.1 Please see my response to Question 12.

**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 Please see my response to Question 12. During my tenure I had no information or indication that there were governance issues in urology, other than those I have specified in my response to Question 97.

**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 I refer to my response to Question 97.

**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 As Chief Executive, I would not have information on patient data collected specifically in the Urology Unit. I have referred in my answer to Question 22 to the independent benchmarking and reported to SMT and Trust Board. I would suggest that this information could more accurately be provided by Dr Gillian Rankin, Director of Acute Services, her Assistant Director responsible for Urology services, Mrs Heather Trouton, or the Head of Service Mrs Martina Corrigan.

88.2 Patient data was regularly collated by the Trust, and reported to Governance Committee and/or Trust Board in the following reports:

- Mortality Report and Patient Safety and quality metrics (Medical Director)
- Complaints and Incidents Report (Assistant Director for Clinical & Social Care Governance.
- Patient & Client Experience Committee reports.

**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 Please refer to my response to Question 22. The Patient & Client Experience Committee of the Trust Board captured user experience data, but clinical outcomes

would have come under the responsibility of the Medical Director to define, monitor and report.

**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 I refer to my response to Question 92 below in relation to work completed on capacity/demand analysis and inclusion of activity objectives in consultant Job Planning (individual and Team) within the Trust. The demand/capacity modelling carried out within the Trust would have ensured this was as accurate as possible. This was the responsibility of operational Directors and Associate Medical Directors. Professional performance objectives would have been agreed through the Medical Appraisal System.

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

**Regarding Consultant Appraisal:**

91.1 Consultant Job Planning, Appraisal and Revalidation came under the professional accountability and responsibility of the Medical Director which was exercised under the Trust's Policy for Medical Appraisal *[52. 20140701 Policy-Southern Trust Appraisal Scheme for Medical Staff located in S21 10 of 2022 Attachments].*

91.2 An annual report on compliance with appraisal was brought to Governance Committee each year for scrutiny and challenge, and any issues raised were addressed as appropriate. The Medical Director also updated the Governance Committee monthly under their Medical Director report which was a standing agenda item on Governance Committee.

91.3 To provide the Inquiry with evidence of this practice I have reviewed the Governance Committee minutes during my tenure from May 2010 to February 2013 and refer to the following minutes, reports and discussions:

- Governance Committee 8 March 2011 [53. 20110308 Approved Governance Committee minutes *located in S21 10 of 2022 Attachments*] references a discussion under Agenda Item 7 (Report on Risk Management, Complaints and Patient/Client Safety) where it was confirmed that under the Consultant Appraisal Scheme in SHSCT, appraisees would get a list of complaints and incidents and their Appraiser would undertake a structured learning process through discussion of one complaint and one incident as part of their annual appraisal.
- Governance Committee 10 May 2011 *[11. Reference 20110510 Approved Governance Committee minutes located in S21 10 of 2022 Attachments],* under Agenda Item 10 (Medical Director Report) Dr Loughan undertook to address the reported low level of consultant appraisals.
- Governance Committee 6 September 2011 *[12. 20110906 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* the Medical Director who replaced Dr Loughran, Dr John Simpson, updated on medical appraisal and revalidation as part of his Medical Director Report under Agenda Item 8 Professional Governance Reports (this new format for Governance Committee Agenda reflected the implementation of the new Clinical & Social Care Governance arrangements following the Trust's Review of Clinical and Social Care Governance 'A System of Trust' as previously referenced in Question 7).
- Governance Committee 6 December 2011 *[20. 20111206 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* Agenda item 7 Medical Director's annual Medical Appraisal Report 2009 which evidenced that, Trust-wide, 98% of consultants had completed their appraisal.
- Governance Committee 7 February 2012 *[25. 20120207 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* Agenda Item 9(i) Medical Directors report, where Dr Simpson reported on Medical Appraisal for 2010 reflecting high performance, and where he confirmed that any doctors who had not completed their 2010 appraisal were being contacted directly by him.
- Governance Committee 4 December 2012 *[30. 20121204 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* Agenda Item 8: Medical Directors report, where Dr Simpson reported on Medical Appraisal and

Revalidation and confirmed that where doctors do not engage in appraisal then the General Medical Council (GMC who licence doctors to practice) would be informed.

- Governance Committee 5 February 2013 *[13. 20130205 Approved Governance Committee minutes located in S21 10 of 2022 Attachments]* Agenda Item 18(i) Medical Directors report, where Dr Simpson reported on Medical Appraisal and Revalidation.

91.4 I believe this evidence demonstrates that the system for Consultant Appraisal worked well in terms of management and scrutiny.

**Regarding Consultant Job Planning**

91.5 Due to the importance of effective and consistent Consultant Job Planning on the performance of the Trust, I personally chaired a Job Consultant Steering Group between 2010 and 2011. This Steering Group was attended by the Medical Director and all Associate Medical Directors, the Director of Human Resources and Organisational Development (Kieran Donaghy) and the Director of Finance (Stephen McNally).

91.6 I have requested and received from the SHSCT a sample of the minutes of this Steering Group meeting and summarise the discussions below:

- Consultant Job Planning Steering Group 17 November 2010 *[54. 20110302 Diary Consultant Job Planning Steering Group notes from 17 Nov 2010 A2 located in S21 10 of 2022 Attachments]* which included a presentation by the Commissioner's [Health & Social Care Board] Project Team for Capacity Evaluation and modelling and refers to work completed on capacity/demand analysis and consultant Job Planning (individual and Team) within the Trust.
- Consultant Job Planning Steering Group 2 March 2011 *[55. 20110928 Diary Consultant Job Planning Steering Group A2 located in S21 10 of 2022 Attachments]* which confirmed that the Medical Director (Dr Loughran) had met with all AMDs, a request to Operational Directors to consider short term measures to allow jo planning to be completed, and under Agenda Item 4i) an updated from Surgery and Elective Care (which covered urology) that draft Job Plans were in place for when there is a full complement of consultant staffing.

It was further agreed at this meeting that a high level summary of each Steering Group meeting would be made available to all consultants.

- Consultant Job Planning Steering Group 28 September 2011 *[55. 20110928 Diary Consultant Job Planning Steering Group A located in S21 10 of 2022 Attachments]* where an update on Capacity Planning was given by Paula Clarke, Director of Performance & Reform.

91.7 From the work of this Steering Group and supported by the Medical Director and Medical HR, a suite of agreements on consultant job planning were reached, which are summarised in the Trust's Framework on Consultant Job Planning for Medical Managers *[56. 20150216 E and Reports Consultant Job Planning Framework on Job Planning for Medical Managers located in S21 10 of 2022 Attachments]*

91.8 I believe this evidence demonstrates that the system for Consultant Job Planning was developed through engagement with Medical Managers and worked well in terms of management and scrutiny.

**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 During my tenure as Chief Executive, concerns that had the potential to impact on patient safety were broadly dealt with as set out in my response to Question 7 which details the Clinical and Social Care process, roles and responsibilities and those Directors with responsibility for same.

92.2 Governance concerns related to patient care and safety could be raised in a variety of ways as detailed in the Board Assurance Framework:

- The Trust's Complaints procedure
- The Serious Adverse Incident Reporting System
- Trust and Directorate level Risk Management processes

- The Trust's Whistleblowing and Raising Concerns processes
- Medical appraisal and revalidation
- Staff appraisal

**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 I felt and was very supported in my role as Chief Executive by the Chair of the Board, Trust Board and my Senior Management Team including the Medical Director. I cannot recall any specific examples relating to urology but would refer to my response to Question 30 relating to the Pseudomonas incident as an example of how I was supported in my role as Chief Executive.

**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 Directors - the Inquiry understand these to have been Patrick Loughran and John Simpson;**

**(iv) The Directors of Acute Service – the inquiry understands these to have been Gillian Rankin and Debbie Burns;**

**(v) The Director of Human Resources and relevant Human Resources personnel – (please name)**

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

**(vii) The Associate Medical Directors - the inquiry understands this to have been Eamon Mackle (Surgery) and Charlie McAlister (Anaesthetics)**

**(viii) The Clinical Directors, the inquiry understands this to have been Robin Brown and Sam Hall;**

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

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

**(xi) The Nurse Managers – the inquiry understands this to have been Shirley Tedford and Gillian Henry.**

**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 The Trust Board: As Chief Executive I was required to attend all Trust Board meetings, Trust Board workshops and the Governance Committee. These formal meetings, as well as informal discussions with Non-Executive Directors ensured that I had significant contact with Trust Board members. With the Chair of the Trust Board, I would also meet formally with the Non-Executive Chairs of Board Sub-Committees. I would also have met informally with the Chair at least weekly and with Non Executive Directors as I met them on their visits to the Trust. My formal and informal meetings with my Directors, who also attended Trust Board and Board sub-committee meetings including Governance Committee, are detailed in my response to Question 9.

94.2 The Chair of the Trust Board: As Chief Executive, I had an extremely good working relationship with both the Chairs during my tenure, Mrs Ann Balmer and Mrs Roberta Brownlee, this relationship was mutually respectful but with appropriate challenge and scrutiny. I have set out in my response to Question 11 my formal and informal meetings with the Chair of Trust Board.

94.3 The Medical Directors, the Directors of Acute Services, the Director of Human Resources and relevant Human Resources personnel (please name): In my response to Questions 9 and 11 I have set out my liaison, formal and informal meetings with members of my Senior Management Team which includes the above Directors. The Director of Human Resources and Organisational Development during my tenure was Kieran Donaghy who reported to me as a member of the Senior Management Team. I did not have regular contact with his personnel.

94.4 The Assistant Directors – Heather Trouton and Ronan Carroll: These Assistant Directors were line managed by the Director of Acute Services, and so I would have had little contact through formal meetings. I did however have informal discussions as I would have met them fairly regularly on my walkabouts.

94.5 The Associate Medical Directors – Eamon Mackle (Surgery) and Charlie McAllister (anaesthetics): These Associate Medical Directors (AMDs) were line managed by the Director of Acute Services and professionally supervised by the Medical Director, and so I would have had little contact through formal meetings other than my attendance at the Medical Forum chaired by the Medical Director and attended by all AMDs, at the Medical Staff Committees for Craigavon and Daisy Hill Hospital which I also regularly attended, and during the duration of the Consultant Job Planning Group which was chaired by the Medical Director and attended by all AMDs which I regularly attended. I also had informal discussions with these AMDs as I would have met them fairly regularly on my walkabouts and visits to services. I would consider that I had an open and trusting relationship with all AMDs and would be confident that they would have raised significant concerns with me should they feel that these concerns were not being addressed.

94.6 The Clinical Directors – Robin Brown and Sam Hall: These Clinical Directors were line managed by the Associate Medical Directors (AMDs) and the Assistant Directors and professionally accountable to the Medical Director, and so I would have had little contact through formal meetings other than my attendance at the Medical Forum chaired by the Medical Director and attended by all AMDs (when these Clinical Directors would have deputized for their AMD), at the Medical Staff Committees for Craigavon and Daisy Hill Hospital where Mr Brown was based. As I regularly attended

the Consultant Job Planning Group, referred to above, I would have met them at this Group if they were deputising for their AMDs. I also had informal discussions with these Clinical Directors, particularly Mr Brown, as I would have met them fairly regularly on my walkabouts and visits to services. Although not as frequent as for AMDs I would consider that I had regular contact with Clinical Directors over my years in SHSCT and would be confident that they would have raised significant concerns with me should they feel that these concerns were not being addressed.

94.7 The Head of Service, namely Martina Corrigan: As Martina Corrigan was line managed by Heather Trouton I would have very little formal contact with her other than at the urology meetings on 'Team South' which I would have attended as able to.

94.8 The consultant urologists in post: The consultant urologists were line managed through the Clinical Directors and Head of Service by the Associate Medical Directors (AMDs) and the Assistant Directors and professionally accountable to the Medical Director, and so I would have had little contact through formal meetings other than my attendance at the Medical Staff Committee for Craigavon Hospital. I would have known Mr Young and Mr O'Brien best out of the consultant urology team due to their long tenure, but I also attended meetings related to service change and particularly 'Team South' where I would have had discussions with the urology consultants in post. I also had informal discussions with most consultants, as I would have met them fairly regularly on my walkabouts and visits to services.

94.9 The Nurse Managers – Shirley Tedford and Gillian Henry: I can only recall Shirley Tedford being in post as Nurse Manager during my tenure as Chief Executive, and I believe she was line managed by Martina Corrigan as Head of Service with professional accountability through the nursing workforce governance put in place by Mr Rice as Director of Nursing & AHPs. I would have no regular meetings with Nurse Managers and only informal discussions with most Nurse Managers, as I would have met them fairly regularly on my walkabouts and visits to services.

I have described my liaison with the individuals listed in my response above.

**In providing your answer, please set out in detail the precise nature of how your roles interacted in terms of:**

**(i) governance generally, and (ii) specifically with reference to urology services concerns.**

94.10 My role as Chief Executive and the governance relationships with Operational and Professional Directors and the Assistant Director for Clinical and Social Care Governance are set out in 'A System of Trust' *[3. A System of Trust – Review of CSCG located in S21 10 of 2022 Attachments]* and detailed in my response to Question 7. In relation to urology services concerns related to the general capacity of the urology service I attending the meetings referred to in paragraph 50.3 of my response to Question 50. I did not attend any meetings related to the concerns referred to in the Investigation Reports by Dr Chada and Dr Khan referred to paragraph 98.2 in my response to Question 98 and in my response to Question 118 as these post-dated my tenure.

**Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken.**

94.11 During my tenure as Chief Executive and based on the documents provided to me by the SHSCT PI Team I did not attend any meetings or have access to any such documents other than those provided to SMT Governance, Governance Committee and Trust Board or referred to in my response in paragraph 94.10 above.

94.12 I have requested from SHSCT PI Team any minutes and papers for the above meetings where any urology concerns (other than performance against waiting time targets) were raised during my tenure and, other than in my response to Question 97, I have not been provided with any further evidence in response to this question. Should such evidence be discovered and shared with me following this submission I will review same, amend my statement accordingly and resubmit to the Inquiry.

**Your answer should include any individuals not named in (i) – (xi) above but with whom you interacted on matters falling within the Inquiry's Terms of Reference.**

94.13 I do not believe there are any other individuals I would have interacted with that are not included in the list above or that I have not already mentioned in my response to other questions.

**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 During my tenure as Chief Executive until I left in March 2015, I understood all the Trust's services, including urology services, were operating in line with the requirements of 'A System of Trust' *[3. A System of Trust – CSCG Review located in S21 10 of 2022 Attachments],* with the relevant assurance mechanisms under the responsibility of the Operational Director for Acute Services and the Professional Directors, and underpinned by the processes for complaints, staff raising concerns, controls assurance standards, risk management policies procedures, and associated assurance reporting to SMT, Governance Committee and Trust Board referred to in my response to Question 22.

95.2 My conversation with Martina Corrigan on 27th May 2022, as referred to in my response to Question 79, confirmed that the Acute Directorate was compliant with governance requirements during my time in tenure as Chief Executive.

95.3 There was nothing of significant concern raised through these assurance mechanisms that alerted me to issues of serious concern in terms of patient care and safety within urology service, with the exception of the urology service's performance against patient access standards as highlighted in Trust Board performance reports.

**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.**

I believed the Urology service to be operating adequately in terms of clinical and social care governance, but not in respect of performance against the Commissioner's targets for waiting times as is referenced in my response to Question 81.

**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.**

97.1 During my five and a half years as Chief Executive in SHCST until 31 March 2015, and having sought and been provided with considerable documentation by the SHSCT PI Team which I have reviewed, I can only recall four specific issues that would have been come to my attention in addition to the issues of urology performance against waiting time standards reported in Trust Performance Reports, which I have detailed in my response to Question 81.

97.2 I have detailed these issues below, referring to the specific matters, as relevant, listed in (a) to (h) of this question:

(1) An email on 17 July 2009, copied to Colm Donaghy (the then Trust Chief Executive) attaching two letters to Mr Aiden O'Brien from Dr Patrick Loughran, then Trust Medical Director *[20090717 E letters to Aiden O'Brien from Dr Loughran located in Relevant to PIT/Evidence Added or Renamed 19 01 2022/Evidence no 77/No 77 – Mairead McAlinden.* Letter 1) dated 17 July 2009 refers to previous conversations and correspondence between Dr Loughran and Mr O'Brien regarding the list of patients who were in the programme for repeated IV fluids and antibiotics, the commissioner's uncertainty of the evidence base for these therapies, an action to undertake an independent formal clinical assessment to inform advice to the Chief Executive (then Colm Donaghy). This letter asks Dr O'Brien to take a final opportunity to consider an alternative way to treat these patients and offers an opportunity to Mr O'Brien and Mr Young to discuss further with Dr Loughran. Letter 2) dated 17 July 2009 refers to two clinical incidents in patients admitted for IV Therapy and advises that these patient notes have been requested to get further details.

(a) These concerns were raised in an email from Dr Loughran, then Medical Director, which was forwarded to me on 17 July 2009 'in Colm's absence' and I assume I was covering for the Chief Executive's annual leave as I was Director of Performance and Reform/Deputy Chief Executive at that time. The actions taken as a result of those concerns are detailed in a verbal update given by Dr Rankin in the confidential section of the Trust's Governance Committee on 7 September 2010 [2. 20100907 Approved Governance Committee minutes *located in S21 10 of 2022 Attachments*] under Any Other Business Agenda Item 8. A Briefing Note on clinical issues in Urology Services *[57. 20100920 E Briefing Note to Trust Brd located in S21 10 of 2022 Attachments],* referring to this issue and that of a slightly increased rate of cystectomies for benign pathology in Craigavon Hospital was brought to Trust Board Confidential Section on 30 September 2010 *[58. 20100930 Confidential minutes located in S21 10 of 2022 Attachments],* setting out the actions for both issues as follows:

(b) The Director of Acute Services (Dr Gillian Rankin) and Associate Medical Director (Mr Eamon Mackle) had met with the two urology consultants (I believe

this referred to Mr O'Brien and Mr Young) individually to require the immediate case review of the cohort of patients receiving IV Fluids and Antibiotics, which had reduced considerably to approximately 10 patients since January 2010, which indicates ongoing action following Dr Loughran's letter above. This review was to be chaired by the Clinical Director of Surgery and Elective Care and involved Dr Nizam Damani, Consultant Microbiologist SHSCT, to advise on optimal antimicrobial therapy, with all future patients for whom the urologists sought to treat in this way having to be reviewed in this manner. Both consultant urologists had agreed to participate in this process which was underway at this date.

(c) and (d) To assess the potential impact on patient care and safety in relation to the slightly increased rate of cystectomies, the Trust had commenced a process of screening where the file of each patient who had undergone cystectomy in the past 10 years would be reviewed by the Associate Medical Director for Surgery and Elective Care (I believe that to be Eamon Mackle). The professional advice of a UK urologist with direct knowledge of this field would be sought as required. The report of this screening review would identify if no further action was required or if a more in-depth analysis is required. Each of the two consultants had been informed of this process in discussion and in writing. This briefing also updated Trust Board on the progress against a recommendation of the Regional Urology Review [all radical pelvic urological surgery to be moved to the Belfast Trust which now explicitly covered both malignant and benign conditions], referring to ongoing discussions with Health and Social Care Board and Belfast Trust regarding individual cases during the transition period.

(e) and (f) Although I was not Chief Executive at this time, I was assured that these issues were being satisfactorily dealt with at operational level by the Director of Acute Services (Dr Gillian Rankin) and on a professional level by the Medical Director (Dr Patrick Loughran).

(g) and (h) I believe the systems and agreements put in place were successful in addressing the concern raised, I have been advised by Martina Corrigan that a system of ensuring there were no inpatient admissions for IV Therapy and Antibiotics was in place, and the transfer of all radical pelvic urological surgery to

be moved to the Belfast Trust which now explicitly covered both malignant and benign conditions was underway.

(2) Given my attendance at the Consultant Job Planning Group, as described in my response to Question 91, and the procedures agreed therein, (a) I was advised in a memo dated 12 October 2011 *[20111012-E Re Facilitation Case located in Relevant to PIT/Evidence Added or Renamed 19 01 2022/Evidence no 77/No 77 – Mairead McAlinden]* from Malcolm Clegg, SHSCT Medical Staffing, that Mr O'Brien Consultant Urologist and his Associate Medical Director Mr Eamon Mackle had been unable to conclude a finalised Job Plan for Mr O'Brien and (b) that the matter had been referred to facilitation. (c) and (d) There were no concerns in relation to patient care and safety raised. (e) The consultant job planning process had defined escalation routes when job plans could not be agreed, referral for facilitation in this case. In response to (f), (g) and (h) assurance had previously been given that draft urology job plans (team and individual) were in place for when a full complement of staff was in place as noted in the minutes of the Consultant Job Planning Steering Group on 2 March 2011 under Agenda Item 4: Update by AMDs towards completion of 2011/12 job plans by April 2011 *[55. 20110928 Diary Consultant Job Planning Steering Group A].* This was the responsibility of the Associate Medical Director to pursue, address and escalate as necessary to the Medical Director.

(2) I have a recollection, but no evidence, of an informal discussion with the (a) Director of Acute Services (Debbie Burns) at some period in 2014 informing me that a backlog of urology referrals for triage had been located in Mr O'Brien's office. She assured me that this was being promptly addressed at operational level and that she would have a meeting with Mr O'Brien and his Clinical Director, who I believe was Mr Michael Young at that time, to agree preventative action to ensure this issue did not recur. I do not have any notes of this meeting. (b) and (c) I am not aware of the operational steps taken to risk assess the potential impact of this backlog of referrals or that there were any concerns about impact on patient care and safety. (d) I understood (and this has been confirmed in my reading of the Report of Investigation *[Report of Investigation – MHPS Mr A O'Brien – Final June*

*18* ***bates reference TRU-00661-TRU00705****]* which post-dated my tenure) that there was an action taken by Mr Michael Young, Clinical Director for Urology, to assist Mr O'Brien by doing his 'consultant of the week' triage as Mr O'Brien was chairing a regional group. (e) and (f) As Chief Executive I was assured that the Director of Acute Services would monitor this issue and alert me again if the situation recurred. (g) and (h) Given what I have read in the Report of Investigation referred to above, this mitigating action did not address the concern of Mr O'Brien's triage in the longer term, and I have referred to this under my response to the questions on 'Learning'.

(3) During my tenure as Chief Executive, I regularly received letters of general complaint into my office. I specifically recall letters to complain about the withdrawal of the inpatient IV Fluids and Antibiotics service referred to in (1) above, the majority were in relation to the extended waiting times for access (which was not unique to urology). These letters would have been forwarded to the Director of Acute Services for investigation and response, with a corporate overview reported in the Incidents and Complaints report to Governance Committee as referenced in my response to Question 74.

97.3 By far the greatest issue that I was aware of in respect of urology services was the extending patient waiting times which I have referred to in my response to Question 81.

**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 During my tenure as Chief Executive I believed that the issues of concern I have referred to in my response to Question 97 were, on the whole, properly identified, their extent and impact assessed, and the potential risk to patients properly considered. concerns, that the potential risk to patients was properly considered, and that communication and escalation of concerns to the Chief Executive, Governance

Committee and Trust Board were at an appropriate level with regard to the level of concern.

98.2 Having read the Reports of Investigation by Dr Chada *[Report of Investigation – MHPS Mr A O'Brien FINAL June 2018* ***bates reference TRU-00661-TRU00705****]* and Dr Khan *[20180928 email Case Manager Determination AO'B FINAL 280918 attachment located in Relevant to MDO, Evidence after 4 November MDO, Reference no 77, no 77 Dr Kahn and Dr Wrights emails]* that post-dated my tenure, it would now appear that the issues of Mr O'Brien's triage has subsequently been a matter of persistent concern that was not properly escalated.

**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 During my tenure as Chief Executive, I had responsibility to provide, as far as possible within the constraints of finance and workforce on the Trust, the resources needed to support staff to do their job well, and specifically to have the appropriate professional and HR support structures in place to enable this support. While operational directors had general responsibilities in terms of the Trust as a good employer, there were specific professional workforce responsibilities on the Medical Director (for Medical staff) and the Director of Nursing and AHPs. I was not aware that the concerns I have referred to in my response to Question 97 identified that any such support was required or requested for the Urology Department.

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

100.1 In November 2008, when I was Director of Performance and Reform in SHSCT, the SMT agreed an exploration of 'Lean Methodology' as a key enabler of the Trust's Continuous Improvement (CI). My Assistant Director, Paula Clarke, brought a paper in January 2009 which is included towards the end of the electronic papers for this meeting *[59. CE Candidate Info Pack located in S21 10 of 2022 Attachments]* CE

Candidate Info Pack on progress and proposing 'next steps' for SMT approval, and refers to an initial list of 'spotlight' projects that had been agreed with the Directors.

100.2 To the best of my recollection, this would have specifically supported urology services in terms of:

- Productive Theatres
- A review and reset of outpatient templates/aligning with and establishing booking rules, with an output to include a demand/capacity model worked through to action plan stage/steps required to increase capacity. This refers to a diagnostic on internal demand/capacity being completed, which would have included urology services.
- The 'Productive Ward' initiative

100.3 A specific quality improvement initiative in urology was 'Blue Skies Thinking' for Outpatients, which took forward ideas and experience from other Trusts raised by a new urology consultant, Mark Haynes, who was appointed in 2014. From the evidence provided to me I am aware that there was a meeting in June 2015 with HSCB and Trust managers and clinicans to discuss improvement proposals, but I have no further details as this took place after my 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)?**

101.1 As Chief Executive, I had ultimate responsibility for the c14,000 staff employed by the Southern Trust. In Mr O'Brien's case, this was a delegated responsibility to the Director of Acute Services for operational purposes including patient safety and quality of care, and to the Medical Director for arrangements for professional supervision and revalidation. I would have had very infrequent contact with Mr O'Brien during my tenure in my role as Chief Executive, and I have referred to specific meetings which I attended related to the Review of Urology where Mr O'Brien may have been in attendance.

**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 Other than my participation in the Consultant job Planning Group which set out the policies and procedures for Consultant Job Planning and monitoring the implementation of same, as detailed in paragraph 91.5 of my response to Question 91 I had no direct involvement in Mr O'Brien's job plan(s).

**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 Other than the issues referred to in my response to Question 97, I was not aware of any other significant concerns regarding Mr O'Brien. I understand that a Serious Adverse Incident was reported in 2016, but as I left the Trust in March 2015 and moved to Devon in England at that time, I was not aware of such issues being raised. I have had no work-related contact with Mr O'Brien since I left the Trust.

**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.**

104.1 Please see my response to Question 103.

**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 Please see my response to Question 103.

**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 Please see my response to Question 103.

**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 Please see my response to Question 103.

**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 Please see my response to Question 103.

**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 Please see my response to Question 103.

**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 Please see my response to Question 97.

**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 Please see my response to Question 98.

**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 Please see my response to Question 103.

**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 During my tenure with the SHSCT, I had no occasion to raise concerns about Mr O'Brien's conduct/performance.

**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 Please see my response to Question 103.

**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 Please see my response to Question 103, and for the clinical concerns about outpatient backlogs see my response to Question 54.

**116. Did you communicate in any way, either formally or informally, with your predecessor Chief Executive, Colm Donaghy, or your successor, Paula Clark, 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 I had no reason to, and did not, communicate, either informally or formally, with my predecessor Chief Executive, Colm Donaghy, or my successor, Paula Clark, in relation to any specific concerns regarding urology services such as patient safety, clinical risk or governance issues.

**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 Please see my response to Questions 97 and 98.

117.2 The position in terms of waiting times for urology services in SHSCT, as generally across Northern Ireland at that time, were not compliant with access targets set by the Minister for Health and the Health and Social Care Board. Indeed in August 2014 I was approached by the Chief Executive of the Northern Health & Social Care Trust, Tony Stevens, seeking SHSCT urology services support to undertake Waiting List Initiatives (WLI) to address the capacity issues in that Trust *[20140813-E CONFIDENTIAL – SHSCT urology support to NHSCT located in Relevant to*

*PIT/Evidence Added or Renamed 19 01 2022/Evidence no 77/No 77 – Mairead McAlinden]*

**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 As detailed in paragraph 98.2 of my response to question 98, I have been provided by the SHSCT PI Team the Investigation Reports authored by Dr Neta Chada and Dr Khan which post-dated my tenure as Chief Executive of SHSCT. I was not aware of these concerns during my tenure, with the exception of one concern raised in relation to Mr O'Brien's triage which I have detailed in my response to Question 97. I believe a more robust escalation to the Assistant Director of Acute Services with responsibility for the Referral & Booking Centre in respect of delayed returns of referral letters from consultant triage should have been in place, both within the Acute Services Directorate and in terms of organisational governance. While this concern was informally raised with me by the Director of Acute Services, as referenced in my response to Question 97, there was no organisational reporting of such triage delays that would have alerted me or Trust Board to this issue.

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

119.1 Please see my response to Question 118, I believe while there was most definitely pressure on urology services at that time (and indeed still are) it would appear from reading the Investigation Reports that it was not endemic to the Trust or the Urology Team but rather with Mr O'Brien's administrative practice.

**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?**

120.1 Please see my responses to Questions 118 and 119.

**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 As the concerns raised in 2016 and the subsequent Investigation Reports post-date my tenure, I can only refer to the content of these reports.

**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?**

122.1 Please see my responses to Questions 118 and 119.

**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 Please see my response to Question 12 and my actions to ensure that governance arrangements within the Trust were fit for purpose during my tenure as Chief Executive. My actions were in response to previous concerns being raised by staff in the Trust-wide review of Clinical & Social Care Governance arrangements as detailed in paragraph 31.2 of my response to Question 31. Any system of governance is a continual 'work in progress' by adopting best practice and a learning focus. In terms of governance arrangements for Urology, I refer to paragraph 79.2 of my response to Question 79, which would indicate a good system of governance.

**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?**

Urology Services Inquiry

124.1 I believe there is nothing else relevant to add to my responses to the questions in this Notice.

**Statement of Truth**

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

Signed: Personal Information redacted by USI

Date: 11th June 2022

Section 21 Notice Number 10 of 2022

Attachments

| Attachment | File Name |
|---|---|
| 1 | Chief Executive MAIREAD McALINDEN JD |
| 2 | 20100907 Approved Governance Committee Minutes |
| 3 | A System of Trust – CSCG Review |
| 4 | 20130829 Confidential Minutes |
| 5 | 20110825 TB Public Minutes |
| 6 | ANNUAL_REPORT_AND_ACCOUNTS_2014-15 |
| 7 | 2014-2015 Schedule of Reporting to Governance Committee |
| 8 | 20120514 Briefing for ST End Year Strategic Review and Accountability meeting S and G report |
| 9 | 20101207 (20110118) Confidential Governance Committee minutes |
| 10 | 20150326 Performance Report a |
| 11 | 20110510 Approved Governance Committee minutes |
| 12 | 20110906 Approved Governance Committee minutes |
| 13 | 20130205 Approved Governance Committee minutes |
| 14 | Edition-01-SAI-Learning-Report-April-September-2011 |
| 15 | 201809 Risk Management Strategy |
| 16 | 20120719 E Chairs Visit to In CAH and Thorndale CAH A |
| 17 | 20141001 SHSCT Incident Management Procedure |
| 18 | 20110224 TB Public Minutes |
| 19 | 20100429 TB Public minutes |
| 20 | 20111206 Approved Governance Committee minutes |
| 21 | 20140909 CRR a |
| 22 | Employment Info for SJ and JH |
| 23 | 20120226 Pseudomonas – Trust Chronology of events Timeline – updated 3feb2012 |
| 24 | 20130829 E and IPT SHSCT Pseudomonas 5 Aug 13 A |
| 25 | 20120207 Approved Governance Committee minutes |
| 26 | 20120301 TB Public Minutes |
| 27 | 20120515 Approved Governance Committee minutes |
| 28 | 20120515 Confidential minutes |
| 29 | 20120614 TB Public Minutes |
| 30 | 20121204 Approved Governance Committee minutes |
| 31 | 20100325 TB Public Minutes |
| 32 | 20140529 TB Public Minutes |
| 33 | 20100915 Guidelines for Handling Concerns about Doctors |
| 34 | 20141023 TB Public Minutes |
| 35 | 2010 11 IPR Chief Executive |
| 36 | 20100128 TB Public Minutes |
| 37 | 20090924 TB Public minutes |
| 38 | 20140402 Diary Urology Pre Meeting |
| 39 | 20140510 E for diary Urology Review Stocktake |
| 40 | 20140731 E re urology modernisation meeting |
| 41 | 20140819 E Urology Sustainability Proposal |

| | |
|---|---|
| 42 | HM700-ltr to Trust Directors of Acute re urology review implementation |
| 43 | Team South Implementation Plan v0.3 |
| 44 | Integrated Elective Access Protocol (IEAP) Awareness presentation Oct 2008 |
| 45 | 20130910 CRR |
| 46 | 20120320 E urology review revenue case A2 |
| 47 | 20120320 Urology Review Final Report A |
| 48 | 20120719 E Chairs Visit to 1N CAH and Thorndale Unit CAH A |
| 49 | 20130827-E Mr MJO |
| 50 | Policy for the Management of Complaints 2013 |
| 51 | 20141015 Speciality Programme Review of Urology for the ST A2 |
| 52 | 20140701 Policy- Southern Trust Appraisal Scheme for Medical Staff |
| 53 | 20110308 Approved Governance Committee minutes |
| 54 | 20110302 diary consultant job planning steering group notes from 17 Nov 2010 A2 |
| 55 | 20110928 Diary consultant job planning steering group A |
| 56 | 201502016 E and reports Consultant Job Planning framework on job planning for medical managers |
| 57 | 20100920 E Briefing note to Trust Brd |
| 58 | 20100930 Confidential minutes |
| 59 | CE Candidate Info Pack |

Southern Health and Social Care Trust

## JOB DESCRIPTION

| | |
|---|---|
| **JOB TITLE** | Chief Executive |
| **INITIAL LOCATION** | Trust Headquarters, Craigavon Area Hospital |
| **REPORTS TO** | Trust Board |
| **ACCOUNTABLE TO** | Trust Board through to the Minister for Health |

### 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, Social Services and Public Safety (DHSSPS), Health and Social Care Board (HSCB).

As the Accountable Officer for the Trust, the Chief Executive is accountable to the Trust Board, DHSSPS 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 performance targets established.

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

The Chief Executive will lead reform within the Trust including the achievement of all organisational objectives, ensuring that appropriate, robust systems are in place and necessary changes are achieved.

The Chief Executive is responsible for ensuring the Trust delivers high quality services and achieves the vision, values and priorities of the Trusts business in line with the 5 year 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. In particular, work with the HSCB to ensure

that the business plan fully reflects the priorities of the Board and its expectations in terms of delivery.

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 DHSSPS 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 high levels of performance and excellence against Controls Assurance and other standards required.

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

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

**STRATEGIC LEADERSHIP**

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

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

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

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

**CORPORATE MANAGEMENT**

14. With the Chairman, be responsible for the organisational structure of the Trust, its probity and effectiveness.

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

16. 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.

17. 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.

18. Ensure that systems and processes are in place to enable the Trust Board and the HSCB 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**

19. 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.

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

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

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

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

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

**EXTERNAL RELATIONSHIPS**

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

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

27. Work with the DHSSPS, 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.

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

**FINANCES**

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

30. 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.

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

## STAFF RESOURCES

32. 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.

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

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

35. 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.

36. 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

37. 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.

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

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

## HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

40. 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.

41. Maintain staff relationships and morale amongst staff.

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

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

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

**GENERAL REQUIREMENTS**

45. 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.

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

47. 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

48. 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.

49. 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.

50. 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.

Southern Health and Social Care Trust

# PERSONNEL SPECIFICATION

**JOB TITLE** Chief Executive

**Ref No** 73210029

**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 a university degree or recognised professional qualification or equivalent qualification in a relevant[1] subject AND have a minimum of 5 years experience in a senior management[2] role in a major complex organisation[3]

2) Have at least 3 years' experience of managing major change programmes addressing significant[4] organisational, managerial or service change.

3) Have a minimum of 2 years experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant[4] improvements.

4) Have a minimum of 2 years experience working with a diverse range of both internal and external stakeholders in a role which has contributed to the successful implementation of a significant[4] change initiative.

5) Had personal accountability for a budget for a minimum of 3 years, in a major complex organisation[3], securing value for money by effective prioritisation and driving efficiencies.

6) Hold a full current driving license valid for use in the UK and have access to a car on appointment[5]. 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***

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

8) Demonstrate evidence of high level skills in;
   (a) effective planning and organisation
   (b) Governance and Risk Management
   (c) Financial Control
   (d) People Management

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

10) 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) Experience in the managing of a range of services within a health and / or social care setting.

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

[1] *'relevant subject' will be interpreted to mean any business, administrative, corporate function or health related qualification*

[2] *'senior management' is defined as experience gained at Chief Executive, Director, Assistant Director or equivalent in a major complex organization*

Southern Health and Social Care Trust

[3]*'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*

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

[5]*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;

- Political Astuteness
- Effective and strategic influencing
- Seizing the future
- Drive for results
- Leading Change through people
- Holding to Account
- 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**

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

**GOVERNANCE COMMITTEE**

# Minutes of a meeting of the Governance Committee of the Southern Health and Social Care Trust held on Tuesday, 7th September 2010 at 9.30 a.m. in the Boardroom, Trust Headquarters

## PRESENT:

Mrs D Blakely, Non Executive Director (Chairman)
Mrs R Brownlee, Non Executive Director
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Dr R Mullan, Non Executive Director

## IN ATTENDANCE:

Mrs M McAlinden, Acting Chief Executive
Dr P Loughran, Medical Director
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Mr B Dornan, Director of Children and Young People's Services/Executive Director of Social Work
Dr G Rankin, Interim Director of Acute Services
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs A McVeigh, Acting Director of Older People and Primary Care Services
Mrs P Clarke, Acting Director of Performance and Reform
Dr T Boyce, Head of Pharmacy (Item No. 4)
Mrs S Judt, Committee Secretary (Minutes)

## 1. APOLOGIES

Apologies were recorded from Mrs E Mahood, Non Executive Director, Mr A Joynes, Non Executive Director and Mr S McNally, Acting Director of Finance

2. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held on 11th May 2010 were agreed as an accurate record and duly signed by the Chairman.

3. **MATTERS ARISING FROM PREVIOUS MEETING**

i) **Analysis of Regional Baseline Questionnaire on Complaints**

Dr Loughran reminded members that a baseline audit of staff awareness of the complaints procedure had been carried out in each Trust within the Province. A standardised questionnaire was developed and in terms of the Southern Trust, 10% of staff were randomly selected and asked to complete this. He advised of a 55% response rate and stated that overall the response to the questionnaire was positive, however, key pieces of work have been identified which need to be taken forward. referred members to the report detailing the survey results.

Members discussed the report detailing the survey results. The Non Executive Directors emphasised the importance of the Trust having mechanisms in place to support staff throughout the complaints process and that there are opportunities for learning and improvement from complaints for the benefit of patients and staff. Mrs McAlinden stated that one of the themes emerging from the Clinical and Social Governance Review is the ownership and control over incidents, complaints etc. to ensure that lessons are learned and a recommendation that this should be as close to the point of service delivery as possible.

Training on complaints handling was also discussed. Dr Loughran reported on progress since the survey was undertaken and advised that over 3,000 staff have now been trained in general awareness training. Dr Rankin and Mr Rice advised of how training has been delivered in situ at team meetings and meetings of medical staff and this has been very beneficial.

Dr Loughran concluded by advising of the Trust's intention to repeat this audit at some stage.

ii) **Update on harmonisation of Trust Policies and Procedures**

Mr Donaghy provided a verbal update advising that 4 new policies have been introduced within the Trust since the previous Governance Committee meeting.

iii) **PMETB Visit: Northern Ireland Deanery**

Dr Rankin provided an update on the two actions the Trust had been required to take following the PMETB visit in January 2010 as follows:-

1. To ensure adequate supervision of O&G trainees at Daisy Hill Hospital. This concern has been addressed and the Trust responded in early July 2010 to confirm completion of this action.

2. To ensure O&G trainees at Craigavon Hospital are not subjected to an unreasonable workload intensity and are not undertaking activities of limited educational value that block acquisition of competencies. Dr Rankin advised that the Trust is well positioned to achieve completion of this action by increasing the consultant presence on the labour ward and antenatal clinics. The Deanery will be undertaking a follow up visit to Obstetrics and Gynaecology training in October 2010 when both Craigavon and Daisy Hill Hospitals will be visited.

4. **MEDICINES GOVERNANCE REPORT**

Dr Boyce presented the Medicines Governance Report for the first quarter of 2010/11. During this period, 118 medication incidents were reported. The average number of reports received per month was 39, representing a decrease from 55 per month in the previous quarter. This remains less that the highest average of 114 reports per month achieved

during 2008/09. Members noted the actions resulting from Trust incident monitoring.

Dr Boyce drew members' attention to the broad and narrow spectrum antibiotic usage trends and noted the significant progress in increasing the use of narrow spectrum antibiotics and decreasing the use of broad spectrum antibiotics in line with the C.Difficile reduction policy. She referred to Tazocin and advised that due to a contract with a generic manufacturer, a significant price reduction has been achieved, with a saving to the Trust of approximately £70k in year. Members noted the content of the Medication Safety Today Newsletter (May 2010) and Dr Boyce reported on Trust progress in relation to Rapid Response Reports and Alerts.

5. **REPORT ON RISK MANAGEMENT, COMPLAINTS, LITIGATION AND PATIENT/CLIENT SAFETY**

Dr Loughran presented the above-named report which provides a summary analysis of activity and trends for the period January – March 2010. He began by advising that the Trust's response rate to complaints resolved within 20 working days was 78% during the period, with no major areas of concern regarding new complaints. In light of the cessation of DHSSPS funding for the complaints process, the Senior Management Team has agreed that complaints training would be delivered within existing resources and members expressed concern at this. Mrs McAlinden stated that the Senior Management Team shared the Governance Committee's concerns and advised that the situation would be reviewed in six months' time.

Referring to the Patient Safety Interventions, Dr Loughran spoke of continued progress with positive outcomes. He stated that the Terms of Reference of the Thrombosis Committee are currently being reviewed and will be brought to the Governance Committee meeting on 7th December 2010.

The quarterly report on incidents was discussed. Mrs Brownlee sought clarification on the high level incidents from

the Acute Directorate. Dr Rankin responded by advising that the risk relating to staffing levels was due to the absence of a nurse at a Speech & Language clinic, but assured members that this had no direct impact on patients. She further advised that the delay in diagnosis incident has now been downgraded from a high severity. Mrs McAlinden advised that it has been agreed with Clinicians that their involvement in an RCA will be discussed with them as part of their appraisal process.

Dr Loughran advised members that the Trust's internal review of Litigation Services has now been completed and a report will be discussed by the Senior Management Team in September 2010.

6. **UPDATE ON CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW**

Mrs D Burns joined the meeting for this item. She updated members on the Review of Clinical and Social Care Governance (CSCG) and presented the Review findings. Members were advised that the emerging issues and associated professional views have been presented to the SMT on an ongoing basis and worked through in a series of SMT workshops. As a result, the SMT has agreed the following 3 components of the CSCG :-

Professional Executive Function;
Operational Director Function;
Corporate Co-ordinating Function

Mrs Burns referred members to the detail of these 3 components as outlined in the report, previously circulated to members. Mrs McAlinden stated that the SMT seeks the Committee's endorsement of these recommendations which will then be translated into proposals for new organisational structures and issued for staff consultation.

Discussed ensued in which members welcomed the Review and endorsed the proposed recommendations, whilst acknowledging that resources are an issue that require to be addressed.

## 7. CORPORATE RISK REGISTER

Dr Loughran presented the updated Corporate Risk Register as at June 2010. Two risk assessments were provided for members' consideration on i) staff morale and ii) reputation. Mr Donaghy spoke to the risk assessment on staff morale and stated that the overall risk of low staff morale has been graded as moderate. He outlined the indicators of risk and the current control measures and advised that this risk is on the HR Directorate Risk Register and regularly monitored. It was agreed to defer discussion on the risk assessment of reputation until the next meeting when Mr Joynes is present.

## 8. SERIOUS ADVERSE INCIDENTS

### i) Report for the period 1 April 2010 – 30 June 2010

Mrs McAlinden presented the report for the period 1st April 2010 – 30th June 2010. She noted and commended the significant efforts of Directors over the quarter to close reports with HSCB/RQIA. As a result, only 1 case remains outstanding from 2007/08 with none outstanding from 2008/09. From 1st April 2009 – 31st March 2010, 12 cases remain open at the 30 June 2010 and the situation is being closely monitored. From 1 April 2010 to 30 June 2010 of the 8 cases reported, 5 cases are within the 12 week reporting period and 3 cases are awaiting closure.

## 9. INDEPENDENT REVIEWS AND OMBUDSMAN UPDATE

Members discussed the Independent Reviews update as at 30 July 2010 and noted that the action plans for two of the Independent Reviews were being discussed under the confidential section of the meeting. Cases ongoing with Ombudsman's Office as at 30th July 2010 were also noted.

10. **CONTROLS ASSURANCE STANDARDS 2009/10 AND 2010/11**

Mrs McAlinden referred members to the following documents in their papers:-

i) Composite report of levels of compliance with Controls Assurance Standards across the HPSS for 2009/10;
ii) Directors' comments in relation to the 11 standards where scores had decreased below substantive (70%) for some criterion. Mrs McAlinden referred to recent correspondence from the DHSSPS asking that action plans are in place to address areas where performance fell short of 'substantive' in 2009-10 and she assured members that the Trust is well placed to meet this requirement;
iii) Implementation Programme for Controls Assurance Standards for 2010-11.

11. **CLINICAL AND QUALITY INDICATORS**

Dr Loughran gave a short presentation on the progress of the Clinical and Quality Indicators programme and outlined the next steps. Members were advised of the significant amount of work ongoing and noted the calendar of presentations scheduled for the Governance Committee. An overarching Clinical and Quality Indicators report will be produced in due course. Dr Loughran provided members with copies of the Register of Clinical and Quality Indicators 2010/11.

12. **ACTION PLANS RE POMH-UK AUDITS**

**i) Topic 6b: assessment of the side effects of depot antipsychotics**
**ii) Topic 1e: prescribing of high-dose and combination antipsychotics on adult acute and intensive care wards**

The Trust had participated in these national audits and Mr Rice presented the action plans to take forward the issues to be addressed.

13. **NCEPOD REPORT 'A MIXED BAG'**

Members noted the content of a letter from Dr Livingstone, DHSSPS, dated 30th July 2010 in relation to the report published by the National Confidential Enquiry into Patient Outcome and Death entitled 'A Mixed Bag'. The enquiry reviewed the hospital care of adult and neonatal patients who were given parenternal nutrition and found good practice in less than a quarter of all cases. Trusts have been asked to consider the report and develop action plans to address the recommendations by 31st October 2010. Dr Rankin advised that she is leading a group with representation from Directorates to progress this work.

14. **RQIA REVIEWS STATUS UPDATE**

Members noted the content of this report which provided a progress update on the following RQIA Reviews:-

. i) Child Protection Inspection Review
ii) CAMHS Review
iii) Review of Hyponatraemia
iv) Unannounced Hygiene Inspections
v) Patient Experience Review
vi) Review of Intrapartum Care
vii) Review of GP Out of Hours Services

15. **RECOMMENDATIONS FROM THE INVESTIGATION OF AN OUTBREAK OF LISTERIOSIS IN BELFAST H&SCT**

Dr Rankin spoke to the action plan to take forward the recommendations following the investigation of an outbreak of Listeriosis in the Belfast Trust and provided assurance regarding the Southern Trust position.

16. **FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REQUESTS – SUMMARY REPORT FOR THE PERIOD APRIL – JUNE 2010**

Mrs Clarke presented the above-named summary report for the period April – June 2010 advising that a total of 23 requests were responded to during this period. Of these responses, 12 were processed within the 20 day deadline

and 11 were processed outside the 20 day deadline. Most of the requests were received from members of the public.

17. **CLINICAL PATHOLOGY ACCREDITATION – DEPARTMENT OF CELLULAR PATHOLOGY**

Dr Rankin advised that following a surveillance visit by the CPA (UK) Ltd, the Department of Cellular Pathology has maintained its accredited status. She stated that this was a rigorous inspection by the Authority and there were no significant issues to report.

18. **ANY OTHER BUSINESS**

None

***The next meeting will be held on Tuesday, 7th December 2010 at 9.30 a.m. in the Boardroom, Southern Trust Headquarters***

Southern Health and Social Care Trust

# Consultation on Proposed Structures for Clinical and Social Care Governance

Consultation Period 8th Dec to 22nd Dec 2010

# "A SYSTEM OF TRUST"

Contents: Page No

## SECTION 1: Context

## Introduction

In September 2010 the Trust Governance Committee approved the initial findings and recommendations of the Review of Clinical & Social Care Governance. The document, previously circulated, (see Appendix I) recommended a model for clinical and social care governance (CSCG) within the Southern Trust and the rationale for the proposed model. This consultation document is an addendum to the review, summarising it, but with the specific purpose of proposing how the review recommendations could be translated into new organisational structures which would deliver high quality CSCG and with the aim of consulting the wider workforce on these structural proposals.

## Background

The Southern Health and Social Care Trust (the Trust) is committed to **providing safe, high quality care**. Key to the achievement of safe, quality care is effective structures, systems and processes to ensure that standards for services, care and our workforce are agreed, understood, implemented monitored and reported, and that where these standards are not met, this is known at all levels in the organisation and effective actions are taken to address any gap and manage any resultant risks.

In the current and future environment, with increasing standards for safety and quality of care, rising public and political expectations and reducing resources, it is even more important that Trust Board and staff at all levels are focused on the delivery of safe care; that there are systems in place to measure and assure our compliance with key standards, and systems and processes to quickly and effectively address any gap in compliance which could impact on the delivery of safe care. Where compliance is not possible within our resources, it is equally important that the Trust understands the constraints in

achieving compliance and the resulting risks, effectively communicating these both internally and to our commissioner and DHSSPS.

Service Reviews from England and elsewhere have highlighted organisational and practice issues which have resulted in poor quality, and in some cases unsafe care. The Mid Staffordshire NHS Foundation Trust Inquiry and the resultant reports provide an important framework against which to judge our capability to provide safe, high quality care.

It is in this context that the Senior Management Team of the Trust commissioned a review of CSCG arrangements within the Trust.

## Purpose and Objectives of Review

The review was commissioned by the Acting Chief Executive and SMT in March 2010 with the remit to critically appraise the Trust's current operational and assurance systems in relation to CSCG, including processes, capacity, capability and outcomes from the current system (see Appendix 2 for Terms of Reference).

## Methodology

The Review, while intending to satisfy its terms of reference and benchmark the organisation against the findings of Independent Inquiries in other Trusts, for example the Mid Staffordshire Inquiry, adopted a very basic and fundamental template on which to assess the current CSCG system and make recommendations for improvement. Four basic questions were considered in the examination of the current roles, responsibilities, accountability arrangements and systems, and the resolution of these questions shaped and informed the Senior Management Team (SMT) recommendations:

1. What does the Trust mean by clinical and social care governance – what are its components?
2. Who is responsible and accountable for delivering these components?
3. How does the Trust deliver these components?

4. What products does the Trust get from these components, and will these products address the findings and recommendations of other Inquiries?

The methodology adopted within the Review considered each of these questions against the current position and derived recommendations for improvement, based on best practice literature and interviews with all key staff groups including the Medical Directorate and the CSCG team within that, professional governance staff from Medicine, Nursing, Social work and Allied Health Professionals (AHP's) and operational staff from all Directorates and all disciplines. The emerging issues and associated professional views were presented to SMT on an ongoing basis and worked through in a series of SMT workshops. The recommendations emerging from these workshops were endorsed by the Trust Governance Committee in September 2010 and have formed the basis of this consultation document.

## SECTION 2:

## Rationale for Change

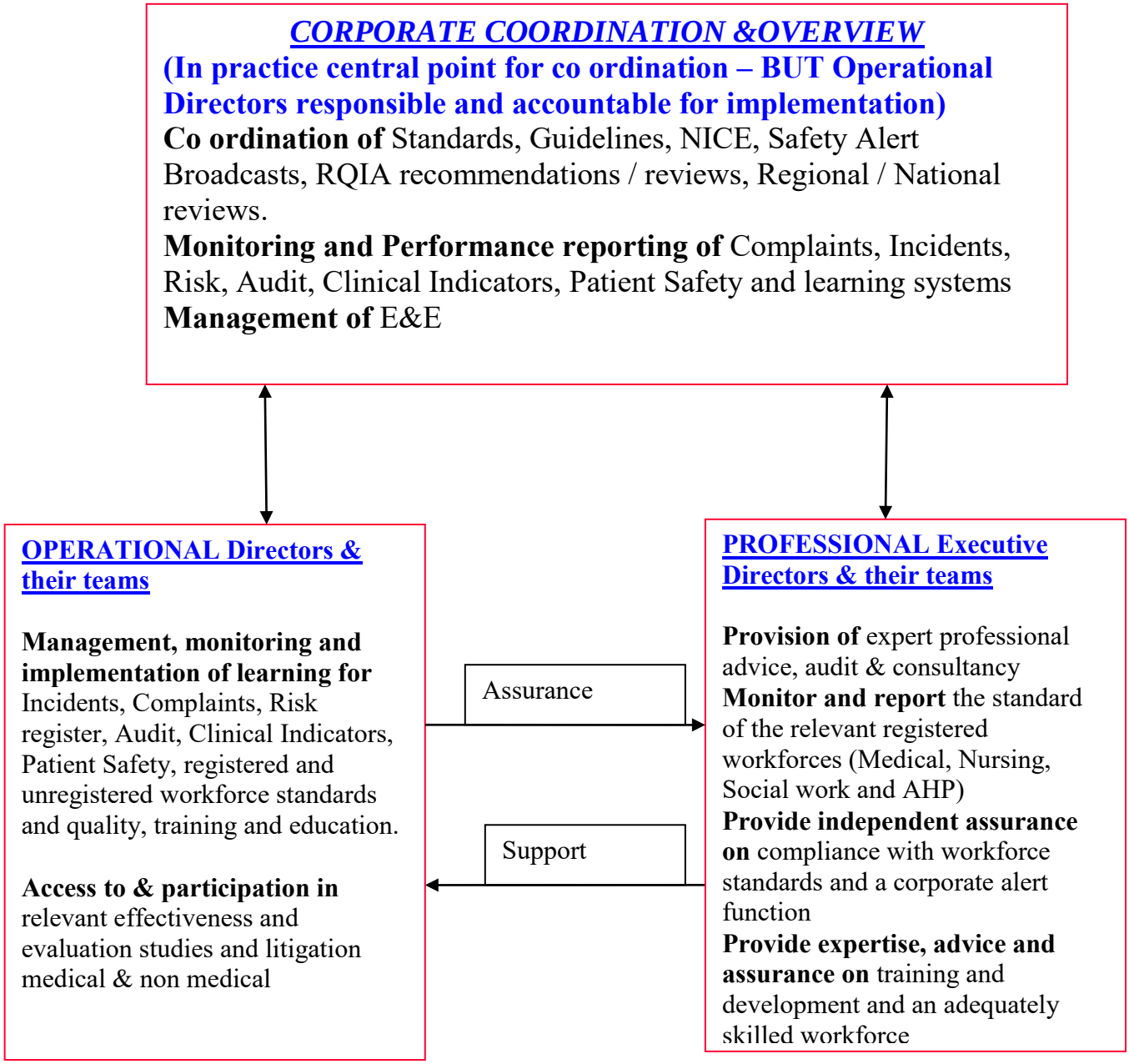
During the review, while within the Southern Trust it was evident that although there were no major operational shortcomings identified with respect to patient safety and quality of care, a number of significant system and organisational issues emerged. Through a series of workshops SMT produced recommendations and developed a pathway for change and improvement to the CSCG systems and processes within the Trust. The recommendations are summarised below:

- Effective decision making on issues of safety and quality should be taken as close to the point of service delivery as possible.
- Clarity and singularity of responsibility and accountability are required with respect to CSCG within the organisation.
- An in-depth understanding and agreement of the 'professional' Executive Director role and responsibilities, to provide the organisation with resolved professional guidance, advice and expertise in relation to standards for quality and safety of care and of the professional workforce (medical, nursing, social work and AHP). They will also independently assess and provide assurance on the levels of compliance to SMT Governance and Governance Committee, while providing a corporate alert when compliance with standards is at an unacceptable level.
- The operational management of services carries the responsibility and accountability for the safety and quality of those services and of the workforce delivering the care, supported by the Executive Directors when appropriate in relation to professional workforce matters.
- Service teams have a clear understanding of the roles and responsibilities within the organisation for clinical and social care governance. They have both confidence and ownership of their role, combined with the support mechanisms to provide the capacity for them to respond to the current and increasing CSCG agenda.

- Clear arrangements are needed to ensure shared learning across the organisation.
- Effective organisational intelligence is critical to the identification and effective management of patient and client safety and service quality, and this must be available both corporately and at all levels in the organisation.
- These principles are underpinned by the organisation's continued commitment to a culture of openness, transparency and fairness.

In order to achieve these recommendations the SMT agreed a model of CSCG with three clear core components

## Three Core Components of CSCG




In order to meet the recommendations from the review and achieve the above model of CSCG where appropriate safety and quality actions happen in real time, at the frontline, by the people involved in service delivery who are given the means to make and effect change, the current central structures of CSCG need to be decentralised and supported by an improved information management system accessible by all frontline staff. The proposed changes to the current structure are outlined in Section 3.

## SECTION 3:

## Proposed Structures

Within this section the three core components of the Trust CSCG model have been populated with the proposed structure to deliver them. How the new structure will actually work in practice is then described. It is essential that the concepts described earlier – decision making as close to the point of service delivery as possible by those who can effect change and learn from it, clarity and singularity of accountability, communication and Trust wide patient safety learning and organisational intelligence are the foundations of how the CSCG system needs to function.

We need to understand the Trust systems for CSCG:

- Who takes decisions and who is accountable for the decisions and the following action or inaction?
- How will we communicate these decisions and provide organisational intelligence to improve patient safety learning?
- How will we achieve the actions which flow from these decisions and meet the increasing CSCG agenda?

The description of Trust systems will then be followed by a brief synopsis of the processes within the CSCG model, for example complaints, incidents, etc. The description will be at a high and generic level as the core business for each Directorate varies in nature and thus so will the detail. However it is expected that the Directorate detail, if not already in place, will be worked through by the Operational Director and their teams facilitated by the Directorate Governance Coordinator when appointed.

Finally within this section a brief description of each of the new job roles within the CSCG system will be presented. Detailed job descriptions for new roles are available on request; those whose role will be essentially similar with the same banding, but whose lines of reporting will change, will be invited to participate in formulating revised job descriptions for their modified roles.

What category each post falls into, new or modified will be detailed in section 4.

**It should be noted that the banding for these posts are indicative bandings which are yet to be subject to desktop banding process.**

# Three Core Components of CSCG - Structure

## *CORPORATE COORDINATION &OVERVIEW*

**Reporting to Chief Executive's Office:**

1 wte Band 8C AD CSCG
1 wte Band 5 Governance Officer
1 wte Band 3 Governance admin Assistant
1 wte Band 7 (Temporary for 1 year) Governance Training Officer
Current central reporting team (Systems manager will report to Informatics Division)
Current Effectiveness and Evaluation team

**OPERATIONAL Directors & their teams**

Will be supported by a Directorate Governance team using both existing arrangements and complemented by proposed new arrangements

**Existing Structure**:
AMD's,
CD's,
AD's,
AD / HOS senior Directorate advisor for nursing, AHP and Social work
In reach nurse workforce, dev & training
In reach Social work governance, workforce dev & training

**New Structure:**
1 wte Band 8B governance coordinator reporting to Director
1 wte Band 5 governance officer (*1.6 wte in Acute services)
1 wte Band 3 governance admin assistant (*1.6 wte in Acute service)
Pro rata wte Band 7 nurse governance facilitator (previously practice support & governance lead)
1 wte AHP Directorate Lead (Operational and Governance lead)
****Acute services only**
1 wte Band 7 Patient Safety & Quality Manager (Encompass standards &Guidelines)
1 wte Band 6 Patient Safety & Quality Officer

Assurance

Support

**PROFESSIONAL Executive Directors & their teams**

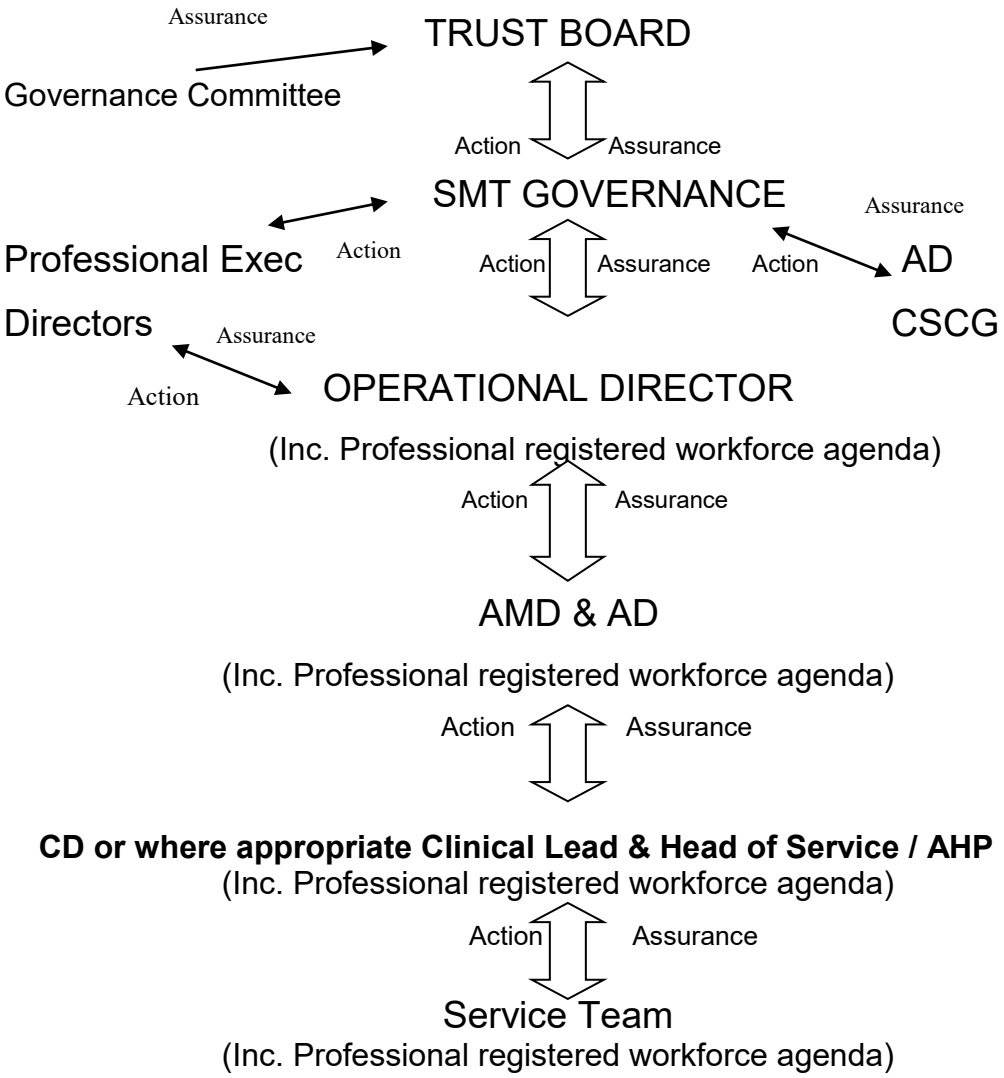
**Nursing:**
2 wte Band 8C (current posts)
Education, training & Development team (current team)

**AHP:**
1 wte Band 8C (current post)
1 wte Band 7 workforce development and training (new post, temporary for one year in the first instance)

**Social Care:**
1 wte Band 8C (Current post)
Governance, workforce development and training team (current team)

**Medical:**
8b Medical workforce (current post)
Band 7 (Current post)
Band 6 Patient Safety Initiatives Officer (current post)
Litigation team (current posts)

# SYSTEM FOR DECISION, ACTION & ACCOUNTABILITY



**Explanatory Notes:**

- Each level in the diagram is both a decision making point and a point of accountability following a decision and action.

- SMT Governance is the central point for decision making in relation to the **organisational CSCG agenda.** They are guided, advised and obtain organisational intelligence from the Executive Directors, Operational Directors and their teams and the AD CSCG. The forum for this to take place is described in the next flow diagram on page 12. This should result in a clear, single corporate agenda for all aspects of CSCG, and an awareness of the CSCG workload across the Trust, preventing too many initiatives being worked on at any one time.

- The central point for decision making in relation to CSCG decisions involving procedure, resources or a change in practice is the Operational Director who will be advised by and communicate with SMT Governance, AD's and AMD'S and where appropriate Executive Directors.

- SMT Governance are accountable to Trust Board

- The Governance Committee provide independent assurance to Trust Board that SMT Governance is undertaking it's responsibilities in a thorough and acceptable way. The Executive Directors assist Governance Committee by providing independent assurance to the latter and Trust Board.

- Executive Directors assure and advise SMT Governance on workforce standards, training, education & development and provide exception alerts to SMT Governance.
- This facilitates decisions on the Professional registered workforce agenda to be agreed at SMT Governance before dissemination to the wider organisation

- The Executive Director of Nursing will for the most part delegate to their Assistant Directors for governance and workforce standards, training, education & development. For the purposes of this document where Executive Director Nursing & Midwifery is used this is interchangeable with the AD positions in this office.

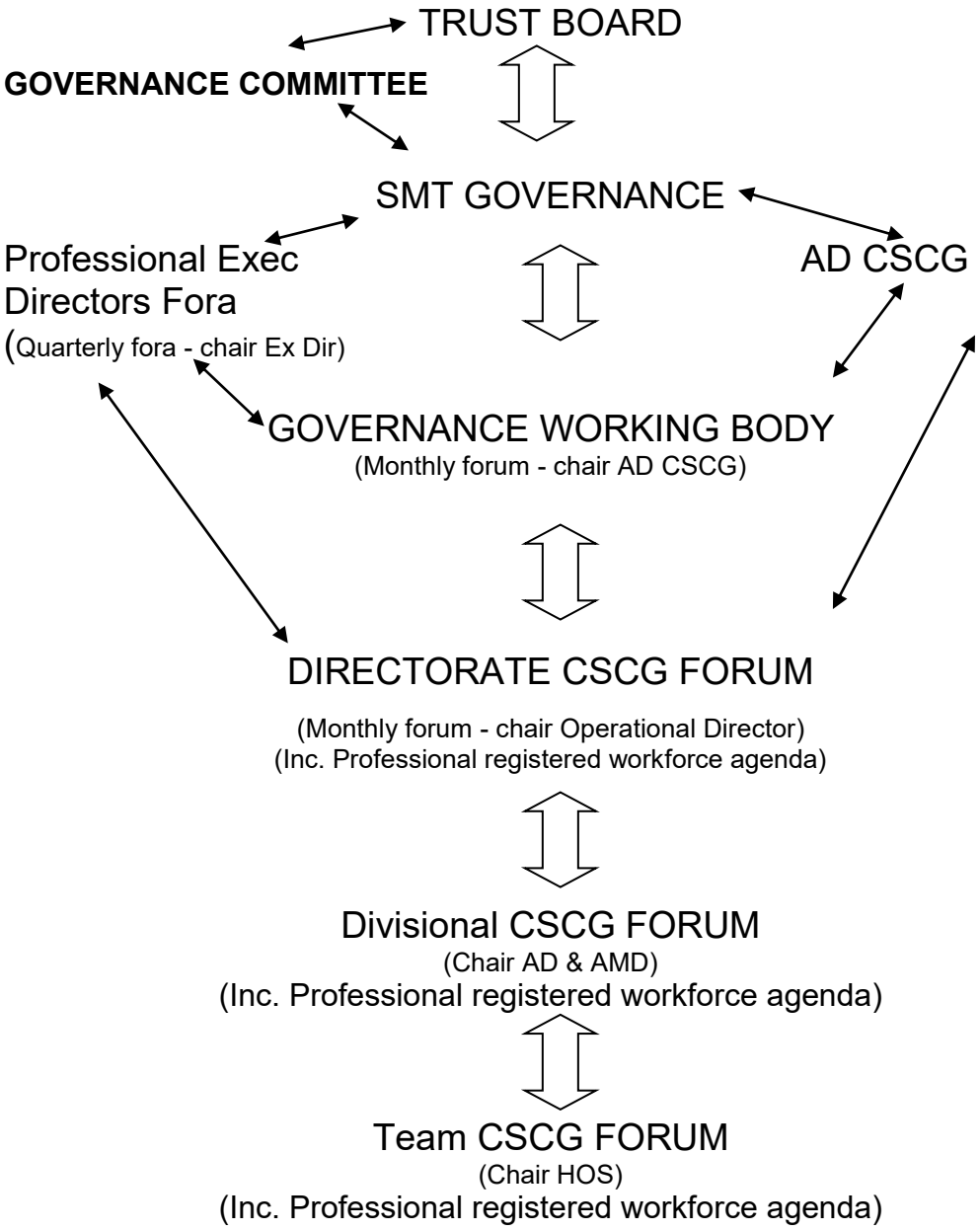
- The Executive Medical Director / Responsible Officer will have additional responsibilities which include litigation, medical appraisal, fitness to practice, research & development, emergency planning, infection control and lead for Healthcare Acquired Infection performance. They will also be the lead professional Director for information governance and the Trust representative on the Regional Patient Safety forum and for the performance monitoring and reporting of specific DHSSPS Patient Safety Initiatives. In discharging the latter role the Medical Director will agree monitoring arrangements for DHSSPS Patient Safety Initiatives with the appropriate Service Director.

- Responsibility and accountability for patient safety and quality lies with the Operational Directors.

- Operational Directors provide assurance to Executive Directors on workforce standards, training, education & development. The Executive Directors will agree and assess the assurance information which should be provided and give SMT Governance an independent and considered view on the professional workforce.

- Operational Directors are responsible & accountable for all aspects of CSCG to SMT Governance and its chair the Chief Executive, and via this body through to Trust Board.
- The AMD & AD are responsible & accountable for all aspects of CSCG within their area to the Operational Director

# System for Communication & Organisational Connectivity (Intelligence Flows)



**Explanatory Notes:**

- As previously illustrated the decision hub of SMT Governance will be informed by the Governance Working Body. This group chaired by the AD CSCG will be instrumental in proposing, forward planning, implementing and reviewing a practical and robust CSCG agenda to be endorsed by SMT Governance. This will provide SMT Governance with the capacity to focus on the strategic and operational direction of CSCG based on good intelligence and sound information and allow them to focus on critical issues, organisational risks and decisions on prioritisation of CSCG issues.

- The Governance working body will therefore have a Trust wide membership including Executive Directors or their representatives (Medical, Nursing & midwifery, AHP, Social work), AD's and AMD's, Directorate CSCG Coordinators, Pharmacy, Estates, Health & Safety, Human Resources, Litigation, Effectiveness & Evaluation and other co-opted members as required. All other CSCG committees, such as Drugs and Therapeutics will be represented at the working body and feed in their reports for assimilation to SMT Governance. It will meet monthly and have corporate priorities, plans and proposals, progress and outcomes endorsed by SMT Governance.

- This working group is central to the coordination and success of the CSCG agenda within the Trust and in order to facilitate membership, attendance and participation there will be a streamlining in the frequency and agenda of uni-professional fora held during a financial year. There will be one Nursing & Midwifery forum across the Trust, one social work & care forum, one AHP forum and one Medical forum focussed on workforce standards, training and development, each chaired by the respective Executive Director. These will be held quarterly for resolved professional advice on workforce issues which will be fed into the Governance working body and SMT Governance, information sharing,

communication and debate. No other uni-professional fora will take place as the Governance Working Body and Directorate Governance Fora will now be responsible for, on a wider and more coordinated platform, implementing the agreed standards within the significant professional workforce agenda.

- Another essential decision hub is the Directorate Governance Forum chaired by the Operational Director. Again this monthly forum will be another key point for input from the Executive Director teams and will monitor progress and review outcomes of CSCG initiatives within the Directorate including implementation of the agreed workforce standards.

- The Executive Director's delegated representatives (usually the Band 8C for each profession) will attend the appropriate parts of this monthly forum. They will on behalf of the Executive Director provide expert advice and guidance as well as a performance management role in relation to seeking assurances on workforce standards and an acceptable level of compliance with quality and safety indicators.

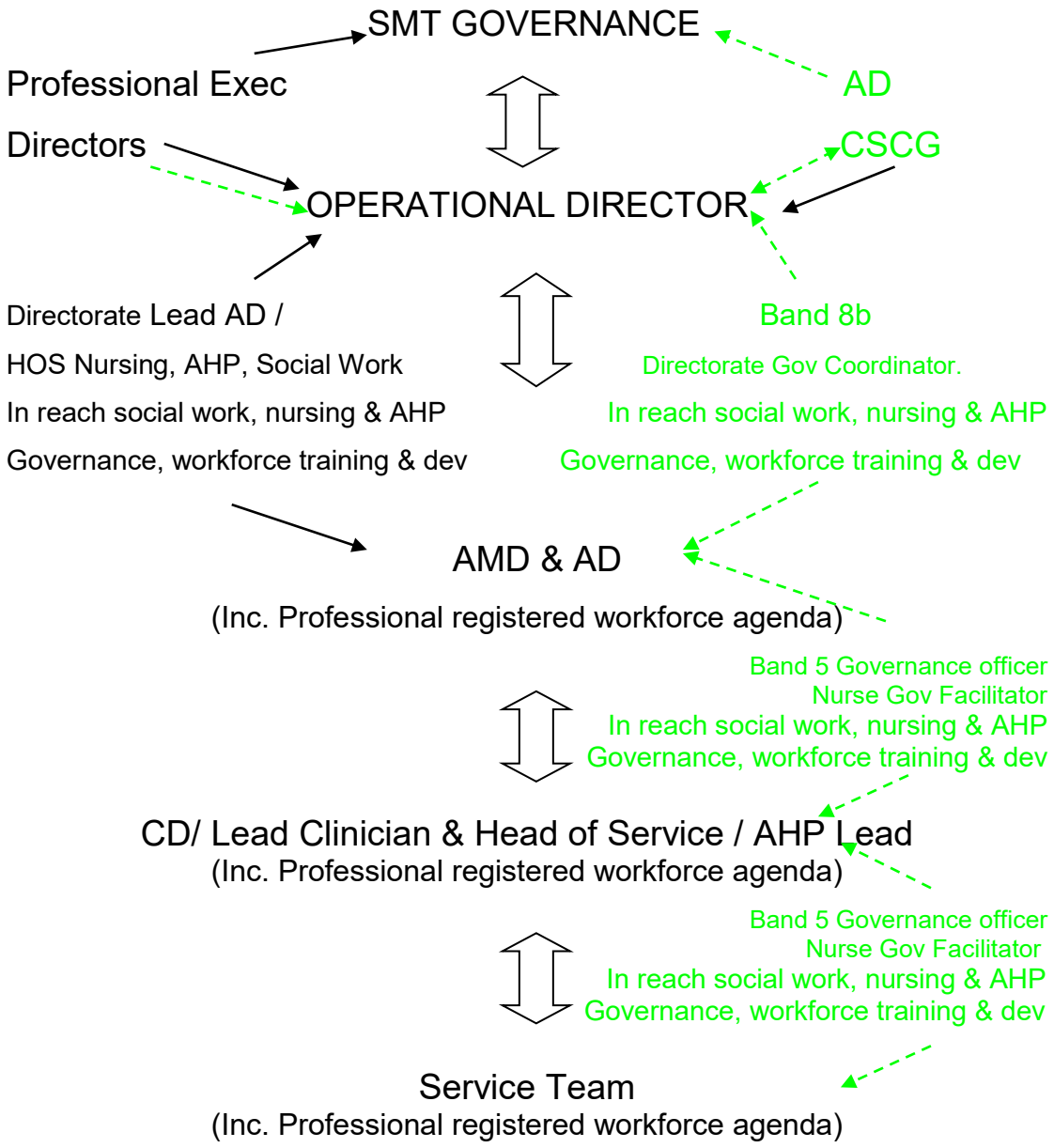
- Within this forum the Executive representatives will discuss any aspects of poor or unacceptable levels of compliance with the Directorate and will by exception alert the corporate organisation if performance against indicators is unacceptable and irresolvable.

- It is essential that all decisions on issues of CSCG policy, procedure, resources and changes in practice are brought to the Governance Working Body for discussion and organisational learning and intelligence. They should also be escalated to SMT Governance for endorsement or a decision or as an alert and then be devolved to Directorate Governance fora for implementation and / or further action. Decisions taken outside these hubs or interaction at other levels of the organisation with teams or individuals should be avoided as this could lead to confusion of accountability, conflicting communication and non optimum accountability.

- In the exceptional circumstance where a registered or non registered member of staff at any level within the organisation believes that an issue of CSCG is not being addressed at team, division, directorate or a corporate level they should highlight this in the first instance through the accountability and communication lines set out above. However if the highlighted issue is not being addressed and the reasons for this are either not communicated or not acceptable, staff are encouraged once all line management communication lines are exhausted to raise the issue to either the Executive Directors office or that of the Chief Executive through the AD CSCG. This exception reporting is a further safety mechanism within the organisation to ensure that all CSCG decisions and actions are taken as intended by the accountable officers involved, namely SMT Governance.

# SYSTEM FOR SUPPORTING THE CSCG AGENDA

**Key:** Advice & expertise = ⟶
Facilitation = - - - ⟶



**Explanatory Notes:**

- As with communication, decision making and accountability, facilitation and expert advice by the right people at the right level of the organisation is key to the success of the CSCG agenda.

- SMT governance will be facilitated by the AD CSCG, who will provide intelligence, information and real time data from across the Trust and via the Governance Working Body.

- SMT Governance will also be provided with expert advice and receive compliance monitoring on professional workforce standards, education, training & development from Professional Executive Directors.

- Operational Directors will provide further Directorate information and assurance on compliance with CSCG standards to SMT Governance.

- Operational Directors will be supported in their role by the AD CSCG, their Band 8b CSCG Coordinator and in reach support from the Professional Executive Directors' offices. The Operational Director will also receive expert advice and guidance on uni - professional issues from their most senior staff within each profession – the AD/HOS/Lead for Nursing, AHP, Social Work and AMD's for Medicine, this is an existing role within each Directorate.

- The above assistance to the Operational Director and their team are advisory and facilitatory providing expert guidance and "another pair of hands" to assist with this large agenda. However each individual AD and AMD for each division / Directorate are responsible and accountable to the Operational Director for the delivery of the CSCG agenda within their specific service area, as in turn is the Operational Director to SMT Governance.

## PROCESSES TO SUPPORT THE CSCG AGENDA

These processes are essential components of the CSCG systems and should be viewed as individual parts of a larger patient and client safety and quality reporting process, which when combined, maps the journey through Trust services from the user perspective. This mapping should give the organisation a clear picture in relation to user experience and outcomes and identify when and where these outcomes are sub-optimal; some literature describes these measurable, sub-optimal outcomes as the 6 D's, death, disease, dysfunction, disability, dissatisfaction and dollars or the follow up to poor care. While these measure the less positive side of the service user's journey these are the outcomes we need to prevent whenever possible to protect staff and those who use our services. When fed into the CSCG systems the outcomes from the processes of complaints, incidents, effectiveness & evaluation, litigation etc should enable the organisation to predict where problems may arise, manage risk by making uncertainty visible and ensuring we have contingencies and controls to minimise these risks and ensure learning.

Participation by clinical teams in CSCG processes in which they have confidence is essential to build a safe organisation. It is clearly recognised that in an organisation of this size where we provide health and social care for those who need it most that there will inevitably be poor outcomes for a number of patients and clients. However where the poor outcome was not inevitable but preventable, this in itself only becomes a disaster when it is allowed to be repeated. That is why we need organisational processes that frontline staff will use to detect, analyse and respond to poor outcomes to prevent the likelihood of them being repeated. At all levels the organisation needs to identify the important problems and issues, analyse and respond to them in an appropriate and coordinated way.

The processes described below are dependent on the roll out of the web based management information system - DATIX, which will take place over the next year to eighteen months. Several of the processes will also require

review and potential revision following phased implementation of the recommendation within the governance review.

**Process 1: Complaints**

- Complaint received by central reporting in AD CSCG office. Logged on system. Sent electronically to Directorate Governance coordinator.
- Governance coordinator screens and prioritises for Assistant Director (AD), Associate Medical Director (AMD) and Director attention or Head of service (HOS) and service team attention. Electronically transferred to AD / AMD/ Director or HOS /team.
- Directorate governance officer monitors complaint progress and ensures timeframes adhered to as laid out in the Trust Complaints policy. Provides assistance as required to service team
- Response agreed with service team, AD, AMD and Director, as appropriate, by Directorate Governance Coordinator before being sent to complainant - eventually this process will be managed by the Directorate governance officer and rely less on input from the Governance coordinator
- It is envisaged that this system will be improved by the potential roll out of the web based datix module for complaints which will be on staff desktops. The roll out of the information management system will also significantly improve our ability to track trends of complaints and share learning at a team, division, directorate and corporate level – a role taken on by the Directorate governance coordinators and the AD CSCG. Shared learning will take place via the Governance Working Body and recommendations for change will be agreed and prioritised by SMT Governance

NB: Ombudsman issues will be dealt with in a similar format but will have input from the AD CSCG to ensure organisational learning. Chief Executive will sign off these responses.

**Process 2: Incidents**

This area of work will change significantly from the current process with the piloting and roll out of web based datix for incident management during the next 6- 9 months. Described below is a vision of what the process will be when the web based system is in place.

- Incident occurs within service team – reported by a member of the team via the web based system on their desktop.
- The reporting format will have been designed by the team and the incident will then be electronically alerted to the team line management
- Directorate Governance coordinator and service AD'S / AMD's /HOS will have an agreed process for service teams to action and deal with incidents in real time. An example of how this is achieved currently within one team can be found in Appendix 4. The detail of this may vary within each Division and Directorate – particularly the who and the how, however the principles of senior clinical involvement and a practical, workable mechanism to ensure learning is shared within the teams / division / directorate must be a key element of the process that is clearly visible.
- Incidents will then be reviewed on weekly real time reports by teams, Divisions, Directorates and at a corporate level, as will the recorded action and learning by the teams.
- Incidents that have not been actioned, closed and learning taken from them will be evident at team, Divisional, Directorate level and a corporate level by the AD CSCG
- Trends, learning and failure to effectively address incidents will also be identified and actioned by the Directorate Governance coordinator through the Directorate CSCG forum and the AD CSCG. These will be shared within the Governance working body and analysed as to whether escalation of learning is required to SMT Governance.

**Process 3: Patient Safety & Quality (inc. Standards & Guidelines):**

The Trust currently receives a significant volume of standards and guidelines and key performance indicators from various professional and patient safety bodies including NPSA, NICE, NCEPOD, RQIA, Chief Nursing Officer, the Chief Medical Officer and the Departmental Director of Safety, Quality and Standards. The following describes the process of how these publications will be dealt with.

- The office of the Chief Executive will be the central receptacle for these standards, guidelines and recommendations. Any such communication received at any other point within the Trust should be redirected to this central point.
- They will be logged on a database within the office of the AD CSCG and early distribution will take place to relevant Directors for information and consideration prior to a work plan being developed by the Governance working body.
- The AD CSCG will table the publications at the Governance working body meeting and a relevant implementation team will be identified within each Directorate including any assistance required from professional, operational and governance leads.
- A timetable and implementation plan will be agreed by this team and reports on progress and constraints and monitoring of progress will be via the Governance working body.
- Executive Directors requiring monitoring progress on any professional specific standards and guidance will also receive progress reports and updates on assurance from Directorates via their AD representatives on the Governance working body.
- The Medical Director will receive information on the specific Departmental Patient Safety Initiatives in the same way via his Band 6 representative.
- Each Directorate can then monitor the number of ongoing implementation plans and feasibility of implementing standards and

guidelines through their Directorate Governance coordinator who sits on the Governance working body

- Due to the highest percentage of standards, guidelines and recommendations requiring implementation being within the Acute Services Directorate, this service will have 1 wte Band 7 Patient Safety and Quality manager and 1 wte Band 6 Patient Safety and Quality officer
- These posts will assist with implementation of standards and guidelines within Acute services, including key performance indicators relating to specific patient safety initiatives and alerts in relation to medical devices and equipment.
- They will also maintain the ongoing programme of undertaking the ISO quality standard for equipment management in order to support the maintenance and safe use of equipment.
- The Patient Safety and Quality Manager will also chair a small sub committee of the Governance Working Body which includes estate services, representation from the older people and primary care Directorate and Acute services together with Health & Safety representation. This will ensure the ability to address any issues arising from Medical Devices on a Trust wide basis and should include the procurement of new equipment from a user and continuity perspective.

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**Process 4: Risk Management**

This process will be taken forward by the Directorate Governance Coordinators and service teams. Again it is envisaged that during the phased implementation of the web based Datix management information system this process will become less labour intensive. Further work is required within this area to ensure that there is an organisational understanding of the principles behind risk management and a clear process for the management of identified risk. Risk registers should not be a long list of concerns; it is a formal record of potential / possible / probable dangers which could result in loss, harm or failure and detail how this risk

is being managed. The organisation at every level must have a mechanism for detection, prevention and contingency for risks and have a resolved position at each level in the Trust as to acceptable levels of risk which can be borne and those which cannot.

The improvement of the organisational understanding of risk management at a team, division, directorate and corporate level will be a follow up project for the AD CSCG, Directors, service teams and Directorate Governance Coordinators when the new structures are in place. Training to support effective organisational understanding and operation of risk management systems will be led by the Governance Training Officer within the central coordinating function.

**Process 5: Registered & Unregistered Workforce Standards, Quality, Training & Education**

- CSCG and workforce training, education and development are inextricably linked, the latter flowing from the need to ensure patient and client safety and quality care and the systems and processes of the organisational model of CSCG indicating issues of safety and quality. Therefore to ensure these links are made and that a coordinated approach is taken both across Directorates and at a corporate level and that the profile of education, training and development is raised and is targeted at supporting patient and client safety and quality care, there is a need to describe how this function will be delivered and where the lines of communication and accountability lie. This has been done in diagrammatic form earlier within the paper but will be repeated for clarity.
- The offices of the current Executive Directors will continue to be responsible for setting, advising on and monitoring standards of safety, quality, training and education of the registered workforce including Medicine, Nursing, AHP and Social work. They will also independently assess and provide assurance on the levels of compliance with these standards to SMT Governance, Governance

Committee and Trust Board, while providing a corporate alert when compliance with standards is at an unacceptable level.

- However as the Executive function is neither a line management nor an operational role, it cannot be held accountable for delivering the actions required to implement agreed workforce standards and quality and safety of care.

- This accountability, for implementing agreed workforce standards, clearly lies with the Operational Director charged with delivering this service, who must provide assurance to the Executive function that action is taking place to ensure a workforce of an acceptable standard and safe and high quality care is delivered.

- The Operational Directors will achieve this through their Directorate Governance team. The Accountability chain for implementing the required standards and for highlighting training, education and development needs flows up from Heads of Service, AHP leads and Clinical Directors to Assistant Directors and Associate Medical Directors to the Operational Director who assures the appropriate Executive Director and is accountable to the Chief Executive. This Operational team will be supported and facilitated internally by the Directorate Governance Coordinator, the Nurse Governance Facilitators, the Lead AD Nursing Advisor, the AHP lead, lead for Social Work and AMD's. They will have in reach support from the Social Work governance, workforce development and training team, Nursing and Midwifery education, training and development team, the AHP governance and workforce development and training support and the medical workforce team all of whom are within the relevant Executive Director's office.

- The vehicle for this to take place should be the Directorate, divisional and service team governance meetings, with final sign off

of any issues pertaining to workforce standards, training, education and development being achieved at the Directorate Governance meeting. This ensures that there is a coordinated approach to this issue by Directorate, due consideration given to Directorate workloads and pressures and that those who will be held accountable for implementation – the Operational Directorate - are engaged in the process. Those described above who facilitate, advise and monitor workforce issues should therefore attend the Directorate Governance meeting to provide expert advice and to seek assurances on compliance with agreed standards.

- In relation to the non registered workforce, to ensure that standards, quality and opportunities for workforce training and development are afforded to them, each staff group will have a lead Director appointed to implement this agenda.

- To ensure a corporate, value for money approach to workforce training, development and education the SMT has recommended that the Director of Human Resources chairs a Trust wide forum to enable a uniform approach to workforce development and training for both registered and unregistered staff. This forum will be fed by the collaborative working between Directorate and Executive functions described above and will have Directorate and Executive representation.

**Process 6: Clinical indicators and Audit**

- Executive Directors will provide expert advice and guidance on the organisational and service level quality indicators that will provide evidence of the safety and quality of care of care systems and the competence of the professional workforce within the Trust.
- The responsibility for progress and achievement of acceptable performance against these indicators rests with the Operational Directors and their teams. Again the Directorate Governance teams will support the service teams with this process.

- Directorate level audit, as agreed by SMT, will be undertaken and reviewed by service teams. The Executive Directors will also review these audits to ensure an acceptable level of compliance with quality and safety indicators and will alert the corporate organisation if performance against the indicators is unacceptable.

**Process 7: Effectiveness and Evaluation**

- Effectiveness and Evaluation team will in the main undertake audit of quality and safety indicators which are of a more corporate nature and provide a sound basis for a patient and client safety learning system.
- This programme of work will be decided by the SMT Governance, with advice and input from the Governance Working Body.
- Although having a corporate function and being centrally managed, the E&E team will continue to provide expert advice to Directorate teams in methodologies etc.

**Process 8: Litigation**

- Increased collaborative working between Operational Directors, their AMD's and AD's will be facilitated by the Medical Director and the litigation team.
- The Medical Director will bring forward a recommendation on how this will be achieved and through what forum.
- The Director of HR will act as an expert advisor on all non medical litigation, and will seek professional expert advice in relation to Social Work, AHP, and nursing when appropriate.
- The Directorate Governance coordinator will act as a conjugate within this system having a collaborative working relationship with the Litigation team.

**Process 9: Morbidity and Mortality**

- A review of current processes for the above has commenced with the purpose of ensuring integration and accountability structures within the wider CSCG systems in the Trust.

- This review will complete by the end of December and its recommendations will be integrated into the implementation plan of the CSCG Review.

**Process 10: Managing Poor Professional Conduct and Performance**

- The processes for the above have been the subject of revision as part of the Review of Governance. The Trust processes are attached in appendix 3
- It is evident from the processes that those involved are also those who can action change and effect patient and client safety. These processes should be reported on a regular basis at Directorate level and learning issues raised through the Governance Working Body

**Supporting Infrastructure - Web Based Datix**

As discussed previously the above processes will be significantly enhanced and supported by the roll out across the Trust of the Web based information management system Datix. This will mean that all clinical teams will have on their desktops modules for incident management, complaints, risk management and standards and guidelines management.

Following roll out and training staff will be able to for example log incidents in real time, line managers and others can be alerted to incidents and there is a real time view of how these are being actioned and who is taking this forward. This should result in staff getting real time feedback on incidents reported and actually seeing changes to practice being made. It will also enable everyone to have access to much improved data on how safe our services are and how we are improving them.

This is an exciting new development which will give service teams the opportunity to tailor a system to meet their requirements and get real time information from it on issues of CSCG. Roll out commences in January 2011 with two pilot sites which are Delivery Suite, CAH and Bluestone Unit within Mental Health and Disability services.

## New and Modified Job Roles

**Function:** Corporate Coordination and Overview

**WTE Band 8C AD CSCG:** (Modified role)

- This role will provide the SMT Governance with a Trust wide overview on all the CSCG systems and processes and their outputs. They will provide well analysed information to support decision making, prioritisation and awareness re exceptions and trends, thus enabling improved information to support both the SMT Governance and provide assurance to Governance Committee.
- The post holder will provide an early warning system from the process outcomes and highlight potential Directorate and Trust risks and will monitor trends.
- They will chair the Governance working body and ensure standards, guidance; alerts etc are planned, implemented and reviewed.
- They will ensure that corporate strategic intent is interpreted correctly at operational level and that it can be implemented. They will provide assistance to individual Directorates and their Directorate Governance team as required.
- They will continue to implement the Governance review findings in a phased approach and assist the Informatics Directorate with the information system roll out.
- They will manage the Serious Adverse Incident (SAI) process at a corporate level and the subsequent RCA reports required at a regional level
- Within the Trust this post holder will when appointed oversee a review of the internal use of RCA's and produce a policy and procedure detailing incident review and learning
- This post will report to the Chief Executive

**WTE Band 5 Governance Officer** (New Role)

- Manage staff and processes in relation to Central Reporting.

- Produce reports on a trust wide basis for all CSCG processes together with an early warning alert for exceptions to the AD CSCG.
- Manage the administration of the processes and systems relating to CSCG within this corporate function including the Governance working body, complaints, SAI reporting and subsequent regional RCA's together with the receipt and monitoring of standards and guidelines, RQIA reports etc
- This post reports to the AD CSCG

**WTE Band 7 (Temporary for 1 year) Governance Training Officer** (New Role)

- To embed the new systems and processes within the organisation by the provision of targeted training in incident and complaint management, resolution and learning.
- Specifically in the area of risk management to provide targeted training in respect of risk, recording, management and provision of contingencies.
- To work with all affected groups of staff to assist them in identifying issues or constraints within the processes and systems and to enable the successful adoption of the new model of CSCG.
- This post reports to the AD CSCG

**WTE Band 3 Governance Admin Assistant** (Modified role)

- This post will also exist in Operational Directorates with the same role, it currently exists within the Medical Directorate and would be similar in nature within the new structure
- To provide general administration to both the Corporate and Directorate CSCG offices.
- This post reports to the Band 5 Governance Officer

**Function:** Operational Directorate Governance Team

**WTE Band 8B Directorate Governance Coordinator:** (New role)

- On behalf of the Service Director, to take the lead within the Directorate

in providing assurance to the organisation that both the operational and professional aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and are providing timely action, risk management, assurance and alerts to both the Service Director and the organisation.

- Be the lead within the Directorate in relation to sharing and learning from CSCG trends, exceptions, alerts and risk at an organisational wide level via the Trust CSCG working body. Disseminate this information throughout the Directorate and ensure learning has resulted in changes in practice.
- Lead on the interpretation and implementation planning of all standards and guidelines in relation to patient and client safety and service provision within the Directorate and facilitate service teams to ensure that these are implemented, monitored and reviewed in a timely manner.
- This post reports to the Service Director

**WTE Band 5 Governance Officer:** (Modified role)

- This role will support the Band 8B and will line manage the Governance Admin Assistant.
- Specifically the tracking, compilation and administration of the complaints process will be undertaken for the Directorate by this post holder, under the supervision of the Band 8b.
- They will provide support to the Directorate teams with respect to identifying reports, trends and alerts and will monitor follow up action
- They will provide project assistance when required to the Directorate in relation to CSCG initiatives that are being undertaken
- They will liaise with the corporate CSCG office to ensure timely responses and information flows.
- This post will report to the Directorate Governance Coordinator.

**WTE Band 8b AHP Directorate Lead** (Modified role)

- This post will be responsible and accountable for both the operational and professional management of all AHP's within the Directorate, with the exception of those who are already operationally line managed as part of an integrated team. Where this is the case the AHP lead will be responsible for the professional standard of those AHP's within that Directorate who are part of an integrated team. This type of post currently exists within the Acute Directorate.
- The post holder will liaise closely with senior staff at Band 8a and below within each profession in their Directorate. They will recognise and continue to utilise the experience and expertise of team leaders in uni – professional services.
- The AHP lead will also liaise closely and receive expert advice and guidance from the AD AHP Governance and workforce Development, training and education within the office of the Executive Director and should also seek advice and guidance as required from the most senior Trust employee in each individual profession.
- To assist with the provision of expertise and advice the most senior staff in each of the 7 AHP professions will meet with AHP leads via the AHP forum which will be chaired quarterly by the Executive Director.
- This post will report to a nominated AD within each Directorate.

**WTE Band 7 Nurse Governance Facilitator** (Modified role)

- This role, currently the practice support and governance team, will report to the Band 8b Directorate Governance Coordinator.
- They will support the service teams in the delivery of the significant nursing governance agenda which is inextricably linked to the service governance agenda.
- The resource will be provided to Directorates on a pro rata nursing wte basis
- This current group of staff will continue to receive supervision from the Band 8c AD for Nursing Governance.

**Function:** Operational Directorate Governance Team (Acute Services Only)
**WTE Band 7 Patient Safety and Quality Manager and Band 6 Patient Safety and Quality Officer** (Encompassing standards & guidelines)

- These posts will assist with implementation of standards and guidelines within Acute services, including key performance indicators relating to specific patient safety initiatives and alerts in relation to medical devices and equipment. They will project manage and monitor these functions within the Acute Directorate
- They will also maintain the ongoing programme of undertaking the ISO quality standard for equipment management in order to support the maintenance and safe use of equipment.
- The Band 7 will be responsible for the Band 6 and will report to the Directorate Governance Coordinator.

**Function:** Executive Director Support (AHP & Medical are the Executive teams receiving new support)
**WTE Band 7 Workforce Development, training and Education Officer AHP** (new post temporary for 1 year)

- This post will assist the AD AHP Governance, workforce development, education and training. The post remit will be focused on education, training and development and will have a similar role to the equivalent team in within nurse education.
- This post will be available for 1 year in the first instance, after which the benefits of the role will be reassessed.
- This post will report to the AD AHP Governance and workforce development, education and training.

## Section 4:

## Achieving the New Organisational Structures

Following the consultation period the implementation of the final organisational structures will be undertaken in accordance with the principles and protocols of the Trust's agreed *Management of Change Framework.*

At this point staff directly affected will have opportunity for a personal meeting to discuss individual circumstances and requirements. Staff wherever possible will be offered a suitable alternative employment opportunity and where it is not possible to do so, immediately affected staff will be placed on the Redeployment Register so that any suitable posts throughout the Trust will be brought to their attention before it is advertised more widely. This meeting will be followed up in writing.

Under the terms of it's agreed "Traceability Scheme" the Trust will consider applications for Voluntary Redundancy and Voluntary Early Retirement on a "without prejudice" basis.

**Phasing:**

The impact that the roll out of the new web based management information system (Datix) will have on the recommended CSCG systems, processes and proposed structures is in part an unknown. It is therefore proposed that while the structure as is proposed on page 10 of this document will be phase 1 of the implementation of the Review of CSCG, following the information system rollout over the next one to two years there will be a need to re- examine areas of the CSCG system administration in order to determine their future structure. However this can only be done following the completion of phase 1 and when the organisation has a clear understanding of the new embedded systems and processes and the impact of information technology.

**Phase 1:**

As described earlier a number of CSCG posts within the organisation will remain the same, another set of posts will have a similar job role with minor modifications to accommodate different reporting structures, while there will

be a third group of posts which are new and will therefore be available for open competition.

Obviously the exciting development of creating new posts available for open competition within the Trust is coupled with the fact that as a result some current posts no longer exist within the new structure. The Trust recognises the work that staff in these posts have undertaken since the inception of the new organisation in the field of CSCG during a difficult time of merger; in the intervening period much has been learnt with respect to what makes a successful CSCG system and so with the benefit of recent National reviews the Trust must move forward and implement a system designed for the current and future climate of patient and client safety and quality.

**CURRENT POSTS WHICH REMAIN UNCHANGED:**

**Professional Executive Directors & their teams**
**Nursing:**
2 wte Band 8C
Education, training & Development team

**AHP:**
1 wte Band 8C

**Social Care:**
1 wte Band 8C
Governance, workforce development and training team

**Medical Workforce:**
1 wte Band 8B
Band 7
Band 6
Litigation team

**Explanatory Note:**

- The current Practice Support & Governance Team for nursing (Band 7's) will be realigned to Service Directorates.
- The Band 8C AHP Governance will have an additional new post for 1 year in the first instance – AHP workforce development, education and training officer, Band 7.
- These changes will be summarised overleaf

**CURRENT POSTS TO BE REALIGNED**

**To Service Directorates:**

Band 7 Nurse Governance Facilitators (current Practice Support & Governance Team for nursing).

Band 5 Governance Officers (current governance support administrators within the Medical Directorate)

Band 3 Governance admin support (currently governance administrators within the Medical Directorate)

Band 8B AHP Leads (currently AHP HOS)

**To Corporate Office of the Chief Executive:**

Current Central Reporting Team

Please note the current systems manager will be realigned to the Informatics Division within the Planning and Performance Directorate

Current Effectiveness and Evaluation team

**Explanatory Notes:**

- It should be recognised that with any realignment there will be a modification of roles and responsibilities. It is intended that for those involved it should be minimal and modifications to job descriptors will be done in collaboration with the post holders.
- The Band 5 and band 3 realignment from the Medical Directorate will not be sufficient to meet the whole time equivalency recommended in the review; therefore there would be open competition for the additional posts within the Trust.

- It is recognised that the role of AHP lead is a distinct modification of the current role of AHP HOS. It is intended that all the current HOS will be widely consulted with and that the job description for the role and which Directorate individuals will be reporting to will be worked on collaboratively with the HOS as a staff group.

**NEW POSTS FOR OPEN COMPETITION WITHIN THE TRUST**

**Corporate Office of the Chief Executive:**

Band 8C AD CSCG

Band 5 Governance Officer

Band 3 Governance Admin Assistant (additionality)

Band 7 (1 year) Governance Training Officer

**Service Directorates:**

Band 8B Governance Coordinator (4 posts)

Additional Band 5 Governance Officer (balance of those that currently exist in the Medical Directorate)

Additional Band 3 Governance admin assistant (balance of those that currently exist in the Medical Directorate)

**Acute Services only:**

Band 7 Patient Safety and Quality Manager (Encompass standards & Guidelines)

**Executive Director Teams:**

**AHP:** Band 7 Workforce development, education and training officer (1 year)

## SECTION 5: Equality Screening

The proposed organisational structures for Clinical &Social Care Governance (CSCG) emulating from the Review of CSCG within the SHSCT " A System of Trust" has been screened in line with the Trust's Guidance on Equality and Human Rights Screening. The outcome of the screening exercise has indicated that the proposed structures are not likely to have significant/major implications for equality of opportunity and therefore will not be subject to a full Equality Impact Assessment. The structures were considered not to have an impact on human rights of staff. A copy of the Screening Template is available on request from the Equality Assurance Unit, Hill Building, St Luke's Hospital Site, Armagh.

## SECTION 6: The Consultation Process

The purpose of the consultation paper is to seek your views on the proposed restructuring and in particular the following questions:

- Do you think that any aspects of an effective CSCG system and/or its processes are missing

- Do you think that any aspects of an effective CSCG system and/or its processes are unclear within the model described?

- Are the new and modified roles as described within the CSCG model sufficiently clear?

- The role of the Directorate Governance Coordinator is key in achieving clinical and operational management engagement in the model and therefore critical to its success. Do you think post holders should have a clinical background?

- Are there any other barriers to achieving the necessary clinical engagement and ownership required to make the CSCG model work effectively?

- Do you have any other comments on the consultation document?

To this end, the Trust intends to consult as widely as possible with those directly affected and those with a vested interest. The consultation period will commence on 8th December and will conclude on 22nd December, following which the final structures will be determined.

Staff who wish to discuss the proposed structures with the Chief Executive and Director of Human Resources & Organisational Development may do so

by contacting the HR office overleaf and arrangements will be made to meet with individuals or teams during the consultation period.

Staff are encouraged to participate in this consultation exercise and express their individual and/or collective views on the proposed structures. Staff can participate by sending their comments by writing/e-mailing to Catherine Irwin, Employee Engagement & Relations Department, Human Resources & Organisational Development Directorate, at the address below:-

Mrs Catherine Irwin
Employee Engagement & Relations Department
Hill Building
St Luke's Hospital Site
Armagh
Tel: Personal Information redacted by USI

Personal Information redacted by the USI

Appendix 1 Review of CSCG

Please refer to separate attachment with this email

Appendix 2 - Terms of Reference for Review of CSCG

Southern Health
and Social Care Trust



Our ref: MMcAl/ew

11 March 2010

To: Directors

**REVIEW OF CLINICAL AND SOCIAL CARE GOVERNANCE**

I refer to the recent review of assurance mechanisms for clinical and social care governance and the recommendations approved by Senior Management Team which included the establishment of the post of Head of Governance and a virtual Clinical and Social Care Governance Team.

An internal recruitment process for the Head of Governance post was recently undertaken however, while the post was offered, we have been unable to complete the recruitment process. The post will now be externally advertised.

Through engagement and consultation with staff, a number of issues have been raised regarding the robustness of our current governance operational and assurance systems, processes, capacity and capability. It is critical that these issues are explored and addressed, and should not be delayed pending appointment to the Head of Governance post.

I have therefore commissioned an urgent review of the effectiveness of current clinical and social care governance arrangements at operational level, and the information available to provide assurance on the safety and quality of our care.

Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon BT63 5QQ
Tel: Personal Information redacted by USI Fax: Personal Information redacted by USI www.southerntrust.hscni.net

This review will focus on the effectiveness of current mechanisms to ensure that safety and quality indicators are being properly captured, identified and addressed, and will provide advice to SMT Governance on any actions required to improve the Trust's governance arrangements.

The Review will be carried out by Mrs Deborah Burns and will commence on 1 April for a three month period, reporting to myself as Chair of SMT Governance.

I would be grateful if you would share this letter with your Assistant Directors and Associate Medical Directors for circulation, as I am aware of the high degree of interest in this issue.

Yours sincerely

Personal Information redacted by the USI

**MAIREAD McALINDEN**
**ACTING CHIEF EXECUTIVE**

# TERMS OF REFERENCE

## REVIEW OF CLINICAL AND SOCIAL CARE GOVERNANCE ARRANGEMENTS

### Context

The Trust has moved to implement new arrangements designed to ensure an effective assurance framework for Clinical and Social Care Governance within the Southern Trust.

Under this model, direction will be provided by the Senior Management Team working through a new post of Head of Governance. The Head of Governance will lead a "virtual" integrated Clinical & Social Care Governance (C&SCG) Team with the aim of providing assurance that Trust services are delivered to the appropriate standards in relation to quality and safety of care, and that any risks in relation to quality and safety are effectively identified and managed.

This process is designed to ensure the identification and effective control of risks within the Trust's Board Assurance Framework, assurance on the effectiveness of the Trust's C&SCG arrangements, and the provision of expert advice and support to Directorate Governance arrangements.

The Trust was not successful in making an appointment when the post was advertised internally within the Trust in January 2010 and has decided to advertise externally for the post.

Due to the urgent nature of the work to be undertaken the Chief Executive has commissioned a review of the effectiveness of current clinical and social care governance arrangements at operational level, and the information and systems available to provide assurance on the safety and quality of our care.

**Review Terms of Reference**

The Trust has agreed to appoint a project manager on an interim basis for three months.

The aim of the review is to assess the effectiveness of the Trust's clinical and social care governance mechanisms in relation to:

- The appropriate and timely identification of risks in relation to the safety and quality of clinical and social care.
- The use of adverse incident reporting, 'near misses', risk assessments, complaints and other information sources to inform the identification of such risks.
- The effectiveness of current systems, processes, capabilities and capacity in providing effective management of such risks.
- Systems to ensure that lessons are learned from these internal processes and embedded throughout the Trust.
- Systems to draw and evaluate learning from elsewhere and use this information to assess and where necessary improve safety and quality of care.
- Clinical engagement and involvement in clinical and social care governance systems, processes and assurance mechanisms.
- Processes for ensuring the implementation of standards and guidelines.
- Support to and within Directorates to effectively implement the above.
- The selection, capture, measurement and reporting of safety and quality indicators and information to provide robust assurance to SMT Governance, Governance Committee and Trust Board on the safety and quality of Trust services.

- The definition, communication and understanding of responsibility, accountability and reporting mechanisms for clinical and social care governance.

The Project Manager will undertake a process of in-depth engagement with key stakeholders to ensure this assessment of effectiveness is robust, and to ensure ownership for any associated recommendations for improvement. Part of this engagement process will be the establishment of the 'Virtual Clinical and Social Care Governance Team' as to act in support of the Project Manager and as a key stakeholder group.

This assessment and engagement process will inform the Project Manager's recommendations to SMT Governance in relation to current and planned future clinical and social care governance arrangements, and will complement and integrate with the development of an action plan which ensures the findings and learning from the report into Mid-Staffordshire NHS Foundation Trust are implemented within the Southern Trust.

This assessment, recommendations and action plan will be presented to SMT Governance by the end of June, with updates on progress being provided on a monthly basis for the duration of the Review.

The project manager will report to the Chief Executive for the duration of the project.

March 2010

# Appendix 3: Processes for managing poor professional performance and conduct

## Step 1 Screening Process

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→ Clinical Manager/Operational Director informs:

- Chief Executive
- Medical Director
- Human Resources Department
- Practitioner

↓

Chief Executive appoints an Oversight Group – usually comprising of:

- Medical Director / Responsible Officer
- Director of Human Resources and Organisational Development

↓

Clinical Manager and HR Case Manager undertake preliminary enquires to identify the nature of the concerns and assesses the seriousness of the issue on the available information.

↓

Clinical Manager and HR Case Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and HR Case Manager notify the Oversight Group of their assessment and decision. The decision may be:

- No Action Necessary
- Informal remedial action with assistance and input from NCAS
- Formal Investigation
- Exclusion / Restriction

* If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

## Step 2 Informal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the informal process.

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

Local action plan is developed (this may not always involve NCAS)

The Clinical Manager may seek advice from NCAS and this may involve a performance assessment by NCAS if appropriate.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors and provides regular feedback to the Oversight Group regarding

In instances where a practitioner fails to engage in the informal process, management of the concern will move to the formal process.

## Formal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the formal process.

Chief Executive, following discussions with the MD and HROD, appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and

Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

# Conduct Hearings / Disciplinary Procedures

Case Manager makes the decision that there is a case of misconduct that must be referred to a conduct panel. This may include both personal and professional misconduct.

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Case referred under the Trust's Disciplinary Procedures. Refer to these procedures for organising a hearing.

If a case identifies issues of professional misconduct:
- The Case Investigator must obtain appropriate independent professional advice
- The conduct panel at hearing must include a member who is medically qualified and who is not employed by the Trust.
- The Trust should seek advice from NCAS
- The Trust should ensure jointly agreed procedures are in place with universities for dealing with concerns about Practitioners with joint appointment contracts

If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member.

In all cases following a conduct panel (Disciplinary Hearing), where an allegation of misconduct has been upheld consideration must be given to a referral to the GMC/GDC by the Medical Director/Responsible Officer.

If an investigation establishes suspected criminal action, the Trust must report the matter to the police. In cases of Fraud the Counter Fraud and Security Management Service must be considered. This can be considered at any stage of the investigation.

Consideration must also been given to referrals to the Independent Safeguarding Authority or to an alert being issued by the Chief Professional Officer at the DHSSPS or other external bodies.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

# Clinical Performance Hearings

Case Manager makes the decision that there is a clear failure by the Practitioner to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance i.e. a clinical performance issue

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Following assessment by NCAS, if the Case Manager considers a Practitioners practice so fundamentally flawed that no educational / organisational action plan is likely to be successful, the case should be referred to a clinical performance panel and the Oversight Group should be informed.

Prior to the hearing the Case Manager must:
- Notify the Practitioner in writing of the decision to refer to a clinical performance panel at least 20 working days before the hearing.
- Notify the Practitioner of the allegations and the arrangements for proceeding
- Notify the Practitioner of the right to be accompanied
- Provide a copy of all relevant documentation/evidence

Prior to the hearing:
- All parties must exchange documentation no later than 10 working days before the hearing.
- In the event of late evidence presented, consideration should be given to a new hearing date.
- Reasonably consider any request for postponement (refer to MHPS for time limits)
- Panel Chair must hear representations regarding any contested witness statement.
- A final list of witnesses agreed and shared between the parties not less than 2 working days in advance of the hearing.

Composition of the panel – 3 people:
- **Chair -** Executive Director of the Trust (usually the Medical Director)
- **Panel 1 -** Member of Trust Board (usually the Operational Director)
- **Panel 2 -** Experienced medically / dentally qualified member not employed by the Trust

** for clinical academics including joint appointments a further panel member may be required

Advisors to the Panel:
- a senior HR staff member
- an appropriately experienced clinician from the same or similar specialty but not employed by the Trust.

** a representative from a university if agreed in any protocol for joint appointments

# Clinical Performance Hearings

During the hearing:

- The panel, panel advisors, the Practitioner, their representative and the Case Manager must be present at all times
- Witnesses will only be present to give their evidence.
- The Chair is responsible for the proper conduct of the hearing and should introduce all persons present.

During the hearing - witnesses:

- shall confirm any written statement and give supplementary evidence.
- Be questioned by the side calling them
- Be questioned by the other side
- Be questioned by the panel
- Clarify any point to the side who has called them but not raise any

During the hearing – order of presentation:

- Case Manager presents the management case calling any witnesses
- Case Manager clarifies any points for the panel on the request of the Chair.
- The Practitioner (or their Rep) presents the Practitioner's case calling any witnesses.
- Practitioner (or Rep) clarifies any points for the panel on the request of the Chair.
- Case Manager presents summary points
- Practitioner (or Rep) presents summary points and may introduce

Decision of the panel may be:

1. Unfounded Allegations – Practitioner exonerated
2. A finding of unsatisfactory clinical performance (Refer to MHPS Section IV point 16 for management of such cases).

If a finding of unsatisfactory clinical performance - consideration must be given to a referral to GMC/GDC.

A record of all findings, decisions and warnings should be kept on the Practitioners HR file. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. The decision must be confirmed in writing to the Practitioner within 10 working days including reasons for the decision, clarification of the right of appeal and notification of any intent to make a referral to the GMC/GDC or any other

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

# Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision.
The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the

# Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board

**Immediate Exclusion**

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

# Restriction of Practice / Exclusion from Work

**Formal Exclusion**

Decision of the Trust is to formally investigate the issues of concern and appropriate individuals appointed to the relevant roles.

Case Investigator, if appointed, produces a preliminary report for the case conference to enable the Case Manager to decide on the appropriate next steps.

The report should include sufficient information for the Case Manager to determine:

- If the allegation appears unfounded
- There is a misconduct issue
- There is a concern about the Practitioner's Clinical Performance
- The case requires further detailed investigation

Case Manager, HR Case Manager, Medical Director and HR Director convene a case conference to determine if it is reasonable and proper to formally exclude the Practitioner. (To include the Chief Executive when the Practitioner is at Consultant level). This should usually be where:

- There is a need to protect the safety of patients/staff pending the outcome of a full investigation
- The presence of the Practitioner in the workplace is likely to hinder the investigation.

Consideration should be given to whether the Practitioner could continue in or (where there has been an immediate exclusion) could return to work in a limited or alternative capacity.

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

The Case Manager along with the HR Case Manager must inform the Practitioner of the exclusion, the reasons for the exclusion and given an opportunity to state their case and propose alternatives to exclusion. A record should be kept of all discussions.

The Case Manager must confirm the exclusion decision in writing immediately. Refer to MPHS Section II point 15 to 21 for details.

All exclusions should be reviewed every 4 weeks by the Case Manager and a report provided to the Chief Executive and Oversight Group. (Refer to MHPS Section II point 28 for review process.

# Agreement 6: – Managing poor professional performance - Nurse, AHP, SW. Ref – Trust Disciplinary Procedure

Informal info

Incidents

Complaints

Risk register

Litigation

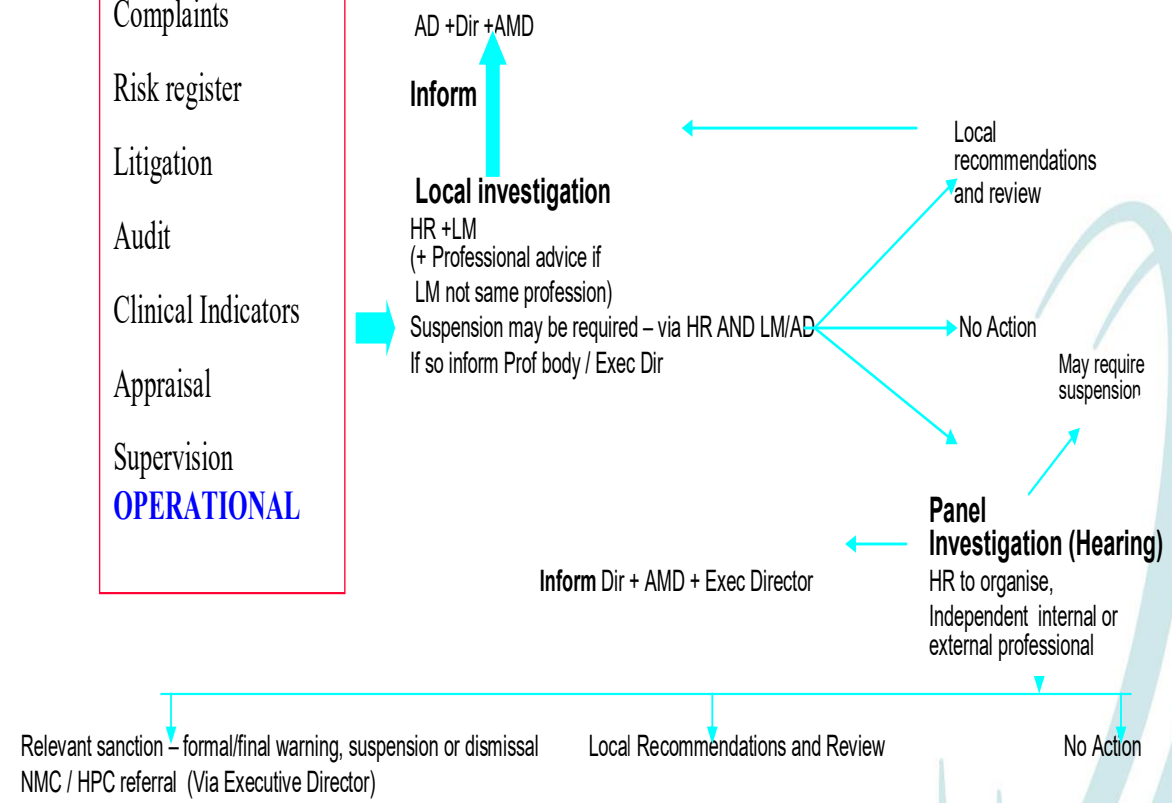
Audit

Clinical Indicators

Appraisal

Supervision

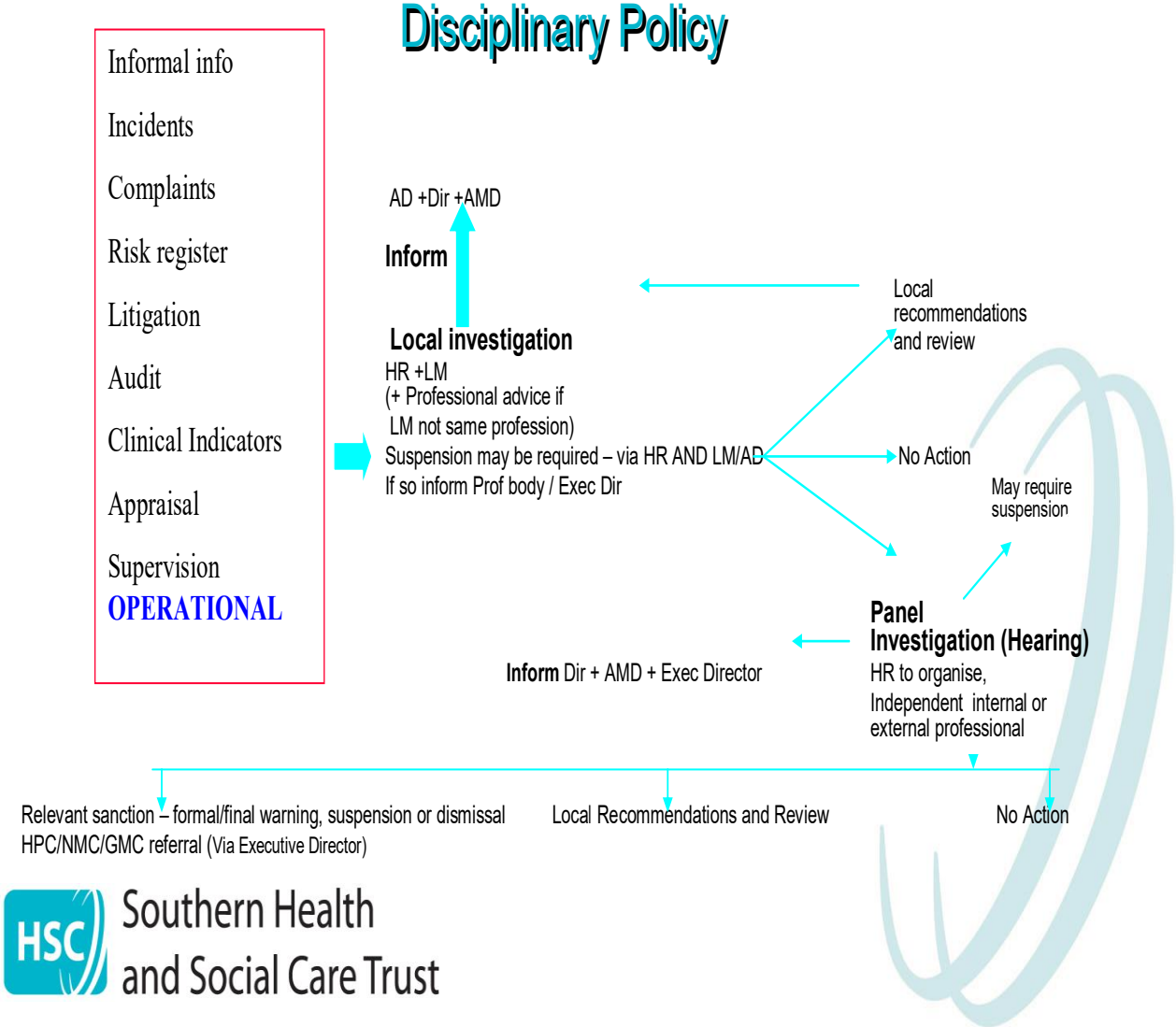
OPERATIONAL




Southern Health and Social Care Trust

# Agreement 8: Managing poor conduct – all employees.

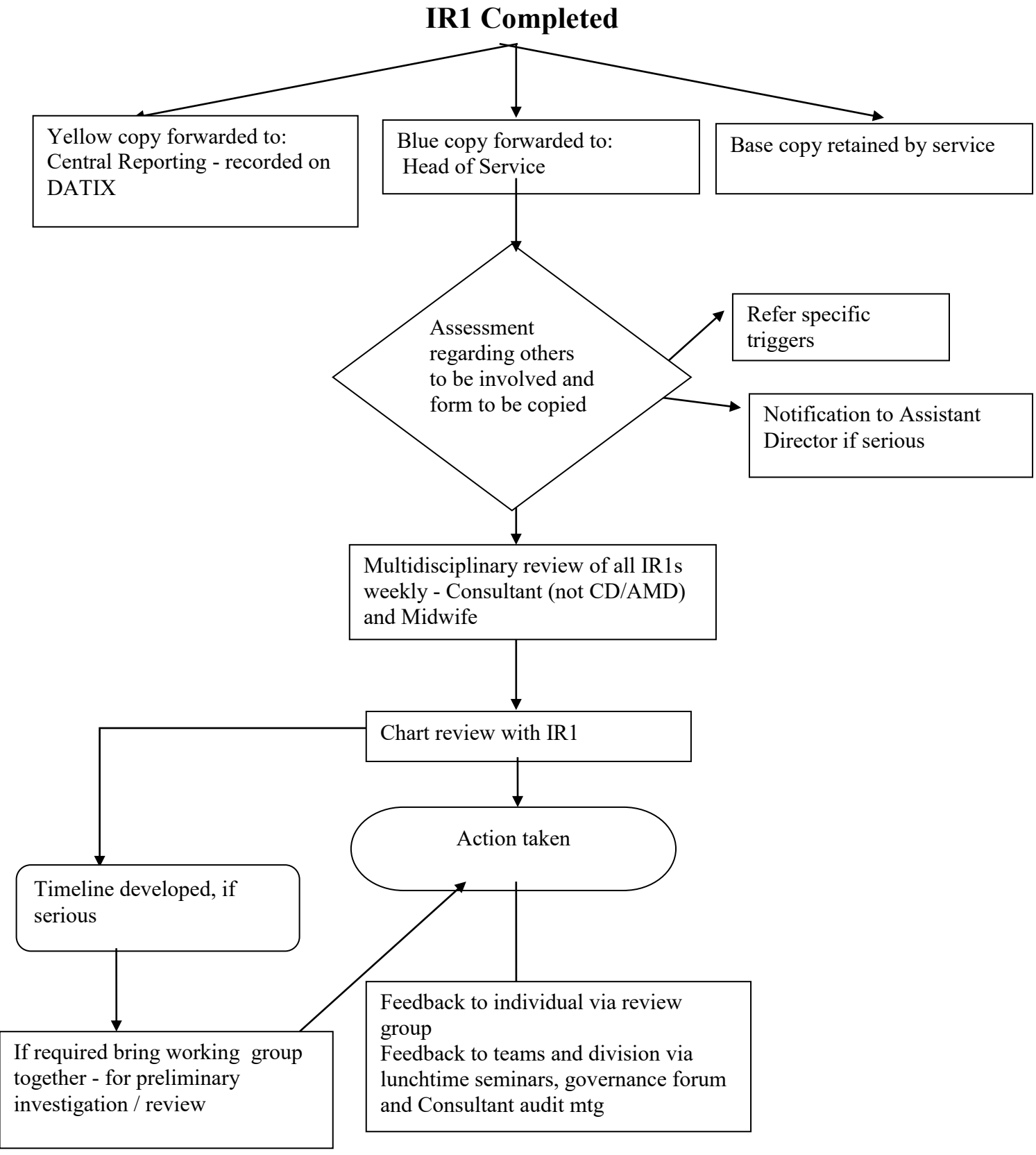
## Ref – Trust Working Well Together Policy and Trust Disciplinary Policy




HSC Southern Health and Social Care Trust

**Appendix 4 Example of - Acute Service Incident Management Process**

**Integrated Maternity and Women's Health - Model**



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

# Minutes of a confidential meeting of Trust Board held on Thursday, 29th August 2013 at 2.00 p.m. in Blessingbourne, Fivemiletown

## PRESENT:

Mrs R Brownlee, Chairman
Mrs M McAlinden, Chief Executive
Mr R Alexander, Non Executive Director
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Dr J Simpson, Medical Director

## IN ATTENDANCE:

Mrs D Burns, Interim Director of Acute Services
Mrs P Clarke, Director of Performance and Reform
Mr Miceal Crilly, Acting Director of Mental Health and Disability Services
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs A McVeigh, Director of Older People and Primary Care/Acting Director of Nursing Services
Mr P Toal, Communications Manager
Mrs S Judt, Board Assurance Manager (Minutes)

## APOLOGIES

None

1. **MINUTES OF MEETINGS HELD ON 30th MAY 2013 AND 13TH JUNE 2013**

The Minutes of the meetings held on 30th May 2013 and 13th June 2013 were agreed as accurate records. The Minutes were duly signed by the Chairman.

2. **MATTERS ARISING FROM PREVIOUS MINUTES**

There were no matters arising that were not addressed elsewhere on the agenda.

**3. PROPOSALS REQUESTED BY HSCB TO ADDRESS £8m GAP 2013/14**

Mrs McAlinden advised that the Trust had been asked for proposals to seek to reduce its projected deficit in year of £8m. She outlined the proposals as submitted to the HSCB and noted that a significant number are extremely challenging. In terms of the next steps, the Minister will receive a collective list of proposals from all 5 Trusts.

**4. PROGRESS UPDATES**

**i)** Personal Information redacted by USI

The Chair welcomed Mrs P Trainor, Head of Safeguarding, to the meeting. Mr Crilly referred members to the following reports in their papers:-

- 2nd Adult Safeguarding Investigation Report including the Proprietors' response dated 16.7.13 to the draft report and the Trust response dated 9.8.13 to the comments received;
- Update on recommendations from the 1st and 2nd Investigation Reports.

Mr Crilly drew members' attention to the recommendations in the

final 2nd investigation report, in particular. He advised that following Trust Board approval, the report will be issued to interested parties in line with the report's recommendations.

Mrs Trainor noted that the 2nd investigation was to establish the facts and substance pertaining to potential financial abuse and noted the significant amount of work undertaken and time spent by Trust staff. She stated that since the draft report, remedial action has been taken by the Proprietors in that draft policies and procedures have now been received from them in relation to transport, supervision and holidays.

The Chair asked if there were any other independent sector homes in the Trust area who operate day care in the same way as [redacted]. Mrs Trainor advised that as far as the Trust was aware, [redacted] were the only provider. She advised, however, of a charging issue that had arisen in one other home and confirmed that a safeguarding strategy meeting has been convened. The Trust's approach is to address issues with the homes as they arise.

Mr Crilly advised that the Trust anticipates a potential legal challenge from the Proprietors' solicitors, Arthur Cox. Dr Mullan asked if there were any areas where the Trust may be vulnerable. Mr Crilly spoke of the significant amount of correspondence/communication with Arthur Cox to which he felt the Trust had robustly responded to. The Chair sought assurance on the robustness of the investigation to date and the factual accuracy of the report to enable Board members to make an informed decision in approving the report. Both Mr Crilly and Mrs Trainor provided that assurance.

**The Board approved the 2nd investigation report**

## ii) Hyponatraemia Inquiry

An update on the Hyponatraemia Inquiry had been included in members' papers. Mrs McAlinden stated that the Directorate of Legal Services (DLS) has informed the Trust that CM's case

will be considered by the Inquiry in early October 2013. 9 members of Trust staff will be required to provide witness statements.

**iii)** Irrelevant information redacted by the USI

Mr Morgan reminded members of the Trust's Review of Residential Care which led to the establishment of a range of early interventions and prevention services which contributed to a reduction in the numbers of young people requiring residential assessment. This led to an opportunity for the Trust to temporarily reconfigure its children's services and to close Irrelevant information redacted by the on a temporary basis. Mr Morgan referred members to the update in their papers on actions taken to ensure the safe care of young people in the context of the temporary closure of Irrelevant information redacted by the since 11th July 2013.

Mrs Mahood asked when the situation would be reviewed to which Mr Morgan advised of ongoing monthly review, however, if an emergency situation arose which required an admission, staff can be made available. He stated that the ongoing reduction of numbers requiring admission had been achieved by the development of good support systems such as the Front Line Service and Specialist Fostering Service. Mrs Mahood asked about the Trust's level of fostercarers to which Mr Morgan advised that additional fostercarers are currently being recruited.

**iv) Child Sexual Exploitation issue**

Mr Morgan advised of recent developments in the child sexual exploitation issue. In terms of this Trust, an internal review of cases has been undertaken and a report will be produced shortly and shared with the PSNI. The first meeting of the regional investigation team took place on 23rd August 2013.

**v) Laboratory/Missed Samples**

Mrs Burns advised of an incident relating to the delayed delivery of samples/specimens from some GP practices in the

Lurgan area to the Labs in Craigavon Area Hospital. Subsequent to this incident, the Trust communicated with the affected practices to advise of this incident, identifying the patients involved and the requirement to have the samples/specimens repeated. A SAI process is underway in order to establish possible areas of learning. Mr Crilly advised processes have been strengthened within Transport to prevent such an incident reoccurring.

5. **SAIs**

**i) Domiciliary Care Incident**

Mrs McVeigh advised that an Independent Domiciliary Care Agency had informed the Trust on 5.8.2013 that a member of their staff had reported that another of the agency's staff had taken two photographs of two service users in their own home and that these were being distributed to members of the public via mobile phone. The Trust has commenced the Protection of Vulnerable Adults (PVA) process.

**ii) Serious Adverse Incidents involving an Independent Inquiry**

Mr Crilly informed members that the HSCB is undertaking a scoping exercise of cases within the region where an Independent Inquiry should have been, but was not carried out between February 1996 – September 2009. The Trust has completed its own screening exercise, the outcomes of which are detailed in the briefing paper. The HSCB will now decide if an Independent Inquiry is warranted in each case. If so, the HSCB will commission the Independent Inquiry.

6. **HCAI**

**i) HCAI Recording on Death Certificates**

Dr Simpson provided data on the number of deaths in the SH&SCT up to 16th August 2013 where HCAI was mentioned and recorded as the underlying cause on the death certification.

**ii) Ramone Ward**

Mrs McAlinden referred to a paper tabled on the step down of the Isolation Ward at Craigavon Area Hospital, advising that this facility was unfunded and outlined the proposed step down arrangements and risk management arrangements in relation to same. Mrs McAlinden stated that Trust Board approval is sought to step down the Ramone Ward in September 2013. She explained that the Ramone Ward remains an unfunded development which is contributing substantially to the Trust's financial pressures in year and recurrently (annual cost of £800,000). This unfunded cost pressure can no longer be borne by the Trust and at a meeting with Dr Harper, PHA, on 23rd August 2013 to discuss this issue and to request in year funding to end March 2013, the Trust was advised that the PHA has no in year funding for infection control this year and were unable to assist the Trust in this regard. Mrs McAlinden stated that this is not a 'risk free' decision and advised that the Medical Director and Infection Prevention and Control Team has serious reservations about the ability of the Trust to maintain current HCAI performance without the isolation facilities provided by Ramone Ward. She advised that this is a difficult issue and a high risk decision which the Senior Management Team has been discussing since June 2013, seeking acceptable risk management solutions. The risks and the actions to mitigate the step down of the Ramone Ward are outlined in the paper.

Mrs Burns stated that she understood the IPC Team's reservations and the need for the isolation ward given that on an average day, there are 12-15 HCAI patients in the main hospital wards. Dr Simpson spoke of the need for the facility as there is inadequate provision throughout the hospital given the limited number of side rooms.

There was a full discussion in which the Chair asked each member individually for their views on the proposal. A number of reservations were expressed about the proposal being tabled at the meeting and without an accompanying Board Report

template. Members therefore felt that they had insufficient time to consider the proposal in detail and required some additional information to enable an informed decision to be made. The Chair asked that members forward their comments, together with details of any additional information they would want included in an updated paper. It was agreed that an updated paper will be provided to the open section of the September 2013 Trust Board meeting for a decision.

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Minutes of a Trust Board Public Meeting held on Thursday, 25 August 2011 at 9.30 a.m. in the Lecture Theatre, Beeches Management Centre, College of Nursing, Craigavon

## PRESENT:

Mrs R Brownlee, Chairman
Mrs M McAlinden, Chief Executive
Mr E Graham, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs H Kelly, Non Executive Director
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Dr P Loughran, Medical Director
Mr S McNally, Director of Finance and Procurement

## IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources & Organisational Development
Dr G Rankin, Director of Acute Services
Mrs A McVeigh, Director of Older People & Primary Care Services
Mrs P Clarke, Director of Performance & Reform
Mrs R Rogers, Head of Communications/
Mrs J McKimm, Communications Manager
Mrs E Wright, PA to Chief Executive (Minutes)
Angela McIntosh, Paediatrician

## 1. CHAIRMAN'S WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting and in particular Dr John Simpson, newly appointed Medical Director and to Mrs Sinead Burns, Assistant Director of Human

Resources. Apologies were recorded from Mr Francis Rice and Dr Raymond Mullen.

The Chairman sought and received confirmation from members that they had read their papers in advance of the meeting.

## 2. DECLARATIONS OF INTEREST

There were no declarations of interest in relation to any items on the agenda.

## 3. CHAIRMAN'S BUSINESS

The Chairman informed members of recent achievements by Trust Staff:

- Congratulations to Ruth Carroll, HV Team Manager who graduated in July with a PhD in Life & Health Sciences
- Commendation to Bronagh Rogers and Paula Brown, off Duty Nurses for their swift and vital assistance provided to the referee who collapsed at a recent GAA match in Newry. Acknowledgement was also made of Mr O'Toole and all the A&E Team at DHH for successfully treating Personal Information redacted by USI.

The Chair reported on recent visits since the last Board Meeting:

- visit to Lurgan Hospital with DUP delegates
- visit to Portadown CTTC
- visit to Daisy Hill Hospital
- Meeting with Mr Jim Wells
- Meeting with SELB
- Opening of Callan Street Community Gardens in Armagh

## 4. CHIEF EXECUTIVE BUSINESS

The Chief Executive advised members that it had been a busy summer and reported on business as follows:

- **Accountability Review Meeting with DHSSPS**
  The Chief Executive advised that the Trust's end of year accountability review meeting was held on 28 July 2011 and attended by the full SMT and Chair. This meeting is a key element of the Department's accountability arrangements for Trusts and covered the full range of governance and performance issue.

  The Trust's SIC 2010/11 was discussed in detail including Priority 1 Internal Audit findings, however there was agreement that pragmatic approaches should be taken where cost outweighed potential risk, etc. The Departmental comments on the SIC will be brought to the next meeting of the Trust's Audit Committee. The minutes of the Accountability meeting, when received, will be brought to the Governance Committee for discussion.

  Other issues raised included the Trust's plans for Bowel Screening, Business Continuity Plans, procurement issues and compliance with safety alerts and guidelines. The RHSCB provided analysis of performance which was generally positive.

  The Trust shared the Corporate Risk Register to highlight the range of risks being managed and identified where regional commissioner/policy support was required. Concerns on the number (58) and complexity of standards and guidelines received Jan- June '11 and the need for improved co-ordination was also raised by the Trust.

  The Chair expressed her gratitude to the Chief Executive and Senior Management Team and commended the quality outcome and performance of all involved in the Accountability Review Meeting. She added that their commitment and responsiveness was evident.

- **Procurement Governance**
  The Chief Executive advised that following the Minister's statement to the Assembly on procurement issues in respect of security at Belvoir Hospital, and the limited assurance by

internal audit in relation to this issue, the Permanent Secretary has written to HPSS Chief Executives to seek assurances in relation to procurement practice. The Trust provided a comprehensive response to Dr McCormick and is continuing to address the recommendations of our internal audit and will report same to Audit Committee.

- **A&E Changes at Lagan Valley Hospital (LVH) and Belfast City Hospital (BCH)**
  Members were updated on the changes in respect of A&E Services at LVH and BSH and due to a lack of junior doctors, LVH A&E Department reduced its opening hours to 8pm from 1 August. The impact on CAH A&E Department is being monitored closely and to date is coping with the additional activity as a consequence of this service change.

  The Chief Executive referred to a Regional Workshop held on 14 August to discuss contingency plans for a predicted shortage of doctors which would potentially require closure of the BCH A&E from 1 October 2011 and was attended by the Chief Executive along with the Director of Acute Services and Director of Nursing/MHD. The information shared at this workshop predicted a very marginal impact on Trust A&E services, with the main transfers of activity affecting Royal and Ulster A&Es and NIAS. In the days following this workshop there was significant media coverage of these proposals and the Minister subsequently visited the Ulster and Royal Hospitals on 15th and 16th August to hear about progress on contingency planning.

  Media coverage included speculation about the future of Daisy Hill Hospital A&E service and the Trust sought to counter this speculation through the provision of information to staffside for communication with DHH staff, positive media regarding recent investments, and input to regional discussions on future standards for A&E services. A visit to DHH by Mr Jim Wells has been arranged for 16 September.

  Mr Graham asked the Chief Executive if she felt the Trust had confidence to deal with any issues arising from the A&E

situation. The Chief Executive responded advising that any concerns regarding turnaround and responsive times have been identified and escalated to the Commissioner and the NI Ambulance Service has been fully involved in the process.

- **Ministerial Visit to Portadown CCTC**
  Members referred to the recent visit by Minister Poots to Portadown CCTC on 27 July. A short presentation was delivered on the planning concepts and services in the Centre, which was followed by a tour of the building. Minister Poots spoke with one of the GPs and a number of staff. Media coverage included very positive comments by Minister.

- **Crossmaglen Social Centre**
  The Chief Executive informed members that following a recent fire inspection and risk assessment of Crossmaglen Social Centre, the Trust made a decision to relocate the Social Centre to alternative premises in Crossmaglen. Copies of a briefing note were included in papers for member's information. There was media coverage of this issue in local media and Director of Older People and Primary Care is meeting local elected representatives in Crossmaglen on 26 August 2011.

- **Lurgan Hospital**
  Members were informed that refurbishment work on Lurgan Hospital has concluded on Phase 1 and a number of local politicians expressed an interest in visiting to see the work completed. Three visits took place in June 2011 - Mr Gardiner MLA, Mrs Kelly MLA and David Simpson MP, Stephen Moutray MLA, Sydney Anderson MLA and Louise Templeton visited. There was positive media coverage in the local papers.

- **Clinical and Social Care Governance Review – Progress Update**
  A progress update with regard to Clinical & Social Care Governance was provided. The Chief Executive advised

that the population of the new structures are proceeding with appointments to the Governance Lead posts in CYP, OPPC and MH&D and a temporary appointment (secondment) in the Acute Directorate. Members also noted that:

- the middle tier of the C&SCG administrative structure (Band 5 posts) is now in place
- the Patient Safety and Quality Team (Band 7 and Band 5) is also in place
- the Nurse Governance Co-ordinators for each operational directorate (posts devolved from central nursing governance) are now re-aligned and in post.

The remaining structure to be populated includes:

- Band 3 administrative posts (being interviewed in September)
- Directorate Lead AHP posts (pooling to be agreed)
- Band 7 Governance Training Officer

The Chief Executive updated on progress in relation to the governance system development and advised that the roll out of the Datix Web-based Incident Reporting Module is progressing successfully – Integrated Maternity and Women's Health are now entirely on this system as is the Acute Mental Health Inpatient Service in Bluestone and the GP Out of Hours service. The next phase of roll out is underway and will include Acute Paediatrics and Neonatology with another Acute division to be finalised.

A new process for Morbidity and Mortality (M&Ms) has been agreed and will phase in from September 2011.

- **RQIA Review of Effectiveness of the Safeguarding Arrangements in place for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals**

Members noted that the RQIA Review which commence in July will plan to be concluded in March 2012 with an Overview Report to be finalised by 30 September 2012.

- **Meeting with SELB**

The Chief Executive informed members of a recent meeting which she and the Chair attended with Chairman and Chief Executive of the SELB on 26 July. The meeting discussed the possibility of joint agreement to take forward further discussions on areas of collaborative work. Chief Executives and Lead Directors from both organisations to meet in September.

- **Meeting with MLAs and Special Advisor**

The Chief Executive and Chair met with a number of local MLAs over the summer and will continue this process into September. The meetings have been useful and continue to build our good relations with local elected representatives.

A meeting with Dr Philip Weir, the Minister's Special Advisor took place on 21 July. A range of topics were discussed and Dr Weir was briefed on a number of key issues for the Trust. It is planned that meetings will be held on a quarterly basis.

## 5. MINUTES OF MEETING HELD ON 23 JUNE 2011

The Minutes of the meeting held on 23 June 2011 were agreed as an accurate record and duly signed by the Chairman.

## 6. MATTERS ARISING FROM PREVIOUS MEETING

**i) Executive Director of Social Work Report – referral statistics**
Please refer to item 8.1

**ii) Medical Director's Report – mortality reporting**
Please refer to item 8.3

## 7. STRATEGIC ISSUES

i) **Update on Children & Young People's Directorate Strategic Direction**

Mr Morgan presented an update on the Children & Young People's Directorate Strategic direction. Mr Morgan advised that the report provides detail and evidences achievements within the Directorate against Trust key strategic priorities, and outlines plans to further develop services in 2011/12, outlining the challenges ahead.

Mr Morgan highlighted the priorities which inform achievements and future developments:

a) contributing and achievement of the 6 high level outcomes within the Governments Strategy 'Our Children & Young People – Our Pledge (2006-16)'
b) developing services within the context of the reform agenda and delivered through the Regional Reform Implementation Team
c) continuing to deliver against the DHSSPS PfA targets
d) Demographic factors

Mr Morgan outlined the Directorates key issues:

**A. <u>Providing Safe High Quality Care</u>**

**1. Changing for Children:**

- Business Case for Neonatal Services Pathway was approved and Commissioner Funding secured
- Plans to consolidate planned surgery for children at a centre of excellence in DHH
- Emergency Care will continue to be provided at CAH and DHH, paediatric ambulatory services will be introduced in CAH alongside the current ambulatory service at DHH and STH

Mr Morgan advised that business cases for the capital and revenue developments required to support the above changes will be presented to Trust Board before November 2011.

Mrs Kelly said it was important to have supportive ambulatory services and to ensure it is maintained and

enhanced. In response, the Chief Executive gave assurance that the current ambulatory service at DH and STH will be maintained and enhance. Mr Morgan further stated that this would be provided in the Armagh area also

2. **Gateway Services:** commencement of a comprehensive review and plans to introduce a single point of referral entry by November 2011.
3. **Health Visiting**: recruitment of Bi-Lingual Health Visiting Assistants to assist the growing needs of the BME Community. Mrs Mahood asked if there was capacity to allow roll-out. Mr Morgan responded advising that there are currently 5 Bi-Lingual Health Visitors who are currently working alongside Social Workers to draw up a plan to bid for further assistants.
4. **Releasing Time to Care:** commitment to project and participated both within the Children's Ward at CAH and the Special Care Baby Unit in DHH. Focus on improving ward processes and environment to help Nurses spend more time on patient care and improving both quality and safety.
5. **Autism:** Autism Diagnoses Pathway operating well. Re-modelling of post-diagnostic education and intervention programme which is being well received by families. Mrs Mahood sought clarification on the position of the Autism Bill and Mr Morgan advised that further work is being developed however, he advised that the Trust was well placed and ahead of other Trusts in the province.

**B: <u>Engaging Children & Families</u>**

1. **Supporting Young Care Leavers in Education, Training & Employment:** development of a number of key initiatives to support young leavers in their transition to adult working life and assist in their participation of education training and employment opportunities.

2. **Person Centred Planning for C&YP with complex health needs/disability:** the involvement of young people in the development of a plan to address their individual needs. Appointment of Transition Workers who facilitate the development of person centred transition plans which commence for every child at the age of 14.
   The Chair suggested using the Patient & Client Experience Committee as a vehicle to assist in this development. Mrs Blakely said it was encouraging to see this progress, however it can be costly in terms of education.
3. **Family Group Conference:** service delivered in partnership with Barnardos and for successive years the Trust has exceeded the PfA target to ensure 95 children take part in a Family Group Conference.
4. **Service User Group:** Service User Group established to ensure all services that work with LAC listen to them when planning and get regular feedback on what they do.

**C: <u>Supporting People & Communities to Improve their Health & Wellbeing</u>**

1. **Healthy Child: Healthy Futures:** Regional Child Health Promotion Programme launched and fully operational. Framework sets out core programme of child health contacts that every family can expect.
2. **CAWT:** Cross Border Diabetics Project ongoing. Outcome for Children based planning to help promote working together to plan and deliver services so that better outcomes are achieved.
3. **Surestart:** 8 Surestart projects which provide extensive coverage across the Trust and operate through a partnership model.
4. **Roots of Empathy:** ongoing work to roll out the model – 8 schools identified as intervention schools and the Trust has established a Steering Group to lead the local implementation.

## D: Being a Good Social Partner

1. **Hubs:** development of 3 Family Support Hubs tasked with the co-ordination and provision of family support resources/services in local areas.
2. **Southern Outcomes Group:** integrated planning and commissioning group aimed to ensure the delivery of improved outcomes for children and young people.

## E: Making Best Use of Resources

1. **SLA:** Mr Morgan advised that the trust has in place a wide range of service delivery partnerships which are reviewed annually and monitored on a 6 month basis to ensure they delivery safe, effective and efficient services to children and their families. The Trust invests nearly £2.5m each year into a range of service delivery partnerships.
2. **Skill Mix:** to date the achievement of 88.12 qualified to unqualified skill mix within the HV workforce, from a baseline of 100% qualified.
3. **Review of Court Welfare:** ongoing review to ensure the Trust provides a responsive, effective and timely service to the Court.
4. **Review of Directorate Structures:** review commenced in March 2011 and ongoing. Major review of Gateway services has commenced. Admin and Clerical Review currently being costed by Finance.

Mrs Blakely asked for clarification regarding the LAC System Review and Mr Morgan replied that an education profile/plan is drawn up and in some areas this can be quite specific.

Mr Graham raised the issue of the Aging Population in terms of parents/grandparents and the Chief Executive advised that work was progressing and information will be tabled at a forthcoming SMT meeting.

The Chairman thanked Mr Morgan for an informative update and asked for further consideration be given to Unallocated Child Care Reviews to ensure challenges are taken on board to so the Trust can assist the Young People as best as we can to secure work. Mrs Blakely added to this by raising the issue of the impact on employer ability and the need to deal with holistically to give young people the best opportunity to achieve an education. The Chief Executive asked if Mrs Blakely would wish to discuss this and specific issues further and agreement was reached to do so.

In concluding, the Chairman encouraged members to view Carrickore which she said was an excellent respite facility. She hoped there will be an official opening in the near future.

ii) **Draft Trust Delivery Plan (ST 324/11)**

Mrs Clarke presented the Trust Delivery Plan for approval. She summarised the key elements and the detailed content of the document. Mrs Clarke advised that TDP is one of the Trusts key documents and represents the Trusts response to the detailed commissioning intentions signaled in the draft Commissioning Plan issued by the HSCB ad PHA and to specific targets set by DHSSPS in the Commissioning Plan. The Plan sets out the financial, workforce, governance and capital investment plans for 2011/12.

Mrs Clarke advised that the TDP follows previous years format and she undertook to highlight the key areas that remain significant to the Trust.

Mrs Clarke referred to the delivery against the key commissioning and ministerial priorities and targets for 2011/12. A total of 46 targets are identified and the Trust believes it can fully achieve 24 targets, 6 achievable depending on regional action, 8 achievable if additional resources are agreed and 8 deemed as likely to be achieved with some delay.

The Chairman stated that those targets which the Trust is not able to achieve, must be examined to ascertain whey. She asked Mrs Clarke to discuss these in further detail.

Mrs Mahood sought clarification as to the meaning of achievable providing additional resources are agreed and Mrs Clarke advised that the Trust must ensure it has quality outcomes and use other money within specific areas. She added that the surplus identified 3 priority areas and the money must be used non-recurrently.

Mrs Clarke highlighted areas of the plan and provided rationale for achievability.

Cancer Services: Dr Rankin undertook to explain the target regarding Urology Services. She advised that the Trust is continuously aiming to improve services and the longer waits are decreasing in numbers however, there is a capacity issue in terms of prioritisation of referrals. Dr Rankin added that the Trust is waiting on written confirmation on funding to recruit 2 additional consultants with 2 additional specialised nurses which should dramatically improve compliance with the cancer pathway.

Care Management Assessments: The Trust continues to work towards the achievement of the 48% target and aims to ensure the right decisions for the right people are being made. Mr Graham referred to the number of episodes of care in terms of nursing home/hospital and Mrs McVeigh clarified at care is based on ‘point of time’.

Mrs Clarke and members aimed to highlight and responded to queries raised and following discussion, members endorsed the content of the TDP and the Chairman commended the efforts of all those involvement. The TDP will remain as a draft response until the Draft Commissioning Plan has received Ministerial approval and is confirmed as being finalized.

iii) **Summary of Internal Capital Business Cases in excess of £300,000 (ST 325/11)**

Mrs Clarke presented a summary of business cases with a capital value greater than £300,000 for approval. She noted that each of these were approved by the Senior Management team during the period April – August 2011 and the full business cases for each of these projects are available, upon request. Mrs Clarke advised that the projects were a mix of Maintaining Existing Services (MES) and the need to keep infrastructure fit for purpose.

The Chairman stated that she felt this was a very useful report and discussion ensued regarding specific projects. Mrs Mahood raised the issue of the isolation ward and the Chief Executive advised that the proposed new isolation ward is strategically better and is more in line with patient safety within the main ward block. The plan would be to close the Ramone ward and maintain one isolation ward.

Mrs Mahood also welcomed the Pharmacy Robot which members were informed would create savings.

Mrs Kelly enquired regarding the issue of the simulation training in South Tyrone once the 2nd Endoscopy Theater is opened. Dr Rankin advised that simulation training will move back into Queens and be conducted there.

The Chief Executive advised that the Trust will promote investments within the local community.

In response to issued raised by Mrs Blakely regarding John Mitchell place, Mrs Clarke assured that works will go ahead as previously planned.

The Chairman acknowledged the hard work involved in bringing these projects to this stage and advised members that the work becomes real when visiting facilities such as Lurgan Hospital and DHH.

The Board of Directors approved the Internal Capital Business Cases in excess of £300,000.

## 8. PATIENT/CLIENT SAFETY & QUALITY OF CARE

### i) Executive Director of Social Work Report

Mr Paul Morgan presented the Executive Director of Social Work Report the purpose of which is to provide assurance to the Board of Directors in relation to the delivery of delegated statutory functions. The report focuses on specific issue raised at Trust Board on 23 June 2011.

#### a) Protection of Vulnerable Adults

Mr Morgan advised that a review of all adult safeguarding referrals will be undertaken by the Trust for the period April 2010 – March 2011. The purpose of the review will be to examine the factors which influence decisions to accept/screen adult safeguarding referrals across programmes of care and locality areas. He advised that the Trust hopes to secure the involvement of the other 4 Trusts in the design and methodology to enable a regional approach to the review of adult safeguarding referrals.

#### b) Care Plan Reviews

At the June 2011 Trust Board, concern was expressed that the issue of Care Plan Reviews for those in nursing and residential homes was not resolved during the year 2010/11. In response to this, Mrs McVeigh assured Trust

Board members that these outstanding annual reviews would have been completed by the end of June 2011. She added, that since that time, further work has been undertaken to ensure that the backlog of reviews for 2010/11 is addressed and also that annual reviews for the first quarter of 2011/12 are completed. Members noted that the position at 15 August 2011 was that there are 99 annual reviews outstanding where client review had not taken place within the last year. Of these 99 review, 24 relate to 2010 and 74 relate to 2011. Members were advised that the reason is down to capacity within teams to undertake the review work in light of more pressing demands from new referrals, assessment activity and vulnerable adult work.

The Chairman expressed her continued concern regarding this and asked if the domiciliary care system can facilitate an 'alert' process. Mrs McVeigh advised that it is anticipated that the Trust will resolve this difficulty regarding reviews this year. The Chief Executive also assured members that there have been extensive discussions regarding this with Senior Management Team, and that this has been placed as a risk on the Corporate Risk Register and reviewed regularly.

**c) Child Protection Referrals**

Figures were presented to members on the total number of referrals made to the Trust.

**ii) Unallocated Child Care Cases**

Mr Morgan spoke to the Unallocated Child Care cases performance management briefing report for August 2011. Mr Morgan advised that the Unallocated Family Support Referrals consists of low, medium and high priority for allocation, however, the SSW and APSW for Gateway regularly review these referrals and re-prioritise. Mr Morgan drew attention to one case waiting over 30 days but assured members this was explainable and the case receives ongoing intervention. Mr Morgan stressed

the importance of noting that there are no unallocated Child Protection Cases and no 'high risk' cases.

Mr Mahood said that the figures were encouraging.

**iii) Medical Director Report**

Dr Simpson presented the Medical Director Report which is to provide Trust Board with an overview of key issues within the Medical Director's area of responsibility.

Dr Simpson referred to specific key areas:

**1. Postgraduate Education – Deanery Visits**

Dr Simpson advised members on the Deanery Visits to Paediatric Department and O&G Departments during recent months. Members noted that a number of areas for improvement were identified and Dr Simpson provided assurances that action was being taken to address these areas.

Dr Simpson drew members attention to the Junior Doctor Training Competencies and advised that an in-house database has been devised which maintains records of all junior doctors within the Trust. Members noted that the Southern Trust is the only Trust to have established such a system.

**2. HCAI**

Dr Simpson reported on performance during 2010/11 financial year, with a total of 11 MRSA infections and 22 C-Difficile infections, which were both well within the target of 14 and 47 respectively, set by the regional HSC Board. Members referred to the supporting graphs, highlighting that the Southern Trust has the lowest target than anywhere else in NI.

Dr Simpson explained that in response to an increased number of C-Difficile cases during the period April-May 2011, the Trust opened the Ramone Ward which provides a 6 en-suite isolation room facility. The Chief Executive informed members that roadshows where held with Ward Nurses which had been well

received and proved helpful in reinforcing infection prevention control measures and issues.

**3. Safety & Quality Indicators**

In response to a matters arising at the June 2011 Trust Board Meeting, Dr Simpson undertook to address the issue of coding further. The Southern Trust internal mortality report reviews statistical process charts which plot mortality over the time period with upper and lower limits. The Trust continues to develop mortality reporting to ensure a robust review of all deaths is carried out. Trigger points have been established and agreed and mechanisms in place to take forward. A full validation of mortality is undertaken on a quarterly basis and details are shared with operational governance forum and also presented to Trust Governance Committee.

**4. Patient Safety Interventions**

Dr Simpson advised that there are 13 Patient Safety Interventions which are a mixture of internal Trust and PfA targets. He assured members that there are no exceptions to report. A full report will be presented to the forthcoming Trust Governance Committee.

**5. Research & Development**

Members noted that a Business Case for the establishment of an Associate Fellow for Nursing and AHP between the Trust and UU has been agreed for a 3 year period.

**6. Emergency Planning**

Dr Simpson informed members of progress and position report on Emergency Planning within the Trust. He advised that the review of the Acute Hospital Major Incident Plan is still underway and plans to complete and finalise by December 2011. Desktop exercises have been conducted for DHH and a Bronze Command and Control exercise held in July 2011. Learning from both events are being addressed and additional roles identified and being taken forward. Members noted the target for a Trust robust Emergency Plan to be put in place by December 2011.

Dr Simpson also advised that a co-ordinated written process will be established for this winter and RQIA have been in contact with the Trust requesting protocols.

*11.45am Break*
*11.45am Ruth Rogers left the meeting/*
*Jane McKimm joined the meeting*
*11.55am Mrs Blakely left the meeting*
*11.58am Meeting Reconvened*

## 9. OPERATIONAL PERFORMANCE

### i) Performance Report (ST 326/11)

Mrs Clarke presented the Trusts Corporate Performance Dashboard for July 2011 which supplements the Corporate Performance Management Report. Mrs Clarke guided members through the dashboard, highlighting the main areas. Members noted the trends, analysis and narrative update on key performance indicators of particular interest. Referring to the issue of reading x-rays, she clarified that 86% are read by Radiologist and the remained by the Consultation. Members noted that improvements have been made regarding Outpatient Review Backlog.

**The Board of Directors approved the Performance Report (ST326/11).**

### ii) Finance Report (ST 327/11)

Mr McNally reported on the financial position to 31 July 2011. He referred members to the Executive Summary and the table outlining the main headline figures noting a surplus generated of £260k. Mr McNally advised that the majority of opening balance reconciliations have now been completed and all budget realignments are finalised. Mr McNally outlined any issues identified and the **Board of Directors approved the Finance Report (ST 327/11).**

**III) Human Resources Report (ST 328/11)**

Mr Donaghy presented the Human Resources Report which he advised focuses on HR High Level Impact Changes, in addition to providing information on recruitment activity, HR productivity information and Agenda for Change. Mr Donaghy advised members that the Trust is in a healthy position with regard to workforce and the Chairperson stressed the importance of staff and their involvement and the need to 'collect' information from staff using our services and hear their experiences. She also added that staff should be encouraged to put forward suggestions. In response, Mr Donaghy referred to Employee Engagement and Relation and stressed that the aim of which is to make staff feel empowered and in doing so, levels of authority should exist for all levels of staff.

Mrs Kelly echoed the Chairperson's comments and said that it is important that staff are listened to at all levels. Mrs Kelly also asked regarding the uptake of e-learning training, and Mr Donaghy replied that participation to date had been enthusiastic and assured members that work on securing a preferred supplied was ongoing.

**The Board of Directors approved the Human Resources Report (ST 328/11).**

10. **2010/11 ANNUAL REPORT REQUIREMENTS**

**i) Draft Annual Report and Accounts for the year ended 31 March 2011 – Trust Funds (ST 329/11)**

Mr McNally referred to the draft Annual Report and Accounts for the year ended 31 March 2011 – Trust Funds. He outlined the format of the accounts and referred to the income/expenditure. He assured members the Trust made good use of its funds and spoke regarding the distribution of funds.

Mr McNally advised members that during the year income totalling £750k were received, a decrease of £190k compared to the prior year. £641k was received in donations compared to

£857k in 2009/10. Investment income increased by £26K compared to 2009/10.

Expenditure on charitable activities for the year amounted to £1,040k, an increase of £196k from 2009/10. This increase was due to the continued drive to encourage the disbursement of Trust Funds for the purposes for which they were donated. Governance costs for the internal financial administration of the funds amounted to £30k.

In concluding, Mr McNally advised of the financial position at year end:
Total fund balances were £2,937k, consisting of £2,906K of restricted funds and £31k of endowment funds.

Mr McNally responded to the issue raised by Mrs Mahood regarding restricted funds advising that receiving donations to existing funds has seized and funds will stay open until they reduce to a particular amount – he advised this process would go through the court system thereafter.

**The Board of Directors approved the Draft Annual Report and Accounts for year ended 31 March 2011.**

**ii) Draft Report to those charged with Governance 2010/11 – Trust Funds**

Mr McNally referred members to the draft report to those charged with Governance 2010/11 – Trust Funds and advised members that the Trust had no issue. Members noted the report.

**iii) Letters of Representation – Trust Funds Accounts (ST 330/11)**

Mr McNally drew member's attention to the letters of representation – Trust Funds Account. He outlined the content of the letters which required Chief Executive signature. Members considered and the **Board of Directors approved**

**the Letters of Representation – Trust Fund Accounts (ST 220/11).**

**iv) Approval of Write-off of Losses (ST 331/11)**

Mr McNally presented to members the details of bad debts, which require to be approved for 'write-off' in accordance with the Southern H&SC Trust's Standing Financial Instructions. Mr McNally advised members that the debts listed all relate to Financial Assessment Debts and have been identified as a result of the ongoing work in the area of debt. In response to issue raised, Mr McNally assured members that control mechanisms are in place to deal with this issue.

**Following consideration, members granted approval to Write-Off of Losses (ST 331/11).**

**v) Report to those charged with Governance 2010/11 – Trust Accounts**

Mr McNally referred to the report to those charged with Governance 2010/11 – Trust Accounts which was tabled for information. Members noted the NIAO letter dated 8 August 2011.

11. **BOARD REPORTS**

**i) ICT Business Plan 2011/12 (ST 332/11)**

Mrs Clarke presented the ICT Business Plan for 2011/12. She advised that the ICT Business Plan is produced to identify and agree the annual priorities for ICT investment and also provides assurance on the Trust's Information Governance arrangements and outlines expenditure and delivery of ICT in 2011/12. Mrs Clarke informed members that the planned capital expenditure in 2011/12 is £827,500 and advised that the detail of the planned projects are contained in section 5 of the Business Plan.

**The Board of Directors approved the ICT Business Plan 2011/12 (ST 332/11).**

12 **SECTION 75 ANNUAL PROGRESS REPORT (ST 333/11)**

Mr Donaghy presented the Section 75 Annual Progress Report for approval. He stated that the content of the annual progress report provides evidence of the Trust's sustained commitment to fully meeting its statutory obligations under Section 75, NI Act 1998 and 49A of the Disability Discrimination Order 2006 and of significant progress in all areas of the Trust's Equality Scheme.

The Chairman, via Mr Donaghy, paid tribute to the Equality Unit on the production of the Section 75 Annual Progress Report.

**The Board of Directors approved the Section 75 Annual Progress Report (ST 333/11).**

13 **BOARD COMMITTEES**

**i) Endowments and Gifts Committee**

- **Minutes of meeting held on 17th January 2011 (ST 334/11)**

Mrs Kelly presented the minutes of 17 January 2011 meeting for approval and highlighted the main discussion points.

- **Feedback from meeting held on 15th August 2011**

Mrs Kelly advised that the Terms of Reference had been agreed with a review to be conducted in 2 years time.
Members noted the date of the next Endowments & Gifts Committee meeting was agreed for 17 October 2011.

**The Board of Directors approved the Minutes of the Endowments and Gifts Committee Meeting held on 17 January 2011.**

14 **ANY OTHER BUSINESS**

**(i) Excellence Awards**

Mrs Mahood, Chair of the Excellence Awards Committee updated members of progress regarding the forthcoming Awards Scheme. Mrs Mahood advised that posters where launched in July and would be going up across all Trust facilities and all pc's will have the awards advertised on screen. Mrs Mahood confirmed the same categories as last years awards and encouraged all members to raise a team meetings and encourage staff to nominate.

Members were informed of key dates and asked to note in diary as appropriate. The Awards Ceremony will be held on Wednesday 14 December 2011.

**(ii) New Non-Executive Directors**

The Chairman informed members that an announcement is due on 26 August informing of the 2 new Non-Executive Directors. She advised that she will email members as soon as the announcement is made and that the new members will take up post with effect from Monday 29 August 2011.

***The next Trust Board Public Meeting will be held on Thursday 29 September 2011 at 9.30am In the Boardroom, Daisy Hill Hospital, Newry***

# SOUTHERN HEALTH AND SOCIAL CARE TRUST

# ANNUAL REPORT & ACCOUNTS

# FOR YEAR ENDED 31 MARCH 2015

# SOUTHERN HEALTH AND SOCIAL CARE TRUST

# ANNUAL REPORT & ACCOUNTS

# FOR YEAR ENDED 31 MARCH 2015

Laid before the Northern Ireland Assembly under Article 90(5) of the Health and Personal Social Services (NI) Order 1972(as amended by the Audit and Accountability Order 2003)

by the Department of Health, Social Services and Public Safety

on

29 June 2015

# SOUTHERN HEALTH AND SOCIAL CARE TRUST

# ANNUAL REPORT & ACCOUNTS FOR YEAR ENDED 31 MARCH 2015

## Contents

**SOUTHERN HSC TRUST**

**ANNUAL REPORT AND ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

## FOREWORD

These accounts for the year ended 31 March 2015 have been prepared in accordance with Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, in a form directed by the Department of Health, Social Services and Public Safety.

## CONTACT US

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## COMMENTS

If you have any comments about this report or would like extra copies please telephone Personal Information redacted by USI.

## DIFFERENT FORMATS

This report can be made available on request in large print, on disk, via email, in Braille, on audiocassette or in minority languages for anyone not fluent in English. Telephone: Irrelevant information redacted by the USI.

**SOUTHERN HSC TRUST**

**REPORT FROM THE CHAIR AND THE INTERIM CHIEF EXECUTIVE**

**Message from Roberta Brownlee, Chair and Paula Clarke, Interim Chief Executive**

**Report from the Chair and the Interim Chief Executive**

We have had another very busy year where despite rising demand for services and continued financial challenges, our staff have once again demonstrated their commitment to providing safe, high quality care to local people living in Craigavon, Banbridge, Armagh, Dungannon and Newry and Mourne and to those from outside the Trust area who choose to use our services.

We are extremely proud that for the third year running, our acute hospital network – Craigavon and Daisy Hill hospitals - received a CHKS Top 40 Hospital Award.

Each year in our very busy hospitals, there are approximately 370,000 outpatient appointments, 117,000 Emergency Department attendances, 30,000 day cases, 56,000 inpatient admissions and over 6,000 births.

While managing over half a million patient contacts each year, our staff are committed to delivering a very high standard of care every day and for every patient, so it is a great reward for them to have their hard work recognised. Of course it is also an assurance to local people that their hospitals are amongst the best performing in the UK in terms of both clinical excellence and efficiency.

Local people can also be reassured in terms of our commitment to Infection Control. Our staff work tirelessly to ensure high standards of infection control practice and they continue to deliver a wide range of initiatives to protect all of our patients from healthcare associated infections and ensure the Southern Trust sustains the lowest rate of Clostridium difficile regionally.

In January 2015, like health and social care right across the UK, we faced one of our busiest winters ever. Despite a 10% increase in attendances over Christmas and into January, our Emergency Departments at both Craigavon and Daisy Hill maintained a steady performance. The weather also added to our pressures when our „snow plans" had to be activated during this time. It is a credit to staff working in our hospitals and across community services, that we were able to maintain our standards, treating patients as safely and quickly as possible and ensuring that care to our vulnerable clients continued during this challenging time.

Not only have staff maintained high standards in challenging times, but they have also shown innovation and a commitment to continuous improvement through many new developments throughout the Trust this year. We are delighted that many of these developments have been recognised, locally, nationally and internationally and supported us in continuing to ensure that people living in the Southern area receive the best possible standards of care.

In the Southern Trust we are committed to using technology where possible to improve the care we provide. We have made significant investment in a wide range of technological developments and being recognised at the first ever eHealth Awards in October was a fitting tribute to the work of our clinical, managerial and ICT staff who have embraced the potential of technology in delivering safe, high quality care.

We were the first Trust in Northern Ireland to introduce an Electronic Discharge Summary for GPs which is greatly improving patient safety through increased accuracy and timeliness of discharge information. Our PARIS system also contributes to patient safety by giving a much fuller profile of a patient which can be used by both community and hospital services. Another first of its kind – a new video conferencing speech and language service is allowing a small team of therapists to reach more stroke clients across a dispersed geographical area, offering more intensive support and a quicker recovery. Other technological developments include; increased access to web based video links between patients and clients in their own homes; the introduction of iPads to help hospital consultants update patient information and make decisions more efficiently during ward rounds; and we now also have bedside entertainment systems in our Renal Unit at Daisy Hill and Cancer Centre in Craigavon, helping to improve the experience for those patients who have to spend a lot of time having dialysis or chemotherapy. These dual purpose systems also contribute to patient care by allowing staff to check and update clinical information at the bedside. The fact that our IT training programme was ranked in fifth place throughout the UK and first in Northern Ireland reinforces our commitment to embrace technology to enable change and help improve the delivery of safe and high quality health and social care.

As the Southern Trust population continues to grow at well above the Northern Ireland average, it is critically important that we have the skills, expertise and high quality facilities to continue to meet this demand, so we have greatly welcomed a number of major capital investments this year to improve our buildings.

Inpatient Mental Health and Learning Disability Services have received a £4.7 million boost with the opening of two new wings at the existing Bluestone Unit on the Craigavon Area Hospital site. The new „Dorsy" unit is for the assessment of adults with a learning disability whilst „Rosebrook" is now home to the Trust"s psychiatric intensive care unit.

As part of our Transforming Your Care plans, we want to ensure that where possible we can support people with mental health issues or learning disabilities to lead as normal a life as possible within their own communities where the majority of people who need a service will receive care and support. These new developments at Bluestone complements our wide

range of community services, ensuring that we can rapidly respond to those clients most in need of short periods of hospital care.

The final phase of a £15.5 million theatre development at Craigavon theatre has now been completed and following last year"s £4.6 million new theatre development at Daisy Hill, an additional £1million has been spent upgrading the original theatres and replacing the Day Procedure Unit. £485,000 has also been invested the replacement of equipment in two of Daisy Hill"s three x-ray rooms to new digital technology. One room was replaced in 2014 so the entire department will be operating from a digital platform following this work.

The former Health Minister, Jim Wells has visited both sites during the year to see progress on some of these developments. In December he officially opened our new dedicated outpatients centre for Neurology at Craigavon, which we are delighted to say is the first of its kind in Northern Ireland.

In January the Minister toured Daisy Hill Hospital where he saw the new Midwifery Led Unit, which is giving low risk mothers the option to deliver in a home from home environment, and met with Paediatric staff to hear all about our exciting £15million plans to modernise hospital services for children and young people across the Trust. All planned paediatric surgery for the Trust will be centralised in a new £8.4m purpose built centre of excellence at Daisy Hill and a further £6.9m will be used to upgrade paediatric services at Craigavon Area Hospital. Design work is now underway and we expect construction to be completed in 2017.


Our Non Acute Hospitals are also making a great contribution to the care of the whole population. South Tyrone recently received a £2.9 million refurbishment and is now home to the Rapid Access and Day Hospitals which are helping to prevent hospital admissions for many older people, the Minor Injuries Unit, the area-wide bowel screening service, and the first Cardiac CT scanner in the Trust. Lurgan Hospital is a central hub for a range of services for older people in the Craigavon and Banbridge area, including a Day Hospital, clinics for Parkinsons Disease, Continence, Falls, Stroke and Pulmonary Rehabilitation. It is also the base for the new Acute Care at Home Service – a team of staff (physios, nurses, OTs, pharmacists, doctors and psychiatric nurses) who led by a Consultant Geriatrician are offering care to patients in their own homes to avoid a hospital admission.

Development of community services is another key theme of Transforming Your Care and so we are

delighted that work on the £16 million Health and Care Centre and Day Care centres in Banbridge is well underway. The new development will replace three existing facilities: Scarva Street Health Centre, Banbridge Social Education Centre for adults with a learning disability and Copperfields which provides day care to adults with a physical disability and staff and clients are really looking forward to moving into their new accommodation early in the new year.

We are now also awaiting Planning approval on the new Community Treatment and Care Centre for Newry. Three bidders have been shortlisted and subject to planning approval and we hope to award a contract in the coming months to ensure we can provide high quality facilities for service users, staff and GPs.

In November, following a period of public consultation, our Trust Board approved major proposals on the future of stroke care, hospital services for older people and dementia inpatient care. The plans include: developing a single specialist stroke inpatient unit at Craigavon Area Hospital; locating all non-acute inpatient services at Daisy Hill and Craigavon Hospitals, with the development of a new non-acute inpatient unit at Craigavon to replace inpatient services at Loane House, South Tyrone and Lurgan Hospital; and the relocation of dementia in-patient series from the Gillis Unit, Armagh to a new build at Craigavon.

These plans give a clear direction for how services must change in future if we are to maintain and develop hospital-based care that is of the highest quality standards, reflects clinical evidence and meets the needs of the population we serve. It could take up to three years to put these plans in place and we will continue to engage with users, carers, staff and our local community as we progress.

We are also developing a wide range of community services to support older people in their own homes and allowing an earlier discharge for those who are medically fit. Community Stroke Teams are providing specialised, intensive support to patients in their own homes following hospital discharge to help with their rehabilitation. Our Reablement workers have helped 3,837 older people to regain their independence after ill health or injury and over 1,000 people with chronic conditions like heart failure, diabetes and respiratory disease are using telemonitoring devices in their own homes to keep check on their vital signs to avoid hospital admission.

Other developments for children and families include: the launch of a new website to help young people up to the age of 18 with their mental and emotional wellbeing www.younghealthymindsni.co.uk; the development of a new mobile app – „About Me" to help young care leavers with a range of health and social issues; and we are particularly proud to appoint the first Health Visitor in the UK specifically for families with multiple births in partnership with the charity TAMBA.

In April we opened the „Acorns" in Armagh - the first dedicated centre for autism assessment, diagnosis and intervention in Northern Ireland. This new centralised facility is making life much easier for families by offering all autism services for children, young people and adults under one roof.

Of course early intervention is another key priority for us and we have introduced a wide range of schemes, helping people to prevent or reduce the implications of conditions that could cause them greater problems in later life for example promoting physical activity, accident prevention and emotional wellbeing. Our new Macmillan Cancer Information Unit opened in Craigavon Hospital this year and we also ran an extremely successful campaign to promote lung cancer awareness and encourage people to attend our new walk in chest x-ray service.

Also on the theme of preventing ill health, our Trust Board has endorsed plans to go completely smoke free by March 2016. The proposal follows the announcement from the Health Minister Jim Wells on No Smoking Day that all health and social care sites should be smoke free by March 2016. We have operated a Smoke Free policy since 2008 which prohibits smoking in all of our buildings but this latest move means that smoking will no longer be permitted anywhere on Southern Trust grounds. We will now be working closely with all interested parties to work out the detail of our new policy to help ensure the best interests of everyone who uses Trust sites.

As such a large employer with so many facilities across a large geographical area we take our Corporate Social Responsibility very seriously, so we were delighted to be awarded with Silver Status from the ARENA Network"s Benchmarking Survey for our contribution to the environment. This is a testament to how our staff are making every effort to reduce our carbon footprint without compromising patient and client care. We have made significant investment to improve energy efficiency, reduce waste and save water across our sites and not only are we creating more comfortable and energy efficient buildings with these measures but we are making financial savings that can be reinvested back into front line health and social care services.


The Gillis Memory Centre and St Luke"s Hospital, have both been recognised in the Northern Ireland Amenity Council"s Best Kept Awards for their dedication to environmental cleanliness.

For the past two years, the Southern Area Hospice has been our „Charity of the Year" and staff have raised thousands of pounds for this very worthy cause. We have now opened nominations for a new Trust Charity of the Year for 2015-2017 and will announce who it is once shortlisting has taken place.

We as a Trust have also greatly benefitted from charitable donations from local people and in the past year have received around £240,000. In such a challenging financial environment, where we must prioritise our budget towards vital medical supplies, equipment and staffing, donations like this can be used on those additional comforts e.g. relatives rooms, toys for children"s areas, televisions or décor which

help to improve the patient and client experience and we want to thank everyone who has donated and encourage this to continue.

As well as monetary donations, many local people have given up their time to volunteer for the Trust both in hospitals and through community schemes. We would like to pay tribute to all of those people who help us with our work and more importantly make a huge difference to the lives of local people.

Mrs Roberta Brownlee
Chair

Mrs Paula Clarke
Interim Chief Executive

**SOUTHERN HSC TRUST**

## DIRECTORS' REPORT

## BOARD OF DIRECTORS

Mrs Roberta Brownlee
Chair
Tel: Personal Information redacted by USI
Personal Information redacted by USI Personal Information redacted by the USI

### Executive Directors

Mrs Mairead McAlinden
Chief Executive ***(until 31 March 2015)***
Tel: Personal Information redacted by USI
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Mrs Paula Clarke
Interim Chief Executive ***(from 1 April 2015)***
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Mr Stephen McNally
Director of Finance and Procurement
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Mr Paul Morgan
Director of Children and Young People"s Services / Executive Director of Social Work
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Dr John Simpson
Medical Director
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Mr Francis Rice
Executive Director of Nursing / Executive Director of Nursing and AHPs
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**Non Executive Directors**

Mrs Deirdre Blakely

Mr Edwin Graham
(Chair of the Patient & Client Experience Committee)

Mrs Hester Kelly
(Chair of Endowments & Gifts Committee)

Mrs Elizabeth Mahood
(Chair of Audit Committee)

Dr Raymond Mullan
(Chair of Governance Committee)

Mrs Siobhan Rooney

Mr Roger Alexander
***(until 31 December 2014)***

## Trust Directors

Mrs Paula Clarke
Director of Performance and Reform ***(until 28 February 2015)***
Deputy Chief Executive ***(from 19 January 2015)***
Interim Chief Executive ***(from 1 April 2015)***
Tel: Personal Information redacted by USI
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Mrs Aldrina Magwood
Acting Director of Performance and Reform
***(from 1 March 2015)***
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Mr Kieran Donaghy
Director of Human Resources and Organisational Development
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Mrs Angela McVeigh
Director of Older People and Primary Care
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Mrs Deborah Burns
Interim Director of Acute Services
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Mr Micéal Crilly
Acting Director of Mental Health and Disability Services
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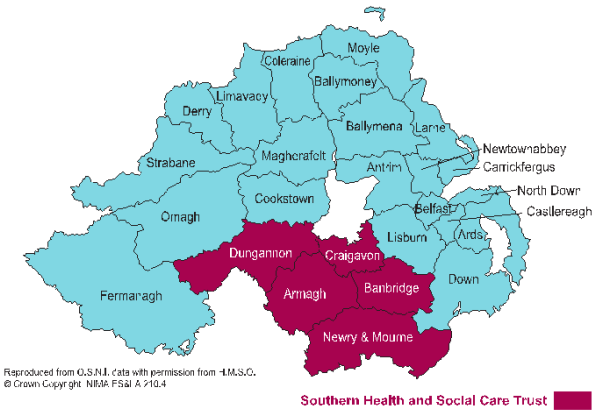
A declaration of Board members' interests has been completed and is available on request from the Chief Executive's Office, Trust Headquarters, College of Nursing, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ. Telephone Personal Information redacted by USI Personal Information redacted by USI

## ABOUT THE TRUST

The Southern Health and Social Care Trust was formed on 1 April 2007 and is responsible for the services which were formerly delivered by four Trusts, namely Armagh and Dungannon Trust; Craigavon and Banbridge Community Trust; Craigavon Area Hospital Group Trust and Newry and Mourne Trust.

### Location and type of facilities provided

Map of NI showing the Southern Health and Social Care Trust




The Trust provides health and social care services to the council areas of Armagh, Banbridge, Craigavon, Dungannon and South Tyrone and Newry and Mourne.

The Trust provides a wide range of hospital, community and primary care services. Main in-patient hospital services are located at Craigavon Area Hospital and Daisy Hill Hospital. Working in collaboration with GPs and other agencies, staff deliver locally based services in Trust premises, in people"s own homes and in the community. The Trust purchases some services including domiciliary, residential and nursing care from independent and community/voluntary agencies.

### Population

| Age | Population |
|---|---|
| **0-15** | 83,414 |
| **16-64** | 232,031 |
| **65+** | 50,267 |
| **Total Population** | **365,712** |

### Expenditure

In 2014/15 the Trust incurred gross expenditure of £603.8m.

### Staff Profile

The Trust employs 14,019 staff with 77.35% of staff providing direct hands on care to patients and clients. Management costs accounted for 3.5% of income in 2014/15.

The sickness and absenteeism rate for the Trust as at 28 February 2015 was 5.24%.*

**Employee Policies**

The Trust"s Joint Consultative & Negotiating Forum is committed to the involvement of staff at all levels in shaping service delivery and being part of the decision making which affects their working lives and the delivery of health and social care. Significant efforts have been made by the Trust and the Trade Unions to develop a partnership working approach to how business is conducted. The Trust"s Partnership Agreement sets out the approach to partnership working and a clear set of values to promote a culture of involvement. This partnership approach has continued to develop across all directorates and clearly has resulted in staff and management working together to deliver a number of very significant change initiatives and service reforms over the past number of years. A Staff Involvement Framework is in place to govern how the Trust involves staff in decisions that affect them through a range of processes, procedures and initiatives to develop a consistent approach to involving staff.

Significant work is on-going across the Trust to continually improve services for patients and clients, and a key focus with many of these improvement initiatives is the involvement of staff who work day by day within the services. Many of these improvement initiatives are reported and showcased in the Trust"s Continuous Improvement Newsletters prepared by the Directorate of Performance & Reform, which are distributed via global email.

The Trust has in place an Equal Opportunity Policy which emphasises its continuing commitment to the provision of equality of opportunity. The scope of the current policy covers age, marital or civil partnership status, sex, sexual orientation, gender reassignment, religious belief, political opinion, race (including colour, nationality, ethnic or national origins, or being an Irish Traveller), disability, pregnancy or maternity leave and with/without dependants.

The Trust also recognises that attention needs to be given to the position of people with disabilities in the service and it is for this reason that the Trust also has a Policy on the Employment of People with Disabilities in place. This Policy takes account of the Disability Discrimination Act 1995 (the DDA), as amended. In developing this policy, the Trust has taken account of its duty under Section 49A of the DDA (as amended), which requires the Trust, when carrying out its functions, to have due regard to the need to promote positive attitudes towards people with disabilities and the need to encourage their participation in public life.

* Please note an issue has been identified with the way % Sickness Absence figures are calculated on HRPTS, which is resulting in slightly inflated figures.

**Data Protection**

The Trust had no incidents during 2014/15 that required investigation by the Information Commissioner.

**Our Vision**

To deliver safe high quality health and social care services, respecting the dignity and individuality of all who use them.

**Our Values**

We will:

- Treat people fairly and with respect;
- Be open and honest and act with dignity;
- Put patients, clients, carers and community at the heart of all we do;
- Value staff and support their development to improve our care;
- Embrace change for the better;
- Listen and learn.

| | |
|---|---|
| **Mrs Roberta Brownlee**<br>**Chair** | Personal Information redacted by USI |
| **Mrs Paula Clarke**<br>**Interim Chief Executive** | Personal Information redacted by USI |
| **Date** | 11 June 2015 |

**SOUTHERN HSC TRUST**

**STRATEGIC REPORT**

**PERFORMANCE**

**Achievement of Ministerial priorities - Trust on Target**

All aspects of Trust business are closely monitored. This enables us to ensure that all our services are running smoothly and on target. It also provides an early warning if something is not on track. Every month the Trust"s senior management team scrutinises detailed information about a wide range of areas, including those below, and will review areas on a weekly basis if we are encountering particular challenges or demands on our services.

- Time patients wait to be seen in the Emergency Department;
- How long patients wait to receive their first outpatient assessment ;
- Turnaround time for diagnostic tests;
- Infection rates and hospital cleanliness; and
- Patients" views.

Our performance reports also go to monthly public Trust Board meetings with papers published on our website www.southerntrust.hscni.net. This level of performance management helps us to ensure that what we do is safe, that we are making best use of our resources and meeting targets which are there to benefit patients and clients.

During 2014/2015 the Trust continued to further develop and improve many important services. Our dedicated staff also worked hard to meet targets designed to ensure better access to high quality services.

In 2014/15 there are 29 Commissioning Plan Targets/Standards applicable to the Trust. These include the following examples:

- From April 2014, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department. No patient attending any Emergency Department should wait longer than 12 hours.
- From April 2014, at least 80% of patients wait no longer than 9-weeks for their first out-patient appointment and no patient waits longer than 15-weeks.
- From April 2014, at least 80% of in-patients and day-cases are treated with 13-weeks and no patient waits longer than 26-weeks.
- From April 2014, ensure that 90% of complex discharges from an Acute Hospital take place within 48-hours.
- By March 2015, resettle the remaining long-stay patients in learning disability and psychiatric hospitals to appropriate places in the community.
- From April 2014, no patient waits longer than 9-weeks for referral to commencement of AHP treatment.
- By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with long-term specified conditions.

- By March 2015 secure a 10% increase in the number of carers assessments offered.
- By April 2014 no patient waits longer than 9-weeks to access child and adolescent mental health services; 9-weeks to access dementia service; and 13-weeks to access psychological therapies (any age).
- From April 2014 increase the number of children in care for 12-months or longer with no placement change to 85%.

Key achievements included:

- 8 out of 10 patients attending A&E departments were treated and admitted or discharged within 4 hours and 0.01% (14 out of 151,381 patients) waited over 12 hours;
- 6 out of 10 patients were seen within 9-weeks for out-patient assessment;
- 6 out of 10 patients were seen within 13-weeks for in-patient or day case treatment;
- 97% of patients who were ready to go home when their hospital treatment was complete were discharged within 48 hours;
- Resettlement of long-stay adults from mental health hospitals was completed with 8 people resettled during the year, in line with the Bamford Report recommendations.
- The Trust have delivered 112, 181 monitored patient days through remote telemonitoring services. This exceeded the Commissioning Plan target of 105, 000 monitored patient days, giving a performance of +7%.

**Southern Trust facts and figures 2014/15**

The Trust spends approximately £1.65m gross per day delivering services to local people.

**During the past year:**

- There were a total of 5,888 births in the Southern HSC Trust. There were 4,038 births in Craigavon Area Hospital and 1,850 in Daisy Hill Hospital.

- 80,497 people attended Craigavon Area Hospital Emergency Department and 46, 590 attended Daisy Hill Hospital Emergency Department.

- A total of 30,871 people received treatment at the Minor Injuries Units across the Southern Trust.
  - 25,666 received treatment at the Minor Injuries Unit at South Tyrone Hospital;
  - 5,205 at the Minor Injuries Unit in Armagh Community Hospital; and

- Total Number of Outpatient Attendances – 375,128
  - new outpatient attendances – 110,608
  - review outpatient attendances – 264,520

- Total number of inpatient admissions – 55,418

  - Elective – 7,218
  - Non-elective – 48,200

- Number of day cases – 33,965

- The Trust received 12,864 child care referrals.

- The GP Out of Hours service:
  - Received 98,029 initial patient telephone calls into the GP OOHs service.
  - 49,963 patients were assessed by a GP, Nurse or Pharmacist via telephone and provided with healthcare advice.
  - 41,670 patient appointments were provided in the Out of Hours centres at Daisy Hill, South Tyrone, Armagh, Craigavon and Kilkeel.
  - 491 patients did not attend for a booked appointment.
  - 6,396 home visits to patients were undertaken by GPs across the Trust area.
  - 319 patients chose to attend the Out of Hours centre in Castleblayney (via the CAWT cross border project).

- The Trust facilitates the transport of 798 people each day into Day Centres (i.e. 516 are on fleet buses and 282 going with a mix of private coaches, taxis and voluntary drivers).

- The Trust provides care and support through:

| Programme of Care | Residential Care | Nursing Home Care | Domiciliary Care | TOTAL |
|---|---|---|---|---|
| Elderly | 382 | 1384 | 3597 | **5363** |
| Mental Health | 55 | 105 | 427 | **587** |
| Learning Disability | 106 | 175 | 731 | **1012** |
| Physical and Sensory Disability | 1 | 47 | 677 | **725** |
| **TOTAL** | **544** | **1711** | **5432** | **7687** |

**Future Developments**

2015/16 is likely to be another challenging year for the Trust. Some of the issues and risks already facing the Trust, both financial and non–financial are outlined in the Governance Statement on pages 43 to 83.

**COMMITMENT TO EQUALITY**

**Delivering high quality care – respecting the dignity and individuality of all who use our services**

During the year under review, the Trust participated in a public inquiry – the first of its kind led by NI Human Rights Commission

NORTHERN IRELAND HUMAN RIGHTS COMMISSION

into emergency healthcare in NI. Public hearings took place across Northern Ireland. The Southern Trust participated in two public events – in Newry and Armagh.

The main focus of the inquiry was to identify the extent to which the human rights of people seeking emergency care are respected, protected and fulfilled in practice.

Senior staff from the Trust gave evidence to the Inquiry at two public hearings – the first of which was held in Newry on Wednesday 10th September and the second in Armagh on Monday 15th September. HSC Trust Equality Leads were later called to give evidence on the 7th and 8th of October 2014.
The Inquiry heard evidence from the Minister for Health as well as a range of HSC organisations, Trade Unions, voluntary groups and individual members of the public.

The Commission is due to publish its report and recommendations to the Northern Ireland Executive. The Trust looks forward to reading the findings from this review which will be released during 2015/16.

**Promoting Inclusion - Disability Action Plan Workshop: Public Appointments – Why Not You**

On the 30 September 2014, Health and Social Care Trusts partnered with the DHSSPS to host a Disability Action Plan Workshop entitled "*Public Appointments – Why Not You*?" The workshop took place in the Glass House on the Stormont Estate. Over 40 participants were in attendance from across the disability sector, including representatives from the Equality Commission for NI.

The aim of the event was to raise awareness of the public appointments process and to encourage greater participation of disabled persons in public life including the public appointments process.

John Keanie, Commissioner for Public Appointments for Northern Ireland discussed the role of the Commissioner and *What is a Public Appointment?* Catherine Donnelly, DHSSPS from the Public Appointments department outlined the public appointments application process. Gerard Guckian, Chair of the Western HSC Trust gave an overview of a day in the life of a Non-Executive Director .

The event was concluded with a questions and answers session which was facilitated by the Chair - Pascal McKeown, MECAP.

**Providing Safe High Quality Care - Working Well With Interpreters**

During the year under review Working Well with Interpreters Training sessions continued across the Trust facilitated by the NI Health & Social Care Interpreting

Service (NIHSCIS), the Drop-in Awareness Training sessions took place on Wednesday 11 March 2015 in the Lecture Theatre Craigavon Area Hospital.

Each session comprised of a half hour awareness session which provided HSC staff with the opportunity to familiarize themselves with the NI Health and Social Care Interpreting Service. The sessions also outlined the risks associated with using untrained interpreters/family/friends, provided clarification on the role off Community Interpreters, an overview of booking systems and procedures and importantly when it is more appropriate to use telephone interpreting and face to face interpreting. Processes on how to procure high quality written translations for those who do not speak English as a first language was also explained. Uptake was very good across the two dates.

**Treating People with Dignity and Respect – Launch of Ethnic Minorities Cultural Competency toolkit**

Service users who are new to NI should be able to access a culturally competent and responsive service. The development and launch of a new cultural competency toolkit is designed to assist mental health practitioners meet the needs of ethnic communities coming into contact with mental health services.

Delivering mental health services can be complex, but this becomes even more difficult when there are added cultural and linguistic differences. In 2013 the Public Health Agency (PHA) provided funding on a regional basis specifically to examine how HSC mental health providers could be supported in the delivery of culturally competent services. Aware Defeat Depression worked in partnership with Health and Social Care Trust representatives to look at how best to support this initiative.

This partnership convened a regional conference in June 2013 for mental health specialists across the statutory, community and voluntary sectors. The focus of this event was “Developing Cultural Competence when delivering Mental Health Services to Black and Minority Ethnic Communities”, and examined the complexities of delivering mental health services in this context.

This toolkit is the result of the conference and is now available to staff online via Trusts intranet. The toolkit is broken down into quick reference sections with hyperlinks to more detailed reports or useful resources.

In support of the role out of this toolkit staff training sessions were offered to HSC staff during 2014. In addition training for trainer"s session was held on 11 December 2014 to train up staff so that they are self-sufficient to deliver these future sessions. A DVD has also been produced to support the training sessions and the role out of the toolkit.

## PROTECTING THE ENVIRONMENT

### Sustainability

The Trust Sustainability Strategy 2020 incorporates the key environmental priorities for the Trust and DHSSPS Northern Ireland including the three key components of sustainability:

- Taking a holistic view of all activities and considering their environmental, social and economic implications.
- Thinking about whole life issues when planning, designing, building and maintaining the Estate.
- Making sure that everyone thinks about the way resources are used each and every day within the Trust and at home.

### Environmental Benchmarking


This year, the Trust took part in the 16th Arena Network Environmental Survey – Northern Ireland"s leading environmental benchmarking exercise. We were awarded Silver status scoring 73% (4% decrease from last year) although this represents a high level of assurance in environmental performance. There was a review of the survey completed this year which increased the attainment levels of compliance for all participants.

### Trust buildings and sustainable development

BREEAM is the measure of the environmental performance of new and refurbished Trust buildings.

All BREEAM qualifying capital development projects must have a BREEAM pre-assessment completed with the preferred option achieving an „excellent" rating for new build projects and a „very good" rating for refurbishment projects.

## ENERGY

### Carbon Reduction Commitment (CRC)

The Trust complies with the CRC legislation by monitoring carbon emissions for all electricity and natural gas consumed and pay the required carbon allowances.

### Waste Management

The Trust recycling rate remains at 12%. Domestic waste generated has reduced by 131 tonnes (9.3%) in the last year. Less waste is being generated indicating increased efficiency across wards and departments.

Waste management e-learning for all staff is now in place providing expert advice on all aspects of waste management. E-learning has made the training much more accessible to staff and has made its delivery much more efficient.

**CLINICAL AND SOCIAL CARE GOVERNANCE**

Clinical and social care governance is a high priority for the Southern Trust. The Trust‟s Governance arrangements continually evolve to meet the needs of the organisation and our accountability to our public. We continue to strive to be one of the leading learning organisations in healthcare, reviewing our strengths and weakness in the provision of care and working to constantly improve this for all service users.

To help us identify areas in which we need to improve we welcome all comments and complaints regarding our services. Information about how you can make a complaint is explained in our “We Value Your Views” leaflet on the Southern Trust website. We recognise that at times, patients, families and carers may have concerns about their care or treatment. We are committed to engage with patients and their families to ensure that we learn from their experiences.

The Trust uses issues raised through the complaints process as an important source of information for safety and quality improvement. This information informs learning and development and is fed into the Trust‟s governance systems as well as being directly fed back to staff involved. Within the Trust it is the responsibility of all Trust Directors, Assistant Directors, Heads of Service and Senior Managers to utilise the information and trends from their complaints to ensure learning and development and to monitor learning. Regular analysis of complaint reports are shared at Senior Management Governance meetings, Governance Committee meetings and Directorate meetings to highlight themes and trends across the Trust to ensure improvement and learning takes place.

Each service directorate is supported by a dedicated team who assist frontline staff in reviewing comments and complaints from service users and the learning from them. Our patient client experience committee meets quarterly and provides an opportunity for lessons learnt from our complaints to be shared across all our service directorates.

The Trust has received a total of 776 formal complaints in the 14/15 financial year.

The Trusts Corporate Complaints Officer is the initial point of contact within the Trust for those wishing to make a complaint; a key component of this role is to facilitate the resolution of complaints at the point of reporting to provide patients and services users with prompt and timely action and resolution to their complaint.

The Trust also provides a Patient Support Service in Craigavon and Daisy Hill Hospitals whose role it is to assist patients and their families in real time with regards to any concerns or issues that they may have. The importance of staff providing local resolution to complaints received is also demonstrated in the Trust complaints training materials.

The Trust has multiple mechanisms in place to promote effective communication processes with patients, their families and those who may make complaints on their behalf. In addition to the formal communications required in line with the requirements of Regional HSC Complaints Policy the provides complainants with individual team contact information and encourage complainants to engage with staff using the communication style which best suits their circumstances. For example we have identified that electronic communication directly from patients has significantly increased.

The Trust also provides complainants with a variety of contact information for external agencies who can support them in communicating with the Trust throughout the complaints process for example the Patient Client Council, NI Ombudsman, and Commissioner for Older People.

The importance of effective and timely communication is also included within the Trust training resources on Complaints handling for staff which is easily accessible via the Trust Intranet. The public can access information about the Trust Complaints pathway via the external Internet and of note this information is available on the Internet in various languages and can be requested for the Blind if required.

There is opportunity within the Trust complaints processes, for patients families and service users to meet with senior staff involved in, or responsible for, the particular area of care. This is an opportunity for staff and complainants to discuss the complainants concerns face to face and to offer an apology. The Trust seeks to provide this opportunity to complainants at an early stage within the Complaints process.

The Learning from Complaints is shared at all levels within the Organisation for example Divisional and Directorate Meetings, Team meetings, Patient Client Experience Committee and Trust Board.

The Trust also disseminates quarterly a “Learning Lessons” newsletter to all staff which incorporates the learning from recent complaints.

**PROFESSIONAL GOVERNANCE**

The Trust"s professional governance team is responsible for promoting safe and effective care, enhancing the quality of services and training and workforce development for nurses, midwives, social work staff and Allied Health Professionals. To support this function the Assistant Directors for professional governance have structural arrangements in place to meet professional/ regulatory body and Trust standards and guidelines.

The Trust Governance Statement can be found at pages 43 - 83 of the Annual Accounts.

**Signed..** [redacted] **Mrs Paula Clarke**

**(Interim Chief Executive) Date: 11 June 2015**

**SOUTHERN HSC TRUST**

**Financial Commentary on the Year Ended 31 March 2015**

The Trust has again faced a challenging year with the added uncertainty of funding levels and the subsequent requirement for contingency measures and recurrent cost reductions. A degree of certainty and stability was, however, provided following the agreement for additional funding between the Assembly and the Treasury in October 2014. The outcome for the Trust was a much reduced requirement for an additional contingency of c. £3m. The Trust worked closely with HSCB and Department colleagues to agree and implement a range of measures to secure this saving while also maintaining patient and client services. The Trust is, therefore, pleased to have delivered a breakeven position in the current difficult economic environment.

As in the prior year, the Trust‟s charitable funds account is consolidated with the public funds account but this has no impact on the reported financial position. During 2014/15, charitable donations of £240k were received by the Trust, a fall of £129k from prior year. These funds were used to support expenditure in the following areas:

- Patient / Client / Relative / Visitor Comfort and Amenity;
- Staff education and training / skills enhancement; and
- Academic Research and Development.

**Results**

The Trust‟s main funding source is its Revenue Resource Limit (RRL) from the DHSSPS. Expenditure remained within the RRL of £565m by £41k. The Trust also receives a limited amount to spend on capital, the Capital Resource Limit (CRL). It kept within the CRL of £31.6m by £280k.

**Public Sector Payment Policy**

The DHSSPS requires that Trusts pay their Non HSC trade creditors in accordance with applicable terms and appropriate Government Accounting guidance. The Trust‟s payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is as follows:

**Public Sector Payment Policy (continued)**

| | 2015 Number | 2015 Value £000s | 2014 Number | 2014 Value £000s |
|---|---|---|---|---|
| **Total bills paid in year** | **172,426** | **224,108** | **114,589** | **208,090** |
| **Total bills paid within 30 days or under agreed payment terms** | **151,068** | **200,413** | **101,829** | **194,388** |
| **Percentage of bills paid within 30 days or under agreed payment terms** | **87.6%** | **89.4%** | **88.9%** | **93.4%** |
| **Total bills paid within 10 days** | **121,745** | **170,785** | **65,694** | **152,379** |
| **Percentage of bills paid within 10 days** | **70.6%** | **76.2%** | **57.3%** | **73.2%** |

The measure of compliance with the Public Sector Payment Policy is shown above for both the number and value of payments made. The variation in the percentage reported under the two measures is due to the high volume of low value payments made by the Trust which results in a smaller percentage being achieved when measuring compliance based on the number of payments made.

Last year, the Trust reported that there was potential for the prompt payment compliance figures to be overstated due to the dates being used for this measure. This was addressed during the year by the Business Services Organisation and the Payment Shared Services Centre is now using the invoice receipt date. However, where invoices are received directly in client organisations or by the Payment Shared Services Centre and not date stamped, the date used for prompt payment compliance is the invoice date as this is considered prudent.

The Trust moved its payment function to BSO Accounts Payable Shared Service from September 2014 and achievement of this target is now dependent both on procedures within BSO Accounts Payable Shared Service and appropriate action by Trust nominated approvers. A fall in compliance against the 30 day target of 95% has been experienced during this year of transition, from 88.9% in 2013/14 to 87.6%, however significant improvement has occurred in the 10 day performance. The Trust continues to work closely with BSO and Trust approvers to ensure that all efforts to improve prompt payment compliance continue.

During the year the SHSCT paid £149 interest and £216 compensation in respect of late payment of commercial debt.

**Related Party Transactions**

The Trust is an Arm"s length body of the DHSSPS and, as such, the Department is a related party with which the Trust has had various material transactions during the year:

Funding – Revenue Resource Limit £565m of which Non-Cash Revenue Resource Limit was £44.59m.

In addition to the above, during the year the Trust entered into transactions with the following related parties (as defined by IAS 24), which are organisations in which one or more Directors disclosed interests:

| | **Total Value of Transactions** | **Balance Outstanding at Year End** |
|---|---|---|
| | **£** | **£** |
| Ann"s Homecare Domiciliary Care Agency | Payments: 4,204,765 | 320,865 (Creditor) |
| Enable NI | Payments: 144,407 | 2,254 (Creditor) |
| Southern Education & Library Board | Payments: 27,988<br>Receipts: 34,564 | 1,000 (Creditor)<br>2,678 (Debtor) |
| Royal School, Armagh | Payments: 335 | 0 |

**Post Balance Sheet Events**

There were no post balance sheet events which have an impact on the financial statements.

**Audit**

The accounts and supporting notes relating to the SHSCT"s activities for the year ended 31 March 2015 have been audited by the Northern Ireland Audit Office. The report of the Comptroller and Auditor General is included on pages 84 - 85. The Interim Chief Executive and each Director has taken all the steps that she/he ought to have taken as Chief Executive/Director to make herself/himself aware of any relevant audit information and to establish that the Trust"s auditor is aware of that information.

So far as the Interim Chief Executive and each Director is aware, there is no relevant audit information of which the Trust"s auditor is unaware.

The notional cost of the audit of the accounts for the year ended 31 March 2015 which pertained solely to the audit of the Public Funds Accounts was £57,000. The notional cost of the audit of the Charitable Funds Accounts was £5,750.

An additional amount of £2,699 was paid to the NI Audit Office in respect of work carried out on the National Fraud Initiative.

**Pension Liabilities**

The accounting treatment of pension liabilities is explained in Note 1.20 of the annual accounts on pages 101 to 102.

**SOUTHERN HSC TRUST**

**Remuneration Report for the Year Ended 31 March 2015**

Fees and allowances paid to the Chairman and other Non-Executive Directors are as prescribed by the Department of Health and Social Services and Public Safety.

The remuneration and other terms and conditions of Executive Directors are by the Remuneration and Terms of Service Committee. Its membership includes the Chair and all Non-Executive Directors. The terms of reference of the Committee are based on Circular HSS (PDD) 8/94 Section B.

For the purposes of this report the pay policy refers to Senior Executives, defined as Chief Executive, Executive Director and Functional Director and is based on the guidance issued by the Department of Health and Social Services and Public Safety on job evaluation, grades, rate for the job, pay progression, pay ranges and contracts.

Pay progression is determined by an annual assessment of performance. It is the responsibility of the Remuneration and Terms of Service Committee to monitor and evaluate the performance of the Chief Executive ensuring that any discretionary awards in terms of performance related pay are justifiable in light of the Trust's overall performance against the annual Trust Delivery Plan. During 2014/15, emphasis continued to be on patient safety, ministerial targets and financial balance. The Chief Executive in turn is responsible for the assessment of performance of the Senior Executives based on the attainment of individual objectives established at the outset of the year, and for the submission of recommendations to the Remuneration and Terms of Service Committee for its annual review of salaries which are conducted in accordance with the relevant circulars issued by the Department of Health, Social Services and Public Safety.

The levels of performance pay permitted applied by the Remuneration and Terms of Service Committee are prescribed by Department of Health and Social Services and Public Safety. Pay progression as at 1 April 2014 based on performance for Senior Executives in the period 1 April 2013 to 31 March 2014 has been set at 2% for fully acceptable performance for those employed on contracts before 23 December 2008 and 1% (non-consolidated) for those employed on contracts after 23 December 2008. There is no „Superior Performance Award". No award is made for unsatisfactory performance. Senior Executive pay ranges have not been increased with effect from 1 April 2014 pending finalisation of the DHSSPS circular in this regard and its consideration by the Trust"s Remuneration Committee.

During 2014/15, all contracts were permanent and provide for three months" notice for both parties, with the exception of:

- Mr Miceal Crilly, who continued to undertake an acting role to Director of Mental Health & Disability to cover for Mr Francis Rice who has been seconded within the Trust to undertake specific projects associated with his Executive Director of Nursing role;

- Mrs Deborah Burns, who continued to undertake the Director of Acute Services role on an interim basis, pending recruitment to the permanent role.
- Mrs Aldrina Magwood, who undertook an acting role to Director of Performance and Reform from 1 March 2015 to provide cover for Mrs Paula Clarke who was Deputy Chief Executive from 19 January 2015 and Interim Chief Executive from 1 April 2015.

Mrs Mairead McAlinden, Chief Executive, resigned from the Trust in December 2014, indicating her intention to leave the Trust on 31 March 2015.

As far as all Senior Executives are concerned, the provisions for compensation for early termination of contract are in accordance with the appropriate Departmental guidance.

## Senior Employees' Remuneration (Audited)

The salary and the value of any taxable benefits in kind of the most senior members of the Southern HSC Trust were as follows:

| | 2014/2015 | | | | 2013/2014 | | | |
|---|---|---|---|---|---|---|---|---|
| **Name** | **Salary £000s** | **Bonus/ Performance pay £000s** | **Benefits in Kind (rounded to nearest £100)** | **Total £000s** | **Salary £000s** | **Bonus/ Performance pay £000s** | **Benefits in Kind (rounded to nearest £100)** | **Total £000s** |
| **Non-Executive Members** | [redacted] | | | | | | | |
| Mrs R Brownlee (Chair) | | | | | | | | |
| Mrs E Mahood | | | | | | | | |
| Mr R Alexander (resigned 31/12/14) | | | | | | | | |
| Mrs D Blakely | | | | | | | | |
| Mr E Graham | | | | | | | | |
| Mrs H Kelly | | | | | | | | |
| Dr R Mullan | | | | | | | | |
| Mrs S Rooney | | | | | | | | |

Personal Information redacted by USI

| | 2014/2015 | | | | | 2013/2014 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Name** | **Salary £000s** | **Bonus / Performance pay £000s** | **Benefits in Kind (rounded to nearest £100)** | **Pension Benefits £000s** | **Total £000s** | **Salary £000s** | **Bonus/ Performance pay £000s** | **Benefits in Kind (rounded to nearest £100)** | **Pension Benefits £000s** | **Total £000s** |
| **Executive Members** | [redacted] | | | | | | | | | |
| Mrs M McAlinden - Chief Executive | | | | | | | | | | |
| Mr S McNally - Director of Finance & Procurement | | | | | | | | | | |
| Dr J Simpson - Medical Director | | | | | | | | | | |
| Mr P Morgan - Director of Children & Young People"s Services | | | | | | | | | | |
| Mr F Rice - Executive Director of Nursing & AHPs | | | | | | | | | | |
| Mr M Crilly – Acting Director of Mental Health & Disability Services | | | | | | | | | | |
| **Other Members** | | | | | | | | | | |
| Mrs P Clarke - Director of Performance & Reform<br><br>(Deputy Chief Executive from 19 January 2015) | | | | | | | | | | |

Personal Information redacted by USI

| | |
|---|---|
| Mrs A Magwood – Acting Director of Performance & Reform (from 1 March 2015) | Personal Information redacted by USI |
| Mrs D Burns - Interim Director of Acute Services | |
| Mr K Donaghy - Director of Human Resources & Organisational Development | |
| Mrs A McVeigh - Director of Older People & Primary Care | |

The value of pension benefits accrued during the year is calculated as: (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increase or decreases due to a transfer of pension rights.

Mrs M McAlinden, resigned from her post as Chief Executive on 31 March 2015.

Mrs P Clarke was appointed to the post of Deputy Chief Executive on 19 January 2015 whilst continuing in her role as Director of Performance and Reform. From 1 April, Mrs Clarke was appointed Interim Chief Executive.

Mrs A Magwood was appointed to the post of Acting Director of Performance and Reform from 1 March 2015.

Dr J Simpson"s salary for 2013/14 has been restated as the amount published in 2013/14 included an error of £7k.

Mr R Alexander resigned from his post of Non-Executive Director on 31 December 2014.

Senior Executive remuneration stated above does not include a pay award for 2014/15 pending finalisation of the DHSSPS circular and consideration by the Trust"s Remuneration Committee.

Of the remaining six Non-Executive Directors, three have had their terms of office extended for a further one year period to 31 March 2016 and two have had their terms of office extended for a further six month period to 30 September 2015 and one will commence their second term of office from August 2015. The Chair has commenced her second term of office.

**Median Remuneration**

| | 2014/2015 | 2013/2014 Restated |
|---|---|---|
| Band of Highest Paid Director"s Total Remuneration (£000s) | £165-£170 | £160-£165 |
| Median Total Remuneration (based on paid salary) | £29,079 | £26,730 |
| Ratio | 5.8 | 6.1 |

The median reflects the aggregation of earnings where staff have multiple contracts. This was not possible in 2013/14 under HRMS.

Reporting entities are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation"s workforce, excluding the highest paid director.

The prior year disclosures for Median Remuneration have been restated due to the restatement of the remuneration of the highest paid Director, as noted above.

In 2014/15, 18 (2013/14: 18 (restated)) employees received remuneration in excess of the highest paid director. Remuneration ranged from £165k to £250k (2013/2014: £165k to £235k (restated)). All of these employees were clinicians.

Total remuneration includes salary, non-consolidated performance-related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

In 2014/15 and 2013/14 the most highly paid Director was the Medical Director.

**Pensions of Senior Management (Audited)**

The pension entitlements of the most senior members of the Southern HSC Trust were as follows:

| | 2014/2015 | | | | |
|---|---|---|---|---|---|
| **Name** | **Real Increase in pension and related lump sum at age 60 £000s** | **Total Accrued pension at age 60 and related lump sum £000s** | **CETV at 31/03/14 £000s** | **CETV at 31/03/15 £000s** | **Real Increase in CETV £000s** |
| **Executive Members** | [redacted] | | | | |
| Mrs M McAlinden - Chief Executive | | | | | |
| Mr S McNally - Director of Finance & Procurement | | | | | |
| Dr J Simpson - Medical Director | | | | | |
| Mr P Morgan - Director of Children & Young People"s Services | | | | | |
| Mr F Rice - Executive Director of Nursing & AHPs | | | | | |
| Mr M Crilly – Acting Director of Mental Health & Disability Services | | | | | |
| **Other Members** | | | | | |
| Mrs P Clarke – Director of Performance & Reform (Deputy Chief Executive from 19 January 2015) | | | | | |
| Mrs A Magwood – Acting Director of Performance & Reform | | | | | |

| | 2014/15 | | | | |
|---|---|---|---|---|---|
| **Name** | **Real Increase in pension and related lump sum at age 60 £000s** | **Total Accrued pension at age 60 and related lump sum £000s** | **CETV at 31/03/14 £000s** | **CETV at 31/03/15 £000s** | **Real Increase In CETV £000s** |
| Mrs D Burns - Interim Director of Acute Services | Personal Information redacted by USI | | | | |
| Mr K Donaghy - Director of Human Resources & Organisational Development | | | | | |
| Mrs A McVeigh - Director of Older People & Primary Care | | | | | |

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of Pensions for Non-Executive members.

**Cash Equivalent Transfer Values**

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member"s accrued benefits and any contingent spouse"s pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSC pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines prescribed by the Institute and Faculty of Actuaries.

**Real Increase in CETV**

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

**Off payroll Engagements**

This reflects the Trust's requirement to disclose the details of off-payroll engagements at a total cost of over £58,200 per annum that were in place during the year.

The Trust's use of Off Payroll Staff Resources in 2014/15 and 2013/14 is shown below:

| | **2014/2015** | | **2013/2014** |
|---|---|---|---|
| | **Number of staff** | | **Number of staff** |
| Off Payroll Staff as 1st April 2014 | 11 | Off Payroll Staff as 1st April 2013 | 7 |
| New engagements during the year | 1 | New engagements during the period | 13 |
| Number of engagements transferred to payroll | 0 | Number of engagements transferred to payroll | 0 |
| Number of engagements that have come to an end during the year | (2) | Number of engagements that have come to an end during the year | (9) |
| Off payroll staff as at 31 March 2015 | **10** | Off payroll staff as at 31 March 2014 | **11** |

**Reporting of Early Retirement and Other Compensation Scheme – exit packages (Audited)**

| Exit Package Cost Band | Number of Compulsory Redundancies | | Number of other Departures Agreed | | Total Number of Exit Packages by Cost Band | |
|---|---|---|---|---|---|---|
| | **2014/15** | **2013/14** | **2014/15** | **2013/14** | **2014/15** | **2013/14** |
| <£10,000 | 0 | 0 | | 0 | 0 | 0 |
| £10,000-£25,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £25,000-£50,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £50,000-£100,000 | 0 | 0 | 2 | 1 | 2 | 1 |
| £100,000-£150,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £150,000-£200,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| Over £200,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total number of exit packages** | **0** | **0** | **2** | **1** | **2** | **1** |

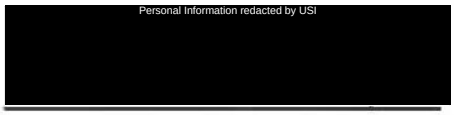
| | **£000s** | **£000s** | **£000s** | **£000s** | **£000s** | **£000s** |
|---|---|---|---|---|---|---|
| **Total Resource Cost** | 0 | 0 | 182 | 178 | 182 | 178 |

| **Total Number of Exit Packages by Types** | | |
|---|---|---|
| | **2014/15** | **2013/14** |
| Change of Management | 2 | 0 |
| Transforming Your Care | 0 | 1 |
| **Total** | **2** | **1** |

The above exit costs of £182k (2013/14: £178k) are reflected in Note 4 of the Annual Accounts within operating expenses.

The exit packages in 2014/15 which impact net expenditure represent voluntary leavers as a consequence of changes in the management structure.

Where early retirements have been agreed, the additional costs are met by the employing authority and not by the HSC Pension Scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

**Signed** 

**(Accounting Officer)**

**Date** **11 June 2015**

# SOUTHERN HEALTH AND SOCIAL CARE TRUST

## Annual Accounts for the Year Ended 31 March 2015

## FOREWORD

These accounts for the year ended 31 March 2015 have been prepared in accordance with Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, in a form directed by the Department of Health, Social Services and Public Safety.

## Southern HSC Trust

## ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

## STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003), the Department of Health, Social Services and Public Safety has directed the Southern Health and Social Care Trust („the Southern HSC Trust") to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of affairs of the Southern HSC Trust, of its income and expenditure, changes in taxpayers equity and cash flows for the financial year.

In preparing the financial statements the Accounting Officer is required to comply with the requirements of Government Financial Reporting Manual (FREM) and in particular to :

- observe the Accounts Direction issued by the Department of Health, Social Services and Public Safety including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- make judgements and estimates on a reasonable basis.
- state whether applicable accounting standards as set out in FREM have been followed, and disclose and explain any material departures in the financial statements.
- prepare the financial statements on the going concern basis, unless it is inappropriate to presume that the Southern HSC Trust will continue in operation.
- keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Southern HSC Trust.
- pursue and demonstrate value for money in the services the Southern HSC Trust provides and in its use of public assets and the resources it controls.

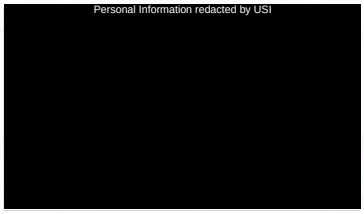
The Permanent Secretary of the Department of Health, Social Services and Public Safety as Accounting Officer for health and personal social services resources in Northern Ireland has designated Mrs Paula Clarke of Southern HSC Trust as the Accounting Officer for the Southern HSC Trust. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Southern HSC Trust"s assets, are set out in the Accountable Officer Memorandum, issued by the Department of Health, Social Services and Public Safety.

## Southern HSC Trust

## ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

## CERTIFICATES OF DIRECTOR OF FINANCE, CHAIR AND CHIEF EXECUTIVE

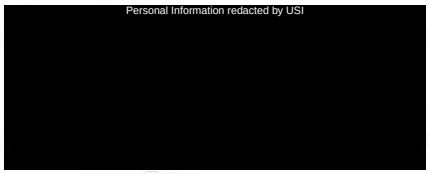
I certify that the annual accounts set out in the financial statements and notes to the accounts pages 86 to 151 which I am required to prepare on behalf of the Southern Health and Social Care Trust (Southern HSC Trust) have been compiled from and are in accordance with the accounts and financial records maintained by the Southern HSC Trust and with the accounting standards and policies for HSC bodies approved by the DHSSPS.




Director of Finance (Southern HSC Trust)

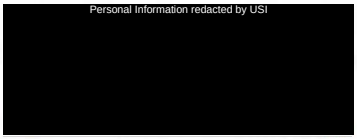
11 June 2015 Date 11/06/2015

I certify that the annual accounts set out in the financial statements and notes to the accounts pages 86 to 151 as prepared in accordance with the above requirements have been submitted to and duly approved by the Board.




Chair (Southern HSC Trust)

11 June 2015 Date




Interim Chief Executive (Southern HSC Trust)

11 June 2015 Date

# Southern HSC Trust

# ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

# Governance Statement

## 1. Scope of Responsibility

The Board of Directors of the Southern HSC Trust (the Trust) is accountable for internal control. As Accounting Officer and Interim Chief Executive of the Trust, I have responsibility for maintaining a sound system of internal governance that supports the achievement of the organisations policies, aims and objectives, whilst safeguarding the public funds and assets for which I am responsible in accordance with the responsibilities assigned to me by the Department of Health, Social Services and Public Safety (DHSSPS).

In delivering these responsibilities, I am accountable for the Trust"s performance to the Health and Social Care Board (HSCB) and DHSSPS and report through agreed performance management arrangements and Service and Budget Agreements.

This has entailed regular performance management meetings at a senior level with the HSCB and both scheduled and ad hoc meetings between Trust officers and the Performance Management Service Improvement Directorate within the HSCB.

In order to improve the quality, safety, effectiveness and efficiency of services, the Trust works in partnership with the HSCB, Public Health Authority (PHA), other public sector partners and the independent sector. A range of processes are in place to facilitate and enable this partnership working with examples including:

- meetings with Trust, HSCB, LCG and PHA senior teams collectively and on issue specific basis;
- monthly meetings between Trust and HSCB Chief Executives;
- regional and local Transformation Programme Boards to work together to implement Transforming Your Care (TYC);
- engagement with local GPs through locality forums and senior Trust attendance at LMC services development committee;
- regular meetings with Independent Health and Care Providers (IHCP) and other independent sector providers about key interface issues;
- forums such as the regional children"s service planning project board that include HSC partners, community/voluntary sector and other statutory agencies such as Education; and
- promoting health and wellbeing processes involving a range of partners focussed on ensuring effective collaboration to address the specific and individual needs of local communities.

With respect to the Trust"s inter-relationship with the DHSSPS, the framework within which the Trust is required to operate is defined and agreed in the Management

Statement and Financial Memorandum. This sets out the Trust"s founding legislation, functions, duties; responsibilities and accountability of the Trust and DHSSPS; processes for planning, budgeting and control with the specific purpose of the Management Statement covered in Annex 7.4 of "Managing Public Money NI" which states that „Departments need arrangements to monitor and understand their NDPBs" strategy, performance and delivery, usually built around a management statement and financial memorandum (MS/FM). This model MS/FM for executive NDPBs is intended to provide departments with a document that sets out a clear framework of strategic control for each of their executive NDPBs. The framework covers the operations, financing, accountability and control of the NDPB and the conditions under which any government funds are provided to the body. All MS/FMs require DFP approval as do any subsequent significant revisions. The specific requirements for the Trust as an Arm"s Length Body („ALB") are further defined and agreed annually in the Annual Business Plan.

**2. Compliance with Corporate Governance Best Practice**

The Trust applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The Trust does this by undertaking continuous assessment of its compliance with Corporate Governance best practice and the effectiveness of the Trust"s governance arrangements are regularly considered by the Governance Committee on behalf of the Board.

The Trust Board has a continued focus on its governance arrangements by undertaking a Board effectiveness evaluation on an annual basis. Progress against identified actions following the 2013/14 assessment was reported at the Board Development Day on 13 November 2014. As part of its review of the Trust"s governance arrangements, Internal Audit undertook a follow up on the 2013/14 self-assessment and this confirmed that identified actions had been taken.

The Board completed the Board Governance Self-Assessment Tool issued by the DHSSPS for the third time in 2014/15. This was approved by the Board at its meeting on 26 March 2015 and subsequently submitted to the Department on 30 March 2015. In line with the requirement for independent verification every three years, Internal Audit will undertake an independent assessment of the Trust"s 2015/16 self-assessment.

The Board has a Register of Interests in place for Trust Board members. This is reviewed on an annual basis (or sooner, if changes are notified by Board members) and is available upon request for members of the public.

**3. Governance Framework**

The Board exercises strategic control over the organisation through a system of corporate governance which includes:

- A schedule of matters reserved for Board decisions;
- A scheme of delegation, which delegates decision making authority within set parameters to the Chief Executive and other officers;
- Standing orders and standing financial instructions;
- Management Statement and Financial Memorandum;
- An Audit Committee;
- A Governance Committee;
- An Endowments and Gifts Committee;
- A Remuneration Committee; and
- A Patient and Client Experience Committee.

The following describe in more detail the role of the Board, its Committee structure and attendance during the reporting period.

**Trust Board**

The composition and membership of the Board is defined by the Membership, Procedure and Administration Arrangements Regulations and is as follows:

- Chair (Appointed by the DHSSPS Public Appointments Unit);
- 7 Non-executive members (Appointed by the DHSSPS Public Appointments Unit); and
- 5 Executive members – Chief Executive; Director of Finance; Medical Director; Director of Nursing; and Director of Social Work.

In addition to the members listed above, other members of the senior management team are in attendance and are as follows:-

- Director Acute Services
- Director of Human Resources and Organisational Development
- Director of Performance and Reform
- Director of Older People and Primary Care Services

In line with Standing Orders, no business shall be transacted unless half of the whole number of the Chair and members (including at least 2 members who are also Executive members of the Trust and two members who are not) are present.

In 2014/15, the Trust Board held 7 formal Board meetings, 3 Board Workshops and a Board Development Day. During the year, attendance at the formal meetings was as follows:

| Date | % Attendance |
|---|---|
| 29th May 2014 | 94% |
| 12th June 2014 | 94% |
| 25th September 2014 | 88% |
| 23rd October 2014 | 94% |
| 27th November 2014 | 100% |
| 29th January 2015 | 88% |
| 26th March 2015 | 94% |

During the reporting period, the following changes occurred with regard to Board membership:-

- The resignation of a Non-Executive Director on 31 December 2014.
- Of the remaining six Non-Executive Directors, three have had their terms of office extended for a further one year period to 31 March 2016, two have had their terms of office extended for a further six month period to 30 September 2015 and one will commence their second term of office from 29th August 2015. The Chair has commenced her second term of office.
- The resignation of the Chief Executive on 31 March 2015.
- With effect from 19 January 2015, a Deputy Chief Executive was appointed from within the Senior Management Team. This individual was appointed Interim Chief Executive with effect from 1 April 2015.

Trust Board meetings were widely publicised through the press and the Trust website. Agenda and minutes of all Trust Board meetings are publicly accessible on the Trust website.

The Board operates via an Annual Board calendar of meetings and agenda topics. Each Board agenda comprises strategic, operational, quality and performance items. Each agenda item had a time allocation to ensure that there was sufficient time for discussion and debate. Operational and patient safety and quality of care items were rotated to ensure equal priority. Time was also allowed at each meeting for the Board to reflect on innovative practice in relation to quality improvement and invitations were extended to staff and service users to hear their experiences of care. The Board received reports at each meeting on the financial position, workforce information and performance against targets.

Three Board workshops were held during the year, at which members explored strategic issues and planned service developments. A Board profiling process and skills analysis was undertaken by members at a facilitated workshop in May 2014. This identified the indicative action required for succession planning to ensure an appropriate balance of skills, experience and knowledge.

The Trust Board held a Development Day „Maintaining a strategic focus with energy, dynamism and resilience in challenging times" in November 2014. This is an important event in the Annual Board calendar in terms of whole Board learning and development and provides the opportunity for the Board to take time out to review its effectiveness and preparedness for the coming year.

All Trust Board Committees are chaired by a Non-Executive Director and have clear terms of reference and lines of reporting and accountability agreed by Trust Board. Minutes of the Sub Committees are presented at Trust Board public meetings in a timely manner with the Chair of each Committee highlighting any specific issues for the attention of the Board. This is evidenced by the agenda and minutes of Trust Board meetings. In addition, the Committee Chairs meet with the Trust Chair and Chief Executive after each meeting to provide feedback on the work of their respective Committees and raise any issues of concern.

In accordance with good practice, the Trust Chair meets with the Committee Chairs on an annual basis to reflect on the work of the Committees and to share any learning.

**Audit Committee**

The Audit Committee is required by its Terms of Reference to meet not less than 3 times a year. During 2014/15, the Committee held 5 meetings to provide the Trust Board with assurance on the adequacy and effectiveness of internal control systems and that all regulatory and statutory obligations are met. In line with its Terms of Reference, which are reviewed on an annual basis, the Committee reviewed governance, risk management and internal control across a planned range of activities.

The membership of the Audit Committee comprises 5 Non-Executive Directors (one of whom resigned on 31 December 2014). A quorum is 2 members. The Director of Finance, Head of Internal Audit, Business Services Organisation (BSO), external auditors (Northern Ireland Audit Office (NIAO)) and their sub-contracted auditors are in attendance. The Committee is also attended by other relevant Finance and Internal Audit staff. During 2014/15, there was full attendance at three out of five meetings.

It is Departmental policy to be represented at one Audit Committee meeting per year. A DHSSPS observer was scheduled to attend the Committee meeting on 7 May 2015 but unfortunately was unable to attend.

To ensure linkages across the Audit and Governance Committees, the Chair of the Audit Committee is a member of the Governance Committee and likewise, the Chair of the Governance Committee is a member of the Audit Committee.

In carrying out its work, the Committee used the findings of Internal Audit, External Audit, assurance functions, financial reporting and Value for Money activities. It approved the Internal Audit programme of work and reviewed progress on implementing internal and external audit recommendations. It considered reports from Internal Audit at each meeting and overall accepted the findings and recommendations

of Internal Audit in its reports for 2014/15. The Audit Committee particularly focused on assuring itself that there was an effective process within the Trust for addressing Priority Audit Findings and received regular updates from the Director of Finance who maintains a log of outstanding issues and receives progress reports from each Director on a quarterly basis. Operational Directors are required to attend Audit Committee meetings where less than satisfactory assurance had been received from Internal Audit for an area within their responsibility.

Fraud is a standing item on the Committee"s agenda and the Trust"s Fraud Liaison Officer presents a report of suspected/actual frauds at most meetings. The Committee received a presentation from Counter Fraud and Probity Services and discussed the NIAO Report on the National Fraud Initiative. There is on-going reporting to the Committee in respect of compliance with Departmental directions/circulars and the Committee received regular updates on the progress of implementing the new systems associated with the Business Services Transformation Programme (BSTP) and the transfer of Finance functions to Shared Services arrangements during 2014/15.

On an annual basis, the Committee reviews the findings of the External Auditor concerning the Trust"s Annual Accounts, including the Governance Statement.

The Board has separate Audit and Governance Committees. Internal Audit reviewed the Terms of Reference of both these Committees against the Audit and Risk Assurance Handbook (NI) 2014 and no gaps or areas of development were identified.

The Committee assessed its effectiveness against the National Audit Office (NAO) Audit Committee self-assessment checklist. An action plan has been devised to address any gaps in compliance with the application of best practice as required by the HM Treasury"s Audit Committee Handbook.

**Governance Committee**

The Governance Committee is required by its Terms of Reference to meet not less than 3 times a year. Meetings are held on a quarterly basis - February, May, September and December and during 2014/15, all 4 meetings were held as per the agreed schedule. The Committee reviewed and updated its Terms of Reference during the year.

The membership of the Governance Committee comprises all Non-Executive Directors, one of whom resigned on 31 December 2014. The Chief Executive, members of the Senior Management Team, the Director of Pharmacy and the Assistant Director of Clinical and Social Care Governance are in attendance. To ensure linkages with other Committees, the Chair of the Audit Committee and the Chair of the Patient and Client Experience Committee are members of the Governance Committee. During 2014/15, there was full attendance at all Governance Committee meetings.

The Governance Committee is the overarching strategic Committee responsible for providing assurance to the Board on all aspects of governance (except financial control) and during the year the Committee regularly considered the effectiveness of the Trust"s

governance arrangements. In order to discharge this remit, the Committee has a Schedule of Reporting in place and the key areas reported at meetings are in line with this. Assurance reports were received from lead Directors in relation to their areas of responsibility being Medical, Social Work and Social Care and Nursing and Allied Health Professions, as well as Medicines Governance. At this Committee, adverse incidents, serious adverse incidents, complaints and corporate risks were presented and reviewed. The Committee sought assurances on system improvements and received progress updates on, for example, Management of Water Systems and Fire Safety, in discharge of its oversight responsibilities to the Board. Reports and findings from external bodies/agencies were presented and discussed, particularly those that indicated practice below acceptable levels and areas of high risk. The Committee sought assurance that action plans were in place to address recommendations and were being effectively implemented through measurable outcomes. Where the organisation has challenges in meeting recommendations, the Governance Committee ensures these are appropriately escalated to Trust Board. Presentations were provided on e.g. National Hip Fracture Database and Post Falls Pathway and the outcome of the Quality Assurance visit by the PHA of Cervical Screening Services. .

The Governance Committee reviewed the Corporate Risk Register at each meeting and ensured that risks that are outside the Trust"s ability to solely manage were escalated to Trust Board and beyond. During the year, the Board instructed the Chief Executive to escalate a number of such risks to the HSCB, including the need for recurring investment to address capacity gaps affecting performance against Ministerial targets and medicines management in domiciliary care.

The Chair of the Governance Committee undertook an evaluation of the performance of the Committee during the year. One action arose relating to the timely issue of Committee papers and the Committee"s Terms of Reference have been amended to address this issue.

**Endowments and Gifts Committee**

The Endowments and Gifts Committee is required by its Terms of Reference to meet not less than 3 times per year. During 2014/15, the Committee held 4 meetings to oversee the administration of the Endowments and Gifts funds, their investment and disbursement.

The membership of the Endowments and Gifts Committee is comprised of three Non-Executive Directors (one of whom resigned on 31 December 2014), the Director of Acute Services and the Director of Performance and Reform. The Director of Finance is in attendance. A quorum is not less than 3 members. Two members had full attendance at all meetings during the year, with the remaining members missing one or more meetings. Where a Director was unable to attend a meeting, a nominated deputy attended.

The Chair of the Endowments and Gifts Committee undertook an evaluation of the performance of the Committee during the year. As a result, the Committee"s quorum was reduced and its Terms of Reference amended to reflect this.

**Remuneration Committee**

The Remuneration Committee is required by its Terms of Reference to meet on at least 2 occasions per year. The Committee held 3 meetings during 2014/15 to progress matters pertaining to the appropriate remuneration and terms of service of the Chief Executive and other senior executives, in accordance with DHSSPS policy and guidance. The Committee is comprised of the Trust Chair and two Non-Executive Directors. A quorum is two members, in addition to the Trust Chair. The Director of Human Resources and Organisational Development is in attendance. There was full attendance by all members during the year.

The Committee reviewed and updated its Terms of Reference during 2014/15.

**Patient and Client Experience Committee**

The Patient and Client Experience Committee is required by its Terms of Reference to meet not less than 4 times per year. During 2014/15, the Committee held 4 meetings and considered information to provide assurance to the Trust Board that the Trust"s services, systems and processes provide effective measures of patient/client and community experience and involvement. This Committee leads the co-ordination, development, implementation and monitoring of the Trust"s PPI Action Plan, monitors the Patient Client Experience Standards Audit programme and complaints across the organisation. The Committee considered the findings of external reports e.g. RQIA, the Donaldson Report and discusses any learning in relation to user experience.

The membership of the Patient and Client Experience Committee comprises the Trust Chair, four Non-Executive Directors and three representatives from the Trust"s PPI Panel. A further representative from the Trust"s PPI Panel became a member of the Committee in the March 2015. Trust Directors, the Assistant Director of Promoting Wellbeing, the Assistant Director of Clinical and Social Care Governance and a representative from the Patient and Client Council are in attendance. Across the four meetings in 204/15, there was 80% attendance at one meeting; 75% at two meetings and 50% at one meeting. It is important to note that these meeting dates coincide with Southern Area Adoption Panel meetings which have Non-Executive Director membership and this will be taken into consideration when setting future meeting dates.

The Chair of the Patient and Client Experience Committee undertook an evaluation of the performance of the Committee during the year and an action plan was developed.

Based on the information contained in the responses, the conclusion reached is that this Committee is operating effectively and no significant issues were raised.

## 4. Business Planning and Risk Management

Business planning and risk management is at the heart of governance arrangements to ensure that statutory obligations and ministerial priorities are properly reflected in the management of business at all levels within the organisation.

This following section provides an overview of the Trust‟s Business planning process and considers how objectives are identified, managed and reviewed.

The Trust‟s Strategic Plan **“Changing for a Better Future”** aims to ensure clarity about the strategic direction for services delivered by the Trust during the 2 year period 2013-2015 and specifically to identify what implementing *“Transforming Your Care”* will mean locally for individual services. This plan builds on the Trusts last 5 year strategic plan *“Changing for the Better”.*

It sets out the actions the Trust will take in support of each of the corporate objectives. This will ensure that our local communities know what to expect from us, that all of our staff are aware of their role in delivering on these priorities and that we can demonstrate improvements and progress by the end of the plan.

This Strategy sets out the Trust‟s vision „to deliver safe, high quality 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 it does and how it does it. 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 their development and improve our care;
- We will embrace change for the better; and
- 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 in providing health and social care to local people. The Trust‟s corporate objectives continue to include:

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

The current strategic plan runs until 2015 with a new plan **"Improving through Change**" 2015 - 2018 under consultation. The Trust"s Strategic Plan is underpinned on an annual basis by the Trust"s Delivery Plan.

The **Trust Delivery Plan (TDP)** represents the annual response of the Trust to Regional and Local Commissioning Plans and to the specific targets signalled in the Minister"s Commissioning Plan Direction. Within this document the Trust identifies how it will seek to deliver on each of the key commissioning and ministerial priorities for the incoming year. The Plan also sets out how the Trust will utilise its resources in the year ahead, including its financial strategy, workforce strategy, capital investment plans, governance strategy and plans to promote wellbeing, personal and public involvement (PPI) and the patient experience.

The preparation of this plan is led by the Directorate of Performance and Reform and requires all Trust Directorates to feed into its development. The Corporate Planning Division link directly with each of the Directorates to co-ordinate responses to the key ministerial themes and TDP requirements as identified above. The targets set out within the Commissioning Plan are allocated to Directorates and each assigned to the relevant Assistant Director for response. Targets are then disseminated to Head of Service level to discuss how the target could be achieved. If it is felt by staff that a target is unachievable or where there is a material risk to service delivery then it is the Directorate"s responsibility to specify this and where possible identify the resources necessary to enable the Trust to achieve the target.

It is the responsibility of Heads of Service to make their team aware of the targets relevant to their area of work and to ensure that issues which may impact on achievement are flagged up through Divisional Team meetings or staff supervision throughout the year.

The TDP is brought to SMT and Trust Board for approval prior to submission to HSCB.

**Directorate Work Plans** are developed annually on the basis of the Strategic Plan and TDP. These plans summarise the key deliverables falling under each objective in the Strategic Plan and TDP but will also detail the actions, action owner and timescales for achievements.

Each Directorate is required to engage with its staff in agreeing the priorities for the year ahead to ensure that there is a clear understanding of roles and responsibilities to support achievement.

The Directorate Work Plan is signed off at Directorate level and used to inform the development of individual Personal Development Plans.

Progress updates are generally carried out on a quarterly basis and some Directorates have found it useful to apply a traffic light system to assist in the monitoring of their actions at a high level for this purpose with more detailed discussion and monitoring taking place through staff supervision.

Decisions on **service development or change proposals** are often informed by a business case process. This may include projects necessary to support service improvement and modernisation as set out in the Trust‟s Strategic Plan and TDP. The need for a service development proposal or business case will be initiated at Director level. The development of the case will be led by a project team, comprising a range of stakeholders from across Directorates and services within the Trust. This is necessary to establish robust project management structures, identify the service need and drivers for change, to appraise potential options and inform a recommendation on the preferred way forward and its associated costs. An equality screening exercise and, where deemed appropriate, a formal consultation process including an Equality Impact Assessment will be undertaken on the preferred option to inform decision-making at SMT.

Once the business case has been completed and signed off by the project team it will proceed through an approval process which, depending on the type and level of funding required, may involve approval at both SMT and Trust Board within the organisation and by Commissioners and DHSSPS. The Trust‟s Guidelines on its Business Case Development and Approvals process was approved by SMT in May 2014. The Corporate Planning Division continues to update this guidance to reflect any DHSSPS Circulars/changing business case requirements.

Performance Monitoring Requirements

In 2014/15 the Trust maintained its focus on the Commissioning Plan Targets and Indicators of Performance that are relevant to the Trust through fortnightly and monthly performance reporting. Performance updates are a standing item on the weekly Senior Management Team meeting agenda.

On a fortnightly basis a Performance Report is circulated to Operational Directors and provides a tool for focus and escalation of areas which are in excess of the required performance standards for access targets. On a monthly basis a Performance Report and Indicator of Performance report is produced for Trust Board. This report is circulated in advance to SMT for approval and then submitted for Trust Board. The monthly Performance Report includes a summary of performance, key actions and issues. The report includes regional benchmarking to facilitate comparison against the other NI Trusts and where applicable benchmarking data obtained through CHKS, a provider of healthcare intelligence and quality improvement services, is used.

Focus is further maintained on performance against Service & Budget Agreement (SBA) baseline delivery (where these exist) and access standards at fortnightly / monthly Operational meetings where the Performance Team challenge the operational teams on their level of delivery against their specialty SBAs and also then on their ability to progress to achievement of the access standards. To assist the Operational Teams the Performance Team produce a weekly SBA activity report as well as a

monthly SBA activity report to detail performance against their expected SBA during the different stages of the year.

In 2014/15, focus on performance against the Service & Budget Agreement levels, where they have been agreed, has been good corporately. Underperformance has been limited to a number of key specialty areas which have in the main been particularly challenged by:

- The impact of sickness; maternity; and other absences in the medical workforce and associated challenges in securing backfill capacity in general and within current funded resources; and

- The requirement to divert resources to other need within that specialty area.

In 2014/15 risks were predominantly associated with the achievement of access standards by the end of March 2015 and the associated need to ensure capacity for the most clinically urgent demand whilst balancing the risk of patients and clients waiting beyond their clinically indicated timescales for planned review or treatment. Analysis has confirmed that this related to a number of factors:

- Capacity gaps where recurrent investment has not been secured and/ or embedded to enable teams to routinely achieve the required level of performance throughout the year. A range of specialty areas continue to require an additional level of capacity beyond to meet demand;
- Insufficient levels of non-recurrent funding from HSCB to provide the level of in-house additionality or to seek independent sector capacity required to maintain access time standards or agreed backstops;
- Accrued volume of patients and clients waiting beyond their clinically indicated timescale for review and or treatment;
- Continued pressures on demand in some areas, including non-elective demand; red flag demand; and urgent referrals; and
- The need to allocate appropriate levels of capacity for service areas not subject to Regional standards / targets to maintain safety and quality of care i.e. review appointments and planned repeat procedures.

The majority of specialty areas with no capacity gaps did achieve the agreed access standards / backstop targets. No specialty area with capacity gaps achieved the access standards/backstop targets due to reduced levels of funding for non-recurrent solutions.

During 2014/15 the Trust worked closely with HSCB and the Southern Local Commissioning Group (SLCG) to manage these risks in year with plans developed and monitored throughout the year, however with non-recurrent capacity limited access times have accrued in a number of specialties. A numbers of offers of recurrent investment were finalised in year and implementation plans are now being developed for these recurrent investments.

Executive Directors provide information to Trust Board and Governance Committee which provide assurance on safety and quality of services.

**Risk Management**

The Corporate Risk Register is reviewed by the Governance Committee at each of its meetings. Over the past six months, due to the volatility and challenges of the Trust"s financial position, the risks on the Corporate Risk Register have been monitored by Trust Board. The Corporate Risk Register is complementary to and works in conjunction with the Board Assurance Framework. A high level summary of the Corporate Risk Register is included in the Board Assurance Framework which is presented to the Board on a six-monthly basis and this provides the Trust Board with information on other significant risks that are under active management and review.

The key components of the Trust"s risk management strategy (2014) are underpinned by the HPSS Controls Assurance Standard for Risk Management. The purpose of this Strategy is to ensure that the Trust manages risks in all areas using a systematic and consistent approach. It provides the framework for a robust risk management process. All supporting procedures for the identification and management of risk also reflect this standard.

Each operational directorate is supported by a Governance Team who facilitates the Director, Assistant Directors and Associate Medical Directors to identify, assess and manage and report on risk within their area of responsibility.

The risk management process is based on HPSS Guidance on the identification and management of risk (Australia/New Zealand Model) August (2003). The Trust"s Risk Assessment Tool ensures that a consistent approach is taken to the evaluation and monitoring of risk in terms of the assessment of likelihood and impact. Risks are monitored through a formal reporting process where the assessed level of risk and its strategic significance determines where it will be reviewed and monitored.

The following key elements are used to identify risk within the organisation:

| | | |
|---|---|---|
| Internal Audit Reports<br><br>Accreditation Bodies Report<br><br>RQIA reports<br><br>Reports from Professional Bodies<br><br>Health and Safety Executive Reports/Visits<br><br>Environmental Health Reports<br><br>Independent Reviews<br><br>Coroner"s Reports | Adverse Incident Reporting<br><br>Whistleblowing<br><br>User Views<br><br>Complaints<br><br>Locally resolved expressions of dissatisfaction<br><br>Legal Claims<br><br>Patient and Client Satisfaction Measures<br><br>Employee Satisfaction Measures<br><br>Sickness and Absence Records<br><br>Staff Turnover<br><br>Levels of Agency Utilisation<br><br>Medical Device and Equipment Alerts<br><br>Introduction of new Standards and Guidelines<br><br>Outcome of Audit | Controls Assurance – Self Assessments<br><br>Performance reporting<br><br>Specialist Committees e.g. Infection Control Health & Safety etc.<br><br>Risk Assessments (including H&S; business/project planning e.g. new activities, services; referrals)<br><br>Management of relationship risk – i.e., service partners/key suppliers taking into account the behaviour and risk priorities of those partners<br><br>Networking – use of media reports and information from other Trusts<br><br>Other self-assessment tools - Health and Social Care Quality Standards Audit Commission. |

Risk registers are in place in all directorates. Risks identified and control measures in place are discussed monthly by the operational teams through the Directorate Governance Forums where they are reviewed, monitored and escalated as appropriate. The Senior Management Team reviews the Corporate Risk Register monthly.

The content of the Trusts Risk management training and awareness is presently being reviewed; it has been identified through an internal audit of risk management in 2015 that the Trust should improve on the numbers of staff trained in this area across all Directorates 2015/16. Training is facilitated by the Directorate Governance Teams. The Trust"s Health and Safety team deliver risk management training also.

All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust. There are structured processes in place for incident reporting, analysis and the investigation of serious incidents. The Trust has reviewed the arrangements in place for communicating and involving patients and their families in incident investigations.

The Trust Board, through the risk management and the incident policy and procedures, promotes open and honest reporting of incidents, risks and hazards. The Trust reporting incidents is supported by an accessible online reporting system available across the Trust (DATIX).

**Serious Adverse Incident Look Back Exercise**

On the 9 April 2014 the Trust Minister of Health instructed that Trusts should take a number of actions to review all serious adverse incidents reported between 1 January 2009 and the 31 December 2014 and provide information for each case with regards to patient/client involvement, statutory requirement to inform the Coroner, and appropriate referral of the case to other agencies. The information requested was provided by the Trust and independently Quality Assured by the RQIA. No areas of concern have been highlighted to date to the Trust with regards to information requested. The Trust continues to develop and improve patient/client engagement processes in this area.

The publication of the Donaldson Report „The Right Time, The Right Place" in January 2015 made recommendations with regards to the development and continued improvement in the management of incident data and SAI review arrangements. These recommendations are presently being consulted on. The Trust has put mechanisms in place to ensure all staff are provided with an opportunity to comment on the report.

**5. Information Risk**

An Information Governance Forum is in place, chaired by the Trust Personal Data Guardian, which provides direction and co-ordination of the strategic Information Governance and Records Management agenda. The Forum meets quarterly and reports to Trust Governance Committee, a sub-committee of Trust Board.

The purpose of the forum is to review the development and maintenance of an effective system of information governance, support the achievement of the Trust"s objectives and to ensure that risks in this area are identified and addressed. The Forum steers the work of the Records Management Committee, Research Governance Committee, Data Protection Sub Group, Data Quality Sub Group, Clinical Coding Sub Group, and ICT Steering Group (Technology Enabled Change).

During 2012/13 the Trust undertook an extensive audit of information assets held by each Directorate. In 2013/14, this was followed up with a risk assessment of each information asset, including an action plan to address any risks raised, in accordance with the DHSSPS Information Governance Framework. In 2014/2015 this work progressed with the capture of further assets and the provision of a report on progress of the framework to the Senior Information Risk Owner (SIRO) at Information Governance Forum in June 2015. The SIRO reports externally to the Information Manager, DHSSPS on an annual basis. The Director of Performance and Reform has been appointed as the Trust SIRO and along with the Trust Medical Director (Personal

Data Guardian) is responsible for ensuring Trust compliance with the requirements of Data Protection legislation.

To assure patients, clients and members of the public that their records are held securely and that only identified staff have access, the Trust implemented a software package in June 2013 to proactively identify potential unauthorised access to information systems. This software continues to monitor access of PAS, Laboratory and Radiology information systems. To ensure corporate awareness of the consequences of inappropriate access, Data Protection clinics have been held in each location in the Trust along with the dissemination of memos, e-brief extracts and desktop messages. Evaluation of the software implementation was reported to the Information Governance Forum in March 2015. An internal audit of information governance was undertaken in 2014/2015 which provided satisfactory assurance. The recommendations from this audit have been taken forward.

All information governance incidents which involve loss of or inappropriate access to data are reviewed by senior staff at quarterly Information Governance Forums. Data breaches are reported to the DHSSPS and the Information Commissioner Office (ICO) where appropriate. The Trust fully cooperates with the ICO and ensures a comprehensive investigation is completed and recommendations are carried out to minimise the risk of a reoccurrence.

An Information Sharing Register which records the details of all episodes of sharing of Trust data with other bodies is in place and reviewed at quarterly Information Governance Forums. A Data Access Form must be signed by the Trust Data Guardian so that all requests for access are approved before sharing is permitted. In addition, an Informatics meeting chaired by the Assistant Director of Informatics has been established to review all contracts held by the Trust.

Freedom of Information and Data Protection requests are monitored to ensure completion within the statutory timeframes. These are placed on a corporate dashboard and are reported to senior managers on a monthly basis and to DHSSPS quarterly.

An Information Governance Strategy and Policy has been approved by the Information Governance Forum and Records Management Committee in March 2015. In compliance with the requirements of the Information Commissioner Office „Definition Document for Health Bodies in NI" a disclosure log of all Freedom of Information requests has been published and staff have been informed on the need to proactively publish Trust documents on the website.

An e-learning suite of modules on Information Governance for regional use have been developed by the Beeches Leadership Centre and have been rolled out in the Trust since April 2013. An e learning module on the „Code of Practice on Confidentiality of Service User Information" has been developed by the Privacy Advisory Committee for regional roll out. Training for Personal Data Guardians is implemented regionally by the Privacy Advisory Committee.

In reducing the risks inherent with the management and storage of paper records, a records scanning pilot has been established in a service area in January 2015. Protection and confidentiality is enhanced with authorised access which is fully audited.

The Trust achieved the required „substantive" compliance in relation to the new Information Management Controls Assurance Standard and has an action plan in place to ensure „substantive" compliance is maintained. This area was also subject to Internal Audit in 2014/15 and achieved satisfactory assurance with one priority one issue as noted on page 70. There were no significant lapses of security requiring reporting to the Information Commissioner in relation to data loss in 2014/15.

**6. Public Stakeholder Involvement**

In line with the Regional Strategy (DHSSPS, 2004), Departmental Guidelines for Personal and Public Involvement (PPI) (DHSSPS, 2007 and 2012), sections 19 and 20 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Quality Standards for Health and Social Care (DHSSPS, 2006) the Trust continues to prioritise PPI within all aspects of its business agenda and has established a range of governance, management and reporting mechanisms that reflect this.

The Trust has recently completed a self-assessment PPI Performance Management Report which was submitted to the PHA on 31 January 2015. This outlines the mechanisms and processes the Trust is implementing to ensure compliance with the new PPI standards launched in March 2015 namely:

- PPI Leadership;
- PPI Governance;
- Opportunities for Involvement;
- Knowledge and Skills; and
- Measuring Outcomes.

The PHA carried out a verification visit on 24 March 2015. This focussed on PPI generally within the Trust and then there was a specific focus on PPI in Cancer Services. The PHA will produce a report on its findings which will confirm the Trust"s current compliance and provide guidance on what other action the Trust is required to take. This will be incorporated in the Trust"s Corporate PPI Action Plan for 2015/16.

In addition the Trust develops and implements annual directorate operational PPI action plans which focus on five key themes to ensure that PPI is embedded in the day-to-day practice of its staff:

- Information;
- Service User and carer Involvement;
- Evidencing Patient and Client Experience Standards;
- Training; and
- Monitoring and evaluation.

This is evidenced by the many initiatives and groups which exist to involve service users and other stakeholders, such as:

- Individual involvement of service users in healthcare and/or treatment plans;
- Patient Client Experience questionnaires, patient stories, observation;
- 10,000 Voices;
- Nursing Quality Indicator questionnaires and research;
- Service evaluations with service users, carers and other family members;
- Involvement of service users and carers in planning groups, steering groups, working groups, focus groups and other fora;
- Learning from complaints;
- Lay Cancer Reviewers;
- Peer Support Workers in Mental Health Services;
- Maternity Services Liaison Committee;
- Carers Reference group;
- User and Carer Service Improvement group;
- Race Equality Forum; and
- Traveller Action Group.

These mechanisms provide the opportunity for the identification of risk as well as risk management.

Further information on the Trust"s involvement mechanisms, processes and resources to support staff and service users and carers is available at **http://www.southerntrust.hscni.net/about/1600.htm**

## 7. Assurance

A systematic approach is taken to ensure that the systems upon which the Trust relies are challenged and tested. The Board Assurance Framework is a statutory requirement for the Trust and is an integral part of the Trust"s governance arrangements. The Framework has been compiled in conjunction with all Directorates and provides the systematic assurances required by the Board on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary to ensure the achievement of corporate objectives and the delivery of high quality health and social care. In its Board Assurance Framework, the Board has determined the level of assurance it requires to manage the principal risks facing the organisation and the Board reviews this on a six-monthly basis. A standard template attached to the Board Assurance Framework ensures that Board members consider, based on sufficient evidence, whether the current controls and assurance systems are sufficient and are working effectively. Board minutes attest to the challenge and scrutiny applied to the Board Assurance Framework.

The sources of external assurance and system validation are identified in the Board Assurance Framework and include, for example, the Regulation and Quality Improvement Authority, Internal and External Auditors, Royal Colleges and Professional Councils.

The Board Assurance Framework sits alongside the Corporate Risk Register, the Controls Assurance Standards process and performance reporting to provide structured assurance about how risks are effectively managed to deliver agreed objectives. Where risks are outside the Trust"s ability to solely manage, these are escalated to Trust Board and beyond.

Compliance with the controls assurance standards and the annual self-assessments against the standards provide an important assurance to the Trust Board. Separately, the Audit and Governance Committees review compliance with Controls Assurance Standards to provide assurance to Trust Board that action plans are in place for all 22 standards to maintain/further improve compliance against each standard going forward.

The Trust Board agenda is structured to ensure assurance is provided on key areas such as patient safety and quality and performance in terms of finance, human resources and operational performance.

To ensure the appropriateness and quality of information presented to the Board, feedback on all Board papers is sought at the end of every meeting and feedback provided to SMT where required. This includes the length, clarity and relevance to the Board of the report. A standard template is also attached to the front of all Board papers ensuring that the report is aligned to specific corporate objectives and key issues/risks and decisions required are drawn to Board members immediate attention. Board members regularly discuss and challenge the quality of the information presented to them and collectively reflect on information received. A Non-Executive Director is a member of the Trust Information Governance forum which addresses assurance processes for data quality. No significant issues have been raised.
Where Committee members have not been satisfied with the level of information presented to it, recommendations for improvement are made. Specific examples include:

- a recommendation by the Governance Committee which led the Trust to review and improve its governance systems in relation to complaints. This information is now presented to the Committee in both a qualitative and quantitative way.

- Development of a Performance Report to Trust Board to evidence SBA compliance

Members continue to consider further how to develop the searching questions and processes to ensure effective challenge by the Board. The Executive professional roles (Medical, Nursing and Social Work) ensure executive challenge as these posts are designed to give independent professional assurance to Trust Board. One key area of the Board Effectiveness questionnaire completed by members is the nature of member engagement and constructive challenge. An analysis of responses illustrate that the challenge at Board meetings is constructive and shared.
A template accompanies reports to Trust Board which provides the opportunity for the challenge by the Senior Management Team to a particular proposal/report to be described.

In addition, Trust Board receives reports from external organisations which provide assurance in relation to some areas of data quality.

The Board"s self-assessment evaluation of its effectiveness provides additional assurance on the effectiveness of the organisation"s governance arrangements.

The Trust also attends Mid and End of Year Assurance and Accountability meetings with the DHSSPS and Health and Social Care Board, the purpose of which is to provide assurance on the systems of internal control.

As part of the on-going „Board to Ward" governance assurance process within the Trust, a framework for leadership „walk arounds" has been developed and implemented since July 2011. These provide an informal method for Board members to talk with front line staff about issues in the organisation by asking a series of structured questions. Issues identified are forwarded to the relevant Director for action and a report provided to the Governance Committee to provide assurance that actions are being progressed.

**Controls Assurance Standards**

The Trust assessed its compliance with the applicable Controls Assurance Standards which were defined by the Department and against which a degree of progress is expected in 2014/15. Each standard has an action plan in place to address any areas of non-compliance.

Substantive compliance is required across all 22 standards.

The table below provides a summary of the expected and achieved levels of compliance for 2014/15.

| Standard | DHSS&PS Expected Level of Compliance | Trust Level of Compliance |
|---|---|---|
| Buildings, land, plant and non-medical equipment | 75% - 99% (Substantive) | Substantive* |
| Decontamination of medical devices | 75% - 99% (Substantive) | Substantive |
| Emergency Planning | 75% - 99% (Substantive) | Substantive |
| Environmental Cleanliness | 75% - 99% (Substantive) | Substantive |
| Environment Management | 75% - 99% (Substantive) | Substantive |
| **Financial Management (Core Standard)** | 75% - 99% (Substantive) | **Substantive*** |
| Fire safety | 75% - 99% (Substantive) | Substantive |
| Fleet and Transport Management | 75% - 99% (Substantive) | Substantive |
| Food Hygiene | 75% - 99% (Substantive) | Substantive |
| **Governance (Core Standard)** | 75% - 99% (Substantive) | **Substantive*** |
| Health & Safety | 75% - 99% (Substantive) | Substantive |
| Human Resources | 75% - 99% (Substantive) | Substantive |
| Infection Control | 75% - 99% (Substantive) | Substantive* |
| Information Communication Technology | 75% - 99% (Substantive) | Substantive |
| Information Management | 75% - 99% (Substantive) | Substantive |
| Management of Purchasing | 75% - 99% (Substantive) | Substantive |
| Medical Devices and Equipment Management | 75% - 99% (Substantive) | Substantive |
| Medicines Management | 75% - 99% (Substantive) | Substantive |
| Research Governance | 75% - 99% (Substantive) | Substantive* |
| **Risk Management (Core Standard)** | 75% - 99% (Substantive) | **Substantive*** |
| Security Management | 75% - 99% (Substantive) | Substantive |
| Waste Management | 75% - 99% (Substantive) | Substantive |

**De-notes subject to verification by HSC Internal Audit in 2014/15*

The above table demonstrates that the required levels of compliance have been achieved in 2014/15.

The Trust recognises the follow up work performed by Internal Audit on Procurement and Management of Estates and Pharmacy Contracts during 2014/15 and has considered these issues in the self-assessment scores for the individual criteria affected. The Trust has worked closely with Internal Audit on this process, completing baseline assessments and producing action plans to address areas of weakness.

## 8. Sources of Independent Assurance

The Trust obtains Independent Assurance from the following sources:

- ***Internal Audit;***
- ***Northern Ireland Audit Office;***
- ***RQIA;***
- ***External Review/Benchmarking;***
- ***Clinical Pathology Accreditation (CPA);***
- ***British Standards Institute(BSI) Assessments;***
- ***Human Tissue Authority (HTA); and***
- ***Medicines and Healthcare Products Regulatory Agency (MHRA)***

### Internal Audit

The Trust has an internal audit function which operates to defined standards and whose work is informed by an analysis of risk to which the body is exposed and annual audit plans are based on this analysis.

It provides assurance on audit areas using the assurance categories below. It is important to note that the level of assurance provided is limited to the scope of the audit assignment.

| Level of Assurance | Definition |
|---|---|
| Substantial | There is a robust system of risk management, control and governance, which should ensure that objectives are fully achieved. |
| Satisfactory | There is some risk that objectives may not be fully achieved. Some improvements are required to enhance the adequacy and / or effectiveness of risk management, control and governance. |
| Limited | There is considerable risk that the system will fail to meet its objectives. Prompt action is required to improve the adequacy and effectiveness of risk management, control and governance. |
| Unacceptable | The system has failed or there is a real and substantial risk that the system will fail to meet its objectives. Urgent action is required to improve the adequacy and effectiveness of risk management, control and governance. |

In 2014/15 Internal Audit reviewed the following systems:

| AUDIT ASSIGNMENT | LEVEL OF ASSURANCE |
|---|---|
| **Finance Audits:** | |
| HRPTS (ahead of transfer to Shared Services) | Limited |
| Non Pay Expenditure - FPL (ahead of transfer to Shared Services) | Satisfactory |
| Bank and Cash (FPL) | Satisfactory |
| Acute Directorate Finance Audit | Limited |
| Financial Assessments & Care Management (including Direct Payments) | Satisfactory |
| Adult Supported Living – Mental Health and Disability Directorate | Satisfactory |
| Client Monies and cash and Valuables Handling in Social Services Facilities -<br><br>Older People & Primary Care Directorate(OPPC) | Satisfactory |
| Management of Client Monies in the Independent Sector | Satisfactory -<br><br>Most Facilities<br><br>Limited -<br><br>Castle Lane Lurgan<br><br>Unacceptable (updated to Limited in review audit later in the year) -<br><br>The Valley Nursing Home Clougher |
| Domiciliary Care – Care Bureau | Limited |
| Management of Consultants | Substantial |
| **Corporate Risk Based Audits:** | |
| Efficiencies and Service Reform | Satisfactory |
| GP Out of Hours | Satisfactory |
| **Governance Audits:** | |
| Risk Management | Satisfactory |

| AUDIT ASSIGNMENT | LEVEL OF ASSURANCE |
|---|---|
| Business Cases | Satisfactory |
| Governance including Board Effectiveness | Satisfactory |
| Information Management | Satisfactory |
| Claims Management | Satisfactory |
| Management of ICT Contracts | Satisfactory |

**Consultancy and Other Assignments**

Estates Investigation – During April to August 2014, Internal Audit conducted an investigation into concerns received in respect of Estates. The concerns raised applied to a number of projects undertaken during the period April 2009 to present that involved one particular contractor. The audit report addressed the concerns raised and also considered whether the issues found applied to the one particular contractor or across other contractors. Significant issues were found around the following areas:

- absence of prior approval to variation costs.
- the process for managing/ minimising project delays.
- adherence to procurement regulations.
- communication and cooperation within the estates department.

Given the gaps in the control environment, there is an increased risk of fraud, bribery and corruption. However no evidence of such activity was found during this audit and BSO Counter Fraud and Probity Service considered the report and advised that they had no basis for undertaking an investigation into this matter.

Review of Previous Estates Audit Reports - Internal Audit conducted a Review of Management of Estates Contracts in January 2015. The scope of this assignment was to review and substantively test the implementation of recommendations made in the report, Management of Estates Contracts 2013/14 when unacceptable assurance was provided and the Investigation into Estates Concerns as outlined above. Across both Estates reports, Internal Audit reported that 65% of the recommendations made were fully implemented, 29% were partially implemented and 6% had not yet been implemented. The Trust continues to progress the outstanding recommendations and this is further discussed under Internal Control Divergences on pages 74-76.

Patients Private Property (PPP) - The Trust requested Internal Audit to review a sample of patient monies expenditure for five patients who were previously resident in in a Trust facility for appropriateness. A number of issues were identified, primarily around

clothing spend, and recommendations have been made to the Trust which are currently being taken forward.

Review of Management of Pharmacy Contracts – Internal Audit tested the implementation of recommendations previously made in 2013/14 regarding the management of pharmacy contracts. They confirmed that 57% were fully implemented, a further 22% were partially implemented and 21% were not yet implemented at the time of review. Two priority one issues were identified in relation to the use of Single Tender Awards and purchasing items not covered by a contract. Management accepted the recommendations made and can advise that one of these issues is now complete with the other awaiting a training date from BSO which will complete that issue.

Review of Management of Private Patient Income - Internal Audit tested the implementation of recommendations made in the report on Private Patient Income 2013/14, when Limited assurance was provided. 61% of the recommendations examined were fully implemented, a further 32% were partially implemented and 7% were not yet implemented at the time of review. The Trust is continuing to progress the recommendations made in this report.

GP Out of Hours Procedures – Internal Audit have been commissioned to produce updated procedural documents for use by the GP Out of Hours Service for staff and other payment areas. This is following a serious adverse incident which is currently under investigation by the Counter Fraud and Probity Service and this is further discussed under Internal Control Divergences on page 81.

**Follow up work**

352 of 475 previous priority one and two Internal Audit recommendations which were due to have been implemented, were fully implemented at year end (74%), a further 22% were partially implemented and 4% have not yet been implemented. There were four priority one findings which have not been implemented. Two of these are the same as in 2013/14 and relate to the management of contracts where due to a lack of resources no progress has been possible and the other two relate to private patient income. Both of these will be progressed in 2015/16.

**Shared Services Audits**

During 2014/15, the Trust transferred the income, payments and payroll functions to BSO Shared Services Centres. As the Trust is now a customer of BSO Shared Services, the following audit reports have been shared with the Trust for information.

| Shared Service Audit | Assurance |
|---|---|
| Payments Shared Service (as at September 2014) | Limited |
| Payments Shared Service (as at March 2015) | Satisfactory – Overall<br><br>Limited – Management of Duplicate Payments |
| Payroll Shared Service (as at September 2014) | Limited |
| Payroll Shared Service (as at February 2015) | Limited |
| Income Shared Service | Satisfactory |
| Recruitment Shared Service | Satisfactory |
| Business Services Team | Satisfactory |
| Shared Service Governance | Satisfactory |

Across these audit reports, the need to define roles and responsibilities of the Shared Service centres and customer organisations including clarity over controls exercised is a common theme.

Limited assurance has been provided in respect of the Payroll Shared Service Centre and a significant number of priority one findings and recommendations have been reported. Improvement is required particularly in the following areas: variance checking; management and reporting of overpayments; authorisation and processing of additional payments; management of and assurance over supplier access and responsibilities; and HRPTS access controls and privileges.

Limited assurance was initially provided in respect of the Payments Shared Service Centre in September 2014, however following improvements in processes and controls, satisfactory assurance was provided late in 2014/15. Further improvement is still required particularly in respect of management of duplicate payments, for which Limited assurance is still specifically provided.

Internal Audit also followed up on the implementation of priority one and priority two BSO shared service recommendations at the end of 2014/15. In total, 221 BSO shared service/business services transformation programme recommendations were followed up from reports dating from 2012/13 onwards. 78% of these recommendations have been fully implemented, a further 18% partially implemented and 4% were not yet implemented at the time of review.

Overall Opinion for 2014/15

In her annual report, the Head of Internal Audit reported that the Southern HSC Trust has a satisfactory system of internal control designed to meet the organisation"s objectives. However, the use of the new financial systems requires further embedding.

Weaknesses in control were identified in a number of areas. In total the Trust has 25 priority one findings in 2014/15, which is a fall from 2013/14. A priority one finding is defined as an issue which requires urgent management decision and action without which there is a substantial risk to the achievement of key business/system objectives, to the reputation of the organisation or to the regularity and propriety of public funds. A list of these priority one findings is detailed below:

**HRPTS (Pre – transfer to shared services):** two priority one issues were raised in relation to the new system and shared services developments and then segregation of duties and access rights. Management have accepted the recommendations made to the extent that the associated action is within their control to fulfil.

**Non Pay Expenditure:** two priority one issues were raised relating to duplicate payments and the division of roles and responsibilities between BSO Accounts Payable Shared Services and Trust Staff. Management accepted the recommendations made to the extent that the associated action was under their control.

**Acute Directorate Finance Audit:** three priority one issues were raised concerning the use of HRPTS and FPL – two of these relate to end user engagement with the new finance systems and the other one to BSO Shared Services and is being taken forward by BSO.

**Financial Assessments including Direct Payments**: one priority one issue was identified concerning incomplete documentation. Management have accepted the recommendation made.

**Adult Supported Living:** two priority one issues were identified in relation to the evidencing of review of tenant finances and management of household budget accounts. Management have accepted the recommendations made and will progress during 2015/16.

**Management of client monies in independent sector homes:** three homes/facilities received less than satisfactory assurance in 2014/15 and had priority one issues. These were the Valley Nursing Home (4 priority one issues in second IA review 2014/15), Castle Lane Supported Living facility (3 priority one issues) and Dungannon Care Home (one priority one issue). All homes have met or been engaging with the Trust on addressing the recommendations made during 2014/15 and both the Valley Nursing Home and Castle Lane have been incorporated in the 2015/16 Internal Audit programme. The issues identified included: lack of transport agreements; lack of residents" agreements; completeness and accuracy of residents" personal allowance

records and supporting receipts; documented procedures and supervisory controls and accuracy of management assurances over controls provided to the Trust.

**Domiciliary care bureau:** two priority one issues were identified relating to the agreement of invoices to supporting records and the timely review of invoice verification exception reports. Management accepted the recommendations and progress will be monitored during 2015/16.

**Efficiencies and Service Reform:** one priority one issue was identified which related to a shortfall in achievement of the three year cash releasing target. This was accepted by management.

**GP Out of hours service:** one priority one issue was identified regarding the ability to cover all shifts, meeting the five regional KPIs and budgetary overspend. Management accepted the recommendations made and will progress during 2015/16.

**Governance:** one priority one issue was identified highlighting the need to review and update the Integrated Governance Strategy. This was accepted and will be progressed in 2015/16.

**Information Management**: one priority one issue was identified relating to the % of staff that have completed information management mandatory training. Management continue to issue frequent reminders and monitor this on an on-going basis.

**Management of ICT Contracts**: one priority one issue was identified relating to the management and use of TPA contracts by the Trust. Management accepted the recommendations made and will progress during 2015/16.

The recommendations of the Internal Auditor to address control weaknesses have been considered by the Audit Committee. They have been or are being taken forward by the management of the Trust and their implementation will continue to be monitored by the Audit Committee regularly during 2015/16.

**Northern Ireland Audit Office (External auditor)**

The external auditor undertakes an examination of the annual financial statements in accordance with auditing standards issued by the Auditing Practices Board. Based on the findings of this audit, the Comptroller and Auditor General (C&AG) will report his opinion to the NI Assembly as to the truth and fairness of the annual financial statements, that expenditure and income have been applied to the purposes intended by the Assembly and that the transactions conform to the authorities which govern them (regularity).

In addition, the external auditor will provide a Report to those charged with Governance which brings to the attention of the Accounting Officer findings during the course of the external audit.

The external auditor reports all of these findings to the Audit Committee. During 2014/15, the Audit Committee monitored progress on all external audit recommendations arising from the 2013/14 external audit on a quarterly basis. In relation to the four priority one issues which were raised as part of the 2013/14 audit, action has been taken during the year to progress these but some are not yet complete. This has been reported to the Audit Committee.

In the course of the external audit for 2014/15, the external auditor has brought to the attention of management three priority one issues, all of which are disclosed in within the Governance statement. One relates to controls around the identification and management of payroll overpayments within BSO Payroll Shared Services and a second relates to the use of Direct Contract Awards by the Trust for inappropriate purposes, predominantly to regularise contracts which have expired. The third relates to social care contracts and the impact of the new Public Regulations 2015 on this sector. All of these issues are referenced in section 10 of the Governance Statement.

The Northern Ireland Audit Office also conducts a number of Value for Money studies across the health sector on an annual basis.

**RQIA**

Summary reports from RQIA thematic reviews, inspections and unannounced hygiene inspections, together with action plans in response to any recommendations emerging from these were reviewed by the Governance Committee. The Committee sought assurance that action plans were being effectively implemented through measurable outcomes. Where the Committee has not been assured that sufficient action had been taken, Directors have been asked to put in place further controls and have updated the Governance Committee accordingly.

A number of RQIA reports have provided focus on the social care independent sector and led to establishment of more robust regional and local processes in relation to the management of independent sector social care providers, including the Oversight of Users Finances. Following the Independent Review into Cherry Tree House in Carrickfergus, the Trust established a review team who compiled key areas of action and improvement within the Trust.

The Trust has a formal Liaison meeting with RQIA; the Liaison group strives to improve communication, to share information and concerns about common issues and consider joint and individual actions necessary to ensure safe and effective provision of care services. This meeting considers both statutory and Independent Sector areas of social care provision.

**External Review/Benchmarking**

The Trust has procured a service to facilitate external benchmarking of hospital based data against a UK peer group of like hospitals. This organisation, Comparative Health Knowledge Systems (CHKS), provides annual reporting on a range of key performance indicators including efficiency and safety measures, and quarterly reporting on mortality issues which is a key area of review. It provides assessment of performance against peer and against the top percentile, supporting this function with analysis and support at Directorate level. The Trust is currently working to customise a number of dashboards with themed data content for corporate use within this product.

The Trust also participates in a number of national clinical audits e.g. Cardiac Arrest, Fractures etc.

**Clinical Pathology Accreditation (UK) Ltd**

Reports from the CPA outlining overall conformance with the CPA standards are presented to the Governance Committee.

The Trust has now had all four of its laboratories inspected with CPA and all but one, Biochemistry, has maintained its accreditation. The Trust applied for inspection under the new standards in May 2014 and is awaiting an inspection date.

**British Standards Institution (BSI) Assessments**

Key outcomes from BSi audit review visits are presented to the Governance Committee to provide assurance. Three areas within the Trust are subject to audit:

- The Sterile Services Department (SSDs) at Craigavon Area Hospital and Daisy Hill Hospital are externally audited by the British Standards Institute (BSI) on a six monthly basis to ensure compliance with BS EN ISO 13485:2003 and the Medical Devices Directive (MDD) 93/42/EEC. Both SSDs were externally audited in October 2014 and were successful in achieving continued accreditation.
- The Laundry Department was externally audited by NQA in February 2015 to ensure compliance with BS EN ISO 9001:2008. The visit was satisfactory and re-certification was issued on 13 March 2015 valid to March 2018.
- The Trust"s systems and processes for the management of medical devices are also externally audited by the British Standards Institute (BSi) on a six monthly basis to ensure compliance with BS EN ISO 9001:2008. On the 29th May 2014 the Trust was recertified to this standard with one non-conformity identified. With recertification the Trust entered a new three year audit cycle with BSi, the last audit being held on the 22 & 23 December 2014. During this audit four non-conformities were identified. An action plan had been agreed and submitted to BSi. Progress on the action plan will be assessed during the May 2015 audit.

**Human Tissue Authority (HTA)**

The Human Tissue Authority regulates the removal, storage and use of human tissues. The HTA has granted a licence for removal of tissue samples from a decreased person for specific purposes and related activities to the Trust. In 2010, the Trust underwent an inspection by a team from HTA who concluded that the Trust met all standards. Any recommendations arising from this inspection have been implemented. Annually a statement of compliance with the standards is submitted by the Trust.

Since October 2014 post-mortem examinations are no longer carried out within the Trust and the HTA licence has been updated accordingly.

**Medicines and Healthcare Products Regulatory Agency (MHRA)**

The Trust uses the services of the Northern Ireland Blood Transfusion (NIBTS) and relies on its compliance with the MHRA. NIBTS continues to submit annual compliance reports to that effect. The Trust also continues to complete an annual Blood Compliance Report (BCR) for MHRA i.e. compliance against the Blood Safety and Quality Regulations 2006.

## 9. Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance. My review of the effectiveness of the Trust"s system of internal governance is informed by the work of the internal auditors, the executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Senior Management Team, Trust Board, Head of Internal Audit, Audit Committee and Governance Committee. I have referred to the Annual Report from the Head of Internal Audit which details the assurance levels provided from reports in 2014/15 and also the Trust"s implementation of accepted internal audit recommendations. A plan to address weaknesses and ensure continuous improvement to the system is in place.

## 10. Internal Governance Divergences

**Progress on prior year issues which are no longer considered to be control issues**

### Trust Adult Supported Living Facilities

An unacceptable level of assurance was provided by the Internal Auditor in relation to Adult Supported Living Facilities in the Mental Health and Disability Directorate. A follow up audit of supported living financial procedures was conducted in October/November 2014 which reported that a satisfactory level of assurance had been achieved.

### Trust Estate Risks

In 2013/14, the Trust reported that the mechanical infrastructure in Craigavon Area Hospital remained a risk. The high risk elements have now been completed and the risk is removed.

### Standards and Guidelines

The Trust reports regularly to our Governance Committee, RHSCB and DHSSPS in relation to our level of compliance with standards and guidelines. Our reporting identifies those standards and guidelines where the Trust has not achieved full compliance, the regional and local constraints on compliance, and identifies those areas where this creates patient safety risks.

### Break Even Target

The Trust began the financial year with a projected overspend of £27.6m, however there was an expectation that the DHSSPS and HSCB would seek to find additional funding during the year. Additional funding was secured in October 2014 which greatly improved the financial forecast and reduced the Trust"s contingency plan for 2014/15. The savings from contingency measures were achieved and the Trust is able to report achievement of the break even target in 2014/15.

Moving forward into 2015/16 financial year, some £13m of additional funding has now been allocated on a recurring basis and the Trust has secured additional recurrent savings. These factors leave a contingency requirement of around £7m.

**Progress on Prior Year Issues which continue to be considered as control issues**

### Contract & Procurement Management

### Estates

The procurement of Service and Maintenance contracts, which are within the scope of the CoPE, has been an area of concern. The Procurement and Logistics Service (PaLS) has not had sufficient capacity to undertake the majority of this procurement,

approx. 250 contracts (reduced from approx. 380 contracts the previous year through amalgamation). The annual value of these contracts is £2.8M. PaLS currently continue to manage 19 Estates contracts regionally and a further 14 associated SHSCT Regional Tenders capturing Consumables / Waste and Transport. Local PaLS continue to manage 21 Estates Contracts and are currently procuring a further 3, with 2 more timetabled to commence at the beginning of 2015.

A proposal paper, setting out a new Regional model (including the requirement for additional PaLS resources) for PaLS to undertake Estates procurement in collaboration with Trust Estates teams, has now been agreed by Trusts. An Internal Business Case detailing the additional resources required by the Trust to undertake this procurement is currently under consideration (the Trust only has one Estates Officer to support the procurement of all of these contracts and successful implementation of the Regional PaLS Model will be dependent upon sufficient resources being in place at both PaLS and the Trust). The Trust"s SMT have acknowledged this is an area of risk.

E-Sourcing has been adopted by Estates in this area of procurement as a more transparent, effective and efficient procurement method, and whilst the Trust have had DLS approval of the Terms and Conditions used for local procurement, this process is still considered to be outside CoPE (PaLS) influence but will be addressed through the roll out of the new model.

Future plans for this area include: further resolution of CoPE coverage, resourcing issues and procurement guidance (CoPE); pursuit of adequate staff resources (Trust); continued rationalisation of contracts; and implementation of the replacement E-Sourcing platform. Estates have procured and awarded 8 tenders from the introduction of E-sourcing during 2013/14 and so far during 2014/15 have awarded 1 tender and currently processing a further 6 towards award.

In summary, although great efforts have been made, it has not been possible to make any significant progress within the procurement of service and maintenance contracts in the absence of adequate resources being made available both within Estates and at Local/Regional PaLs levels. There is a significant shortfall in procurement capacity, within BSO/PaLs and the Trust, to process all the Estates service and maintenance contracts - the Trust only has one Estates Officer to support the procurement of all of these contracts. This results in the creation of more STA/DACs for longer time periods with escalating approval values increasing the likelihood of a requirement for Permanent Secretary approval. To reduce these incidents occurring Estates prioritise tenders to the COPE and if it is not possible for PaLS to accommodate the request within the required time period, Estates procure where possible. Adoption of the Regional Model will address the lack of clarity and direction which exists regarding PaLs/Estates procurement roles. It will also address the shortfall in resources which has generated on-going difficulties and delays in getting services procured in a timely manner – further exacerbated by the increasing number of challenges to procurements being referred to DLS.

Contract and Procurement Management outside the COPE continue to be highlighted by the Internal Auditor in their follow up reports in 2014/15.

**Estates Works Management Improvement Plan**

Recommendations arising from BSO Internal Audit (BSOIA) work which commenced in April 2014 have continued to be managed through the Estates Works Management Improvement Plan. All priority 1 recommendations have now been addressed and the majority fully implemented with four partially implemented with agreed plans in place for completion. The majority of others have also been addressed with the few remaining actions being managed through the agreed plan. The status of the recommendations was verified by BSOIA during a follow up audit in 2014/15 and assessed as 61% complete.

**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. A review of these arrangements was carried out in 2013/14 by an independent specialist and a further review was carried out in 2014/15. These audits are in accordance with Departmental requirements and advise the Trust on its compliance. The Water Safety plan has been updated to take into account the new HTM addendum on Pseudomonas and the latest version of the HSE guidance on legionella. The revised water safety plan and the imminent Independent Review report will be shared with HEIG and the PHA.

Based on system performance data and Clinical data the Trust Water Safety Group further refined the Water Sampling programme which was approved for implementation by Trust Board. The financial implications of delivering the water safety plan and specifically the control of legionella remain as a cost pressure under discussion with the commissioner.

Despite extensive efforts, sporadic instances of positive legionella results continue to occur across Craigavon Area Hospital. To combat this, the Water Safety Group approved the installation of a Copper Silver Ionisation water treatment system throughout the hospital. This installation was completed in April 2015 and will provide the Trust with a mechanism to further reduce the likelihood of positive results. In addition, where appropriate, under used outlets have been removed and system flushing has been increased with the support of the Support Services team. This will further reduce the risk of prolific water borne pathogen growth, such as legionella, which can occur in areas of low water use. An STA was in place for an extended period of time to maintain the existing Trust contract in this area over a number of years, but during 2014/15 a procurement exercise was completed with contract award commencing on 1 June 2015.

**Trust Estate Risks**

The age, condition and nature of the estate continue to pose potential risks and are exacerbated by limited capital investment in major renewal and replacement projects. All key risks are included on the Trust Corporate Risk Register ensuring regular scrutiny and follow up on action plans. The Trust prioritises available funding to the mitigation of these estates risks and continues to pursue additional funding through all appropriate streams. Specific risks include:

**Electrical infrastructure**, **Craigavon Area Hospital:** the action plan is focussed around a three phased approach for low/high voltage works and consists of: (1) Installation of Peak Lopping to prevent the risk of power outages on site due to site demand exceeding available NIE supply (complete); and (2) Installation of CHP units to increase on site generation capacity and resilience (to be commissioned March 2015); Installation of new NIE HV supply and upgrade of LV/HV infrastructure (to be completed March 2016).

**Fire Safety:** Three priority one issues were previously identified relating to completing and keeping updated, fire risk assessments; fire training attendance and record keeping; recording fire safety checks by nominated fire officers. Management accepted the recommendations made and have implemented 4 of the 6 associated actions.

Attendance at Fire Safety Training (as at 31 December 2014) was 69%. The new Fire Prevention Officer posts have been recruited and fire risk assessments have been given a high priority. The Fire Safety Manager took a lead role in conducting a live exercise (ward evacuation at CAH with students from a local college being substituted for patients) which involved all the key agencies (NIFRS, NIAS PSNI, Craigavon Council) – this was the first exercise of its kind undertaken in the Trust and is the culmination of extensive preparation which has been underway for several years now (NFO training; staff training; preparation of Evacuation Plans; Simulation exercises etc.). The exercise was highly successful in building staff awareness/confidence and in strengthening relationships with our partner agencies. A further exercise is being considered for Daisy Hill Hospital in 2015/16. Key learning will be used to further refine processes and plans.

The remaining recommendations will be addressed over an extended time period as the full complement of fire safety officers is put in place.

**Business Continuity:** The safe delivery of facility based clinical services is heavily reliant upon key estates systems such as electricity, water, medical gas, heating and upon the specialist teams managing those systems. The loss of any of these key systems would almost certainly lead to partial or complete service failure in the associated facility.

The aim of Estate Services Continuity Planning is to ensure that the Trust is able to maintain the highest level of service possible whatever happens to the infrastructure. The Trust may face unplanned interruption to a utility supply (electricity, water, gas, sewerage, etc.), unexpected equipment or service disruption (telecommunications, medical gases, waste disposal, etc.) and civil or environmental incident (pandemics with respect to staffing, weather extremes, floods, etc.). In order to mitigate against loss of clinical services through loss of any of these systems or resources Estates Services is developing a Service Area Recovery Management plan (based on Functional Area Recovery Management Team, Massachusetts Institute of Technology and incorporating aspects of BS 25999 - Business continuity management). Progress in this area is hampered by competing demands on a very limited staff resource.

The Trust has received funding in 2014/15 to address some of the risks identified above but an additional £12 million (approximately) is required to address all the risks identified to date; however, a further constraining factor in enabling these works to be carried out is the capacity of Estates Development Officers. Following approval by the Trust senior management team, two additional officers have been appointed to assist in taking this forward.

**Financial Risks**

**Safeguarding of Residents' Interests**

The Trust continues to liaise with the home owners, their legal representatives and external agencies in relation to the issues identified following two adult safeguarding investigations into two independent sector residential homes. The Trust has engaged with families/clients to outline the actions taken by the Trust to date to recoup monies owed to residents and our inability to reach agreement. The Trust continues to cease admissions/respite to the two Homes, the rationale for which has been communicated to the Home Owners. The Trust understands that court processes are on-going between the Home Owners and RQIA.

An implementation officer took up post on 10 March 2014 in order to progress the implementation and embedding of the new case management procedures across directorates and NISAT within Physical Disability & Learning Disability. The procedures have now been implemented since 2 February 2015. An evaluation and assessment of compliance with same will be conducted. The Trust continues to monitor all clients via the case management process and additional controls initiated following two adult safeguarding investigations remain in place.

**Compliance by Independent Sector Homes with circular HSS (F) 57/2009**

Following the issue of an RQIA report into Oversight of Service Users‟ Finances in Residential and Supported Living Settings in 2014, the DHSSPS has issued a revised

circular on this area, HSC (F) 8/2015 “Safeguarding of Service Users" Finances within Residential and Nursing Homes and Supported Living Settings.” This has been issued by the Trust to providers in March 2015 for completion and outstanding responses are currently being chased by the Trust. Both regionally and locally, the importance of adherence to this process has been re-inforced during 2014/15 and performance management arrangements reviewed to address non-compliance going forward.

**Clinical and Social Care Risks**

**Hyponatraemia Enquiry**

The Trust contributed to the governance section of the above Enquiry and awaits the learning points and recommendations from that Enquiry during 2015/16.

**New Control Issues in 2014/15**

**Elective Care**

The Trust continues to have a number of specialty areas with capacity gaps where no allocation for additional activity was provided in Quarters 3 and 4. This has resulted in increased access times at March 2015 with demand in excess of capacity and backlogs accrued. This position will deteriorate further if no funding is made available for areas with agreed capacity gaps in 2015/16.

**Unscheduled Care**

The Trust continues to be challenged in respect of significant service demand for unscheduled care services on both acute sites. One site has experienced a 10% increase in unscheduled demand to the Emergency Department. The Trust continues to review the challenge, service profile and design and mitigate risk as it emerges.

**Child Sexual Exploitation/Marshall Inquiry/SBNI Thematic Review**

The Trust has fully participated in the Marshall Inquiry and Thematic Review into young people. It is involved in work at both a regional and local level to take forward the recommendations of the Marshall Inquiry and has developed strong links with other bodies to both monitor, prevent and treat cases of potential/confirmed child sexual exploitation. The Trust completed a desk top exercise of its young people identified within the Thematic Review. This concluded that the Trust has followed procedures and governance systems; shared all relevant information and had good communication with the PSNI. The Trust is awaiting the final Thematic Review Report. Regional Guidance has been developed on the management of CSE Referrals. CSE is now a standing item on a number of Trust and Regional Fora to ensure appropriate training; improved assessments; interagency working and good governance arrangements.

**Estates risks**

**Estates Staffing**

Trust financial contingency measures in 2014/15 meant that a number of vacancies remained unfilled within the Estates Structure during 2014/15. The risk associated with these vacancies and the impact upon the service delivered was reflected on the Trust‟s Corporate Risk Register during the year. Following a review by the senior management team, approval has been given to proceed to recruit staff to fill a number of these vacancies. It is anticipated that staff will take up post early in 2015/16.

**Sewage**

There have been on-going issues with blocked sewers in CAH leading to occasional sewage leaks. The main cause is the flushing of inappropriate sanitary items.
Ward managers and Domestic Service are continuing to advise patients of the problems with disposing of inappropriate sanitary items down toilets. Signage and other communications, advising people using the hospital of what not to flush down toilets, have been widely displayed. Estates are also proactively checking and flushing main sewers to mitigate against blockages.
In addition, Estates are in the process of replacing pipe fittings and pipe runs with fusion welded pipe and fittings – this system reduces the likelihood of leaks but cannot prevent the blockages.

Planning and capital teams are to instruct future ward upgrades of the requirement to use fusion weld waste pipe system in all areas of the hospital.

**Contract and Procurement Management**

**Social Care Procurement**

It has not been possible to make any significant progress with the procurement of health & social care contracts in the absence of an agreed regional approach to be adopted in light of the new 2015 Public Contract Regulations and the absence of resources being made available within Social Care at both Local and Regional CoPE level.

One priority one issue was identified by Internal audit in 2013/14 which related to the inability to evidence, via the absence of procurement, that value had been obtained in relation to social care contracts. In accepting the recommendations the Trust highlighted action taken within its control and the context for social care procurement that is reliant on an agreed regional approach. As an interim position the Trust has developed a discipline around the roll forward of contracts which provides assurance that:

- That objectives of the provider are/continue to be in line with objectives of the Trust
- That a service specification has been prepared or reviewed defining the service delivery outcomes with clear measures of performance
- That value for money has been examined and efficiencies sought or obtained accordingly.

The Trust will continue to work with the Social Care Procurement Group of the Regional Procurement Board, HSCB to develop an agreed approach for social care procurement in the context of the 2015 Public Contract Regulations and proposed „Light Touch Regime" for health and social care procurement.

**General Contract Management**

Due to lack of resource, no progress was possible on the implementation of a central contracts database or improvement in contract management arrangements/training in the Trust during 2014/15. Further new posts are required to establish and maintain a central contracts database. Generating the resources for this investment will require the stand down of other less risk activities. The Trust is currently assessing the source and associated risk attached to alternative actions.

The Trust is also aware that with the new Public Contracts Regulations 2015 and the fall in the EU threshold will result in further pressure on procurement and contract management demands in 2015/16.

**Finance Risks**

**Fraud cases**

In 2014/15 there have been 15 reported cases of fraud. In particular there is a serious adverse incident reported by the Trust for which there is an on-going investigation by the Counter Fraud and Probity Services. The Trust has a zero tolerance approach to fraud, which has resulted in staff dismissals/disciplinary action for inappropriate claims and underworked hours during the year.

One case reported in 2013/14 remains with the Public Prosecution Service for a decision on pursuing prosecution.

An increased incidence of reported cases of alleged financial abuse has continued in 2014/15 to the adult safeguarding team and investigations are initiated as appropriate. As referred to previously, significant work and training has been undertaken on new case management procedures in the Trust and the Trust has also participated in a DHSSPS led group to review the findings of the , RQIA report on “Oversight of Service

Users' Finances in Residential and Supported Living Settings" during 2014/15. The Trust is in the process of implementing the new DHSSPS circular arising from this work.

**Transfer of Finance functions to BSO Shared Services Centres**

Following the implementation of the Finance, Procurement and Logistics (FPL) and Human Resources, Payroll, Travel and Subsistence System (HRPTS) in the Trust in previous years, the functions for Accounts Receivable, Accounts Payable and Payroll transferred to BSO Shared Services in June 2014, September 2014 and January 2015 respectively.

The Head of Internal Audit reviewed these functions in BSO and limited assurances were received for both Accounts Payable and Payroll Shared Services in September 2014, with a number of priority one issues being raised. Both of these functions were re-visited in the last quarter of 2014/15 and an improved position was reported for Accounts Payable, with an overall satisfactory assurance. However, the Payroll Shared Services Centre has remained as a limited assurance. There have been a number of difficulties experienced with both the HRPTS system itself and Internal Audit have highlighted that improvement is required by BSO Payroll particularly in the areas of: variance checking; management and reporting of overpayments; authorisation and processing of additional payments; management of and assurance over supplier access and responsibilities; and HRPTS access controls and privileges. In addition, throughout 2014/15, the division of roles and responsibilities between BSO Shared Services functions and Trust staff was not clearly defined and documented, thus raising control risk in these transferred functions. The Trust, however, is working closely with BSO Shared Services both at a local and regional level to continue to manage the risks, resolve the issues identified, review performance and embed learning in 2015/16.

The Trust has received correspondence from the Chief Executive of BSO regarding a range of BSO services provided to the Trust in 2014/15, noting a range of limited assurances in respect of Shared Services, Information Management and the Regional Interpreting Service. The Director of Finance of BSO has also issued an assurance report for the quarter ended 31 March 2015. This notes some control weaknesses and non-achievement of KPIs in accounts receivable, payroll and accounts payable. The Trust will continue to monitor progress in the implementation of the audit recommendations in 2015/16.

## 11. Conclusion

The Trust has a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in Managing Public Money NI. The system operates on a principle of continuous improvement where the performance and effectiveness of governance arrangements are subject to regular review.

As outlined above, the internal audit review of control systems has resulted in a number of limited assurances and a number of priority one issues have been raised with management and extensively examined by the Audit Committee. The findings of these reports and others such as those issued by RQIA will be incorporated into action plans aimed to address the weaknesses/gaps in control.

Further to considering the accountability framework within the Trust and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the Trust has operated a sound system of internal governance during the period 2014/15.


**Accounting officer Date 11 June 2015**

## SOUTHERN HEALTH AND SOCIAL CARE TRUST

## THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

I certify that I have audited the financial statements of the Southern Health and Social Care Trust and its group for the year ended 31 March 2015 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. The financial statements comprise the Consolidated Statements of Comprehensive Net Expenditure, Financial Position, Changes in Taxpayers' Equity, Cash Flows, and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

### Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

### Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the group's and the Southern Health and Social Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Southern Health and Social Care Trust; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

### Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

### Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the group's and of the Southern Health and Social Care Trust's affairs as at 31 March 2015 and of the net expenditure, cash flows and changes in taxpayers' equity for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health, Social Services and Public Safety directions issued thereunder.

**Opinion on other matters**

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with Department of Health, Social Services and Public Safety directions made under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which I report by exception**

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with Department of Finance and Personnel's guidance.

**Report**

I have no observations to make on these financial statements.

Personal Information redacted by USI

*KJ Donnelly*
*Comptroller and Auditor General*
*Northern Ireland Audit Office*
*106 University Street*
*Belfast*
*BT7 1EU*

25 *June 2015*

## SOUTHERN HSC TRUST

## CONSOLIDATED STATEMENT OF COMPREHENSIVE NET EXPENDITURE for the year ended 31 March 2015

| | NOTE | 2015 Trust £000s | 2015 CTF £000s | 2015 Consolidated £000s | 2014 Trust £000s | 2014 CTF £000s | 2014 Consolidated £000s |
|---|---|---|---|---|---|---|---|
| **Expenditure** | | | | | | | |
| Staff costs | 3.1 | (345,067) | 0 | (345,067) | (339,786) | 0 | (339,786) |
| Depreciation | 4 | (16,171) | 0 | (16,171) | (14,021) | 0 | (14,021) |
| Other Expenditures | 4 | (242,520) | (261) | (242,781) | (219,982) | (492) | (220,474) |
| | | (603,758) | (261) | (604,019) | (573,789) | (492) | (574,281) |
| **Income** | | | | | | | |
| Income from activities | 5.1 | 27,972 | 0 | 27,972 | 25,930 | 0 | 25,930 |
| Other Operating Income | 5.2 | 10,684 | 350 | 11,034 | 12,723 | 462 | 13,185 |
| | | 38,656 | 350 | 39,006 | 38,653 | 462 | 39,115 |
| **Net Expenditure** | | **(565,102)** | **89** | **(565,013)** | **(535,136)** | **(30)** | **(535,166)** |
| Revenue Resource Limit (RRL) | 25.1 | 565,143 | 0 | 565,143 | 531,979 | 0 | 531,979 |
| Add back charitable trust fund net expenditure | | 0 | (89) | (89) | 0 | 30 | 30 |
| **Surplus/(Deficit) against RRL** | | **41** | **0** | **41** | **(3,157)** | **0** | **(3,157)** |
| **OTHER COMPREHENSIVE EXPENDITURE** | | | | | | | |
| **Items that will not be reclassified to net operating costs:** | | | | | | | |
| Net (loss)/gain on revaluation of property, plant and equipment | 6.1/ 10/ 6.2/ 10 | (5,115) | 0 | (5,115) | 15,127 | 0 | 15,127 |
| Net gain/(loss) on revaluation of intangibles | 7.1/ 10/ 7.2/ 10 | 0 | 0 | 0 | 0 | 0 | 0 |
| Net gain on revaluation of charitable assets | | 0 | 167 | 167 | 0 | 69 | 69 |
| **Items that may be reclassified to net operating costs:** | | | | | | | |
| Net gain/(loss) on revaluation of available for sale financial assets | | 0 | 0 | 0 | 0 | 0 | 0 |
| **TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March 2015** | | **(570,217)** | **256** | **(569,961)** | **(520,009)** | **39** | **(519,970)** |

The notes on pages 90 to 151 form part of these accounts.

## SOUTHERN HSC TRUST

## CONSOLIDATED STATEMENT OF FINANCIAL POSITION as at 31 March 2015

| | | 2015 | | 2014 | |
|---|---|---|---|---|---|
| | NOTE | Trust | Consolidated | Trust | Consolidated |
| **Non Current Assets** | | £000s | £000s | £000s | £000s |
| Property, plant and equipment | 6.1/6.2 | 284,328 | 284,328 | 297,485 | 297,485 |
| Intangible assets | 7.1/7.2 | 69 | 69 | 214 | 214 |
| Financial assets | 8.0 | 0 | 2,845 | 0 | 2,678 |
| Trade and other receivables | 12.0 | 906 | 906 | 1,062 | 1,062 |
| **Total Non Current Assets** | | **285,303** | **288,148** | **298,761** | **301,439** |
| **Current Assets** | | | | | |
| Assets classified as held for sale | 9.0 | 1,108 | 1,108 | 1,285 | 1,285 |
| Inventories | 11.0 | 2,880 | 2,880 | 3,060 | 3,060 |
| Trade and other receivables | 12.0 | 15,771 | 15,834 | 15,789 | 15,801 |
| Other current assets | 12.0 | 4,526 | 4,526 | 2,997 | 2,945 |
| Financial assets | 8.1 | 0 | 0 | 0 | 100 |
| Cash and cash equivalents | 13.0 | 1,575 | 1,750 | 2,168 | 2,266 |
| **Total Current Assets** | | 25,860 | 26,098 | 25,299 | 25,457 |
| **Total Assets** | | **311,163** | **314,246** | **324,060** | **326,896** |
| **Current Liabilities** | | | | | |
| Trade and other payables | 14.0 | (65,756) | (65,800) | (70,097) | (70,150) |
| Provisions | 16.0 | (5,231) | (5,231) | (6,129) | (6,129) |
| **Total Current Liabilities** | | (70,987) | (71,031) | (76,226) | (76,279) |
| **Non Current Assets plus Net Current Liabilities** | | **240,176** | **243,215** | **247,834** | **250,617** |
| **Non Current Liabilities** | | | | | |
| Provisions | 16.0 | (23,888) | (23,888) | (24,136) | (24,136) |
| **Total Non Current Liabilities** | | (23,888) | (23,888) | (24,136) | (24,136) |
| **Assets less Liabilities** | | **216,288** | **219,327** | **223,698** | **226,481** |
| **Taxpayers' Equity** | | | | | |
| Revaluation reserve | | 34,585 | 34,585 | 40,540 | 40,540 |
| SoCNE reserve | | 181,703 | 181,703 | 183,158 | 183,158 |
| Other reserves - charitable fund | | 0 | 3,039 | 0 | 2,783 |
| | | **216,288** | **219,327** | **223,698** | **226,481** |

The notes on pages 96 to 151 form part of these accounts.

Signed [redacted] (Chairman) Date: 11 June 2015

Signed [redacted] (Interim Chief Executive) Date: 11 June 2015

## SOUTHERN HSC TRUST

## CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2015

| | NOTE | SoCNE Reserve | Revaluation Reserve | Charitable Fund | Total |
|---|---|---|---|---|---|
| | | £000s | £000s | £000s | £000s |
| **Balance at 1 April 2013** | | **161,331** | **25,421** | **2,744** | **189,496** |
| **Changes in Taxpayers Equity 2013-14** | | | | | |
| Grant from DHSSPS | | 556,900 | 0 | 0 | 556,900 |
| Transfers between reserves | | 8 | (8) | 0 | 0 |
| (Comprehensive expenditure for the year) | | (535,136) | 15,127 | 39 | (519,970) |
| Transfer of asset ownership | | 0 | 0 | 0 | 0 |
| Non cash charges - auditors remuneration | 4 | 55 | 0 | 0 | 55 |
| **Balance at 31 March 2014** | | **183,158** | **40,540** | **2,783** | **226,481** |
| **Changes in Taxpayers Equity 2014-15** | | | | | |
| Grant from DHSSPS | | 562,750 | 0 | 0 | 562,750 |
| Transfers between reserves | | 840 | (840) | 0 | 0 |
| (Comprehensive expenditure for the year) | | (565,102) | (5,115) | 256 | (569,961) |
| Non cash charges - auditors remuneration | 4 | 57 | 0 | 0 | 57 |
| **Balance at 31 March 2015** | | **181,703** | **34,585** | **3,039** | **219,327** |

The notes on pages 90 to 151 form part of these accounts.

## SOUTHERN HSC TRUST

## CONSOLIDATED STATEMENT OF CASHFLOW FOR THE YEAR ENDED 31 MARCH 2015

| | NOTE | 2015 £000s | 2014 £000s |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Net expenditure after interest | | (565,013) | (535,166) |
| Adjustments for non cash costs | | 44,688 | 19,971 |
| (Increase)/Decrease in trade and other receivables | | (1,458) | 2,627 |
| Decrease in inventories | | 180 | 482 |
| (Decrease)/increase in trade payables | | (16,210) | 5,328 |
| *Less movements in payables relating to items not passing through the NEA* | | | |
| Movements in payables relating to the purchase of property, plant and equipment | | 11,860 | (3,635) |
| Use of provisions | 16 | (7,756) | (5,094) |
| **Net cash outflow from operating activities** | | (533,709) | (515,487) |
| **Cash flows from investing activities** | | | |
| Purchase of property, plant & equipment | 6.1/6.2 | (29,956) | (39,487) |
| Proceeds of disposal of property, plant & equipment | | 169 | 46 |
| Proceeds on disposal of assets held for resale | | 130 | 0 |
| Movement in Short term investment | | 100 | 611 |
| Movement in long term investment value | | (167) | (570) |
| **Net cash outflow from investing activities** | | (29,724) | (39,400) |
| **Cash flows from financing activities** | | | |
| Grant in aid | | 562,750 | 556,900 |
| Movement in Charitable Trust Funds | | 167 | 69 |
| **Net financing** | | 562,917 | 556,969 |
| **Net (decrease)/increase in cash & cash equivalents in the period** | | (516) | 2,082 |
| **Cash & cash equivalents at the beginning of the period** | 13 | 2,266 | 184 |
| **Cash & cash equivalents at the end of the period** | 13 | **1,750** | **2,266** |

The notes on pages 90 to 151 form part of these accounts.

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**STATEMENT OF ACCOUNTING POLICIES**

## 1. Authority

These accounts have been prepared in a form determined by the Department of Health, Social Services and Public Safety based on guidance from the Department of Finance and Personnel"s Financial Reporting Manual (FReM) and in accordance with the requirements of Article 90(2) (a) of the Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14) as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003.

The accounting policies follow IFRS to the extent that it is meaningful and appropriate to HSC Trusts. Where a choice of accounting policy is permitted, the accounting policy which has been judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The Trust"s accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

## 1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

## 1.2 Currency and Rounding

These accounts are presented in UK Pounds Sterling. The figures in the accounts are shown to the nearest £1,000.

## 1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Land, Buildings, Dwellings, Transport Equipment, Plant and Machinery, Information Technology, Furniture and Fittings, and Assets under Construction.

### Recognition

Property, plant and equipment must be capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and
- The item has cost of at least £5,000; or

- collectively, a number of items have a cost of at least £5,000, and individually have a cost of more than £1,000 where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

On initial recognition property, plant and equipment are measured at cost including any expenditure such as installation, directly attributable to bringing them into working condition. Items classified as “under construction” are recognised in the Statement of Financial Position to the extent that money has been paid or a liability has been incurred.

**Valuation of Land and Buildings**

Land and buildings are carried at the last professional valuation, in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation - Professional Standards in so far as these are consistent with the specific needs of the HSC.

The last valuation was carried out on 31 January 2015 by Land and Property Services (LPS) which is part of the Department of Finance and Personnel. The valuers are qualified to meet the „Member of Royal Institution of Chartered Surveyors‟ (MRICS) standard.

Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

Land and buildings used for the Trust‟s services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Fair values are determined as follows:

- Land and non-specialised buildings – open market value for existing use;
- Specialised buildings – depreciated replacement cost; and
- Properties surplus to requirements – the lower of open market value less any material directly attributable selling costs, or book value at date of moving to non-current assets.

**Modern Equivalent Asset**

DFP has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. Land and Property Services (LPS) have included this requirement within the latest valuation.

**Assets under Construction (AuC)**

Properties in the course of construction for service or administration purposes are carried at cost less any impairment loss. Cost includes professional fees as allowed by IAS 16 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

**Short Life Assets**

Short life is defined as a useful life up to and including 5 years. From 1 April 2008 HSC entities had the option to elect to cease indexing all short life assets (other than IT which is not indexed). The Trust did not elect to cease indexing all short life assets, (other than IT), as these assets are not held separately on its fixed asset register. Therefore, fixtures and equipment, whether they are short life or have an estimated life in excess of 5 years, are indexed each year and depreciation will be based on the indexed amount. All other short life assets are not indexed but carried at depreciated historic cost as this is not considered to be materially different from fair value and are depreciated over their useful life.

**Revaluation Reserve**

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

**1.4 Depreciation**

No depreciation is provided on freehold land since land has unlimited or a very long established useful life. Items under construction are not depreciated until they are commissioned. Properties that are surplus to requirements and which meet the definition of “non-current assets held for sale “are also not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and similarly, amortisation is applied to intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over the lower of their estimated useful lives and the terms of the lease. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. The following asset lives have been used:

| Asset Type | Asset Life |
|---|---|
| Freehold Buildings | Up to 88 years |
| Leasehold property | Remaining period of lease |
| IT Assets | 3 – 10 years |
| Intangible assets | 3 – 10 years |
| Other Equipment | 3 – 15 years |

## 1.5 Impairment Loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure within the Statement of Comprehensive Net Expenditure. If the impairment is due to the consumption of economic benefits the full amount of the impairment is charged to the Statement of Comprehensive Net Expenditure and an amount up to the value of the impairment in the revaluation reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

## 1.6 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure which meets the definition of capital restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

The overall useful life of the Trust"s buildings takes account of the fact that different components of these buildings have different useful lives. This ensures that depreciation is charged on those assets at the same rate as if separate components had been identified and depreciated at different rates.

## 1.7 Intangible Assets

Intangible assets comprise software and licences. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

### Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust"s business or which arise from contractual or other legal rights. Intangible assets are considered to have a finite life. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised while intangible assets which fall within

the grouped asset definition must be capitalised if their individual value is at least £1,000 each and the group is at least £5,000 in value.

The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

Intangible assets acquired separately are initially recognised at fair value. Following initial recognition, intangible assets are carried at fair value by reference to an active market, and as no active market currently exists depreciated replacement cost has been used as fair value.

### 1.8 Donated Assets

With effect from 1 April 2011, DFP changed the policy on Donated Asset Reserves. The Donation Reserve no longer exists. What used to be contained in the Donated Asset Reserve has moved to the Statement of Comprehensive Net Expenditure Reserve (previously known as the General Reserve) and to the Revaluation Reserve. Income for donated assets is now recognised when received.

### 1.9 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. In order to meet this definition IFRS 5 requires that the asset must be immediately available for sale in its current condition and that the sale is highly probable. A sale is regarded as highly probable where an active plan is in place to find a buyer for the asset and the sale is considered likely to be concluded within one year. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value, less any material directly attributable selling costs. Fair value is open market value, where one is available, including alternative uses. Assets classified as held for sale are not depreciated.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount. The profit from sale of land, which is a non-depreciating asset, is recognised within income. The profit from sale of a depreciating asset is shown as a reduced expense. The loss from sale of land or from any depreciating assets is shown within operating expenses. On disposal, the balance for the asset on the Revaluation Reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve.

Property, plant or equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

### 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

### 1.11 Income

Operating income relates directly to the operating activities of the Trust and is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

**Grant in Aid**

Funding received from other entities, including the Department of Health, Social Services and Public Safety and the Health and Social Care Board is accounted for as grant in aid and is reflected through the Statement of Comprehensive Net Expenditure Reserve.

### 1.12 Investments

The Trust does not have any investments.

### 1.13 Other Expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

### 1.14 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

## 1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases is initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust"s surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land may be either an operating lease or a finance lease depending on the conditions in the lease agreement and following the general guidance set out in IAS 17. Leased buildings are assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust"s net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust"s net investment outstanding in respect of the leases. Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

## 1.16 Private Finance Initiative (PFI) Transactions

The Trust has had no PFI transactions during the current or prior year.

## 1.17 Financial Instruments

- **Financial assets**

Financial assets are recognised on the balance sheet when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

- **Financial liabilities**

Financial liabilities are recognised on the balance sheet when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

- **Financial risk management**

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within Trusts in creating risk than would apply to a non public sector body of a similar size, therefore Trusts are not exposed to the degree of financial risk faced by business entities. Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Trusts in undertaking activities. Therefore the HSC is exposed to little credit, liquidity or market risk.

- **Currency risk**

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

- **Interest rate risk**

The Trust has limited powers to borrow or invest and therefore has low exposure to interest rate fluctuations.

- **Credit risk**

Because the majority of the Trust"s income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

- **Liquidity risk**

Since the Trust receives the majority of its funding through its principal Commissioner which is voted through the Assembly, it is not exposed to significant liquidity risks.

## 1.18 Provisions

In accordance with IAS 37, provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, it is assumed the settlement is made at the beginning of the year rather than its cessation and its carrying amount is the present value of those cash flows using DFP"s discount rate of -1.50% (negative real rate) for 1 year up to and including 5 years, -1.05% (negative real rate) after year 5 up to 10 years and +2.20% in real terms for 10 years or more (+1.30% for employee early departure obligations for all periods).

The Trust has also disclosed the carrying amount at the beginning and end of the period, additional provisions made, amounts used during the period, unused amounts reversed during the period and increases in the discounted amount

arising from the passage of time and the affect of any change in the discount rate.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

## 1.19 Contingencies

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to the Assembly separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to the Assembly. Under IAS 37, the Trust discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

In addition to contingent liabilities disclosed in accordance with IAS 37, HSC Trusts should disclose for Assembly reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to the Assembly in accordance with the requirements of Managing Public Money Northern Ireland.

## 1.20 Employee Benefits

### Short-term Employee Benefits

Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been estimated using staff numbers and costs applied to the average untaken leave balance determined from the results of a survey to ascertain leave balances as at 31 March 2015. It is not anticipated that the level of untaken leave will vary significantly from year to year. Untaken flexi leave is estimated to be immaterial to the Trust and has not been included.

### Retirement Benefit Costs

Past and present employees are covered by the provisions of the HSC Superannuation Scheme.

The Trust participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Superannuation Scheme can be found in the HSC Superannuation Scheme Statement in the Departmental Resource Account for the Department of Health, Social Services and Public Safety.

The costs of early retirements are met by the Trust and charged to the Statement of Comprehensive Net Expenditure at the time the Trust commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. A full valuation for Resource

Accounts purposes as at 31 March 2012 was certified in February 2015 and is used in the 2014/15 accounts.

## 1.21 Reserves

### Statement of Comprehensive Net Expenditure Reserve

Accumulated surpluses are accounted for in the Statement of Comprehensive Net Expenditure Reserve.

### Revaluation Reserve

The Revaluation Reserve reflects the unrealised balance of cumulative indexation and revaluation adjustments to assets.

## 1.22 Value Added Tax

Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets.

## 1.23 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 24 to the accounts.

## 1.24 Government Grants

Government assistance for capital projects whether from UK, or Europe, are treated as a Government grant even where there are no conditions specifically relating to the operating activities of the entity other than the requirement to operate in certain regions or industry sectors. Such grants (does not include grant-in-aid) were previously credited to a government grant reserve and were released to income over the useful life of the asset.

DFP issued new guidance effective from 1 April 2011. Government grant reserves are no longer permitted. Income is generally recognised when it is received. In exceptional cases where there are conditions attached to the use of the grant, which, if not met, would mean the grant is repayable, the income should be deferred and released when obligations are met. The note to the financial statements distinguishes between grants from UK government entities and grants from European Union

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

## 1.25 Losses and Special Payments

Losses and special payments are items that the Assembly would not have contemplated when it agreed funds for the HSC or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had HSC Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

## 1.26 Charitable Trust Account Consolidation

In accordance with IAS 27, the Trust consolidates the accounts of the SHSCT Charitable Trust Funds with the Trust‟s financial statements. It is important to note, however, the distinction between public funding and the other monies donated by private individuals still exists.

As far as possible, donated funds have been used by the Trust as intended by the benefactor. It is for the Endowments and Gifts Committee within the Trust to manage the internal disbursements. The committee ensures that the charitable donations received by the Trust are appropriately managed, invested, expended and controlled in a manner that is, as far as possible, consistent with the purposes for which they were given and with the Trust‟s Standing Financial Instructions, Departmental guidance and legislation.

## 1.27 Accounting Standards that have been issued but have not yet been adopted

The IASB have issued new and amended standards (IFRS 10, IFRS 11 & IFRS 12) that affect the consolidation and reporting of subsidiaries, associates and joint ventures. These standards are effective with EU adoption from 1 January 2014.

Accounting boundary IFRS' are currently adapted in the FReM so that the Westminster departmental accounting boundary is based on ONS control criteria, as designated by Treasury. A review of the NI financial process, which

will bring NI departments under the same adaptation, has been presented to the Executive, but a decision has yet to be made. Should the Executive agree to the recommendations, the accounting boundary for departments will change and there will also be an impact on departments around the disclosure requirements under IFRS 12. ALBs apply IFRS in full and their consolidation boundary may change as a result of the new Standards.

Management considers that any other new accounting standards issued but not yet adopted are unlikely to have a significant impact on the accounts in the period of the initial application.

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 2 ANALYSIS OF NET EXPENDITURE BY SEGMENT

| | 2015 | | | 2014 | | |
|---|---|---|---|---|---|---|
| Directorate | Staff Costs £000s | Other Expenditure £000s | Total Expenditure £000s | Staff Costs £000s | Other Expenditure £000s | Total Expenditure £000s |
| Children's Services | 49,138 | 20,239 | 69,377 | 48,423 | 19,736 | 68,159 |
| Acute Hospital Services | 154,028 | 63,528 | 217,556 | 151,316 | 64,971 | 216,287 |
| Older People's Services | 64,674 | 80,370 | 145,044 | 64,392 | 78,948 | 143,340 |
| Mental Health and Disability Services | 52,129 | 40,443 | 92,572 | 51,274 | 40,409 | 91,683 |
| Corporate | 25,098 | 9,423 | 34,521 | 24,381 | 9,968 | 34,349 |
| **Expenditure for Reportable Segments net of Non Cash Expenditure** | **345,067** | **214,003** | **559,070** | **339,786** | **214,032** | **553,818** |
| **Non Cash Expenditure** | | | 44,688 | | | 19,971 |
| **Total Expenditure per Net Expenditure Account** | | | 603,758 | | | 573,789 |
| **Income Note 5** | | | 38,656 | | | 38,653 |
| **Net Expenditure** | | | 565,102 | | | 535,136 |
| **Revenue Resource Limit** | | | 565,143 | | | 531,979 |
| **Surplus/(Deficit) against RRL** | | | **41** | | | **(3,157)** |

The Trust is managed by way of a directorate structure, each led by a Director, providing an integrated healthcare service for the resident population. The Directors along with Non-Executive Directors, Chair and Chief Executive form the Trust Board which coordinates the activities of the Trust and is considered to be the Chief Operating Decision Maker. The information disclosed in this statement does not reflect budgetary performance and is based solely on expenditure information provided from the accounting system used to prepare the accounts.

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 2 (continued) ANALYSIS OF NET EXPENDITURE BY SEGMENT

**Acute Directorate**

- Cancer and clinical services (includes Laboratory & Radiology Services)
- Surgery and Elective Care
- Medicines and Unscheduled Care
- Integrated maternity and Women's Health
- Functional Support Services (includes all hotel services, health records, laundry and CSSD)
- Pharmacy

These services are delivered at the Acute Hospital Sites at Craigavon Area Hospital and Daisy Hill Hospital. Services including outreach clinics, day procedure services and diagnostic services are also delivered on South Tyrone Hospital Site, Lurgan Hospital Site and at Banbridge Polyclinic, Kilkeel and Crossmaglen Health Centres and Armagh Community Hospital.

**Directorate of Mental Health and Disability Services**

- Provides a range of hospital and community services, including social services, community nursing, home treatment, crisis response, Allied Health Professionals and specialist teams.
- Acute Mental Health Services are provided at the Bluestone Unit, Craigavon and at St Lukes Hospital, Armagh.
- On the St Lukes site there is a long-stay hospital
- Longstone Hospital for Learning Disability patients
- Nursing & residential home, domiciliary, respite and day care services as well as support to tenants who reside in supporting people accommodation
- Trust Transport services

**Older People and Primary Care Services**

- Domiciliary care, residential and nursing care and dementia support
- District nursing and allied health professionals supporting the elderly population
- Specialist services such as family planning, continence and GP out of hours and minor injuries units and all aspects of supporting people in the community
- Partnership working with Voluntary and community organisations incorporating grant aid payments and community support.

**Children and Young People Services**

- Includes all health services provided for children and adolescents
- Paediatric wards and special care baby units located in Acute facilities
- Disability services including respite, CAMHS, Children Community nursing of complex needs, Dental services and Allied Health Services
- Corporate Parenting
- Family support, Early Years, Health visiting and school nursing are included together with all Sure Start Projects.
- Social Services Training Unit

**Corporate Services**

- Office of the Chief Executive, including Trustwide Communication Team
- Finance and Procurement Directorate
- Human Resource Directorate, (including Health & Safety and Occupational Health)
- Performance & Reform (IT, Estates, Corporate Planning and Performance Improvement)
- Medical Directorate (Governance Patient/Client Safety, Medical Management, Clinical Audit and Emergency Planning)

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 3 STAFF NUMBERS AND RELATED COSTS

**3.1 Staff Costs**

| Staff costs comprise: | 2015 Permanently employed staff £000s | 2015 Others £000s | 2015 Total £000s | 2014 Total £000s |
|---|---|---|---|---|
| Wages and salaries | 288,406 | 8,079 | 296,485 | 290,508 |
| Social security costs | 18,965 | 0 | 18,965 | 19,485 |
| Other pension costs | 29,936 | 0 | 29,936 | 30,069 |
| **Sub-Total** | 337,307 | 8,079 | 345,386 | 340,062 |
| Capitalised staff costs | (319) | 0 | (319) | (276) |
| **Total staff costs reported in Statement of Comprehensive Expenditure** | 336,988 | 8,079 | 345,067 | 339,786 |
| Less recoveries in respect of outward secondments | | | (498) | (1,519) |
| **Total net costs** | | | **344,569** | **338,267** |

| | £000s | £000s |
|---|---|---|
| Southern HSC Trust | 344,569 | 338,267 |
| **Total** | **344,569** | **338,267** |

Staff Costs exclude £319K charged to capital projects during the year (2014: £276k)

The Trust participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. A full valuation for Resource Accounts purposes as at 31 March 2012 was certified in February 2015 and is used in the 2014/15 accounts.

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### 3.2 Average number of persons employed

The average number of paid whole time equivalent persons employed during the year was as follows:

| | 2015 | | | 2014 |
|---|---|---|---|---|
| | Permanently employed staff | Others | Total | Total |
| | No. | No. | No. | No. |
| Medical and dental | 606 | 64 | 670 | 651 |
| Nursing and midwifery | 3,228 | 4 | 3,232 | 3,163 |
| Professions allied to medicine | 1,077 | 1 | 1,078 | 1,088 |
| Ancillaries | 705 | 79 | 784 | 760 |
| Administrative & clerical | 1,591 | 35 | 1,626 | 1,700 |
| Estates & Maintenance | 71 | 0 | 71 | 87 |
| Social services | 1,149 | 9 | 1,158 | 1,114 |
| Domiciliary/Homecare Workers | 920 | 0 | 920 | 993 |
| **Total average number of persons employed** | 9,347 | 192 | 9,539 | 9,556 |
| Less average staff number relating to capitalised staff costs | (8) | 0 | (8) | (6) |
| Less average staff number in respect of outward secondments | (11) | 0 | (11) | (36) |
| **Total net average number of persons employed** | **9,328** | **192** | **9,520** | **9,514** |

Of which:

| | |
|---|---|
| Southern HSC Trust | 9,520 |
| Charitable Trust Fund | 0 |
| | **9,520** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### 3.3 Senior Employees' Remuneration

Details of Senior Employees" Remuneration are shown in the Annual Report.

### 3.4 Reporting of Early Retirement and Other Compensation Schemes – Exit Packages

Details of early retirement and other compensation schemes – exit packages are shown in the Annual Report.

### 3.5 Staff Benefits

There were no staff benefits in 2014/15. (2013/14: £Nil)

### 3.6 Trust Management Costs

| | Trust 2015 £000s | Trust 2014 £000s |
|---|---|---|
| Trust management costs | 20,905 | 20,213 |
| **Income:** | | |
| RRL | 565,143 | 531,979 |
| Income per Note 5 | 38,656 | 38,653 |
| Non cash RRL for movement in clinical negligence provision | (6,089) | (3,710) |
| Less interest receivable | (2) | 0 |
| **Total Income** | 597,708 | 566,922 |
| **% of total income** | **3.5%** | **3.6%** |

The above information is based on the Audit Commission's definition "M2" Trust management costs, as detailed in HSS (THR) 2/99.

### 3.7 Retirements due to ill-Health

During 2014/15 there were 13 early retirements from the Trust (2013/14: 13), agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £12k (2013/14: £20k). These costs are borne by the HSC Pension Scheme

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 4 OPERATING EXPENSES

| | 2015 | | | 2014 | | |
|---|---|---|---|---|---|---|
| | Trust £000s | CTF £000s | Consolidated £000s | Trust £000s | CTF £000s | Consolidated £000s |
| **Operating Expenses are as follows:-** | | | | | | |
| Purchase of care from non-HPSS bodies | 102,507 | 0 | 102,507 | 103,333 | 0 | 103,333 |
| Revenue grants to voluntary organisations | 5,375 | 0 | 5,375 | 5,703 | 0 | 5,703 |
| Personal social services | 6,371 | 0 | 6,371 | 5,757 | 0 | 5,757 |
| Recharges from other HSC organisations | 1,730 | 0 | 1,730 | 1,954 | 0 | 1,954 |
| Supplies and services - Clinical | 43,029 | 0 | 43,029 | 41,860 | 0 | 41,860 |
| Supplies and services - General | 6,530 | 0 | 6,530 | 6,489 | 0 | 6,489 |
| Establishment | 11,032 | 0 | 11,032 | 13,864 | 0 | 13,864 |
| Transport | 2,619 | 0 | 2,619 | 2,721 | 0 | 2,721 |
| Premises | 24,347 | 0 | 24,347 | 22,117 | 0 | 22,117 |
| Bad debts | 803 | 0 | 803 | 1,516 | 0 | 1,516 |
| Rentals under operating leases | 835 | 0 | 835 | 850 | 0 | 850 |
| Interest charges | 0 | 0 | 0 | 10 | 0 | 10 |
| BSO services | 3,075 | 0 | 3,075 | 2,260 | 0 | 2,260 |
| Training | 871 | 0 | 871 | 914 | 0 | 914 |
| Professional fees | 347 | 23 | 370 | 535 | 26 | 561 |
| Patients travelling expenses | 445 | 0 | 445 | 392 | 0 | 392 |
| Costs of exit packages not provided for | 182 | 0 | 182 | 178 | 0 | 178 |
| Other charitable expenditure | 0 | 238 | 238 | 0 | 466 | 466 |
| Miscellaneous expenditure | 3,905 | 0 | 3,905 | 3,579 | 0 | 3,579 |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 4 OPERATING EXPENSES (continued)

| | 2015 | | | 2014 | | |
|---|---|---|---|---|---|---|
| | Trust £000s | CTF £000s | Consolidated £000s | Trust £000s | CTF £000s | Consolidated £000s |
| **Non cash items** | | | | | | |
| Depreciation | 16,171 | 0 | 16,171 | 14,021 | 0 | 14,021 |
| Amortisation | 145 | 0 | 145 | 176 | 0 | 176 |
| Impairments | 21,872 | 0 | 21,872 | 2,035 | 0 | 2,035 |
| (Profit) on disposal of property, plant & equipment (excluding profit on land) | (179) | 0 | (179) | (225) | 0 | (225) |
| Loss on disposal of property, plant & equipment (including land) | 12 | 0 | 12 | 125 | 0 | 125 |
| Provisions provided for in year | 6,709 | 0 | 6,709 | 3,981 | 0 | 3,981 |
| Cost of borrowing of provisions (unwinding of discount on provisions) | (99) | 0 | (99) | (197) | 0 | (197) |
| Auditors remuneration | 57 | 6 | 63 | 55 | 7 | 62 |
| Add back of notional charitable expenditure | 0 | (6) | (6) | 0 | (7) | (7) |
| **Total** | **258,691** | **261** | **258,952** | **234,003** | **492** | **234,495** |

During the year the Southern HSC Trust purchased £2,699 (2013/14: £Nil) of non-audit services from its external auditor (NIAO). This related to the National Fraud Initiative exercise.

The Southern HSC Charitable Trust Funds Auditors remuneration of £5,750 (2014 £6,750) related solely to the audit, with no other additional work undertaken.

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 5 INCOME

| | 2015 | | | 2014 | | |
|---|---|---|---|---|---|---|
| **5.1 Income from Activities** | **Trust £000s** | **CTF £000s** | **Consolidated £000s** | **Trust £000s** | **CTF £000s** | **Consolidated £000s** |
| GB/Republic of Ireland Health Authorities | 309 | 0 | 309 | 160 | 0 | 160 |
| HSC Trusts | 214 | 0 | 214 | 235 | 0 | 235 |
| Non-HSC:- Private patients | 376 | 0 | 376 | 601 | 0 | 601 |
| Non-HSC:- Other | 1,199 | 0 | 1,199 | 1,204 | 0 | 1,204 |
| Clients contributions | 25,874 | 0 | 25,874 | 23,730 | 0 | 23,730 |
| **Total** | **27,972** | **0** | **27,972** | **25,930** | **0** | **25,930** |
| | | | | | | |
| **5.2 Other Operating Income** | | | | | | |
| Other income from non-patient services | 9,022 | 0 | 9,022 | 8,270 | 0 | 8,270 |
| Seconded staff | 498 | 0 | 498 | 1,519 | 0 | 1,519 |
| Charitable and other contributions to expenditure by core trust | 830 | 0 | 830 | 1,474 | 0 | 1,474 |
| Donations / Government grant / Lottery funding for non current assets | 130 | 0 | 130 | 383 | 0 | 383 |
| Charitable Income received by charitable trust fund | 0 | 241 | 241 | 0 | 369 | 369 |
| Investment Income | 0 | 109 | 109 | 0 | 93 | 93 |
| Other Income | 202 | 0 | 202 | 1,077 | 0 | 1,077 |
| Interest Receivable | 2 | 0 | 2 | 0 | 0 | 0 |
| **Total** | **10,684** | **350** | **11,034** | **12,723** | **462** | **13,185** |
| | | | | | | |
| **5.3 Other income** | | | | | | |
| Income released from conditional grants | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** | **0** | **0** |
| | | | | | | |
| **TOTAL INCOME** | **38,656** | **350** | **39,006** | **38,653** | **462** | **39,115** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 6.1 Consolidated Property, Plant & Equipment Year Ended 31 March 2015

| | Land | Buildings (excluding dwellings) | Dwellings | Assets under Construction | Plant and Machinery (Equipment) | Transport Equipment | Information Technology (IT) | Furniture and Fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| **Cost or Valuation** | | | | | | | | | |
| At 1 April 2014 | 37,246 | 245,005 | 14,492 | 9,356 | 51,016 | 6,696 | 23,746 | 935 | 388,492 |
| Indexation | 0 | 0 | 0 | 0 | 858 | 0 | 0 | 0 | 858 |
| Additions | 0 | 8,937 | 0 | 9,508 | 3,435 | 673 | 7,820 | 15 | 30,388 |
| Donations / Government grant / Lottery funding | 0 | 0 | 0 | 0 | 130 | 0 | 0 | 0 | 130 |
| Reclassifications | 0 | 6,305 | 0 | (6,305) | 0 | 0 | 0 | 0 | 0 |
| Transfers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | (4,873) | (47,428) | (2,183) | 0 | 37 | (312) | (9) | 0 | (54,768) |
| Impairment charged to the SoCNE | (5,414) | (16,227) | 123 | (342) | 0 | 0 | 0 | 0 | (21,860) |
| Impairment charged to the revaluation reserve | (120) | (5,827) | (604) | 0 | 0 | 0 | 0 | 0 | (6,551) |
| Reversal of impairments (indexn) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (Disposals) | 0 | (267) | 0 | 0 | (2,156) | (619) | (5,124) | 0 | (8,166) |
| At 31 March 2015 | **26,839** | **190,498** | **11,828** | **12,217** | **53,320** | **6,438** | **26,433** | **950** | **328,523** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 6.1 (continued) Consolidated Property, Plant & Equipment Year Ended 31 March 2015

| | Land | Buildings (excluding dwellings) | Dwellings | Assets under Construction | Plant and Machinery (Equipment) | Transport Equipment | Information Technology (IT) | Furniture and Fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| **Depreciation** | | | | | | | | | |
| At 1 April 2014 | 4,950 | 41,480 | 2,185 | 0 | 28,883 | 3,546 | 9,243 | 720 | 91,007 |
| Indexation | 0 | 0 | 0 | 0 | 503 | 0 | 0 | 0 | 503 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation | (4,950) | (48,124) | (2,500) | 0 | (45) | (312) | 59 | 0 | (55,872) |
| Impairment charged to the SoCNE | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairment charged to the revaluation reserve | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of Impairments (indexn) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (Disposals) | 0 | (14) | 0 | 0 | (1,888) | (592) | (5,120) | 0 | (7,614) |
| Provided during the year | 0 | 7,935 | 376 | 0 | 3,254 | 676 | 3,858 | 72 | 16,171 |
| At 31 March 2015 | **0** | **1,277** | **61** | **0** | **30,707** | **3,318** | **8,040** | **792** | **44,195** |
| **Carrying Amount** | | | | | | | | | |
| At 31 March 2015 | **26,839** | **189,221** | **11,767** | **12,217** | **22,613** | **3,120** | **18,393** | **158** | **284,328** |
| At 31 March 2014 | **32,296** | **203,525** | **12,307** | **9,356** | **22,133** | **3,150** | **14,503** | **215** | **297,485** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 6.1 (continued) Consolidated Property, Plant & Equipment Year Ended 31 March 2015

| | Land £000s | Buildings (excluding dwellings) £000s | Dwellings £000s | Assets under Construction £000s | Plant and Machinery (Equipment) £000s | Transport Equipment £000s | Information Technology (IT) £000s | Furniture and Fittings £000s | Total £000s |
|---|---|---|---|---|---|---|---|---|---|
| **Asset Financing** | | | | | | | | | |
| Owned | 26,839 | 189,221 | 11,767 | 12,217 | 22,613 | 3,120 | 18,393 | 158 | 284,328 |
| **Carrying Amount** | | | | | | | | | |
| At 31 March 2015 | **26,839** | **189,221** | **11,767** | **12,217** | **22,613** | **3,120** | **18,393** | **158** | **284,328** |
| Of which: | | | | | | | | | |
| Southern HSC Trust at 31 March 2015 | 26,839 | 189,221 | 11,767 | 12,217 | 22,613 | 3,120 | 18,393 | 158 | 284,328 |
| Charitable trust fund at 31 March 2015 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **26,839** | **189,221** | **11,767** | **12,217** | **22,613** | **3,120** | **18,393** | **158** | **284,328** |
| Southern HSC Trust at 31 March 2014 | 32,296 | 203,525 | 12,307 | 9,356 | 22,133 | 3,150 | 14,503 | 215 | 297,485 |
| Charitable trust fund at 31 March 2014 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **32,296** | **203,525** | **12,307** | **9,356** | **22,133** | **3,150** | **14,503** | **215** | **297,485** |

| | |
|---|---|
| Of which: | |
| Trust | 284,328 |
| Charitable Trust Funds | 0 |

Any fall in value through negative indexation or revaluation is shown as an impairment.

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure Account in respect of assets held under finance leases and hire purchase contracts is £Nil (2013/14: £Nil).

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 6.1 (continued) Consolidated Property, Plant & Equipment Year Ended 31 March 2015**

The fair value of assets funded from the following sources during the year was:

| | 2015 £000s | 2014 £000s |
|---|---|---|
| Donations | 130 | 383 |
| Government grant | 0 | 0 |
| Lottery funding | 0 | 0 |

Professional revaluations of land and buildings are undertaken by Land and Property Services (LPS) at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS. The last valuation was carried out on 31 January 2015. See Accounting policy note 1.3 for more details of valuation of Property, Plant & Equipment.

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 6.2 Property, Plant & Equipment Year Ended 31 March 2014

| | Land | Buildings (excluding dwellings) | Dwellings | Assets under Construction | Plant and Machinery (Equipment) | Transport Equipment | Information Technology (IT) | Furniture and Fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| **Cost or Valuation** | | | | | | | | | |
| At 1 April 2013 | 37,673 | 210,169 | 13,395 | 4,359 | 42,868 | 5,917 | 16,142 | 854 | 331,377 |
| Indexation | 0 | 17,242 | 1,063 | 0 | 914 | 0 | 0 | 14 | 19,233 |
| Additions | 0 | 15,945 | 0 | 11,400 | 8,551 | 956 | 7,785 | 81 | 44,718 |
| Donations / Government grant / Lottery funding | 0 | 39 | 0 | 0 | 344 | 0 | 0 | 0 | 383 |
| Reclassifications | (450) | 3,577 | 0 | (4,894) | 193 | 0 | 0 | 4 | (1,570) |
| Other Revaluations | 0 | 0 | 0 | (35) | 0 | 0 | 0 | 0 | (35) |
| Revaluation | 23 | (22) | 2 | (6) | (33) | (3) | (110) | 0 | (149) |
| Impairment charged to the SoCNE | 0 | (2,292) | 0 | (1,468) | (445) | 0 | 0 | (16) | (4,221) |
| Reversal of Impairments charged to the Revaluation Reserve | 0 | (94) | 0 | 0 | 0 | 0 | 0 | 0 | (94) |
| Reversal of Impairments SoCNE | 0 | 2,137 | 99 | 0 | 106 | 0 | 0 | 0 | 2,342 |
| (Disposals) | 0 | (1,696) | (67) | 0 | (1,482) | (174) | (71) | (2) | (3,492) |
| At 31 March 2014 | **37,246** | **245,005** | **14,492** | **9,356** | **51,016** | **6,696** | **23,746** | **935** | **388,492** |

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 6.2 (continued) Property, Plant & Equipment Year Ended 31 March 2014**

| | Land £000s | Buildings (excluding dwellings) £000s | Dwellings £000s | Assets under Construction £000s | Plant and Machinery (Equipment) £000s | Transport Equipment £000s | Information Technology (IT) £000s | Furniture and Fittings £000s | Total £000s |
|---|---|---|---|---|---|---|---|---|---|
| **Cost or Valuation** | | | | | | | | | |
| At 1 April 2013 | 4,978 | 31,383 | 1,667 | 0 | 26,382 | 3,072 | 6,730 | 643 | 74,855 |
| Indexation | 0 | 3,165 | 167 | 0 | 666 | 0 | 0 | 11 | 4,009 |
| Reclassifications | (28) | (119) | 0 | 0 | 0 | 0 | 0 | 0 | (147) |
| Revaluation | 0 | 3 | 0 | 0 | (43) | 1 | (79) | 1 | (117) |
| Impairment charged to the SoCNE | 0 | (6) | 0 | 0 | (7) | 0 | 0 | (1) | (14) |
| (Disposals) | 0 | (86) | (5) | 0 | (1,209) | (174) | (125) | (1) | (1,600) |
| Provided during the year | 0 | 7,140 | 356 | 0 | 3,094 | 647 | 2,717 | 67 | 14,021 |
| At 31 March 2014 | **4,950** | **41,480** | **2,185** | **0** | **28,883** | **3,546** | **9,243** | **720** | **91,007** |
| Carrying Amount At 31 March 2014 | **32,296** | **203,525** | **12,307** | **9,356** | **22,133** | **3,150** | **14,503** | **215** | **297,485** |
| At 1 April 2013 | **32,695** | **178,786** | **11,728** | **4,359** | **16,486** | **2,845** | **9,412** | **211** | **256,522** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 6.2 (continued) Property, Plant & Equipment Year Ended 31 March 2014

| | Land | Buildings (excluding dwellings) | Dwellings | Assets under Construction | Plant and Machinery (Equipment) | Transport Equipment | Information Technology (IT) | Furniture and Fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| **Asset Financing** | | | | | | | | | |
| Owned | 32,296 | 203,525 | 12,307 | 9,356 | 22,133 | 3,150 | 14,503 | 215 | 297,485 |
| **Carrying Amount** | | | | | | | | | |
| At 31 March 2014 | **32,296** | **203,525** | **12,307** | **9,356** | **22,133** | **3,150** | **14,503** | **215** | **297,485** |
| **Asset financing** | | | | | | | | | |
| Owned | 32,695 | 178,786 | 11,728 | 4,359 | 16,486 | 2,845 | 9,412 | 211 | 256,522 |
| **Carrying Amount** | | | | | | | | | |
| At 1 April 2013 | **32,695** | **178,786** | **11,728** | **4,359** | **16,486** | **2,845** | **9,412** | **211** | **256,522** |

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 6.2 (continued) Property, Plant & Equipment Year Ended 31 March 2014**

| | Land £000s | Buildings (excluding dwellings) £000s | Dwellings £000s | Assets under Construction £000s | Plant and Machinery (Equipment) £000s | Transport Equipment £000s | Information Technology (IT) £000s | Furniture and Fittings £000s | Total £000s |
|---|---|---|---|---|---|---|---|---|---|
| Southern HSC Trust at 31 March 2014 | 32,296 | 203,525 | 12,307 | 9,356 | 22,133 | 3,150 | 14,503 | 215 | 297,485 |
| Southern HSC Trust charitable trust fund at 31 March 2014 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Southern HSC Trust at 31 March 2014 | **32,296** | **203,525** | **12,307** | **9,356** | **22,133** | **3,150** | **14,503** | **215** | **297,485** |
| Southern HSC Trust at 31 March 2013 | 32,695 | 178,786 | 11,728 | 4,359 | 16,486 | 2,845 | 9,412 | 211 | 256,522 |
| Southern HSC Trust charitable trust fund at 31 March 2013 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Southern HSC Trust at 31 March 2013 | **32,695** | **178,786** | **11,728** | **4,359** | **16,486** | **2,845** | **9,412** | **211** | **256,522** |

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 7.1 Consolidated Intangible Assets Year Ended 31 March 2015**

| | Software Licenses | Software | Total |
|---|---|---|---|
| | £000s | £000s | £000s |
| **Cost or Valuation** | | | |
| At 1 April 2014 | 1,399 | 0 | 1,399 |
| Indexation | 0 | 0 | 0 |
| Additions | 0 | 0 | 0 |
| Donations / Government grant / Lottery funding | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 |
| At 31 March 2015 | **1,399** | **0** | **1,399** |
| **Amortisation** | | | |
| At 1 April 2014 | 1,185 | 0 | 1,185 |
| Reclassifications | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 |
| Provided during the year | 145 | 0 | 145 |
| At 31 March 2015 | **1,330** | **0** | **1,330** |
| **Carrying Amount** | | | |
| At 31 March 2015 | **69** | **0** | **69** |
| At 31 March 2014 | **214** | **0** | **214** |
| **Asset financing** | | | |
| Owned | 69 | 0 | 69 |
| **Carrying Amount** | | | |
| At 31 March 2015 | **69** | **0** | **69** |

There were no assets funded by Donations/Government Grant or Lottery Funding during the year. (2013/14: £Nil)

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 7.2 Consolidated Intangible Assets Year Ended 31 March 2014**

| | Software Licenses | Software | Total |
|---|---|---|---|
| | £000s | £000s | £000s |
| **Cost or Valuation** | | | |
| At 1 April 2013 | 1,399 | 0 | 1,399 |
| Indexation | 0 | 0 | 0 |
| Additions | 0 | 0 | 0 |
| Donations / Government grant / Lottery funding | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 |
| At 31 March 2014 | **1,399** | **0** | **1,399** |
| **Amortisation** | | | |
| At 1 April 2013 | 1,009 | 0 | 1,009 |
| Reclassifications | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 |
| Provided during the year | 176 | 0 | 176 |
| At 31 March 2014 | **1,185** | **0** | **1,185** |
| **Carrying Amount** | | | |
| At 31 March 2014 | **214** | **0** | **214** |
| At 31 March 2013 | **390** | **0** | **390** |
| **Asset financing** | | | |
| Owned | 214 | 0 | 214 |
| **Carrying Amount** | | | |
| At 31 March 2014 | **214** | **0** | **214** |
| **Asset financing** | | | |
| Owned | 390 | 0 | 390 |
| **Carrying Amount** | | | |
| At 1 April 2013 | **390** | **0** | **390** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 7.2 Consolidated Intangible Assets Year Ended 31 March 2014

**Carrying amount comprises:**

| | Software Licenses £000s | Software £000s | Total £000s |
|---|---|---|---|
| Southern HSC Trust at 31 March 2015 | 69 | 0 | 69 |
| Southern HSC Trust charitable trust fund at 31 March 2015 | 0 | 0 | 0 |
| | 69 | 0 | 69 |
| Southern HSC Trust at 31 March 2014 | 214 | 0 | 214 |
| Southern HSC Trust charitable trust fund at 31 March 2014 | 0 | 0 | 0 |
| | 214 | 0 | 214 |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 8 FINANCIAL INSTRUMENTS

**NOTE 8 Financial Instruments**

| | Investments | Assets | Liabilities | Investments | Assets | Liabilities |
|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s |
| Balance at 1 April | 2,678 | 100 | 0 | 2,109 | 711 | 0 |
| Additions | 0 | 0 | 0 | 500 | 4 | 0 |
| Withdrawals | 0 | (100) | 0 | 0 | (615) | 0 |
| Revaluations | 167 | 0 | 0 | 69 | 0 | 0 |
| Balance at 31 March | **2,845** | **0** | **0** | **2,678** | **100** | **0** |
| Trust | | | | | | |
| Charitable trust fund | 2,845 | 0 | 0 | 2,678 | 100 | 0 |
| | **2,845** | **0** | **0** | **2,678** | **100** | **0** |

**NOTE 8.1 Market value of investments as at 31 March 2015**

| | Held in UK | Held outside UK | 2015 Total | 2014 Total |
|---|---|---|---|---|
| | £000s | £000s | £000s | £000s |
| Investments in a Common Deposit Fund or Investment Fund | 2,845 | 0 | 2,845 | 2,678 |
| **Total market value of fixed asset investments** | **2,845** | **0** | **2,845** | **2,678** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 9 ASSETS CLASSIFIED AS HELD FOR SALE

| | Land | | Buildings | | Total | |
|---|---|---|---|---|---|---|
| | 2015 | 2014 | 2015 | 2014 | 2015 | 2014 |
| | £000s | £000s | £000s | £000s | £000s | £000s |
| **Cost** | | | | | | |
| At 1 April | 0 | 0 | 1,482 | 0 | 1,482 | 0 |
| Transfers in | 0 | 0 | 0 | 1,570 | 0 | 1,570 |
| (Disposals) | 0 | 0 | (168) | 0 | (168) | 0 |
| Impairment | 0 | 0 | (121) | (88) | (121) | (88) |
| At 31 March | **0** | **0** | **1,193** | **1,482** | **1,193** | **1,482** |
| **Depreciation** | | | | | | |
| At 1 April | 0 | 0 | 197 | 0 | 197 | 0 |
| Transfers in | 0 | 0 | 0 | 147 | 0 | 147 |
| (Disposals) | 0 | 0 | (26) | 0 | (26) | 0 |
| Impairment | 0 | 0 | (86) | 50 | (86) | 50 |
| At 31 March | **0** | **0** | **85** | **197** | **85** | **197** |
| **Carrying amount at 31 March** | **0** | **0** | **1,108** | **1,285** | **1,108** | **1,285** |

Non current assets held for sale comprise non current assets that are held for resale rather than for continuing use within the business.

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 10 IMPAIRMENTS

| | 2015 | | |
|---|---|---|---|
| | Property, Plant & Equipment | Intangibles | Total |
| | £000s | £000s | £000s |
| Total value of impairments for the period | 28,432 | 0 | 28,432 |
| Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement) | (6,560) | 0 | (6,560) |
| **Impairments charged to Statement of Comprehensive Net Expenditure** | **21,872** | **0** | **21,872** |

| | 2014 | | |
|---|---|---|---|
| | Property, Plant & Equipment | Intangibles | Total |
| Total value of impairments for the period | **2,097** | **0** | **2,097** |
| Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement) | **(62)** | **0** | **(62)** |
| **Impairments charged to Statement of Comprehensive Net Expenditure** | **2,035** | **0** | **2,035** |

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 11 INVENTORIES**

| | 2015 | | | 2014 | | |
|---|---|---|---|---|---|---|
| **Classification** | **Trust £000s** | **CTF £000s** | **Consolidated £000s** | **Trust £000s** | **CTF £000s** | **Consolidated £000s** |
| Pharmacy supplies | 1,835 | 0 | 1,835 | 1,625 | 0 | 1,625 |
| Building & engineering supplies | 70 | 0 | 70 | 73 | 0 | 73 |
| Fuel | 239 | 0 | 239 | 395 | 0 | 395 |
| Community care appliances | 225 | 0 | 225 | 218 | 0 | 218 |
| Laboratory materials | 184 | 0 | 184 | 157 | 0 | 157 |
| Stationery | 0 | 0 | 0 | 6 | 0 | 6 |
| Laundry | 55 | 0 | 55 | 61 | 0 | 61 |
| Other | 272 | 0 | 272 | 525 | 0 | 525 |
| **Total** | **2,880** | **0** | **2,880** | **3,060** | **0** | **3,060** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 12 TRADE RECEIVABLES AND OTHER CURRENT ASSETS

| | 2015 | | | | 2014 | | | |
|---|---|---|---|---|---|---|---|---|
| | Trust | CTF | Consolidation Adjustments | Consolidated | Trust | CTF | Consolidation Adjustments | Consolidated |
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| **Amounts falling due within one year** | | | | | | | | |
| Trade receivables | 10,013 | 0 | 0 | 10,013 | 11,333 | 0 | (47) | 11,286 |
| VAT receivable | 5,421 | 0 | 0 | 5,421 | 4,336 | 0 | 0 | 4,336 |
| Other receivables - not relating to fixed assets | 337 | 91 | (28) | 400 | 120 | 59 | 0 | 179 |
| **Trade and other receivables** | **15,771** | **91** | **(28)** | **15,834** | **15,789** | **59** | **(47)** | **15,801** |
| Prepayments and accrued income | 4,526 | 0 | 0 | 4,526 | 2,997 | 0 | (52) | 2,945 |
| **Other current assets** | **4,526** | **0** | **0** | **4,526** | **2,997** | **0** | **(52)** | **2,945** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 12 (continued) TRADE RECEIVABLES AND OTHER CURRENT ASSETS

| | Trust | CTF | 2015 Consolidation Adjustments | Consolidated | Trust | CTF | 2014 Consolidation Adjustments | Consolidated |
|---|---|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| **Amounts falling due after more than one year** | | | | | | | | |
| Trade receivables | 906 | 0 | 0 | 906 | 1,062 | 0 | 0 | 1,062 |
| **Trade and other receivables** | **906** | **0** | **0** | **906** | **1,062** | **0** | **0** | **1,062** |
| **TOTAL TRADE AND OTHER RECEIVABLES** | **16,677** | **91** | **(28)** | **16,740** | **16,851** | **59** | **(47)** | **16,863** |
| **TOTAL OTHER CURRENT ASSETS** | 4,526 | 0 | 0 | 4,526 | 2,997 | 0 | (52) | 2,945 |
| **TOTAL RECEIVABLES AND OTHER CURRENT ASSETS** | **21,203** | **91** | **(28)** | **21,266** | **19,848** | **59** | **(99)** | **19,808** |

The balances are net of a provision for bad debts of £6,095k (2014: £5,522k).

The Southern HSC Trust did not have any intangible current assets at 31 March 2015 or at 31 March 2014.

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 12.1 TRADE RECEIVABLES AND OTHER CURRENT ASSETS: INTRA-GOVERNMENTAL BALANCES

| | Amounts falling due within 1 year 2014/15 | Amounts falling due within 1 year 2013/14 | Amounts falling due after more than 1 year 2014/15 | Amounts falling due after more than 1 year 2013/14 |
|---|---|---|---|---|
| | £000s | £000s | £000s | £000s |
| Balances with other central government bodies | 8,085 | 6,752 | 906 | 1,062 |
| Balances with local authorities | 2 | 9 | 0 | 0 |
| Balances with NHS /HSC Trusts | 269 | 1,059 | 0 | 0 |
| Balances with public corporations and trading funds | 0 | 7 | 0 | 0 |
| **Intra-government balances** | 8,356 | 7,827 | 906 | 1,062 |
| Balances with bodies external to government | 12,004 | 10,919 | 0 | 0 |
| **Total receivables and other current assets at 31 March** | **20,360** | **18,746** | **906** | **1,062** |

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 13 CASH AND CASH EQUIVALENTS**

| | 2015 | | | 2014 | | |
|---|---|---|---|---|---|---|
| | Core Trust £000s | CTF £000s | Consolidated £000s | Core Trust £000s | CTF £000s | Consolidated £000s |
| Balance at 1st April | 2,168 | 98 | 2,266 | 96 | 88 | 184 |
| Net change in cash and cash equivalents | (593) | 77 | (516) | 2,072 | 10 | 2,082 |
| **Balance at 31st March** | **1,575** | **175** | **1,750** | **2,168** | **98** | **2,266** |

**The following balances at 31 March were held at**

| | 2015 | | | 2014 | | |
|---|---|---|---|---|---|---|
| | Core Trust £000s | CTF £000s | Consolidated £000s | Core Trust £000s | CTF £000s | Consolidated £000s |
| Commercial banks and cash in hand | 1,575 | 175 | 1,750 | 2,168 | 98 | 2,266 |
| **Balance at 31st March** | **1,575** | **175** | **1,750** | **2,168** | **98** | **2,266** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 14 TRADE PAYABLES AND OTHER CURRENT LIABILITIES

| | 2015 | | | | 2014 | | | |
|---|---|---|---|---|---|---|---|---|
| | Trust | CTF | Consolidation Adjustments | Consolidated | Trust | CTF | Consolidation Adjustments | Consolidated |
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| **Amounts falling due within one year** | | | | | | | | |
| Other taxation and social security | 11,342 | 0 | 0 | 11,342 | 10,516 | 0 | 0 | 10,516 |
| Trade capital payables - property, plant and equipment | 7,215 | 0 | 0 | 7,215 | 19,075 | 0 | 0 | 19,075 |
| Trade revenue payables | 16,377 | 0 | 0 | 16,377 | 16,299 | 0 | 0 | 16,299 |
| Payroll payables | 21,310 | 0 | 0 | 21,310 | 15,023 | 0 | 0 | 15,023 |
| Clinical negligence payables | 1,027 | 0 | 0 | 1,027 | 0 | 0 | 0 | 0 |
| VER payables | 538 | 0 | 0 | 538 | 1,146 | 0 | 0 | 1,146 |
| BSO payables | 1,449 | 0 | 0 | 1,449 | 2,193 | 0 | 0 | 2,193 |
| Other payables | 990 | 72 | (28) | 1,034 | 1,422 | 152 | (99) | 1,475 |
| Accruals and deferred income | 5,508 | 0 | 0 | 5,508 | 4,423 | 0 | 0 | 4,423 |
| **Trade and other payables** | **65,756** | **72** | **(28)** | **65,800** | **70,097** | **152** | **(99)** | **70,150** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 14.1 TRADE PAYABLES AND OTHER CURRENT LIABILITIES – INTRA-GOVERNMENT BALANCES

| | Amounts falling due within 1 year 2014/15 | Restated Amounts falling due within 1 year 2013/14 | Amounts falling due after more than 1 year 2014/15 | Amounts falling due after more than 1 year 2013/14 |
|---|---|---|---|---|
| | £000s | £000s | £000s | £000s |
| Balances with other central government bodies | 13,332 | 13,237 | 0 | 0 |
| Balances with local authorities | 0 | 0 | 0 | 0 |
| Balances with NHS /HSC Trusts | 1,434 | 2,044 | 0 | 0 |
| **Intra-government balances** | **14,766** | **15,281** | **0** | **0** |
| Balances with bodies external to government | **51,034** | **54,869** | **0** | **0** |
| **Total payables and other liabilities at 31 March** | **65,800** | **70,150** | **0** | **0** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 14.2 Loans

The Southern HSC Trust did not have any loans payable at 31 March 2015 or at 31 March 2014.

### NOTE 15 PROMPT PAYMENT POLICY

### NOTE 15.1 Public Sector Payment Policy – Measure of Compliance

The Department requires that Trusts pay their non HSC trade creditors in accordance with applicable terms and appropriate Government Accounting guidance. The Trust"s payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is:

| | 2015 Number | 2015 Value £000s | 2014 Number | 2014 Value £000s |
|---|---|---|---|---|
| Total bills paid | 172,426 | 224,108 | 114,589 | 208,090 |
| Total bills paid within 30 day or under agreed payment terms | 151,068 | 200,413 | 101,829 | 194,388 |
| % of bills paid within 30 day target or under agreed payment terms | **87.6%** | **89.4%** | **88.9%** | **93.4%** |
| Total bills paid within 10 day target | 121,745 | 170,785 | 65,694 | 152,379 |
| % of bills paid within 10 day target | **70.6%** | **76.2%** | **57.3%** | **73.2%** |

A fall in the compliance against the 30 day target occurred in 2014/15 due to the transition of the Trust"s payments function to BSO Accounts Payable Shared Service and the associated embedding of new processes.

### 15.2 The Late Payment of Commercial Debts Regulations 2002

| | £ |
|---|---|
| Amount of compensation paid for payment(s) being late | 216 |
| Amount of interest paid for payment(s) being late | 149 |
| **Total** | **365** |

This is also reflected as a fruitless payment in note 26.

New late payment legislation (Late Payment of Commercial Debts Regulations 2013) came into force on 16 March 2013. The effect of the new legislation is that a payment is normally regarded as late unless it is made within 30 days after receipt of an undisputed invoice.

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 16 PROVISIONS FOR LIABILITIES AND CHARGES – 2015**

| | Pensions relating to former directors | Pensions relating to other staff | Clinical negligence | CSR restructuring | Other | 2015 |
|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s |
| **Balance at 1 April 2014** | 262 | 3,949 | 21,504 | 0 | 4,550 | 30,265 |
| Provided in year | 27 | 165 | 9,662 | 0 | 686 | 10,540 |
| (Provisions not required written back) | 0 | 0 | (3,422) | 0 | (409) | (3,831) |
| (Provisions utilised in the year) | (15) | (199) | (6,912) | 0 | (630) | (7,756) |
| Cost of borrowing (unwinding of discount) | 3 | 49 | (151) | 0 | 0 | (99) |
| **At 31 March 2015** | **277** | **3,964** | **20,681** | **0** | **4,197** | **29,119** |

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 16 (continued) PROVISIONS FOR LIABILITIES AND CHARGES – 2015**

| **Comprehensive Net Expenditure Account charges** | **2015 £000s** | **2014 £'000** |
|---|---|---|
| Arising during the year | 10,540 | 5,714 |
| Reversed unused | (3,831) | (1,733) |
| Cost of borrowing (unwinding of discount) | (99) | (197) |
| **Total charge within Operating expenses** | **6,610** | **3,784** |

**Analysis of expected timing of discounted flows**

| | **Pensions relating to former directors** | **Pensions relating to other staff** | **Clinical negligence** | **CSR restructuring** | **Other** | **2015** |
|---|---|---|---|---|---|---|
| | **£000s** | **£000s** | **£000s** | **£000s** | **£000s** | **£000s** |
| Not later than one year | 14 | 202 | 3,911 | 0 | 1,104 | 5,231 |
| Later than one year and not later than five years | 61 | 833 | 7,670 | 0 | 1,953 | 10,517 |
| Later than five years | 202 | 2,929 | 9,100 | 0 | 1,140 | 13,371 |
| **At 31 March 2015** | **277** | **3,964** | **20,681** | **0** | **4,197** | **29,119** |

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 16 (continued) PROVISIONS FOR LIABILITIES AND CHARGES – 2014**

| | Pensions relating to former directors | Pensions relating to other staff | Clinical negligence | CSR restructuring | Other | 2014 |
|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s |
| **Balance at 1 April 2013** | 268 | 4,082 | 22,204 | 0 | 5,021 | 31,575 |
| Provided in year | 4 | 15 | 5,017 | 0 | 678 | 5,714 |
| (Provisions not required written back) | 0 | 0 | (1,046) | 0 | (687) | (1,733) |
| (Provisions utilised in the year) | (14) | (218) | (4,410) | 0 | (452) | (5,094) |
| Cost of borrowing (unwinding of discount) | 4 | 70 | (261) | 0 | (10) | (197) |
| **At 31 March 2014** | **262** | **3,949** | **21,504** | **0** | **4,550** | **30,265** |

Provisions have been made for 7 types of potential liability: Clinical Negligence, Employer's and Occupier's Liability, Early Retirement, Injury Benefit, Employment Law, Agenda for Change and Restructuring in connection with Transforming Your Care (TYC). The provision for Early Retirement and Injury Benefit relates to the future liabilities for the Trust based on information provided by the HSC Superannuation Branch. For Clinical Negligence, Employer's and Occupier's claims and Employment Law the Trust has estimated an appropriate level of provision based on professional legal advice. The costs of exit packages associated with TYC are included on the basis of the policy outlined in TYC and HR advice.

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 16 (continued) PROVISIONS FOR LIABILITIES AND CHARGES – 2014**

**Analysis of expected timing of discounted flows**

| | Pensions relating to former directors | Pensions relating to other staff | Clinical negligence | CSR restructuring | Other | 2014 |
|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s |
| Not later than one year | 14 | 222 | 4,299 | 0 | 1,594 | 6,129 |
| Later than one year and not later than five years | 60 | 930 | 7,442 | 0 | 1,976 | 10,408 |
| Later than five years | 188 | 2,797 | 9,763 | 0 | 980 | 13,728 |
| **At 31 March 2014** | **262** | **3,949** | **21,504** | **0** | **4,550** | **30,265** |

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 17 CAPITAL COMMITMENTS**

| | 2015 | 2014 |
|---|---|---|
| | £000s | £000s |
| Contracted capital commitments at 31 March not otherwise included in these financial statements | | |
| Property, Plant & Equipment | 11,139 | 29,263 |
| | **11,139** | **29,263** |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 18 COMMITMENTS UNDER LEASES

#### Note 18.1 Operating Leases

Total future minimum lease payments under non-cancellable operating leases are given in the table below for each of the following periods.

| Obligations under operating leases comprise | 2015 £000s | 2014 £000s |
|---|---|---|
| **Land & Buildings** | | |
| Not later than 1 year | 311 | 0 |
| Later than 1 year and not later than 5 years | 659 | 0 |
| | **970** | **0** |
| **Other** | | |
| Not later than 1 year | 477 | 757 |
| Later than 1 year and not later than 5 years | 797 | 2,445 |
| | **1,274** | **3,202** |

#### Note 18.2 Finance Leases

The Southern HSC Trust did not have any finance leases at 31 March 2015 or at 31 March 2014.

### NOTE 18 COMMITMENTS UNDER LESSOR AGREEMENTS

#### Note 18.3 Operating Leases

Total future minimum lease income under operating leases are given in the table below for each of the following periods.

**Obligations under operating leases issued by the Trust comprise:**

| | 2015 £000s | 2014 £000s |
|---|---|---|
| **Land and Buildings** | | |
| Not later than 1 year | 79 | 66 |
| Later than 1 year and not later than 5 years | 68 | 83 |
| Later than 5 years | 119 | 153 |
| | **266** | **302** |

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

## NOTE 19 COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENT CONTRACTS

### 19.1 Off balance sheet PFI and other service concession arrangements schemes

The Trust has no off balance sheet (SoFP) PFI and other service concession arrangement schemes.

### 19.2 On balance sheet (SoFP) PFI Schemes

The Trust has no on balance sheet (SoFP) PFI and other service concession arrangements schemes.

### 19.3 Charge to the Statement of Comprehensive Net Expenditure account and future commitments

As the Trust has no commitments there is no charge to the Statement of Comprehensive Net Expenditure account .

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

## NOTE 20 OTHER FINANCIAL COMMITMENTS

The Southern HSC Trust did not have any other financial commitments at either 31 March 2015 or 31 March 2014.

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 21 FINANCIAL GUARANTEES, INDEMNITIES AND LETTERS OF COMFORT

Because of the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within Trusts in creating risk than would apply to a non public sector body of a similar size, therefore Trusts are not exposed to the degree of financial risk faced by business entities. Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Trusts in undertaking activities. Therefore the HSC is exposed to little credit, liquidity or market risk.

The Southern HSC Trust has not entered into any quantifiable guarantees, indemnities or provided letters of comfort, at either 31 March 2015 or 31 March 2014.

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 22 CONTINGENT LIABILITIES**

Material contingent liabilities are noted in the table below, where there is a 50% or less probability that a payment will be required to settle any possible obligations. The amounts or timing of any outflow will depend on the merits of each case.

**Contingent Liabilities**

| | 2015 £000s | 2014 £000s |
|---|---|---|
| Clinical negligence | 2,045 | 2,317 |
| Public Liability | 5 | 0 |
| **Total** | **2,050** | **2,317** |

There are a number of active employment claims against the Trust. The expenditure which may arise from such claims cannot be determined as yet.

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 23 RELATED PARTY TRANSACTIONS

The Southern HSC Trust is an Arm"s length body of the Department of Health, Social Services and Public Safety and as such the Department is a related party with which the Southern HSC Trust has had various material transactions during the year

- Funding – Revenue Resource Limit of £565,143k (2014: £531,979k) of which the Non Cash Revenue Resource Limit is £44,590k (2014: £19,971k)

During the year, none of the board members, members of key management or other related parties has undertaken any material transactions with the Southern HSC Trust, apart from the transactions with the Department noted.

Interests in the following organisations were declared by non-executive, executive and other Directors and recorded on the Trust"s Register of Interests. Where an interest is disclosed, the related party is not involved directly in the award of a contract with the related organisation.

The interests declared and the value of the related party transactions was as follows:

Mrs Roberta Brownlee held two positions:

Board Member of Southern Education and Library Board. The value of payments made by the Southern HSC Trust was £Personal Information in respect of Social Service clients and funding for Healthy Eating Programmes delivered in the SELB region and £Personal Information was received by the Trust in respect of salary recharges for joint projects. The total number of transactions was 97 and the balance outstanding at year end was Personal Information.

School Governor of Personal Information redacted by the USI. The value of transactions between related parties was Personal Information (3 transactions) in respect of Social Service clients. Balance outstanding at year end: £Nil.

Mr Edwin Graham, Committee Member of Personal Information. The value of transactions between related parties was £Personal Information redacted by the USI (26 transactions) in respect of grant payments for respite services and day care. Balance outstanding at year end was £Personal Information.

Mrs Angela McVeigh, has a personal friend who is the owner of Personal Information redacted by the USI. The value of transactions between related parties was £Personal Information redacted by the USI (144 transactions) in respect of Domiciliary Care Provision. The balance outstanding at year end: £Personal Information redacted by the USI.

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 24 THIRD PARTY ASSETS**

The Southern HSC Trust held £7,184k cash at bank and in hand at 31 March 2015 (31 March 2014: £6,659k) which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts. A separate audited account of these monies is maintained by the Trust.

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 25 FINANCIAL PERFORMANCE TARGETS

### NOTE 25.1 Revenue Resource Limit

**The Southern HSC Trust is given a Revenue Resource Limit which it is not permitted to overspend**

The Revenue Resource Limit (RRL) for Southern HSC Trust is calculated as follows:

| | 2015 Total £000s | 2014 Total £000s |
|---|---|---|
| HSCB | 508,453 | 500,874 |
| PHA | 5,458 | 4,950 |
| SUMDE & NIMDTA | 6,772 | 6,567 |
| Non cash RRL (from DHSSPS) | 44,590 | 19,971 |
| Total agreed RRL | 565,273 | 532,362 |
| Adjustment for income received re Donations / Government grant / Lottery funding for non current assets | (130) | (383) |
| **Total Revenue Resource Limit to Statement Comprehensive Net Expenditure** | **565,143** | **531,979** |

### 25.2 Capital Resource Limit

The Trust is given a Capital Resource Limit (CRL) which it is not permitted to overspend.

| | 2015 Total £000s | 2014 Total £000s |
|---|---|---|
| Gross capital expenditure | 30,388 | 44,718 |
| Prepayment for Capital Scheme | 1,227 | 0 |
| (Receipts from sales of fixed assets) | (299) | (46) |
| Net capital expenditure | 31,316 | 44,672 |
| Capital Resource Limit | 31,596 | 45,482 |
| Underspend against CRL | (280) | (810) |

## SOUTHERN HSC TRUST

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### NOTE 25 FINANCIAL PERFORMANCE TARGETS

#### 25.3 Financial Performance Targets

The Southern HSC Trust is required to ensure that it breaks even on an annual basis by containing its net expenditure to within 0.25 % of the Revenue Resource Limit.

| | 2014/15 £000s | 2013/14 £000s |
|---|---|---|
| Net Expenditure | (565,102) | (535,136) |
| RRL | 565,143 | 531,979 |
| Surplus/(Deficit) against RRL | 41 | (3,157) |
| Break Even cumulative position(opening) | (2,138) | 1,019 |
| Break Even cumulative position (closing) | **(2,097)** | **(2,138)** |

**Materiality Test:**

| | 2014/15 % | 2013/14 % |
|---|---|---|
| Break Even in year position as % of RRL | 0.01% | (0.59)% |
| Break Even cumulative position as % of RRL | (0.37)% | (0.40)% |

The Southern HSC Trust reduced its cumulative overspend by achieving a small surplus in 2014/15. However, as the Trust continues to face a challenging financial position, it is unclear when the cumulative reported overspend will be recovered.

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 26 LOSSES & SPECIAL PAYMENTS**

| Type of Loss and Special Payment | | 2014/15 | | 2013/14 |
|---|---|---|---|---|
| | | CASES | £ | £ |
| **Cash Losses** | | | | |
| | Cash Losses – Theft, fraud etc. | 0 | 0 | 0 |
| | Cash Losses – Overpayments of salaries, wages and allowances | 0 | 0 | 0 |
| | Cash Losses – Other causes | 95 | 7,208 | 180 |
| | | **95** | **7,208** | **180** |
| **Claims abandoned** | | | | |
| | Waived or abandoned claims | 3 | 54,679 | 0 |
| | | **3** | **54,679** | **0** |
| **Administrative write-offs** | | | | |
| | Bad debts | 394 | 223,305 | 44,554 |
| | | **394** | **223,305** | **44,554** |
| **Fruitless payments** | | | | |
| | Late Payment of Commercial Debt | 9 | 365 | 9,167 |
| | Other Fruitless payments and constructive losses | 2 | 1,719 | 344,742 |
| | | **11** | **2,084** | **353,909** |
| **Stores Losses** | | | | |
| | Losses of accountable stores through any deliberate act | 1 | 1,800 | 0 |
| | Other stores losses | 0 | 65,598 | 28,051 |
| | | **1** | **67,398** | **28,051** |
| **Special Payments** | | | | |
| | Compensation payments | | | |
| | - Clinical Negligence | 89 | 6,911,848 | 4,410,217 |
| | - Public Liability | 17 | 101,395 | 102,005 |
| | - Employers Liability | 32 | 459,081 | 269,610 |
| | | **138** | **7,472,324** | **4,781,832** |
| | Ex-gratia payments | **5** | **3,571** | **745** |
| | **TOTAL** | **647** | **7,830,569** | **5,209,271** |

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

**NOTE 26 (continued) LOSSES & SPECIAL PAYMENTS**

**NOTE 26.1 Special Payments**

The Southern HSC Trust did not make any special payments or gifts during the financial year (2014: £Nil)

**NOTE 26.2 Other Payments**

The Southern HSC Trust did not make any other payments during the financial year (2014: £Nil)

**NOTE 26.3 Losses and Special Payments over £250,000**

| Losses and Special Payments over £250,000 | Number of Cases | 2014/15 £ | 2013/14 £ |
|---|---|---|---|
| **Special Payments** | | | |
| Clinical Negligence Cases | 3 | 2,989,600 | 3,084,994 |
| **TOTAL** | **3** | **2,989,600** | **3,084,994** |

**SOUTHERN HSC TRUST**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015**

## NOTE 27 POST BALANCE SHEET EVENTS

There are no post balance sheet events having a material effect on the accounts.

## DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 25 June 2015.

# ACCOUNT OF MONIES HELD ON BEHALF OF PATIENTS/RESIDENTS

## YEAR ENDED 31 MARCH 2015

**SOUTHERN HSC TRUST**

**ACCOUNT OF MONIES HELD ON BEHALF OF PATIENTS/RESIDENTS**

**YEAR ENDED 31 MARCH 2015**

**STATEMENT OF TRUST'S RESPONSIBILITIES IN RELATION TO PATIENTS/RESIDENTS MONIES**

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, the Trust is required to prepare and submit accounts in such form as the Department may direct.

The Trust is also required to maintain proper and distinct accounting records and is responsible for safeguarding the monies held on behalf of patients/residents and for taking reasonable steps to prevent and detect fraud and other irregularities.

**SOUTHERN HEALTH AND SOCIAL CARE TRUST**

**THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY**

I certify that I have audited the Southern Health and Social Care Trust's account of Monies held on behalf of Patients/ Residents for the year ended 31 March 2015 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended.

**Respective responsibilities of the Trust and auditor**

As explained more fully in the Statement of Trust Responsibilities in relation to Patients' and Residents' Monies, the Trust is responsible for the preparation of the account in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health, Social Services and Public Safety's directions made thereunder. My responsibility is to audit, certify and report on the account in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

**Scope of the audit of the account**

An audit involves obtaining evidence about the amounts and disclosures in the account sufficient to give reasonable assurance that the account is free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Southern Health and Social Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Southern Health and Social Care Trust; and the overall presentation of the account. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited Patient's and Resident's Monies account and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the financial transactions recorded in the account conform to the authorities which govern them.

**Opinion on regularity**

In my opinion, in all material respects the financial transactions recorded in the account conform to the authorities which govern them.

**Opinion on account**

In my opinion:

- the account properly presents the receipts and payments of the monies held on behalf of the patients and residents of the Southern Health and Social Care Trust for the year ended 31 March 2015 and balances held at that date; and

- the account has been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health, Social Services and Public Safety directions issued thereunder.

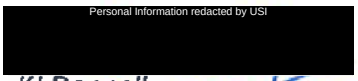
**Matters on which I report by exception**

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the account is not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with Department of Finance and Personnel's guidance.

**Report**

I have no observations to make on this account.




*KJ Donnelly*
*Comptroller and Auditor General*
*Northern Ireland Audit Office*
*106 University Street*
*Belfast*
*BT7 1EU*

25 *June 2015*

**SOUTHERN HSC TRUST**

**ACCOUNT OF MONIES HELD ON BEHALF OF PATIENTS/RESIDENTS**

**YEAR ENDED 31 MARCH 2015**

| Previous Year | | | | |
|---|---|---|---|---|
| | **RECEIPTS** | | | |
| **£** | Balance at 1 April 2014 | | **£** | **£** |
| 4,761,062 | 1. | Investments (at cost) | 5,794,912 | |
| 1,285,295 | 2. | Cash at Bank | 860,443 | |
| 6,839 | 3. | Cash in Hand | 3,936 | 6,659,291 |
| 6,053,196 | | | | |
| 2,672,749 | Amounts Received in the Year | | 2,222,976 | |
| 46,809 | Interest Received | | 54,301 | 2,277,277 |
| **8,772,754** | **TOTAL** | | | **8,936,568** |
| | **PAYMENTS** | | | |
| 2,113,463 | Amounts paid to or on Behalf of Patients/Residents | | | 1,752,592 |
| | Balance at 31 March 2015 | | | |
| 5,794,912 | 1. | Investments (at Cost) | 6,249,213 | |
| 860,443 | 2. | Cash in Bank | 930,592 | |
| 3,936 | 3. | Cash in Hand | 4,171 | |
| 6,659,291 | | | | 7,183,976 |
| **8,772,754** | **TOTAL** | | | **8,936,568** |

| Cost Price £ | Schedule of investments held at 31 March 2015 | Nominal Value £ | Cost Price £ |
|---|---|---|---|
| 5,794,912 | Bank of Ireland | 6,249,213 | 6,249,213 |

I certify that the above account has been compiled from and is in accordance with the accounts and financial records maintained by the Trust.

**Director of Finance** Personal Information redacted by USI

**Date** 11/10/2015.

I certify that the above account has been submitted to and duly approved by the Board.

**Interim Chief Executive** Personal Information redacted by USI

**Date** 11/6/2015

ISBN Number

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**Appendix 1**

## Schedule of Reporting to Governance Committee 2014 - 2015

| Governance Area | Report details | Lead Person | Frequency | Date presented |
|---|---|---|---|---|
| **Clinical and Social Care Governance** | • Incidents and Complaints Management Report and Update on Ombudsman Cases | ADC&SCG | Quarterly | 13th May 2014<br>9th September 2014<br>9th December 2014<br>3rd February 2015 |
| | • SAI Report | ADC&SCG | | 13th May 2014<br>9th September 2014<br>9th December 2014<br>3rd February 2015 |
| **Risk** | Corporate Risk Register | Chief Executive/ Board Assurance Manager | Quarterly | 13th May 2014<br>9th September 2014<br>9th December 2014<br>3rd February 2015 |
| **Professional Governance** | Nursing and Allied Health Professionals | Executive Director of Nursing | Six-monthly | 9th September 2014<br>3rd February 2015 |
| | Social Work and Social Care Governance Report | Executive Director of Social Work | Six-monthly | 13th May 2014 |
| | Medical Director Report (including HCAI; Patient Safety Interventions; Medical Workforce; Litigation) | Medical Director | Quarterly | 13th May 2014<br>9th September 2014<br>3rd February 2015 |

| | | | | |
|---|---|---|---|---|
| **Medicines Governance** | Medicines Governance Report | Director of Pharmacy | Quarterly | 13th May 2014<br>9th September 2014<br>9th December 2014<br>3rd February 2015 |
| **Information Governance** | • Freedom of Information, Environmental Information and Subject Access Requests<br>• SIRO Information Governance Report | Director of P&R<br>" | Quarterly<br>Annually | 13th May 2014<br>9th September 2014<br>9th December 2014<br>3rd February 2015<br>9th September 2014 |
| **External/Internal Inspections/Independent Reviews** | • RQIA Reviews and Inspections Status Update | Directors | Quarterly | 13th May 2014<br>9th September 2014<br>9th December 2014<br>3rd February 2015 |
| **Controls Assurance Standards** | Report on Compliance | Chief Executive/ Board Assurance Manager | Annually | 13th May 2014 |
| **Governance Statement and Mid Year Assurance Statement** | • Draft Governance Statement<br>• Draft Mid Year Assurance Statement | Chief Executive | Annually | 13th May 2014 |
| **Health and Safety Governance** | Health and Safety Report | Director of HR & Organisational Development | Annually | 9th September 2014 |

| | | | | |
|---|---|---|---|---|
| **Service User Involvement** | Update from Patient and Client Experience Committee | Mr E. Graham | Quarterly | 13th May 2014<br>9th September 2014<br>9th December 2014<br>3rd February 2015 |
| **Leadership Walkabouts** | Summary Report for 1.1.2014 – 30.6.2014<br><br>Summary Report for 1.7.2014 – 31.12.14 | Dr Mullan | Six Monthly | 9th September 2014<br><br>5th February 2015 |
| Non-Executive **Director's visits to Children's Homes** Report | Summary Report for 1.1.2014 – 30.9.2014 | Dr Mullan | Six Monthly | 9th December 2014 |
| **Effectiveness of Governance Committee** | • Self-Assessment<br><br>• Review and update the Committee's Terms of Reference<br><br>• Draft Annual Report of the Governance Committee | Members<br><br>Members<br><br>Committee Chair/Board Assurance Manager | Annually<br><br>Annually/as required<br><br>Annually | 9th September 2014<br><br>13th May 2014<br>3rd February 2015<br><br>9th September 2014 |

| | | | | |
|---|---|---|---|---|
| **Other reports presented for assurance during 2014/15** | Accountability Report for Standards and Guidelines | Chief Executive | Annually | 9th September 2014 |
| | Carers Action Plan | Non Executive Director/Director of Older People and Primary Care | Six Monthly | 13th May 2014<br>9th September 2014 |
| | Annual Mortality Review, Oct 2012 – Sept 2013<br><br>Jan 2013 – Dec 2013 | Medical Director | Annually | 9th September 2014<br><br>3rd February 2015 |
| | NI Organ Donation Report | Director of Acute Services | Annually | 9th September 2014 |
| | Hip Fractures Database | Director of Acute Services | As available | 9th December 2014 |
| | Report of PHA Quality Assurance Visit to Cervical Screening Services SHSCT | Director of Acute Services | " | 3rd February 2015 |
| | Safer Births and Peri-Natal Report | Director of Acute Services | " | 3rd February 2015 |

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Accountability Report for Standards & Guidelines

(01 January 2012 – 30 April 2012)

***Report Author:*** ***Mrs Caroline Beattie***
***Patient Safety & Quality Manager – Acute Services***

***Date of submission:*** ***10 May 2012***

# Accountability Report for Standards & Guidelines

(01 January 2012 – 30 April 2012)

## 1. *Summary Statement*

From 01 January 2012 – 30 April 2012 the SHSCT has received 57 new standards and guidelines from the DHSSPS or other external agencies.
*Table 1* provides a summary of these by title, identification of the external agency from which they were issued, and a breakdown of relevance to the Directorates within the organisation.

Of these 57 newly issued guidelines, 28 have been issued with a requirement to provide an assurance response back to the HSC Board within a specified timescale. Where required, short life working groups have been established to take forward the recommendations outlined within the guidance and processes have been established to ensure Director and SMT approval of the assurance response / action plan prior to issue to relevant external agency.
*Table 2* provides a summary of this work.

In addition to this work, 4 standards/guidelines that were issued prior to 1 January 2012 had assurance response deadlines dates during the period from 01 January 2012 to 30 April 2012. Three out of the four assurance responses were sent back on time to the HSC Board or external agency with a measure of compliance and an action plan indicating (were necessary) the work that is required to achieve full compliance status.
*Table 3* provides an overview of this work and includes, where relevant, any constraints that may limit the Trust's ability to achieve this.

Since 01 April 2010 until 31 December 2011 a total of 33 assurance responses have been sent back to the HSC Board or external agency with a measure of compliance. At the time of reporting all of these assurances indicated a partial level of compliance and the response was accompanied by an action plan that outlined the work that was required to achieve full compliance status. On-going and significant work continues to be undertaken to ensure that full compliance is achieved and *Table 4* provides an overview of this work and includes, where relevant, any constraints that may limit the Trust's ability to achieve this.

Table 5 provides a summary of current position on Standards & Guidelines that have been issued from 01 January 2011 to 31 December 2011 and do not have a specified timescale for assurance to the HSC Board / external agency. Work is on-going to provide a compliance summary for the 29 standards and guidelines which have been issued from 01 January 2012.

***New SHSCT Processes for the Management of Standards & Guidelines***

As evidenced within this report, standards and guidelines can be issued from a variety of sources and are received by a number of regional bodies for regional endorsement. Such external agencies include the HSC Board, Public Health Agency (PHA) and Safety & Quality Unit at the DHSSPS. These agencies disseminate these standards and guidelines to the HSC Trust's for action and with a requirement that an assurance will be provided to confirm that the required recommendations have been embedded within local practice.

In recent years the volume of standards and guidelines has become increasingly challenging for providers and commissioners to manage within existing risk management and clinical governance arrangements. As a consequence regional discussions have been undertaken to agree the most effective and efficient process for disseminating, implementing and assuring these standards and guidelines.

On 26 September 2011 the Chief Medical Officer issued a circular (reference HSC (SQSD) 04/11) to outline the new processes for the Endorsement, Implementation, Monitoring and Assurance of NICE Guidelines and NICE Technology Appraisals in Northern Ireland. These new processes came into effect from 28 September 2011. All of the 23 NICE Technology Appraisals that are outlined in Table 1 have been managed in line with these new regional requirements.

On 28 September 2011 Dr Carolyn Harper at the PHA issued a draft regional consultation paper which outlined the proposed systematic and integrated approach by these external agencies regarding the issue and management of safety alerts.

In response to both of these circulars the Trust has reviewed it's arrangements for the management of standards and guidelines and as a consequence of this review the Trust's Standards & Guidelines Prioritisation and Risk Review Group has been created. The inaugural meeting of this group was held for 19 April 2012 and Mrs Deborah Burns, Assistant Director for Clinical & Social Care Governance is the chairperson of this forum.
The aim of this group is to provide a forum to ensure that the Trust has in place a systematic and integrated approach for the implementation, monitoring and assurance of clinical standards and guidelines. *Appendix 1* of this report

outlines the agreed Terms of Reference for the Standards & Guidelines Prioritisation and Risk Review Group.

In order to provide the Trust with clear guidance on the communication pathways and approval processes for standards and guidelines an algorithm was developed. This information is presented within *Appendix 2* of this report. In addition a risk assessment proforma (*Appendix 3*) has also been developed to record the outcomes / decision making of the Standards & Guidelines Prioritisation and Risk Review Group following the review of all endorsed standards and guideline that have been sent to the Trust for implementation.

| TABLE 1: Newly Issued Standards & Guidelines from period 01 January 2012 to 30 April 2012 | | | | |
|---|---|---|---|---|
| ***Type*** | ***No*** | ***Relevance per Directorate*** | ***Reference (if applicable)*** | ***Title*** |
| Chief Medical Officer | 16 | Acute Services | HSS(MD) 01-2012 | PiP Silicone gel breast implants (update on HSS(MD)32/2011) |
| | | Acute Services | HSS(MD) 02-2012 | PiP Silicone gel breast implants (update on HSS(MD)01/2012) |
| | | All Op Directorates | HSS (MD) 03-2012 | Legionnaires' Disease Cluster Associated with Costa Blanca, Spain |
| | | Acute Services / CYP | HSS (MD) 04-2012 | Interim Guidance on Pseudomonas and Neonatal Units |
| | | All Op Directorates | HSS (MD) 05/2012 | Vitamin D - Advice on Supplements for at Risk Groups |
| | | Acute Services / CYP | HSS (MD) 06/2012 | Water Sources and Potential for Pseudomanas Aeruginosa Infection from Taps and Water Systems |
| | | Acute Services | HSS (MD) 07/2012 | Suspension of Marketing Authorisation: Teva and Numark Levothyroxine 100 microgram tablets |
| | | Acute Services | HSS (MD) 08/2012 | PIP Silicone Gel Breast Implants - Update Guidance |
| | | All Op Directorates | HSS (MD) 09/2012 | Severe Reactions To Potentially Illicit Diazepam |
| | | Acute Services | HSS (MD) 10/2012 | Metal on Metal Hip Replacement |
| | | Acute Services | HSS (MD) 11/2012 | PIP Silicone Gel Breast Implants Supplied before 2001 - updated guidance |
| | | All Op Directorates | HSS (MD) 12/2012 | Best practice on Screening for MRSA colonisation' (HSS MD 12/2008) |

| | | | | |
|---|---|---|---|---|
| | | Acute Services | HSS (MD) 13/2012 | NICRN Diabetes Portfolio Template |
| | | Acute Services | HSS (MD) 14/2012 | Use of imported fresh frozen plasma (FFP) to treat those born on or after 1 January 1996 and adult patients with TTP. |
| | | All Op Directorates | HSS (MD) 15/2012 | Guidance on Death, Stillbirth and Cremation Certification |
| | | Acute Services / CYP | HSS MD 16-2012 | Pseudomonas updates interim report of the independent review of Pseudomonas infection in neonatal units. Water sources and potential Pseudomonas aeruginosa contamination of taps and water systems |
| DHSS&PS Publications | 4 | OPPC | N/A | Care Standards for Day Care Setting |
| | | All Op Directorates | N/A | Supporting Safer Services 2011 - Addendum |
| | | All Op Directorates | N/A | Review of Early Warning System |
| | | All Op Directorates | PCCD 01/12 | Arrangements for handling outstanding debtors to the health service in NI and co-operative work with the UK Border Agency |
| HSCB circulars | 4 | Acute & OPPC | Reminder of assurance processes for Safety Alerts - HSS MD 13/12, HSS MD 14/12 and HSC SQSD 02/12 | |
| | | All Op Directorates | NPSA Alerts – request for an updated assurance position to a number of NPSA alerts issued in 2008/9 | |
| | | All Op Directorates | HSCB Arrangements for the consideration of requests for care and/or treatment on behalf of individual patients | |
| | | All Op Directorates | Notification to Practices on Death of Hospital Patients | |
| NCEPOD | 1 | Acute Services & CYP | "Are We There Yet?" A review of organisational and clinical aspects of children's surgery | |

| | | | | |
|---|---|---|---|---|
| NPSA Alert | 1 | All Op Directorates | HSC 02/2012 | Harm from flushing of nasogastric tubes before confirmation of placement |
| NICE Technology Appraisals | 23 | | HSCB (NICE) 01 /2011 NICE TA 75<br>HSCB (NICE) 02/2011 NICE TA 166<br>HSCB (NICE) 03/2011 NICE TA 169<br>HSCB (NICE) 04/2011 NICE TA 187<br>HSCB (NICE) 05/2011 NICE TA 188<br>HSCB (NICE) 06/2011 NICE TA 190<br>HSCB (NICE) 07/2011 NICE TA 193<br>HSCB (NICE) 08/2011 NICE TA 195<br>HSCB (NICE) 09/2011 NICE TA 198<br>HSCB (NICE) 10/2011 NICE TA 200<br>HSCB (NICE) 11/2011 NICE TA 208<br>HSCB (NICE) 12/2011 NICE TA 215<br>HSCB (NICE) 13/2011 NICE TA 216<br>HSCB (NICE) 14/2011 NICE TA 221<br>HSCB (NICE) 15/2011 NICE TA 222<br>HSCB (NICE) 16/2011 NICE TA 223<br>HSCB (NICE) 17/2011 NICE TA 226<br>HSCB (NICE) 18/2011 NICE TA 227<br>HSCB (NICE) 19/2011 NICE TA 228<br>HSCB (NICE) 20/2011 NICE TA 229<br>HSCB (NICE) 21/2011 NICE TA 230<br>HSCB (NICE) 22/2011 NICE TA 232<br>HSCB (NICE) 23/2011 NICE TA 234 | Peginterferon alfa and ribavirin for the treatment of chronic hepatitis C Hearing Impairment – cochlear implants for severe to profound deafness in children /adults<br>Sunitinib for the Treatment of Renal Cell Carcinoma<br>Infliximab (review) and adalimumab for the treatment of Crohn's<br>Human growth hormone (somatropin) for the treatment of growth failure in children<br>Pemetrexed for the maintenance treatment of non-small-cell lung cancer<br>Rituximab for the treatment of Relapsed Chronic Lymphocytic Leukaemia<br>Adalimumab, Etanercept, Infliximab, Rituximab and Abatacept for Treatment of RA<br>Tocizilumab for rheumatoid arthritis<br>Peginterferon alfa and ribavirin for the treatment of chronic hepatitis<br>Trastuzumab for the treatment of HER2-positive metastatic gastric cancer<br>Pazopanib for the First-line Treatment of Advanced and/or Metastatic Renal Cell Carcinoma<br>Bendamustine for the treatment of chronic lymphocytic leukaemia<br>Romiplostim for the treatment of chronic immune or idiopathic thrombocytopenic purpura<br>Trabectedin for the treatment of relapsed ovarian cancer<br>Cilostazol, naftidrofyryl oxalate, pentoxifylline and inositol nicotinate for the treatment of PVD<br>Rituximab for the maintenance treatment of follicular non-Hodgkin's lymphoma<br>Erlotinib monotherapy for maintenance treatment of non-small-cell lung cancer<br>Bortezomib and Thalidomide for the first-line treatment of multiple myeloma<br>Dexamethasone intravitreal implant for the treatment of macular oedema caused by retinal vein occlusion<br>Bivalirudin for the treatment of ST-segment elevation myocardial infarction (STEMI)<br>Retigabine for the adjunctive treatment of adults with partial onset seizures in epilepsy<br>Abatacept for the treatment of rheumatoid arthritis only after the failure of conventional disease-modifyinganti-rheumatic drugs |

| | | | | |
|---|---|---|---|---|
| Public Health Agency | 3 | Acute Services / CYP | N/A | Guideline for prevention and control of group A streptococcal infection in acute healthcare and maternity settings in the UK |
| | | Acute Services | N/A | New born Blood Spot Screening for Sickle Cell Disorders commencing 1 March 2012 |
| | | Acute Services | N/A | Serious Incident in relation to Antenatal Infection Screening |
| Pharmacy (regional groups) | 4 | All Op Directorates | DH1/12/104921 | Amendments to the Misuse of Drugs Regulations (Northern Ireland |
| | | Acute Services | Regional Medicines Governance Forum | Action to minimise the risks with Bucal Midazolam Preparations |
| | | Acute Services | Regional Pharmaceutical Quality Assurance Service | Pharmacy Aseptic Services Audit Report |
| | | Acute Services / OPPC | Interface Pharmacist Network | Neurology Shared Care Guidelines available |
| RQIA | 1 | | MD/ER | Assessments for Admission to Nursing Homes |
| ***TOTAL*** | **57** | | | |

***TABLE 2: Responsiveness & Compliance:***

***Standards & Guidelines that have been issued from 01 January 2012 to 31 April 2012 and have a specified timescale for assurance to the HSC Board / external agency (n=28)***

***Compliance Code:*** 100% Compliance | 70-99% Compliance | 40-69% Compliance | 0-39% Compliance | Pending | Not Applicable

| Title | Deadline Date for responding | Responsiveness | Level of Compliance at time of reporting | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
|---|---|---|---|---|---|
| ***NCEPOD "Are We There Yet?"*** A review of organisational and clinical aspects of children's surgery | 11/06/2012 | Pending but within deadline date | Pending | Short life working group has been established with representatives from CYP & Acute Services. Meeting held on 26 April 2012 and following discussions an action plan is currently being developed. | To be confirmed |
| ***Chief Medical Officer Letter*** NICRN Diabetes Portfolio Template | 30/03/2012 | 20/03/2012 (on time) | N/A | The DHSSPS has recently commissioned an evaluation of the impact of HSC R&D funding and as part of this review there was a need for the SHSCT to confirm at income has been achieved by each Trust form its participation in clinical trials. Trust response provided | |
| ***HSC (SQSD) 2/2012*** NPSA Alert: Harm from flushing of nasogastric tubes before confirmation of placement | 03/09/2012 | Pending but within deadline date | Pending | This work has been integrated into the objectives of the short life working group that was established to take forward the NPSA alert issued in March 2011. This work is led by Lead Gastroenterologist (AM) | To be confirmed |

| | | | | | |
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| ***Letter from the Chief Executive of the HSCB***<br>Update on compliance for 2008/9 issued NPSA alerts namely:<br><br>**NPSA/2009/RRR012:** ***Reducing Risk of harm from oral bowel cleansing solutions*** - issued via Safety Alert Broadcast System (SABs) on 23 March 2009.<br><br>**NPSA/2009/SPN001:** ***Risks of Retained throat packs after surgery*** - issued via the Safety Alert Broadcast System (SABs) on 28 May 2009.<br><br>**NPSA/2008/RRR009:** ***Avoiding wrong side burr holes/ Craniotomy*** - issued via the Safety Alert Broadcast System (SABs) on 19 November 2008.<br><br>**NPSA/2008/RRR010:** ***Resuscitation in Mental Health and Learning Disability settings*** - issued via SABs on 12 December 2008.<br><br>**NPSA/2009/RRR001:** ***Mitigating surgical risks in patients undergoing hip arthroplasty for fractures of the proximal femur*** - issued via SABs on 19 March 2009.<br><br>**NPSA/2009/RRR002:** ***Female urinary catheters causing harm to adult males*** - issued via SABs on 7 May 2009. | 18/05/2012 | Pending but within deadline date | Pending | Each of the issued NPSA alerts have been sent to the relevant operational teams to update the action plan and identify any limiting factors impeding the Trust's ability to achieve full compliance against the recommendations | To be confirmed following update of action plans |

| Title | Deadline Date for responding | Responsiveness | Level of Compliance at time of reporting | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| ***Public Health Agency Letter*** Serious Incident in relation to Antenatal Infection Screening | 27/04/2012 | 27/04/2012 | Full against letter requirements | This PHA letter partially relates to the previously issued Chief medical Officer circular (reference 43/2010) | Full compliance is anticipated once action plan is completed |
| **HSCB (NICE) 1/2011** NICE TA 75 - Peginterferon alfa and ribavirin for the treatment of chronic hepatitis C (to be issued with TA200 | 05/04/2012 | 05/04/2012 | **N/A to SHSCT** | | |
| **HSCB (NICE) 2/2011** NICE TA 166 - Hearing Impairment – cochlear implants for severe to profound deafness in children and adults | 05/04/2012 | 05/04/2012 | **N/A to SHSCT** | | |
| **HSCB (NICE) 3/2011** NICE TA 169 - Sunitinib for the Treatment of Renal Cell Carcinoma | 05/04/2012 | 05/04/2012 | **N/A to SHSCT** | | |
| **HSCB (NICE) 4/2011** NICE TA 187 - Infliximab (review) and adalimumab for the treatment of Crohn's disease (*Includes a review of NICE Technology Appraisal guidance 40* | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |

| Title | Deadline Date for responding | Responsiveness | Level of Compliance at time of reporting | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| **HSCB (NICE) 5/2011** NICE TA 188 - Human growth hormone (somatropin) for the treatment of growth failure in children (review) | 05/04/2012 | 05/04/2012 | **N/A to SHSCT** | | |
| **HSCB (NICE) 6/2011** NICE TA 190 - Pemetrexed for the maintenance treatment of non-small-cell lung cancer | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |
| **HSCB (NICE) 7/2011** NICE TA 193 - Rituximab for the treatment of Relapsed Chronic Lymphocytic Leukaemia | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |
| **HSCB (NICE) 8/2011** NICE TA 195 - Adalimumab, Etanercept, Infliximab, Rituximab and Abatacept for Treatment of Rheumatoid Arthritis After Failure of a TNF Inhibitor | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |
| **HSCB (NICE) 9/2011** NICE TA 198 - Tocizilumab for rheumatoid arthritis | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |

| Title | Deadline Date for responding | Responsiveness | Level of Compliance at time of reporting | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| **HSCB (NICE) 10/2011** NICE TA 200 - Peginterferon alfa and ribavirin for the treatment of chronic hepatitis C *(to be issued in conjunction with TA75)* | 05/04/2012 | 05/04/2012 | **N/A to SHSCT** | | |
| **HSCB (NICE) 11/2011** NICE TA 208 Trastuzumab for the treatment of HER2-positive metastatic gastric cancer | 05/04/2012 | 05/04/2012 | **N/A to SHCST** | | |
| **HSCB (NICE) 12/2011** NICE TA 215 Pazopanib for the First-line Treatment of Advanced and/or Metastatic Renal Cell Carcinoma | 05/04/2012 | 05/04/2012 | **N/A to SHSCT** | | |
| **HSCB (NICE) 13/2011** NICE TA 216 Bendamustine for the treatment of chronic lymphocytic leukaemia | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |
| **HSCB (NICE) 14/2011** NICE TA 221 Romiplostim for the treatment of chronic immune or idiopathic thrombocytopenic purpura | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |

| Title | Deadline Date for responding | Responsiveness | Level of Compliance at time of reporting | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| **HSCB (NICE) 15/2011** NICE TA 222 Trabectedin for the treatment of relapsed ovarian cancer | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |
| **HSCB (NICE) 16/2011** NICE TA 223 Cilostazol, naftidrofyryl oxalate, pentoxifylline and inositol nicotinate for the treatment of intermittent claudication in people with peripheral arterial disease | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |
| **HSCB (NICE) 17/2011** NICE TA 226 Rituximab for the maintenance treatment of follicular non-Hodgkin's lymphoma following response to first-line chemotherapy | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |
| **HSCB (NICE) 18/2011** NICE TA 227 Retigabine for the adjunctive treatment of adults with partial onset seizures in epilepsy with and without secondary generalisation | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |
| **HSCB (NICE) 19/2011** NICE TA 228 Bortezomib and Thalidomide for the first-line treatment of multiple myeloma | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |

| Title | Deadline Date for responding | Responsiveness | Level of Compliance at time of reporting | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| **HSCB (NICE) 20/2011** NICE TA 230 Bivalirudin for the treatment of ST-segment elevation myocardial infarction (STEMI) | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |
| **HSCB (NICE) 21/2011** NICE TA 232 Retigabine for the adjunctive treatment of adults with partial onset seizures in epilepsy with and without secondary generalisation | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |
| **HSCB (NICE) 22/2011** NICE TA 234 Abatacept for the treatment of rheumatoid arthritis only after the failure of conventional disease-modifying anti-rheumatic drugs | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |
| **HSCB (NICE) 23/2011** NICE TA 229 Dexamethasone intravitreal implant for the treatment of macular oedema caused by retinal vein occlusion (RVO) | 05/04/2012 | 05/04/2012 | **FULL** | On-going Monitoring and review | |

***TABLE 3: Responsiveness & Compliance***

***Standards & Guidelines that have been issued from 01 April 2010 and had a specified timescale for assurance to the HSC Board / external agency during period 01 January 2012 to 30 April 2012 (n = 4)*** ***(NOTE:*** ***This report also includes 2 additional guidelines have a Deadline Date for Assurance of 13/06/2012 and 31/08/2012)***

***Compliance Code:*** 100% Compliance | 70-99% Compliance | 40-69% Compliance | 0-39% Compliance | Pending | Not Applicable

| Title | Deadline Date for assurance | Responsiveness | Level of Compliance at time of reporting | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| ***HSC (PHD) Communication 03/2011*** Testing - FFP3 Respirators | 24/02/2012 | Delayed (27/02/2012) | Not requested by DHSSPS | Update provided by Medical Director on details of FFP3 products which are achieving positive fit testing results and a brief assessment of fit testing progress | N/A |
| ***HSC (SQSD) 05/2011*** Keeping new born babies with a family history of MCADD safe in the first hours and days of life | 10/05/2012 | On Time (10/05/2012) | Full - 100% | Collaborative work has been undertaken between IWMH division and CYP Directorate and a new care pathway for the management of MCADD and new Trust procedures for new born bloodspot screening programme have been developed and implemented. | Full compliance has been achieved |
| **S&Q 02-2011** Reducing the Risks associated with patients taking medication in hospital other than that prescribed as an inpatient | 05/02/2012 | On Time (03/02/2012) | Partial - 90% | In order to ensure the accuracy of the patients' medications that are recorded on admission to hospital the use of the Emergency Care Summary is being reviewed with a view to | Full compliance is anticipated once action plan is completed |

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| | | | | increasing its usage, particularly within the Emergency Departments and Medical Admission wards.<br>There is also on-going implementation of the Integrated Medicines Management system across the hospital in-patient areas | |
| **Implementation of CMACE recommendations**<br>Draft commissioning plan 2011/12 | 31/03/2012 | On Time (29/03/2012) | PARTIAL – 70% | A self-assessment against the three referenced documents has been undertaken and some actions include the need for the maternal weight and BMI calculation to be completed at the 35 week antenatal clinic visit and recorded within the maternity hand held records. A communication plan is to be developed to advise staff of this new requirement.<br>If feasible the maternal weight and BMI will be completed on admission to the delivery suite. To facilitate this recording requirement bariatric weigh scales have been ordered for Delivery Suites on both the CAH and DHH sites | Full compliance is anticipated once action plan is completed |
| ***HSC (SQSD) 06/2011*** - Minimising Risks of Mismatching Spinal, Epidural and Regional Devices with Incompatible Connectors | 13/06/2012 | Pending but within deadline date | Pending | Dr Gavin Lavery, Clinical Director, Safety Forum is establishing a time-limited group with Trusts, BSO and as necessary, Health Estates, to develop a regional solution through procurement of a standard product(s), | This will be dependent on the outcomes from the regional working group |

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| | | | | or if that is not feasible, then through other means. The group will complete its work by October 2012 and will provide an update in July 2012. Dr Lavery will contact Trust Clinical Directors for Anaesthetics to seek a nomination from each Trust and the group will liaise with others as necessary to complete its work | |
| ***HSC (SQSD) 03/11 NPSA / 2011 / PSA 003*** The adult patient's passport to safer use of insulin | 31/08/2012 | Pending but within deadline date | Pending | Multi-directorate / multidisciplinary working group has been established and action plan is being developed | Still to be determined |

***TABLE 4: Responsiveness & Compliance***

***Standards & Guidelines that have had a specified timescale for assurance to the HSC Board / external agency during the period from 01/04/2010 to 30/04/2012 (n=33)***

***Compliance Code:*** 100% Compliance | 70-99% Compliance | 40-69% Compliance | 0-39% Compliance | Pending | Not Applicable

| Title | Deadline Date for assurance | Responsiveness | Level of Compliance as denoted at December 2011 | Level of Compliance as denoted at April 2012 | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| **HSC (SQSD) 55/09**<br>**NPSA / 2009 / RRR 005**<br>Minimising the risks of suprapubic catheter insertion | 29/04/2010 | Delayed<br>Response provided on 16/07/10 | PARTIAL – 50% | PARTIAL – 50% | Work is continuing to develop Trust guidelines for the insertion of suprapubic catheters has been developed in adherence with the January 2011 BAUS guidelines.<br>Regional Policy Collaborative have just circulated the SEHSCT protocol that is now being used as a reference to completing the Trust's guidance. | Still to be determined following finalisation of trust procedures (especially in relation to the competency training programme) |
| **HSC (SQSD) 10/10 – Policy Circular**<br>Early Alert System | 01/06/2010 | On time | FULL | FULL | Work has been completed against each of the recommendations. Trust guidance approved on 21 December 2010 and this is now available on the Trust intranet.<br>Questionnaire issued by DHSSPS to evaluate effectiveness of regional processes 0-response due by 30 April 2012 | |

| Title | Deadline Date for assurance | Responsiveness | Level of Compliance as denoted at December 2011 | Level of Compliance as denoted at April 2012 | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| **HSC (SQSD) 63/09**<br>**NPSA / 2009 / RRR 006**<br>Oxygen Safety In Hospitals | 28/06/10 | On time | PARTIAL – 60% | PARTIAL – 60% | Date of next Medical Gas Committee is 18/05/2012 and as part of this forum, work is continuing in compliance with action plan.<br>Actions include a review of cylinders required and procedures. Standard stock of cylinders held at general ward level agreed which would ensure ward staff were aware of their cylinder stock level and could monitor this. (1 x F Oxygen, 4 x E Oxygen and 2 x D Oxygen). Staff member to be allocated for checking.<br>Estates to build bespoke storage for standard stock.<br>A procedure for the issue of all cylinders to be developed and a log to be developed<br>Oxygen prescription discussed at Acute and OPPC Governance meetings and agreement sought. Pilot to be undertaken in surgical ward. Guidelines for oxygen titration being developed.<br>Training in oxygen prescription and administration to be conducted.<br>Audit of Pulse oximetry confirms that suitable equipment is in all locations where oxygen is used. | Full compliance is anticipated once action plan is completed |

| Title | Deadline Date for assurance | Responsiveness | Level of Compliance as denoted at December 2011 | Level of Compliance as denoted at April 2012 | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| **HSC (SQSD) 86/09**<br>**NPSA / 2009 / RRR 007**<br>Reducing risks of tourniquets left on after finger/toe surgery | 19/07/10 | On time | FULL | FULL | Work has been completed against each of the recommendations. On-going audit processes are in place | |
| **HSS (MD) 26-10**<br>Down Syndrome Screening | 31/08/2010 | On time | FULL | FULL | Work has been completed against the recommendations | |
| **HSC (SQSD) 01/10**<br>**NPSA / 2010 / RRR 008**<br>Vaccine Cold Storage | 01/09/10 | On time | PARTIAL – 70% | PARTIAL – 80% | A program has now commenced for direct delivery to GP practices so that vaccine holding centres can be phased out and designated persons for receipt implemented.<br><br>There is a need to complete the program for direct delivery to GP practices with designated person for receipt. Complete the program for direct delivery to GP practices with designated person for receipt.<br><br>Policy and procedure for vaccine cold chain storage to be included in Medicines Code or as separate policy and procedure and this is to be completed by the Director of Pharmacy by 31.05.12 | Full compliance is anticipated once action plan is completed |

| Title | Deadline Date for assurance | Responsiveness | Level of Compliance as denoted at December 2011 | Level of Compliance as denoted at April 2012 | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| **HSC (SQSD) 02/10**<br>**NPSA / 2009 / RRR 003**<br>Preventing harm to children whose parents have mental health needs<br>*(Lead Directorate: MHD)* | 23/09/10 | On time | PARTIAL – 80% | PARTIAL – 85% | Mental Health, Safeguarding and Social Services Training Unit staff have developed and delivered 4 training Sessions across the Southern Trust to ensure awareness and understanding of The Adult and Children's Service Joint Protocol for Responding to the Needs of Children with Parents who have Mental Health / Substance Misuse Problems.<br><br>**Champions Model**<br>The Children's Services Interface Group is developing a Champions Model to ensure that a Shared Learning Culture Develops between Safeguarding and Adult Mental Health Services. This is due to be actioned by September 2012. Once this has been successfully implemented it will add considerable weight to the Trust's overall Assurance Level.<br><br>**Electronic Referral by General Practitioner to Adult Mental Health Services**<br>This revised format for GP Referral includes an updated Family Profile Section to ensure Mental Health Referrals are viewed with Children in mind from the initial stages. | Full compliance is anticipated once action plan is completed |

| Title | Deadline Date for assurance | Responsiveness | Level of Compliance as denoted at December 2011 | Level of Compliance as denoted at April 2012 | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| **HSS MD 17-10**<br>Physiological Early Warning Systems | 30/09/10 | On time | PARTIAL – 80% | PARTIAL – 80% | Work is on-going and this work has been identified as a priority for the Trust's Governance Working Body | Full compliance is anticipated once action plan is completed |
| **HSS MD 25-10**<br>Introducing UK Growth Charts<br>(Lead Directorate: CYP) | 01/10/10 | On time | FULL | FULL | All actions have been implemented within the relevant clinical specialities within the Children's & Young Peoples Directorate. | |
| ***NCEPOD (no reference)***<br>A Mixed bag report | 25/10/2010 | On time | PARTIAL – 80% | PARTIAL – 85% | The SHSCT Parenteral Nutrition guidelines have been finalised to reflect the new processes for the prescribing and management of PN across both CAH and DHH sites. These are now to be agreed and signed off by the Acute Services Clinical Governance forum. A training course for nursing / AHP staff is to be commissioned with the BMC. | Full compliance is anticipated once action plan is completed |
| **HSC (SQSD) 84/09**<br>**NPSA / 2010 / PSA 005**<br>Safer Use of Lithium<br>*(Lead Directorate: MHD)* | 01/12/10 | On time | PARTIAL – 70% | PARTIAL – 70% | Work is on-going regarding implementation of the recommendations. Regional care plan, shared care guideline, lithium packs and record books have been procured and roll-out has commenced with CMH Teams for current patients on Lithium. | Full compliance is anticipated once action plan is completed |

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| | | | | | Pharmacy will keep a small stock of the information pack/records book usually for patients on general wards who may need a replacement.<br><br>A list/database of all current patients on lithium known to secondary MHS has now been developed. A procedure for updating the list with new patients as they arise is being implemented with key workers.<br><br>Dispensing SOP to be introduced when lithium booklets introduced | |
| **HSC (SQSD) 06/10**<br>**NPSA / 2010 / RRR 010**<br>Early detection of complications following gastrostomy | 03/12/2010 | On time | FULL | FULL | Work has been completed against each of the recommendations.<br>Audit work is planned for June 2012 to ensure on-going monitoring | |
| **HSC (SQSD) 07/10**<br>**NPSA / 2010 / RRR011**<br>Checking Pregnancy before Surgery | 03/12/10 | On time | PARTIAL – 80% | PARTIAL – 90% | Patient Information leaflets have been developed for both adult and young persons. These have been integrated into the revised Policy (version 002/ May 2012) and these documents have been placed on the Trust intranet.<br><br>Checking Pregnancy before Surgery & X-Ray / Diagnostics is due to hold its annual meeting in June 2012. | Full compliance is anticipated once action plan is completed |

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| **HSC (SQSD) 09/10**<br>**NPSA / 2010 / RRR 012**<br>Reducing the risk of retained swabs after vaginal delivery and perineal suturing | 04/12/10 | On time | PARTIAL – 90% | FULL | On-going monitoring and review | |
| **HSC – MHDP – MHU – 1/10**<br>Deprivation of Liberty Safeguards (DOLS)<br>*(Lead Directorate: MHD)* | 10/12/10 | Delayed<br>(Response provided on 25/02/11) | PARTIAL – 80% | PARTIAL – 80% | Work is continuing in compliance with action plan.<br>The AD for Learning Disability & Director of Human Resources needs to formulate the DOLS guidance into a Trust policy for approval by / through the Policy Scrutiny Committee. | Full compliance is anticipated once action plan is completed |
| **HSC (SQSD) 12/2010**<br>**NPSA / 2010 / RRR 013**<br>Safer Use of Insulin | 14/01/2011 | On time | PARTIAL – 80% | PARTIAL – 80% | Consultation to be completed on updated Medicines Code with statement added to revised Medicines Code to require use of an insulin syringe when withdrawing a dose from a vial.<br>Nursing training program to be implemented that incorporates NHS Diabetes e-learning program. Consultant Endocrinologist to write to Director NIPEC to request regional approach | Action plan is in place and full compliance is anticipated once work is completed |
| **HSC (SQSD)13/10**<br>**NPSA / 2010 / RRR 014**<br>Reducing treatment dose errors with low molecular weight heparins | 20/02/2011 | On time | PARTIAL – 50% | PARTIAL – 50% | Audit results fed back in July 2011 via memo and presentation at audit meetings. Re-audit to be conducted.<br>Further audit of patients with renal impairment required to confirm that renal | Action plan is in place and full compliance is anticipated once work is completed |

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| | | | | | function is considered when dosing LMWH in patients. Updated anticoagulation in venous thromboembolism guideline to be uploaded to intranet. Cardiology guideline to be reviewed to ensure dosing complies with SPC and incorporate dosing calculation tool.<br>Review of medication incidents involving enoxaparin on 3 monthly basis.<br>A Trust working group to be established to progress further action. | |
| **HSC (SQSD) 14/10**<br>**NPSA / 2010 / RRR 015**<br>Prevention of over infusion of fluid /medicines in Neonates<br><br>*(Lead Directorate: CYP)* | 10/03/2011 | On time | PARTIAL – 70% | PARTIAL – 90% | OSCE style training on the safe administration of intravenous fluids and medicines in neonatal services has been implemented and delivered to all relevant clinical areas now that new infusion equipment has been introduced.<br>Repeat audits have been carried out in SCBU (DHH) in February 2012 and NNU (CAH) in March 2012. Audit findings have been analysed and learning outcomes have been shared with staff. Due to the low numbers of neonates with IV fluid requirements being cared for on the paediatric wards, audit work has been limited but this work will continue as the opportunity arises. | Action plan is in place and full compliance is anticipated once work is completed |

| Title | Deadline Date for assurance | Responsiveness | Level of Compliance as denoted at December 2011 | Level of Compliance as denoted at April 2012 | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| **HSC (SQSD) 03/10**<br>**NPSA / 2010 / RRR 009**<br>Reducing harm from delayed and omitted medicines in hospital | 30/03/2011 | On time | PARTIAL – 70% | PARTIAL – 80% | Significant work has been undertaken and includes a targeted review of undocumented critical medicines.<br>Expanded action plan for implementation addressing the following: Prescribing /Preparation and supply and administration.<br>Annual audit to be conducted. | Action plan is in place and full compliance is anticipated once work is completed |
| **HSC (SQSD) 04/2010**<br>**NPSA / 2010 / PSA 001**<br>Safer Use of IV Gentamicin for Neonates<br>(Lead Directorate: CYP) | 30/03/2011 | On time | PARTIAL – 50% | PARTIAL – 60% | Compliance monitoring to commence in 2012 with view to present at meeting in April 2012. | Action plan is in place and full compliance is anticipated once work is complete. |
| **HSC (SQSD) 15/2010**<br>**NPSA / 2010 / RRR 016**<br>Laparoscopic Surgery: Failure to recognise post-operative deterioration | 26/04/2011 | On time | PARTIAL – 80% | PARTIAL – 80% | Further work is being carried out to finalise the procedures for nurse led discharge and unexpected overnight stays. Next working group meeting is scheduled in June 2012. | Action plan is in place and full compliance is anticipated once work is completed |

| Title | Deadline Date for assurance | Responsiveness | Level of Compliance as denoted at December 2011 | Level of Compliance as denoted at April 2012 | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
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| **NCEPOD Report**<br>An Age Old Problem | 06/05/2011 | On time | PARTIAL – 60% | PARTIAL – 65% | Update on progress against the previously submitted action plan (06/05/2011) was given to the HSC Board on 08/12/2011 (within specified deadline date).<br>Working group met in March 2012 and work is progressing against the recommendations. Progress has been made in regard to the development of an Acute Kidney Injury documentation pack for the admission of both medical and surgical patients aged over 60 years.<br>An audit of the timeliness for patients going to emergency theatre has also been completed in February / March 2012 and results are being analysed.<br>HSCB/PHA have also established a time-limited group, chaired by Dr Joanne McClean, Consultant in Public Health, to engage on implementation of recommendations contained NCEPOD report; Peri-operative Care: Knowing the Risk that was launched in December 2011. This work will correlate to the Age Old Problem action plan. | There are a number of significant resource implications if the Trust is to fully comply with this guidance. This is especially in regard to routine daily input from MCOP for elderly patients undergoing surgery and is integral to inpatient care pathways in this population. |

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| **HSC (SQSD) 16/2010**<br>**NPSA / 2010 / RRR 017**<br>The transfusion of blood and blood components in an emergency | 18/05/2011 | On time (12/05/2011) | PARTIAL – 90% | FULL | On-going monitoring of compliance through the Trust Hospital Transfusion Committee and Better Blood Transfusion 3 (NI) working group | |
| **HSC (SQSD) 17/2010**<br>**NPSA / 2010 / RRR 018**<br>Preventing fatalities from medication loading doses | 18/05/2011 | On time (13/05/2011) | PARTIAL – 50% | PARTIAL – 50% | Work is continuing in compliance with action plan.<br>Work identified by risk assessment to be completed by pharmacists/clinical staff/nursing staff.<br>Following a meeting on 24 April 2012 with Pharmacy representative from the five HSC Trusts a plan for collaborative working on dose tools is now in place to promote consistency. | Full compliance is anticipated once work is completed |
| **S&Q Learning Communication 01/2010**<br>Managing Diabetic Ketoacidosis | 19/05/2011 | On time (19/05/2011) | PARTIAL – 70% | PARTIAL – 70% | Discussions have been on-going between the acute services and CYP directorates to gain agreement regarding the upper age limit for managing patients on an acute paediatric ward. The Trust is still awaiting the outcomes from the recent RQIA Review of Children under 18 years in acute adult wards<br>The IMWH pathway for the management of pregnant young person under the age of 18 needs to be progressed and processes embedded. | Full compliance is anticipated once work is completed |

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| RQIA Follow up Review – Reducing the Risk of Hyponatraemia when Administering Intravenous Fluids to Children | 15/07/2011 | Delayed (Response provided on 18/07/2011) | PARTIAL - 80% | PARTIAL - 80% | The Trust has in place a Competency Framework for nurses on the prescription, administration, monitoring and review of intravenous fluids for children and young people. Following approval in 2011 the competency tool continues to be implemented within the Trust and training on the use of the competency tool is on-going. Training sessions have been organised for nursing staff within Acute during December 2011 and more sessions will be facilitated in the near future. There is a 73% attendance rate for medical staff members who have completed the hyponatraemia training tracker e learning module.<br>Work needs to be taken forward to ensure full implementation of the competency tool within CYP.<br>Any outstanding training needs will be identified as part of the re-audit process and appropriate action will be taken<br>The Acute and Children & Young Peoples Directorates will participate in the consultation process relating to the regional Daily Fluid Balance & Prescription Sheet. In the interim the Trust will continue to use the paediatric fluid balance chart for children and young people up to their 16th birthday.<br>The action plans currently being developed within Directorates (in line with the CMO audit work) will be amalgamated to facilitate shared learning across the organisation | |

| Title | Deadline Date for assurance | Responsiveness | Level of Compliance as denoted at December 2011 | Level of Compliance as denoted at April 2012 | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
|---|---|---|---|---|---|---|
| **HSC(SQSD)18/10**<br>**NPSA 2010 RRR 019**<br>Ambulatory Syringe Drivers | 21/07/2011 | On time (21/07/2011) | PARTIAL – 30% | PARTIAL – 30% | The alert requires all of the Trust's existing 270 Graseby ambulatory syringe drivers to be replaced with devices that have the specified safety features. This replacement programme is to be supported with an implementation plan. | Following the working group meeting on 11 January 2012 very little progress has been achieved in regarding to progressing with a regional procurement process led by PaLS.<br>Dr Rankin wrote to Mary Hinds (PHA) and in her email response on 20 March 2012 she confirmed that she would liaise with PaLS to ascertain way forward. |
| **S&Q 01-2011**<br>Overdosing on Medication | 18/07/2011 | On time (18/07/2011) | PARTIAL – 80% | PARTIAL – 90% | As part of the initiative 'Organisation of Care' observations of practice include second check of IV drugs.<br>The Trust's Medicines Code has been updated in March 2012 to include a statement that if a prescriber has any element of doubt they should seek advice from Pharmacy. | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Perinatal Mortality Report 2008** | 29/07/2011 | On time (29/07/2011) | PARTIAL – 70% | FULL | The new SHSCT Protocol for Recording of death of a baby 20-22 weeks gestation was approved for issue to all relevant staff in March 2012.<br>It has been agreed that the NPSA tool will be used to investigate all deaths from 24 weeks gestation. Learning from these investigation processes is to be shared within the monthly IMWH Morbidity & Mortality Meetings. | |
| **HSC (SQSD) 01/11**<br>**NPSA / 2011 / RRR 001**<br>Essential Care after an Inpatient Fall | 01/08/2011 | On time (21/07/2011) | PARTIAL – 70% | PARTIAL – 70% | The Post Falls protocol has been further modified to more accurately reflect the NICE Head Injury Guidance.<br>Progress to get this work implemented across the in-patient ward areas is dependent on the working group that has been set up as part of the Trust's Governance Working Group priority work streams.<br>This working group will be chaired by the AD for Enhanced Services (OPPC) and it anticipated that once the corporate processes have been agreed the implementation of this specific falls work will follow quickly in the context of an organisational approach. The inaugural meeting of this group is 18 May 2012. | Action plan is in place and full compliance is anticipated once work is completed |

| Title | Deadline Date for assurance | Responsiveness | Level of Compliance as denoted at December 2011 | Level of Compliance as denoted at April 2012 | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
|---|---|---|---|---|---|---|
| **HSS (MD) 17-2011** Better Blood Transfusion 3 Northern Ireland (BBT3 NI) | Submission Action Plan: 01/12/2011<br><br>Compliance statement: 31/12/2012 | On time (22/12/11)<br><br>Pending | PARTIAL – 70% | PARTIAL – 80% | Following completion of the self-assessment / action plan the working group have met to review progress and a sub group has been set up to develop care pathways for the management of patients with Anaemia<br>Work will be on-going over the next 6 months to ensure compliance against the 72 recommendations | Action plan is in place and full compliance is anticipated once work is completed |
| **HSC (SQSD) 02/11**<br>**NPSA / 2011 / PSA 002**<br>Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children & infants | 05/10/2011 | On time (05/10/2011) | PARTIAL – 80% | PARTIAL – 85% | Work continues to be progressed by the Trust's multi-directorate short life working group.<br>An audit completed in November 2011 and audit data has now been analysed and key learning points identified and shared at Directorate Governance meetings for Acute services (March 2012) and OPPC (April 2012)<br>Meeting held with lead nurses on 30 April 2012 to agree implementation plan for the use of the NGT position check chart across the relevant clinical areas.<br>The e-learning module for misinterpretation of x-rays following NGT insertion has been made mandatory in the Junior Doctor and endoscopy induction programmes. | Action plan is in place and full compliance is anticipated once work is completed |

| Title | Deadline Date for assurance | Responsiveness | Level of Compliance as denoted at December 2011 | Level of Compliance as denoted at April 2012 | Actions that still need to be taken | Limiting factors influencing Trust's ability to achieve full compliance |
|---|---|---|---|---|---|---|
| **HSS MD 09/2011**<br>Hep C infected Healthcare Workers: Guidance on the Prevention of Healthcare-Related Hep C and Workplace Management of Hep C Infected Clinical Healthcare Workers | 30/12/2011 | On time (21/12/2011) | PARTIAL – 70% | PARTIAL – 70% | The Trust's Occupational Health Department is continuing to take forward the following actions:<br>• The development of an information leaflet that will advise all healthcare workers who carry out exposure prone procedures of their responsibility regarding Blood Born Viruses<br>• The development of a care pathway for Blood Born Virus exposure. | Whilst the SHSCT currently provides (under SLA) an OH service for all GPs / GDPs and their staff in the SHSCT Trust area, not all Trusts within NI have signed the regional SLA and as a consequence the details of the availability of this service has yet to be circulated to the GPs and GDPs by the PHA. |

| ***TABLE 5: Summary of current position on Standards & Guidelines that have been issued from 01 January 2011 to 31 December 2011 and do not have a specified timescale for assurance to the HSC Board / external agency.*** | | | |
|---|---|---|---|
| ***Reference*** | ***Title*** | ***Level of Compliance*** | ***Summary of current position*** |
| HSS (MD) 01-2011 | Updated JCVI Advice on Seasonal Flu Vaccination of Pregnant Women | SHSCT is fully compliant | Management plan endorsed and adhered to by Trust throughout the 2010/11 flu season |
| HSS (MD) 02-2011 | Seasonal Flu Vaccine Supply | SHSCT is fully compliant | Management plan endorsed and adhered to by Trust throughout the 2010/11 flu season |
| HSS (MD) 03-2011 | Influenza, Meningococcal infection and other bacterial co-infection including pneumococcal and invasive group A Streptococcal infection (iGAS) | **Issued as advice/information only** | |
| HSS (MD) 04-2011 | Change to the Childhood Immunisation Schedule - Vaccinations at 12 and 13 months of age | **Issued as advice/information only** | |
| No reference issued | Guidance for HSC staff on the provision of information to patients affected by cancer | Partial – 50% | Following receipt of this NICaN guidance a cancer information subgroup has been established by the Trust's Cancer Services Steering Group. This group will lead and co-ordinate on the patient information agenda. Funding from has been identified to appoint a three year information project manager post has been funded by Macmillan Cancer Support. This post holder works closely with Trust service managers within Acute Services, OPPC & MHD Directorates as well as within the community and voluntary sector to assist them in understanding their responsibility in supporting the implementation of cancer information. |

| *Reference* | *Title* | *Level of Compliance* | *Summary of current position* |
|---|---|---|---|
| Not indicated on circular | Minimising the risk of Listeriosis in Hospitals | 85% | On-going review. Revenue funding has been made available for ward refrigeration equipment for Daisy Hill Hospital in the sum of £7K. Additionally capital funding of £450k has been made available from DHSSPS and this funding has been allocated as follows - Craigavon Area Hospital £280k Daisy Hill Hospital £135k St Luke's & South Tyrone Hospital £35k. This funding requires to be spent by the 31/3/12 and should improve compliance to 90%.<br>Work is on-going to develop a microbiological testing plan and a specification in order that the service can be tendered by April 2012. |
| HSS MD 05/2011 | TSE – Update to Annex H – After Death Procedures | SHSCT is fully compliant | |
| Not indicated on circular | "Take Home" Medication Supply from Northern Ireland Emergency Departments | SHSCT is fully compliant | Processes are in place and over label packs have been purchased and these are stocked with the Emergency Department for ease of supply |
| SUB/264/11 | Legal issues relevant to donation after circulatory death in NI | PARTIAL – 70% | The document offering guidance on the legal aspects of Donation following Circulatory Death was published in March 2011. This guidance has been incorporated into the Trust's protocols and has been used to guide the Trust's policy on organ donation. This |

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|---|---|---|---|
| | | | policy is currently in draft form and out for consultation.<br>The regional guidance document reflects the current position and this document is being used by all in NI. |
| Not indicated on circular | Temporary haemodialysis away from home | PARTIAL – 80% | Work is on-going to develop a regional protocol. |
| CCaNNI 010 | Standardisation of drug infusion in NI Critical Care Units | SHSCT is fully compliant | |
| HSC (SQSD) (NICE) 10/2011 | Improving Outcomes in People with Skin Tumours Including Melanoma (Partial update) | PARTIAL -50% | The recommendations outlined within this NICE guidance are being reviewed within Cancer Services and an action plan has been developed. |
| HSC(SQSD)(NICE) 01/11 CG 93 | Donor Breast Milk Banks: The Operation of Donor Milk Bank Services | SHSCT is fully compliant | Each of the NICE recommendations have been reviewed with the Lead Midwife and full compliance has been indicated. |
| HSC (SQSD) (NICE) 09/2011 CG 96 | The Pharmacological Management of Neuropathic Pain in Adults in Non-Specialist Settings | PARTIAL – 70% | This guidance has been disseminated to all clinicians. An audit of outpatient prescribing practice was carried out by Pharmacy in October 2011 and the outcomes of the audit revealed some areas of non-compliance. Forms part of Trust D&T Committee monitoring |
| HSC (SQSD) (NICE) 04/2011 CG 107 | The Management of Hypertensive Disorders During Pregnancy | To be determined | This work is being progressed by the IMWH Guidelines Committee |

| *Reference* | *Title* | *Level of Compliance* | *Summary of current position* |
|---|---|---|---|
| HSC (SQSD) (NICE) 08/2011 CG 94 | Unstable Angina & Non-Segment-Elevation Myocardial Infarction | To be determined | The recommendations outlined within this NICE guidance are being reviewed within Cardiology Services and an action plan has been developed |
| HSC (SQSD) (NICE) 03/2011 CG 100 | Alcohol–use disorders: Diagnosis and clinical management of alcohol–related physical complications | To be determined | Work is being progressed by the Trust's Alcohol Detoxification Working Group |
| HSC (SQSD) (NICE) 02/2011 CG 99 | Diagnosis & Management of Idiopathic Childhood Constipation in Primary and Secondary Care | To be determined | The recommendations outlined within this NICE guidance are being reviewed within CYP and an action plan is being developed |
| HSC(SQSD)(NICE) 05/11 TA196 | Sorafenib for the treatment of advanced hepatocellular carcinoma | **Drug not used in SHSCT** | |
| HSC(SQSD)(NICE) 06/11 TA 211 | Prucalopride for the Treatment of Chronic Constipation **in** Women | Awaiting funding | One of the lead Gastroenterologists is currently writing a business case for presentation to the HSCB to identify funding for the use of this drug on specific patients – this continues to be progressed |
| HSC(SQSD)(NICE) 11/11 TA196 | Imatinib for the adjuvant treatment of Gastrointestinal Stromal Tumours | **Drug not used in SHSCT** | |
| HSC(SQSD)(NICE) 12/11 TA210 | Clopidogrel & Modified-release Dipyridamole for the Prevention of Occlusive Vascular Events | SHSCT is fully compliant | Used within Cardiology Services - no funding issues |

| *Reference* | *Title* | *Level of Compliance* | *Summary of current position* |
|---|---|---|---|
| HSC (SQSD) (NICE) 07/2011 CG 92 | Reducing the Risk of VTE in Patients Admitted to hospital | Partial – 60% | Work is being progressed and also takes cognisance of the recently issued CMO letter 13/2011 (dated 22 July 2011) 'Development of a VTE risk assessment tool'. Action plan in place and pilot risk assessment is being |
| HSS (MD) 06-2011 | End of 2010/11 Flu Season and related issues | **Issued as advice/information only** | |
| HSS (MD) 07-2011 | JCVI Advice on the Pneumococcal Vaccination Programme for People Aged 65 years and older | **Issued as advice/information only** | |
| HSC (SQSD) (NICE) 13/2011 CG 109 | Management of Transient Loss of Consciousness in Adults and Young People | Work on going – to be determined | The recommendations outlined within this NICE guidance are being reviewed within Cardiology Services and an action plan has been developed |
| HSC (SQSD) (NICE) 14/2011 TA 191 | Capecitabine for the treatment of Advanced Gastric Cancer | **Drug not used in SHSCT** | |
| HSC(SQSD)(NICE) 15/11 TA201 | Omalizumab for the Treatment of Severe Persistent Allergic Asthma in Children aged 6-12 years | **Drug not used in SHSCT** | |
| HSC(SQSD)(NICE) 16/11 TA202 | Ofatumumab for the Treatment of Chronic Lymphocytic Leukaemia Refractory to Fludarabine and Alemtuzumab | SHSCT is fully compliant | Trust identified that one patient had been prescribed this drug but following issue of guidance this prescribing practice has stopped. |

| *Reference* | *Title* | *Level of Compliance* | *Summary of current position* |
|---|---|---|---|
| HSC (SQSD) (NICE) 17/2011 TA 204 | Denosumab for the Prevention of Osteoporotic Fractures in Postmenopausal Women | | The Lead Orthogeriatrician is taking a proposal paper to HSCB to secure funding for this drug. Whilst the first dose is given by secondary care as a preventative/management measure, funding is not allocated to secondary care so clarity is required as to how funding can be secured to ensure on going provision of this drug to patients who are commenced on it with the secondary care setting. |
| HSC(SQSD)(NICE) 18/11 TA205 | Eltrombopag for the Treatment of Chronic Immune or Idiopathic Thrombocytopenic Purpura | **Drug not used in SHSCT** | |
| HSC(SQSD)(NICE) 19/11 TA212 | Colorectal Cancer (metastatic) - Bevacizumab in combination with Oxaliplatin & either 5-fluorouracil plus Folinic Acid or Capecitabine | **Drug not used in SHSCT** | |
| HSC(SQSD)(NICE) 20/11 TA214 | Bevacizumab in Combination with a Taxane for the First-line Treatment of Metastatic Breast Cancer | **Drug not used in SHSCT** | |
| HSC (SQSD) (NICE) 21/2011 CG 108 | Management of Chronic Heart Failure in Adults in Primary and Secondary Care | To be determined | NI Heart Failure Nurses Sub Group are updating their NI HF Nursing Guidance to bring in line with all new guidance including NICE. The final version should be ready early in the new year. |
| HSC (SQSD) (NICE) 22/2011 CG 111 | Nocturnal Enuresis - Management of Bedwetting in Children and Young People | To be determined | The recommendations outlined within this NICE guidance are being reviewed within CYP and an action plan is being developed |

| *Reference* | *Title* | *Level of Compliance* | *Summary of current position* |
|---|---|---|---|
| HSC (SQSD) (NICE) 23/2011 CG 115 | Alcohol Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence | To be determined | Work is being progressed by the Trust's Alcohol Detoxification Working Group |
| HSC (SQSD) (NICE) 24/2011 CG 116 | Diagnosis and Assessment of Food Allergy in Children and Young People in Primary Care and Community Settings | To be determined | The recommendations outlined within this NICE guidance are being reviewed within CYP and an action plan is being developed |
| HSC(SQSD)(NICE) 25/11 TA213 | Aripiprazole for Schizophrenia in People Aged 15-17 years | SHSCT is fully compliant | These drugs are being used as generic drugs - no cost issues and prescribed when indicated |
| HSC (SQSD) (NICE) 26/2011 CG 102 | Management of Bacterial Meningitis and Meningococcal Septicaemia in Children and Young People younger than 16 years in primary and secondary care | To be determined | The recommendations outlined within this NICE guidance are being reviewed within CYP and an action plan is being developed |
| HSC (SQSD) (NICE) 27/2011 CG 106 | Ablative Therapy for the Treatment of Barrett's Oesophagus | SHSCT is fully compliant | All patients with high grade dysplasia or early oesophageal cancer are considered for ablation or endoscopic mucosal resection. |
| HSS (MD) 08-2011 | Outbreak of Haemolytic Ureamia in Germany | **Issued as advice/information only** | |
| N/A | Prescribing of Intravenous Immunoglogulin | SHSCT is fully compliant | |

| *Reference* | *Title* | *Level of Compliance* | *Summary of current position* |
|---|---|---|---|
| N/A | Family history of medium chain acyl-coA dehydrogenase deficiency (MCADD): advice for practitioners providing antenatal and newborn care | SHSCT is fully compliant | Collaborative work has been undertaken between IWMH division and CYP Directorate to develop a new care pathway for the management of MCADD and new Trust procedures for new born bloodspot screening programme.<br>Once finalised an implementation plan will be developed with the aim to fully implement across all antenatal booking sites and relevant CYP services |
| HSS (MD) 10-2011 | Update on E.Coli outbreaks and reporting of Haemolytic Uraemic Syndrome (HUS), Thrombotic thrombocytopenic Purpura (TTP) and Acute Infectious Bloody Diarrhoea | **Issued as advice/information only** | |
| HSS (MD) 11-2011 | Public Inquiry into the Outbreak of Clostridium Difficile in Northern Trust Hospitals | Partial – 70%<br>(guidance is require from PHA/HSCB regarding how recommendations that require on-going action to maintain full compliance can be maintained<br>(ensuring communication to patients etc) | The SHSCT met with the HSC Board and PHA on 25 October 2011 to review the SHSCT action plan. The Trust awaits feedback and guidance for further monitoring from these agencies. |
| HSS (MD) 12-2011 | Current Potential for Heroin overdose | **Issued as advice/information only** | |

| *Reference* | *Title* | *Level of Compliance* | *Summary of current position* |
|---|---|---|---|
| N/A | Guideline for the Management of Systemic Anti-Cancer Treatment (SACT) Hypersensitivity (NICaN) | To be determined | The recommendations outlined in this NICaN guidance are currently being progressed by Cancer Services in collaboration with relevant clinical specialties |
| HSC (SQSD) (NICE) 28/2011 TA 86 | Imatinib for the treatment of unresentable and/or metastatic Gastrointestinal Stromal Tumours | **Drug not used in SHSCT** | |
| HSC(SQSD)(NICE) 29/11 TA209 | Imatinib for the treatment of unresentable and/or metastatic Gastrointestinal Stromal Tumours (Part review of NICE Technology Appraisal TA86) | **Drug not used in SHSCT** | |
| HSC (SQSD) (NICE) 30/2011 TA 192 | Gefitinib for the first-line treatment of locally advanced or metastatic non-small-cell lung cancer | SHSCT is fully compliant | Prescribing is assessed on a cost per case basis with the HSCB as there is not an agreed funding stream yet |
| HSS (MD) 13-2011 | Development of a Regional VTE Risk Assessment Tool | Partial – 60% | Work is being progressed and also takes cognisance of the recently issued NICE guidance 07/2011 CG 92 (dated March 2011) and the work being taken forward by the Regional Safety Forum. Action plan in place |
| HSS (MD) 14-2011 | The Seasonal Influenza Vaccination Programme 2011/12 | **Issued as advice/information only** | |
| HSS (MD) 15-2011 | Further JCVI Advice on the Pneumococcal Vaccination Programme for People Aged 65 years and older | **Issued as advice/information only** | |
| N/A (GAIN) | NI Cancer Registry Audit on Care of Pancreatic Cancer Patients in NI diagnosed 2007 (with comparisons 2001) | To be determined | This audit work is being facilitated by the SEC and CCS divisions so to ensure there is an increase in the number of patients with pancreatic cancer are discussed at the MDT's |

| *Reference* | *Title* | *Level of Compliance* | *Summary of current position* |
|---|---|---|---|
| HSS (MD) 16-2011 | Updated Guidance from the ACDP TSE Risk Management Subgroup (Formally the TSE Working Group) | To be determined | A short life working group has been established to develop a draft guideline on the management of patients with CJD/vCJD. Once completed there will be a need to develop an implementation/ communication and training plan to ensure appropriate awareness training for medical and nursing staff is provided |
| N/A | Minor Head Injury - Discharge Guidance | **Issued as advice/information to both Emergency Departments and relevant clinical areas** | |
| HSS(F) 40/2009 Supplement 1 | Update to Guidance for Sponsored Bodies on the Use of External Consultants: Changes to Delegated Limits for Ministerial Approval | SHSCT is fully compliant | New processes have been adopted |
| N/A | Transfer of Detained Patients to facilities outside NI | To be determined | The Southern Health & Social Services Trust has a procedure for the Inter Hospital Transfer of Patients and their Records in place, which includes transfer of Mentally Disordered Patients to Great Britain. This Procedure is due to be reviewed and will include the updated guidance on the Transfer of Mentally Disordered Patients detailed under the Mental Health Order (NI) Order 1986 to and from hospitals in Great Britain. Completion date March 2012. |

| *Reference* | *Title* | *Level of Compliance* | *Summary of current position* |
|---|---|---|---|
| HSS (MD) 18-2011 | Guidance on Group B Streptococcus in Pregnancy | Partial – 70% | Significant work has been commenced regionally and the Public Health Agency is undertaking a piece of work to raise awareness of GBS in pregnancy with health professionals and the public, including making available suitable information leaflets and web resources.<br>New antibiotic guidelines have also been drafted and are currently out for consultation.<br>Local level questionnaire is also being designed to determine knowledge base among front line professional staff. |
| HSS (MD) 19-2011 | Management of Seasonal Flu 2011/12 | **Issued as advice/information only** | |
| N/A | Adult and Children's Services Joint Protocol. Responding to the needs of children whose parents have mental health and/or substance misuse issues | Partial – 70% | This work is being taken forward by the Trust's 'Child Services Interface Group.'<br>An implementation plan is already being developed to provide assurances that the required action is being taken forward and embedded within the Trust. |
| HSC (SQSD) 04/2011 | NICE Technology Appraisals and Clinical Guidelines - New Process for Endorsement, Implementation, Monitoring and Assurance | SHSCT is fully compliant | Trust has adopted the new processes |

| *Reference* | *Title* | *Level of Compliance* | *Summary of current position* |
|---|---|---|---|
| HSC (SQSD) (NICE) 31/2011 CG42 | Dementia - supporting people with dementia and their carers in health and social care | Work on going – to be determined | The recommendations outlined within this NICE guidance are being reviewed within Dementia Services and an action plan has been developed. This work is to be integrated into the work associated with the new regional strategy. |
| HSC (SQSD) (NICE) 32/2011 TA 217 | Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease | SHSCT is fully compliant | No restrictions in drug use |
| HSS (MD) 20-2011 | Viroflu vaccine and risk of fever in children under 5 years | **Issued as advice/information only** | |
| HSS (MD) 21-2011 | Legionnaires' Disease | Whilst this has been issued as advice/information, specific awareness training on Legionella has been organised for the Infection Prevention and Control Link Nurses on 14 November 2011 | |
| HSS (MD) 22-2011 | Transfer of seriously ill patients from home to hospital | **Issued as advice/information only** | |
| HSC (PHD) Communication 03/2011 | FFP3 Respirations and Fit Testing Guidance for Health & Social Care Organisations | Work on going – to be determined | This work is being led by the Trust's Occupational Health Department |
| N/A | Safety Alerts Protocol – consultation paper | The Trust has reviewed the draft consultation document and has provided feedback to Dr Harper – will await direction regarding way forward | |

| *Reference* | *Title* | *Level of Compliance* | *Summary of current position* |
|---|---|---|---|
| HSS (MD) 23-2011 | Voluntary Recall of Baxter Preflucel ® Vaccine - Batch VNV5L010C | SHSCT is fully compliant | Actioned by Pharmacy |
| HSS (MD) 24-2011 | Suspected Botulism Case in Scotland | **Issued as advice/ information only** | |
| HSS (MD) 24a-2011 | Update Suspected Botulism Case in Scotland | **Issued as advice/ information only** | |
| AMCC 3152 | DHSSPS & HSC Protocol for sharing service user information for secondary purposes | SHSCT is fully compliant | SHSCT is compliant with the content of this document. The Trust has Data sharing register in place, which is tabled and discussed at quarterly Information Governance Forums, chaired by the Medical Director. |
| HSS (MD) 25/2011 | Carbon Monoxide Poisoning: On-going vigilance to ensure recognition and prevention | **Issued as advice/ information only** | |
| HSS (MD) 26/2011 | HPV Immunisation Programme - Change of supply of HPV Vaccine to Gardasil from September 2012 | SHSCT is fully compliant | Actioned by Pharmacy |
| HSS (MD) 27/2011 | Pre School Booster and 2nd MMR Vaccine Reducing the Age of Vaccination from 4 years to 3 years and 4 months | Pending<br>Discussions are on-going with the PHA in regard to the logistics and storage of vaccine procurement | CMO Letter has been circulated to Health Visitors and School Nurses for information. A letter from the PHA providing the operation guidance for implementation will be circulated to GPs to provide operational guidance for implementation. The change to immunisation schedule will be implemented to allow the extra children to be scheduled. Full compliance is anticipated once work is completed. |

| *Reference* | *Title* | *Level of Compliance* |
|---|---|---|
| HSS (MD) 28/2011 | Verocytoxin - Producing Escherichis Coli (O157): Prevention and Clinical Guidance | **Issued as advice/ information only** |
| HSS (MD) 29/2011 | Confirmed influenza isolates in NI – NICE Guidance on use of Antivirals now applies (b) Changes to schedule 2 of the Health & Personal Social Services (GMS Contracts) (Prescription of Drugs etc) regulations (NI) 2004 - widening access to antivirals | **Issued as advice/ information only** |
| HSS (MD) 31/2011 | Water Sources and Potential Infection Risk to Patients | The SHSCT is able to evidence compliance against the recommendations outlined in the Chief Medical Officer's letter HSS (MD) 34/2010 and HSS (MD) 31/2011, and the previously issued PEL (11)13 guidance letter (July 2011). |
| HSS (MD) 32/2011 | PIP Silicone Gel Breast Implants | **Devices not used within the SHSCT** |

- ***Please note that Table 5 needs to be updated to reflect the 29 additional standards and guidelines that have been issued from 01 January 2012 but which do not have an external assurance requirement***.

Southern Health and Social Care Trust

# Trust Standards & Guidelines Prioritisation and Risk Review Group

## Terms of Reference

### *Introduction*

Standards and Guidelines come from a variety of sources and are received by a number of regional bodies for regional endorsement. Such external agencies include the HSC Board, Public Health Agency (PHA) and Safety & Quality Unit at the DHSSPS. These agencies disseminate these standards and guidelines to the HSC Trust's for action and with a requirement that an assurance will be provided to confirm that the required recommendations have been embedded within local practice.

In recent years the volume of standards and guidelines has become increasingly challenging for providers and commissioners to manage within existing risk management and clinical governance arrangements. As a consequence regional discussions have been undertaken to agree the most effective and efficient process for disseminating, implementing and assuring these standards and guidelines.

On 26 September 2011 the Chief Medical Officer issued a circular (reference HSC (SQSD) 04/11) to outline the new processes for the Endorsement, Implementation, Monitoring and Assurance of NICE Guidelines and NICE Technology Appraisals in Northern Ireland. These new processes have come into effect from 28 September 2011 (*Appendix 1*).

On 28 September 2011 Dr Carolyn Harper at the PHA issued a draft regional consultation paper which outlined the proposed systematic and integrated approach by these external agencies regarding the issue and management of safety alerts (*Appendix 2*).

In response to both of these circulars the Trust has reviewed it's arrangements for the management of standards and guidelines and as a consequence of this review the Trust's Standards & Guidelines Prioritisation and Risk Review Group has been created. The inaugural meeting of this group is scheduled for 19 April 2012.

### *Aim*

The aim of this group is to provide a forum to ensure that the Trust has in place a systematic and integrated approach for the implementation, monitoring and assurance of clinical standards and guidelines.

***Scope***

The Trust's Standards & Guidelines Prioritisation and Risk Review Group will review the following standards and guidelines within it's fortnightly meetings:

- Chief Medical Officer Circulars
- Chief Nursing Officer Circulars
- CaNNI reports
- CMACE
- Drug Alerts
- GAIN reports
- HSCB / PHA communications
- NCEPOD reports
- NPSA alerts
- NICE (Clinical Guidelines and Technology Appraisals)
- Policy Circulars – S&Q Learning Communications
- RQIA reports
- SABS Alerts
- Professional Estates Letters / Estate & Facility Alerts

***Key Performance Indicators***

1. To ensure that there is a process in place to ensure that all regionally endorsed standards and guidelines are formally logged on the Trust's Standards & Guidelines database and reviewed in a timely manner at the Trust's Standards and Guidelines Prioritisation and Risk Review group. This group will meet on a fortnightly basis.

2. To ensure that all regionally endorsed standards and guidelines work streams are prioritised in line with other competing governance requirements. This process of prioritisation will be based on the following:
   a. Collaborative discussions by all of the group members who will be responsible for reviewing the issued standards and guidelines seeking expert opinion from within their own areas of responsibility
   b. Cognisance of organisational intelligence that has been identified by other governance and risk management processes (i.e. lessons learned

from complaints / serious adverse incidents / litigation)

c. Cognisance of the challenging timescales that are being externally driven by regional bodies such as the Safety & Quality Unit at the DHSSPS, HSC Board, Public Health Agency etc.

3. Using the Trust's approved risk assessment proforma, review all new standards & guidelines to determine the following:
   - ✓ Frequency of the risk occurring
   - ✓ Impact on the organisation if something happens
   - ✓ Identification of any incidents / complaints within the Trust
   - ✓ Ascertain if the risk already identified on the risk register and assess if an entry is required?

4. Identification of the Lead Director and if there is a multi-directorate applicability seek agreement between Directors of Lead Directors as to who will take forward the role.

5. Identification of a suitable 'Change Leader' and ensure the communication processes are in place to ensure that the required actions are taken forward within a co-ordinated and time managed process

6. Seek agreement of the time scale for implementation (if not already specified)

7. Outlined the monitoring arrangements that are required so to ensure that the action plan / progress report is submitted to Lead Director / SMT for approval prior to issue to HSCB

8. Ensure that there are good record keeping processes in place to provide written assurances that processes are embedded within the organisation and appropriate action is being taken

9. Ensure that there are effective escalation processes in place should concerns be raised about the Trust's ability to achieve full compliance

10. Ensure that there is on-going monitoring of the Trust's Accountability Report for Standards & Guidelines in order to ensure that progress against safety alert recommendations is monitored on an on-going basis. If it is identified that there has been a lack of progress or if there are

challenges / barriers to gaining full compliance this must be escalated to the relevant Director / Senior Management Team for review

***Group Constitution:***

The Trust Standards & Guidelines Prioritisation and Risk Review Group will be composed of the following members:

- Assistant Director for Clinical & Social Care Governance (*chairperson*)
- Medical Director
- Governance Co-ordinator - Acute Services
- Governance Co-ordinator - Children's & Young Peoples Service
- Governance Co-ordinator - Mental Health & Disability
- Governance Co-ordinator - Older People & Primary Care Services
- Medicines Governance Pharmacist
- Patient Safety & Quality Manager
- Estates Risk & Governance Manager

The membership the Committee will be chaired by the Assistant Director of Clinical & Social Care Governance. Invitations may be extended to other Trust members or outside agencies if deemed appropriate by the group members and will be facilitated by the chairperson.

***Responsibilities of Group Members***

- ✓ Each member will be responsible for reviewing the issued standards and guidelines and seeking expert opinion from within their own areas of responsibility and for representing this view as appropriate.
- ✓ Following each meeting the Governance Co-ordinators will be responsible for reporting the meeting outcomes back to their Director.
- ✓ The Chairperson will be responsible for providing regular summary reports to SMT and to the Trust's Governance Working Body.

***Quorum & Meeting Frequency***

A meeting will be quorate if five members are present. If members cannot attend, they will be expected to send an appropriate deputy.

The committee will meet on a fortnightly basis and to facilitate diary management will be held on the relevant Thursday at 12pm (unless otherwise indicated). However arrangements will be put in place to ensure that any immediate issues that need to be addressed are processed immediately.

***Management of the Steering Group Meetings***

An agenda and required papers will be issued on the Monday of the planned meeting week so to ensure timely review and preparation for the meeting.

***Review of the Terms of Reference***

The terms of reference will be reviewed on an annual basis or earlier if required.

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## Process for the Management of Safety Alerts (April 2012)

**External Safety Alerts Team at the PHA/HSCB will meet to determine what arrangements are required for the dissemination, implementation and assurance of pending safety alerts**

SQS guidance, letters & Learning Letters/NPSA alerts/Safety quality professional letters from DHSSPS/ HSCB letters/ PHA letters / Safety Alert Bulletins (SABS) / NICE Clinical Guidelines and Technology Appraisals / Drug Alerts / PEL's & EFAs

- **Task & Finish Group**
- **Bespoke Project**
- **Using existing governance arrangements within the HSC**
- **Sent to named professionals within the PHA and their deputies for appropriate action**

**The Central Coordinating Office (CCO) at the HSCB will communicate to the Trust the agreed arrangements that have been agreed by the Safety Alerts Team / named professionals**

**The Chief Executives Office / other SMT members receive the circular from the CCO for review, dissemination and implementation**

**Within 2 working days**

- **Circular is sent to Patient Safety & Quality Service for logging on database**
- **Circular is sent to relevant Directors / Senior Managers as information**

**Correspondence from the CCO is reviewed by the Trust's S&G review group and way forward is agreed and recorded using the Risk Proforma :**

- ✓ Assess using the following assessment criteria:
  - Frequency of the risk occurring
  - Impact on the organisation if something happens
  - Identification of any incidents / complaints within the Trust
  - Is the risk already identified on the risk register? If not is an entry required?
- ✓ Who is the Lead Director? Multidirectorate alerts require agreement between Directors of Lead Director
- ✓ Who is the 'Change Leader?'
- ✓ Who needs to be involved in the work to progress the recommendations
- ✓ What is the time scale for implementation (if not specified)?
- ✓ When is the action plan / progress report to be submitted to Lead Director / SMT for approval prior to issue to HSCB

**Meeting to be held within 2 weeks of receipt from HSCB**

**Where the Change Leader identifies limiting factors to progressing the Trust s action plan within the agreed time scales these are to be identified as soon as possible with the Lead Director and CEO to be notified**

- **Risk proforma is completed and agreed with Lead Director**
- **'Change leader' Is contacted working group is co-ordinated for implementation of recommendations within agreed time scales**
- **Assurance statement prepared /sent to Lead Director for approval. Tabled at Directorate Governance Forum for approval**
- **Final assurance statements tabled at SMT for approval prior to issue to the HSCB**

**Audit & Improve**

**Outcomes communicated**

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| ***SHSCT S&H / Safety Alerts Review Team: In attendance*** | | | |
|---|---|---|---|
| **Date & time of Meeting:** | | | |
| **Assistant Director for CSCG** | ☐ | **Governance Co-ordinator - MHD** | ☐ |
| **Medical Director** | ☐ | **Governance Co-ordinator - OPPC** | ☐ |
| **Governance Co-ordinator - Acute** | ☐ | **Medicines Governance Pharmacist** | ☐ |
| **Governance Co-ordinator - CYP** | ☐ | **Patient Safety & Quality Manager** | ☐ |
| | | **Estates Risk & Governance Manager** | ☐ |

| ***Categorisation*** | | | |
|---|---|---|---|
| **CMO / CNO Letter** | ☐ | **Professional Estates Letters / Estate & Facility Alerts** | ☐ |
| **Drug Alerts** | ☐ | **SABS alert / Field Safety Notices** | ☐ |
| **NICE Guidelines** | ☐ | **SQS Learning Letters** | ☐ |
| **NICE Technology Appraisals** | ☐ | **Safety Quality Standards (SQS) Guidance & Letters** | ☐ |
| **NPSA Alerts** | ☐ | **Safety Quality Professional Letter from DHSSPS/PHA/HSCB** | ☐ |
| **Other Specify Below:** | | | |

| | |
|---|---|
| **Circular Reference** | |
| **Title** | |
| **Date of Issue from DHSSPSNI** | |

| ***Risk Assessment:*** ***(Refer to SHSCT risk matrix tool below) see page 3 of this document for guidance*** | | | | | |
|---|---|---|---|---|---|
| **Likelihood of the risk occurring if the Trust does not take forward guidance recommendations** | | **Impact on the organisation if something happens** | | **Risk Impact** | |
| **Identification of any incidents / complaints within the Trust** | | | | | |
| **Is the risk identified on the risk register?** ***(tick)*** | **Yes** | ☐ | **No** | ☐ | |
| **If 'Yes' does the register need to be updated?** ***(tick)*** | **Yes** | ☐ | **No** | ☐ | |
| **If 'No' is an entry required?** ***(tick relevant level) (tick)*** | **Yes** | ☐ | **No** | ☐ | |

| ***Directorate Applicability*** ***(tick)*** | | | |
|---|---|---|---|
| **Acute Services** | ☐ | **Medical** | ☐ |
| **Children's & Young Peoples Services** | ☐ | **Mental Health & Disability** | ☐ |
| **Finance** | ☐ | **Older Persons and Primary Care** | ☐ |
| **Human Resources** | ☐ | **Performance & Reform** | ☐ |

| ***Agreed Lead Director:*** | |
|---|---|
| ***For safety alerts with multi-directorate applicability there will be a need to gain agreement between SMT members to confirm the appointment of a Lead Director. This is to be confirmed following the meetings.*** | |

| *Working Group Membership* | |
|---|---|
| **CHANGE LEADER:** | |
| **WORKING GROUP MEMBERS:** | |
| **Stipulated Date for Implementation** | |
| **If not specified determine SHSCT timescales** | |
| **Date to be presented at SMT/SMT Governance** | |
| **Interim progress report required by:** | |
| *Any additional information* | |
| | |

| | |
|---|---|
| **Signature (Chairperson of review team):** | |
| **Date:** | |

## *Risk Assessment Guidance:*

### *Risk Impact/Consequence Table (5x5 Matrix)*

CONSEQUENCE / IMPACT

| | CATEGORY | | | | |
|---|---|---|---|---|---|
| | **PEOPLE** (Any person affected by an Incident: Patient/Client, Staff, User, Visitor or Contractor) | **RESOURCES** (Premises, money, equipment, Business interruption, problems with service provision) | **ENVIRONMENT** (Air, Land, Water, Waste management) | **REPUTATION** (Adverse publicity, Complaints, Legal/Statutory Requirements, Litigation) | **QUALITY AND PROFESSIONAL STANDARDS** (including Government priorities, targets and organisational objectives) |
| ***CATASTROPHIC*** **5** | Incident that leads to one or more deaths | Severe organisation wide damage / loss of services /unmet need | Toxic release affecting off-site area with detrimental effect requiring outside assistance | National adverse publicity. DHSSPS executive investigation following an incident or complaint. Criminal prosecution. | Gross failure to meet external standards, priorities. |
| ***MAJOR*** **4** | Permanent physical / emotional injuries / trauma / harm. | Major damage, loss of property / service / unmet need. | Release affecting minimal off-site area requiring outside assistance (fire brigade, radiation, protection service etc) | Local adverse publicity. External investigation or Independent Review into an incident / complaint. Criminal prosecution / prohibition notice. | Repeated failure to meet external standards. |
| ***MODERATE*** **3** | Semi permanent physical / emotional injuries / trauma / harm (recovery expected within 1 year). Includes RIDDOR reportable incidents. | Moderate damage, loss of property / service / unmet need. | On site release contained by organisation. | Damage to public relations. Internal investigation (high level), into an incident / complaint. Civil action. | Repeated failure to meet internal standards or follow protocols. |
| ***MINOR*** **2** | Short-term injury / harm. Emotional distress. (Recovery expected within days / weeks.) | Minor damage, loss of property / service / unmet need. | On site release contained by organisation. | Minimal risk to organisation. Local level internal investigation into an incident / complaint. Legal challenge. | Single failure to meet internal standards or follow protocol. |
| ***INSIGNIFICANT*** **1** | No injury / harm or no intervention required | No damage or loss, no impact on service. Insignificant unmet need. | Nuisance release. | Minimal risk to organisation, Informal complaint | Minor non compliance. |

| | CONSEQUENCE (POTENTIAL IMPACT) | | | | |
|---|---|---|---|---|---|
| **LIKELIHOOD** | **Insignificant (1)** | **Minor (2)** | **Moderate (3)** | **Major (4)** | **Catastrophic (5)** |
| **Almost Certain (5)** (will undoubtedly recur, a persistent issue) 1:10 | 5 | 10 | 15 | 20 | 25 |
| **Likely (4)** (will probably recur, not a persistent issue) 1:100 | 4 | 8 | 12 | 16 | 20 |
| **Possible (3)** (may recur occasionally) 1:1,000 | 3 | 6 | 9 | 12 | 15 |
| **Unlikely (2)** (do not expect it to happen again) 1:10,000 | 2 | 4 | 6 | 8 | 10 |
| **Rare (1)** (can't believe it will ever happen again) 1:100,000 | 1 | 2 | 3 | 4 | 5 |

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# Minutes of the confidential section of the Governance Committee of the Southern Health and Social Care Trust held on Tuesday, 18th January 2011 at 11.00 a.m. in the Boardroom, Trust Headquarters *(deferred from 7th December 2010)*

## PRESENT:

Mrs D Blakely, Non Executive Director (Chairman)
Mr E Graham, Non Executive Director
Mr A. Joynes, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director

## IN ATTENDANCE:

Mrs M McAlinden, Chief Executive
Dr P Loughran, Medical Director
Dr G Rankin, Interim Director of Acute Services
Mr S McNally, Director of Finance and Procurement
Mrs A McVeigh, Acting Director of Older People and Primary Care Services
Mrs J Holmes, Board Secretary
Mrs S Judt, Committee Secretary (Minutes)
Mrs M McIntosh (for Mr B Dornan)

## APOLOGIES:

Mrs R Brownlee, Non Executive Director
Mr B Dornan, Director of Children and Young People's Services/Executive Director of Social Work
Mrs P Clarke, Director of Performance and Reform
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Mr K Donaghy, Director of Human Resources and Organisational Development

1. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held on 7th September 2010 were agreed as an accurate record and were duly signed by the Chairman.

2. **MATTERS ARISING FROM PREVIOUS MEETING**

i) **Ref ID:** Personal Information redacted by USI

Mrs McIntosh provided a response to the issues identified by Dr Mullan and Personal Information redacted by USI at the previous meeting. Dr Mullan had referred to the lack of communication and asked for clarification that information in terms of procedures and guidelines are consistent across Trusts to ensure patient safety. Mrs McIntosh confirmed that there is a procedure in place. A telephone call is made from hospital to the Children's Community Nurse notifying of the intention to discharge and identifying the child's needs. One the day of discharge, a further telephone call of confirmation is made to the Children's Community Nurse. Personal Information redacted by USI had also referred to the lack of communication and poor liaison and asked that learning from this incident is shared across the organisation. Mrs McIntosh advised that learning has been shared between Teams and information has been inputted into the Children's and Young People's Directorate Governance Learning Bulletin. The Regional HSCB is taking action to share learning through its professional lead in Pharmacy.

ii) **Look Back Exercise, Daisy Hill Hospital**

The Chief Executive advised that Dr S's Hearing had taken place, the outcome of which is that he is allowed to continue as a fully registered Doctor with no restrictions in place.

iii) **Cardiology Death**

Dr Rankin stated that a range of actions are underway, the majority of which have now been completed. Dr Rankin agreed to bring the final report and the action plan to the next Governance Committee meeting.

iv) **Bullas: ID 21890 NMC Hearing**

Dr Rankin stated that there was no further progress to report at this stage.

3. **CESSATION OF NEW ADMISSIONS TO** [redacted]

Mrs McVeigh reminded members of the Trust's decision to cease admissions to [redacted], further to quality of care issues emanating from RQIA. As a result, the Trust has provided considerable support to the Home in order to assist it in addressing the concerns raised.

Mrs McVeigh outlined the actions taken and progress made. A decision was taken on 17th November 2010 to lift the suspension on Trust admissions to the Home.

Mrs McVeigh advised that there is learning for the Trust from this process and outlined the following actions that have been taken:-

- An RCA will be carried out with Trust staff involved in Glencarron. The outcome will inform the model of care to be developed;
- A workshop was held on 13th January 2011 to identify the learning for the Trust and progress the development of an action plan.

4. **ANY OTHER BUSINESS**

i) **Serious Adverse Incidents**

The Chief Executive provided a verbal update on the following incidents:-

Personal Information redacted by USI

A current joint investigation is being completed by the Trust and the PSNI in relation to an allegation of a sexual assault by a staff member on Mr Personal Information redacted by USI whilst he resided in Riverside Residential Home during 2006-2008.

Personal Information redacted by USI

Personal Information redacted by USI

A Personal Information redacted by USI male known to mental health services died on 03 September 2010. His body, with multiple puncture wounds, was found by his girlfriend in his flat.

The PSNI investigation into Personal Information redacted by USI death showed a high number of sexual partners (male & female). Subsequent blood testing of Personal Information redacted by USI confirmed that he was HIV positive and had Syphilis. It is thought that twenty one individuals have now been identified, 13 of which relate to the SHSCT area. Some of these cases are/have been known to mental health services and some have children. There have also been some allegations made by children that they had been abused by Personal Information redacted by USI Mr Personal Information redacted by USI had previously alleged that a male Personal Information redacted by USI had "given him Aids". This allegation is currently being investigated. There therefore may be a serious unexpected risk to service users and/or members of the public.

Public Health Authority & Regional GUM Clinic aware of situation. A regional strategy meeting was held on 11-01-11 which was attended by SHSCT staff. GUM clinic now intend to write to the persons identified by PSNI. PHA has therefore asked the SHSCT to identify from that list of persons, those who are known to the Trust and who may be classed as "potentially

vulnerable" so that the appropriate support mechanisms can be put in place. A SHSCT strategy meeting was held on 13-01-11 and actions agreed. Trust staff will attend a further regional strategy meeting with PHA on 20-01-11. The Director of Legal Services has been invited to that meeting to ensure that the gathering of information to inform the strategy for dealing with this case is conducted within the parameters of the Data Protection Act.

Personal Information redacted by USI

A self-harming incident on 11th January 2011 resulted in the death of a Irrelevan year old male client with a learning disability Personal Information redacted by USI who was residing in Irrelevant information redacted by the USI Lurgan, a supported living facility which is managed by Irrelevant information redacted by the USI NI. The Trust will lead on the joint multidisciplinary SAI review.

A summary of the above incidents will be provided to the Non Executive Directors.

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**REPORT SUMMARY SHEET**

| | |
|---|---|
| **Meeting:**<br>**Date:** | **TRUST BOARD**<br>**26 March 2015** |
| **Title:** | **Monthly Performance Management Report** |
| **Lead Director:** | **Paula Clarke, Director of Performance and Reform** |
| **Corporate Objective:** | • Provide safe high quality care<br>• Maximise independence and choice for our patient and clients<br>• Support people and communities to live healthy lives and to improve their health and wellbeing.<br>• Make best use of resources. |
| **Purpose:** | **For Approval** |
| **Summary of Key Areas:** | ***High level context:***<br><br>This report reviews performance at the end of February 2015 against the Commissioning Plan standards and targets and provides an assessment of current performance.<br><br>The report highlights a number of areas of risk predominantly with respect to elective access standards. |
| **Summary of Key Areas: (continued)** | ***Key issues/risks for discussion:***<br><br>• **Elective Access** –The Trust continues to work to maintain the access positions achieved at March 2014 (standards 9-weeks/13-weeks with maximum backstops of 15-weeks/26-weeks). As indicated in previous reports to the Trust Board performance against this target has become increasingly challenging, particularly in Acute Service Directorate, associated with the following key issues:<br><br>o Decision taken in July by HSC to temporarily suspend sending any additional new patients to the Independent Sector (IS) for assessment or treatment and to temporarily 'pause' the treatment of a cohort of patients already in the IS;<br>o Revised level of in-house additional capacity in Q1/2 resulting in greater gaps between demand and capacity; and<br>o No confirmed funding for additional capacity in Q3/4(except for radiology).<br><br>Whilst levels of activity continue to improve improving in line with the agreed Service & Budget Agreement (SBA), there are a number of specialty areas with capacity gaps where no allocation for additional activity in out-patients, in-patients and day cases has been provided by HSCB in Q3/4; this compounds |

| | |
|---|---|
| | the backlog accrued in Q1/2 and will result in increased access times at March 2015.<br><br>The HSCB has confirmed a small allocation of funding for additional capacity in diagnostic imaging and endoscopy but this is insufficient in most areas to achieve the target access position.<br><br>• The Trust has updated its access times projected to be achieved at the end of March (Appendix 2).<br><br>o Out-Patients – 18 out of 24 specialties monitored are in excess of the 15-week backstop. Of the 18, 11 specialties are over SBA; 6 of the18 specialties are under SBA with 4 out of the 6 within the <-5% tolerance. The remaining 2 out of the 6 are in excess of -10%.<br>o In-Patients/Day Cases – 7 out of 13 specialties monitored are in excess of the 26-week backstop. Of the 7, 3 specialties are over SBA; 4 of the 7 specialties are under SBA with 2 out of the 4 within the <-5% tolerance. The remaining 2 out of the 4 are between >-5% and <-10%.<br>o Diagnostics – 7 out of 8 specialties monitored are in excess of the 9-week access target. Of the 7 areas 6 have an aligned SBA; 5 of these are performing above SBA and one is under SBA at -3.51% but within the <-5% tolerance;<br>o Mental Health – 2 out of 5 specialties monitored are in excess of the 9-week access target with 1 out of 2 specialty in excess of the 13-week access target; and<br>o Allied Health Professionals – 5 out of 6 professions monitored are in excess of the 9-week access target.<br><br>Other key risks affecting performance remain, relating to a number of common factors:<br><br>o Recurrent investment has not yet been secured for all services with a recognised capacity gap. This, associated with current HSCB review of the level of funding available in-year for implementation of agreed investments, has affected the implementation and roll out of projects where funding has been agreed;<br>o The impact of workforce controls relevant to Trust financial contingency plans;<br>o Particular issues relating to sickness, maternity and other absences in the medical workforce and associated challenges in securing backfill capacity in general;<br>o Continued pressures on demand in some areas including non-elective demand, urgent and red flag referrals; and<br>o The need to allocate appropriate levels of capacity for service areas not subject to regional standards/targets eg. review appointments and planned repeat procedures.<br><br>• **Progress on prioritised recurrent Elective Investments –**<br>o Initial areas prioritised for investment included ENT, Gynaecology, General Surgery, Cardiology, Rheumatology, |

| | |
|---|---|
| | Endoscopy and Orthopaedics;<br>o Agreement has now been reached with HSCB for investment into ENT, T&O, General Surgery; Rheumatology and Gynaecology;<br>o Whilst an IPT had been submitted for Cardiology, this is now being revised, in light of revised service provision requirements. A high level proposal has also been submitted for in-year endoscopy investment for which formal response is awaited; and<br>o The Trust is working to implement in-year plans for areas where agreement has been secured.<br><br>• **Emergency Department** – The Trust continues to focus on effecting improvement and sustainability in performance against the ED Target and has dedicated senior staff to provide a focus on service improvement in ED and on patient flow throughout the hospital system.<br><br>A high volume of attendances and the % of admissions via ED experienced in December has continued throughout January, February and into early March.<br><br>• **Cancer Pathways** – Whilst the Trust has experienced increased demand for cancer (red flag) referrals, which has affected performance against the 62-day pathway, the Trust continues to improve this position and achieved 91% in January, with an unvalidated position indicating February performance remaining relatively static. Regional focus has been on ensuring there are no patients waiting over 85 days. Within the Trust 0 patients waited over 85 days for definitive treatment at the end of January or February.<br><br>In respect of the 14-day breast cancer performance the Trust has maintained its increased performance. Additional capacity, temporarily funded by the Trust, to focus on routine waits has seen the access time for routine patients decrease to 13-weeks at the end of February with an anticipated access time of 9-weeks at the end of March, assuming demand remains static.<br><br>• **AHP** –The Trusts internal review of AHP has identified a number of areas for improvement, including workforce, performance and professional best practice.<br><br>Key performance challenges relate to demand and capacity in paediatric areas and performance against access standards continues to reflect longer waits. The Trust has sought engagement with HSCB/PHA to agree capacity and demand issues and establish a SBA for this service area. In addition, waits beyond the clinically indicated date have occurred for review and treatment in a number of AHP areas. The Trust has provided additional temporary support to address these backlogs and actions are in place to secure an improvement in this area. |

| | |
|---|---|
| | The Trust has engaged with staff side and key AHP representatives to discuss terms for a workforce review of skill and band mix to ensure the profile of staffing is consistent with the needs of the service.<br><br>• **Mental Health Access –** Areas reported under mental health targets which continue to be challenged in the achievement of maximum waiting time targets are the Memory/Dementia service and Psychological Therapy service. In addition emergent issues are impacting in Primary Mental Health Care services which will see an increase in access times beyond the 9-week target.<br><br>• **Memory/Dementia Service** –The Trust in conjunction with HSCB and SLCG has reviewed this service area in light of the current performance issues across the pathway. New agreed reporting arrangements have been implemented from the end of January.<br><br>Whilst the SHSCT has the majority of breaches within the Region, for this target, it is progressing a demand and capacity analysis to define capacity gaps. This work will link into the implementation of the Regional Dementia Strategy.<br><br>• **Primary Mental Health Care** – Demand and capacity issues are both impacting on PMHC. The service has seen an increase in referrals and an increase in the volume of urgent cases within this cohort. In addition there are challenges with capacity associated with staff sickness/absence. Whilst interim plans in place it is anticipated these plans will not be able to stem the increasing access times. The Commissioner has been advised of the issue.<br><br>• **Psychological Therapies** – Due to medical staffing vacancies access times with Psychological Therapies have been affected. The service has attempted to secure temporary staff and additional in-house capacity without success. Permanent recruitment has been successful with staff commencing in Quarter 4.<br><br>***Summary of SMT challenge/discussion***<br><br>• Review of the reduced performance position at the end of Quarter 3 2014 to challenge potential for improvement particularly in the delivered SBA levels agreed to secure improvement for SBA performance.<br>• Discussion of emerging risks within the clinical pathway and re-direction of temporary internal resources to address key areas of emerging clinical risk with noting on the corporate risk register.<br>• Discussion re need for continued re-direction of temporary internal resources to address key areas of emergency clinical risk into April 2015.<br>• Agreement to give priority to addressing patients waiting beyond their clinically indicated review timeline and acceptance that this |

| | |
|---|---|
| | may impact further on access for new patients but this risk to be balanced specialty by specialty.<br>• Assurance sought on adherence to the IEAP in particular strict chronological management and DNA/CNA practices.<br>• Agreement to continue targeting of senior capacity to support improvement in a number of high risk specialties/services with initial focus in ED/unscheduled care, AHP & Memory services. |

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# PERFORMANCE MANAGEMENT REPORT

## COMMISSIONING PLAN STANDARDS/TARGETS FOR 2014/2015

## INCLUDING INDICATORS OF PERFORMANCE

**March 2015 Report for**

**February 2015 Performance**

**CONTENT**

## 1.0 CONTEXT

This report forms part of the Trust's Performance Management Framework and sets out a summary of Trust performance for 2014/2015 against:

- Health and Social Care Commissioning Plan Standards/Targets

A significant number of Indicators of Performance (IoP) have been identified to complement the Commissioning Plan Standards and Targets. These IoPs whilst not identified as specific targets will be monitored in year to assess broader performance. Detailed in the attached report are the Indicators of Performance that are currently reported on a monthly basis.

## 2.0 REPORTING

Qualitative and quantitative updates on performance against the Commissioning Plan Standards/Targets are presented in this performance report under the themes of Ministerial Priority:

- To improve and protect health and well-being and reduce inequalities; through a focus on prevention, health promotion, anticipation and earlier intervention;
- To improve the quality of services and outcomes for patients, clients and carers through the provision of timely, safe, resilient and sustainable services in the most appropriate setting;
- To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long-term conditions;
- To promote social inclusion, choice, control, support and independence for people living in the community, especially older people and those individuals and their families living with disabilities;
- To improve the productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities;
- To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across all our services;

The level of performance, based on the current and anticipated progress, will be assessed as follows:

| | |
|---|---|
| Green (G) | Standard/target achieved/on track for achievement – Monitor progress to ensure remains on track |
| Yellow (Y) | Standard/target substantially achieved/on track for substantial achievement – Management actions in place/monitor progress to ensure standard/target remains on track |
| Amber (A) | Standard partially achieved/limited progress towards achievement of target – Management actions required |
| Red (R) | Standard/target not achieved/not on track to achieve – Management actions/intervention required |
| | Not assessed (due to lack of baseline; target; or robust data) |

The performance trend, representing the direction of progress during the financial year, will be indicated by the arrows below:

| | | | | | |
|---|---|---|---|---|---|
| ↑ | Performance improving | ↓ | Performance decreasing | ⇔ | Performance static |

## 3.0 COMMISSIONING PLAN STANDARDS/TARGETS AND ASSOCIATED PERFORMANCE

**MINISTERIAL PRIORITY: TO IMPROVE THE QUALITY OF SERVICES AND OUTCOMES FOR PATIENTS, CLIENTS AND CARERS THROUGH THE PROVISION OF TIMELY, SAFE, RESILIENT AND SUSTAINABLE SERVICES IN THE MOST APPROPRIATE SETTING**

**CP 5: HIP FRACTURES: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services**

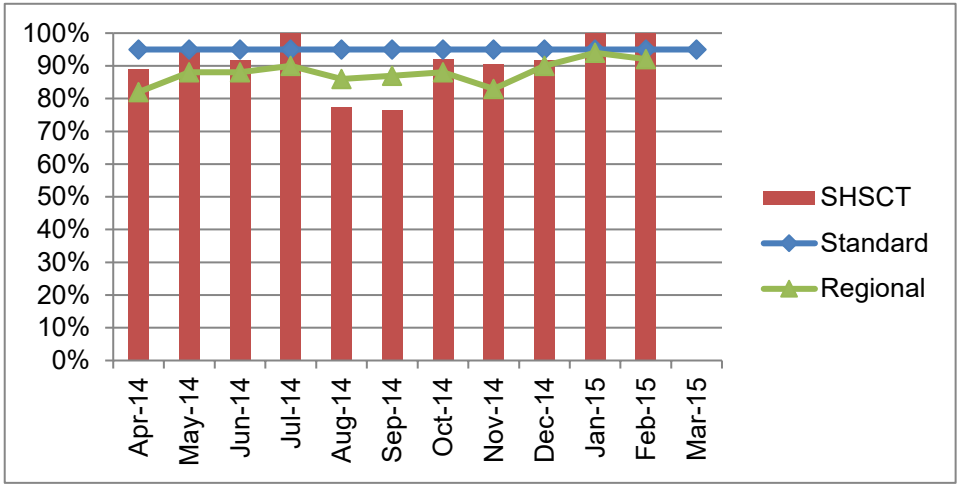
**From April 2014, 95% of patients, where clinically appropriate, wait no longer than 48 hours for in-patient treatment for hip fractures.**

| | |
|---|---|
| **Baseline:** 91% (2013/2014)<br>**TDP Assessment:** Likely to be achieved with some delay / partially achieved | **Standard:** 95% |

**Comments:**

January performance varied across the Region from 78% (SEHSCT) to 100% (SHSCT and BHSCT).

On-going trauma pressures have resulted in the cancellation of elective orthopaedic surgery to facilitate the treatment of the clinically urgent trauma cases. From 1 April to week commencing 9 March 2015 103 elective orthopaedic operative cases have been cancelled to facilitate trauma cases. Whilst HSCB have confirmed in-year funding allocations for Trauma & Orthopaedic (T&O) implementation, this did not include funding to facilitate the re-provision of any cancelled orthopaedic cases which is affecting access times in this specialty. This has also lead to an underperformance on the service and budget level agreement by an estimated -6%.




**Actions to Address:**

- The Trust continues with the T&O in-year implementation plan. Consultant 1 and 2 are in post with consultant 3 commencing August 2015; with the recruitment process ongoing for the 4th Consultant.
- The Trust continues to work with the HSCB Director of

| | |
|---|---|
| Commissioning to develop a 'blue-sky' model to address future service demand and is initiating pilot work in-year to enable this model with release of staff to commence nurse led fracture clinics, training of surgical theatre assistant and additional theatre capacity with specialty doctor working parallel to consultant staff; the impact of the initial work will be assessed by the commissioner in June.<br>• On a daily basis the clinical team ie. Consultants; Junior Medical Staff; and Trauma Co-Ordinator meet, to present each trauma case, and agreed on the clinical priority of the cases and the trauma list for that day. | |

| Site | Monthly Position: | | | | | | | | | | | | Cum. Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **Trust** | 89.5% (17 out of 19) | 95.5% (21 out of 22) | 91.7% (22 out of 24) | 100% (15 out of 15) | 78.3% (17 out of 22) | 76.5% (13 out of 17) | 92% (23 out of 25) | 90.5% (19 out of 21) | 91.7% (33 out of 36) | 100% (30 out of 30) | 100% (26 out of 26) | | **Y** | ↑ |
| **Regional** | 82% | 88% | 88% | 90% | 86% | 87% | 88% | 83% | 90% | 94% | 92.1% | | | |

**CP 6: CANCER CARE SERVICES: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services**

**From April 2014, all urgent breast cancer referrals should be seen within 14-days.**

**Baseline:** 73.9% (April to December 2013)
**TDP Assessment:** Likely to be achieved with some delay / partially achieved

**Standard:** 100%

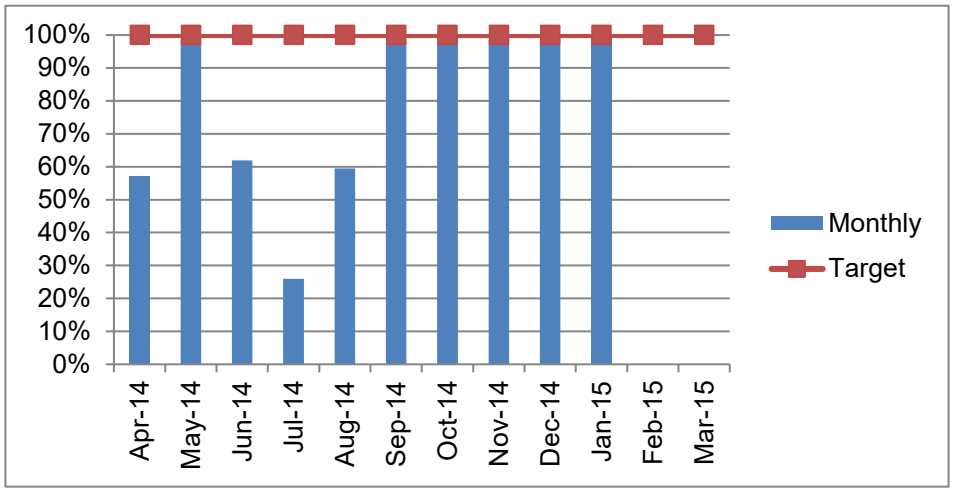
**Comments: February update not available**

January performance across the Region varied from 79% (BHSCT) to 100% (NHSCT; SEHSCT; and SHSCT).

Whilst routine waits had extended out to 24-weeks the service has now commenced additionality through internal funding and has achieved, as per the plan, 13-weeks at the end of February and continues to work to 9-weeks for March, assuming demand remains static.

**Actions to Address:**

- Additional clinics continue to be undertaken in Quarter 4, facilitated through internal funding which will continue to improve access times for routine patients. continue to provide interim funding for this capacity gap
- The Trust has met with the SLCG and confirmed recurrent capacity gap for Symptomatic Breast services. An investment proposal is being prepared.




| Monthly Position: | | | | | | | | | | | | Cum. Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| 57.3% (110 out of 192) | 98.7% (154 out of 156) | 61.9% (112 out of 181) | 25.9% (65 out of 251) | 59.5% (115 out of 284) | 98% (244 out of 248) | 100% (233 out of 233) | 98.6% (218 out of 221) | 100% (249 out of 249) | 99.5% (221 out of 222) | No update | | Y | ↑ |

**CP 6: CANCER CARE SERVICES: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services**

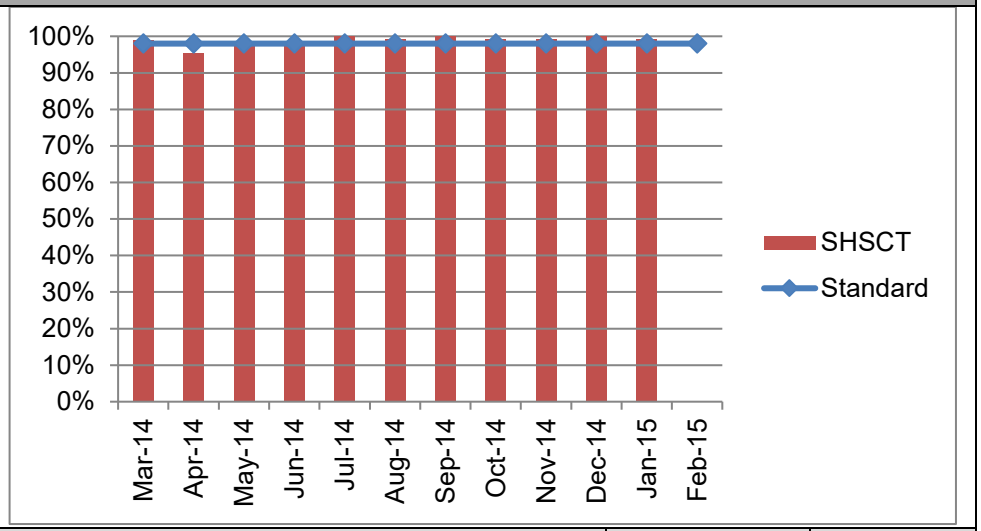
**From April 2014, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31-days of a decision to treat.**

**Baseline:** 99.3% (April to December 2013)
**TDP Assessment:** Likely to be achieved with some delay / partially achieved

**Standard:** 98%

**Comments: Reporting one month in arrears.**
Performance against the 31-day standard is based on completed waits ie. those patients that have had their cancer confirmed and who have received their first definitive treatment.

January performance across the Region remained relatively static with it ranging from 89% (BHSCT) to 100% (SHSCT and WHSCT).




| Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| 95.45% | 97.75% | 98.43% | 100% | 99.06% | 100% | 99.2% | 99.07% | 100% | 99.16% | | | Y | ↑ |

**CP 6: CANCER CARE SERVICES: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services**

**From April 2014, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62-days.**

**Baseline:** 89.6% (April to December 2013)
**TDP Assessment:** Likely to be achieved with some delay / partially achieved

**Standard:** 95%

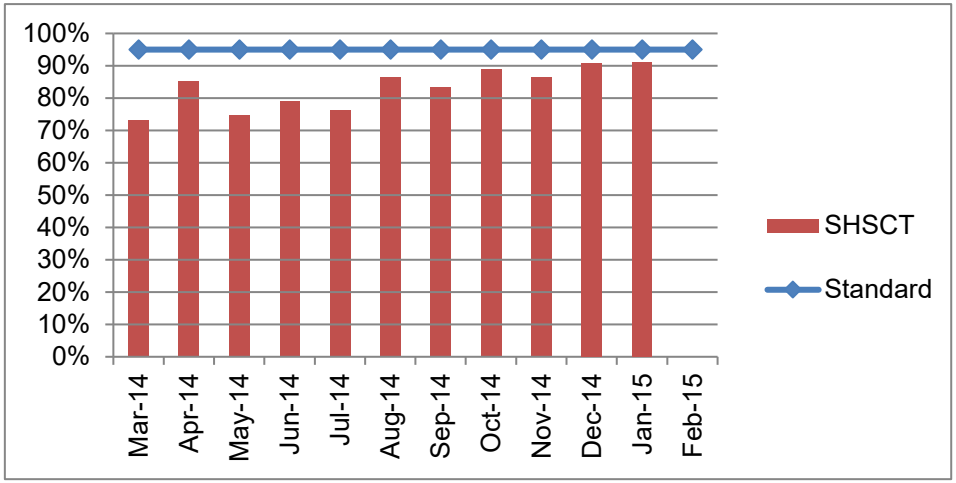
**Comments: Reporting two months in arrears.**
Performance against the 62-day standard is based on completed waits ie. those patients that have had their cancer confirmed and who have received their first definitive treatment.

**62-Day:** In January there were 9 patients in excess of the 62-day standard: 1 Urology (Internal); 1 Head and Neck (External); 2 Lung (External) and 5 Urology (External).

Unvalidated February position is 88.3% with 9 patients in excess of the 62-day standard: 1 Haematology (External); 1 Lung (External); 2 Upper GI (External); 3 Urology (External); 1 Head and Neck (External) and 1 Skin (External).

**Day-85:** There were no breaches of Day 85 in January or February 2015.

January performance across the Region varied from 54% (SEHSCT) to 94% (WHSCT).




| Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| 85.37% | 74.73% | 79.05% | 76.23% | 86.41% | 83.33% | 88.89% | 86.3% | 90.91% | 91.07% | | | A | ↑ |

Note: amendment to October / November data

| CP 7: UNSCHEDULED CARE: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services | |
|---|---|
| **From April 2014, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department.** | |
| **Baseline:** Trust – 82.19% (2013/2014)<br>CAH – 72.8% (2013/2014)<br>DHH – 86.6% (2013/2014)<br>**TDP Assessment:** Likely to be achieved with some delay / partially achieved | **Standard:** 95% |

**Comments:**

Performance continues to be challenging and a range of initiatives have been implemented to improve this position. Patient flow continues to be a particular challenge over the Winter period and the Trust has experienced an unusually sustained period of bed pressures. The high level of attendances and admissions felt over the Christmas and New Year period has continued through, January, February and into March.

In January CAH ED experienced daily admissions from ED ranging from 42 – 64 per day with an average of 52. The average admissions per day in February further increased to 59 with the range from 48 – 74. In the first 11 days of March the average admissions remains static at 58 with the range from 47 – 68.

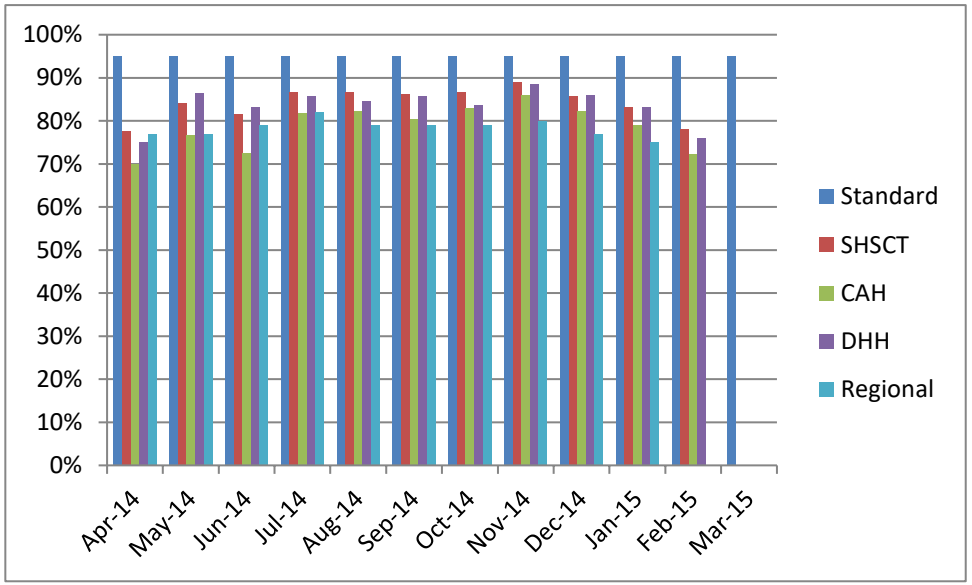
In February DHH ED experienced daily admissions from ED ranging from 13 to 37 with an average of 27. In the first 11 days of March the average admissions remains static at 25 with the range from 20 to 33.

Of note the Trust was the highest performing again in January across the Region with performance ranging from 66% (NHSCT) to 83% (SHSCT).

Graph 2 demonstrates the volume and percentage of admissions via ED, on the CAH site, from the period 21/12/14 to 11/3/15 with the % of admissions via ED, which averaged at 27%, peaking at 35%.

**Actions to Address:**

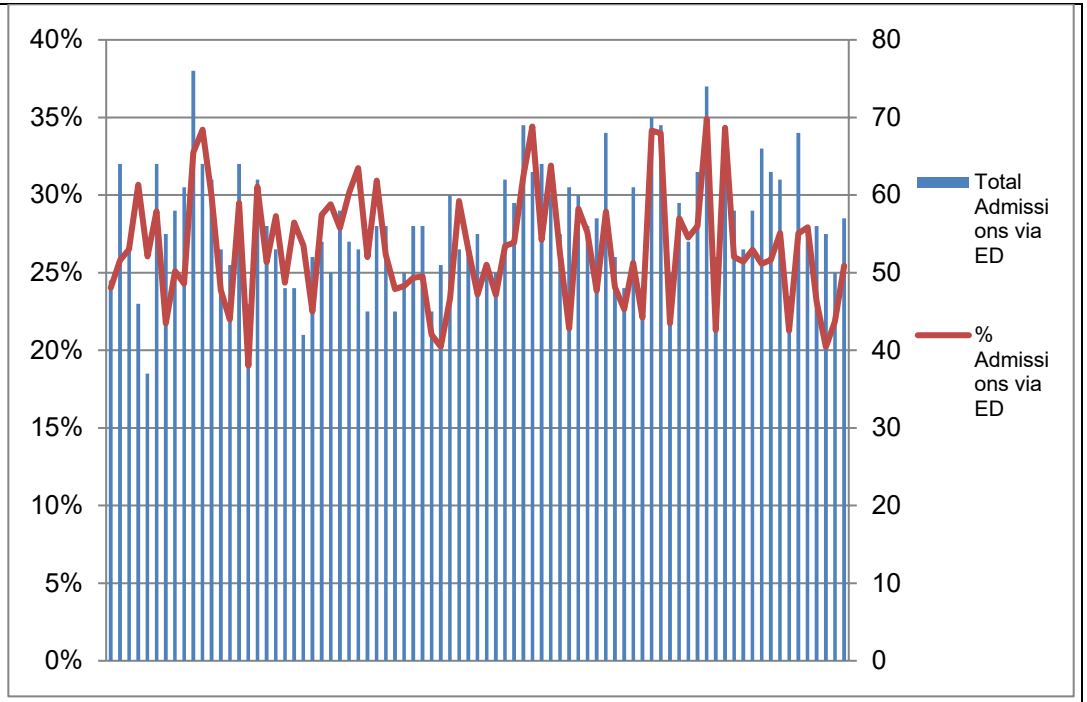
- Sustained management & clinical focus in and out of hours to maintain focus and support to staff during this prolonged period of




Graph 1 – 4-Hour Performance

Winter pressures

- Ongoing review of the '60 minute plan' to focus on triage, front loading investigation, streaming and early assessment and treatment to review practice and take appropriate actions to support this as appropriate. The improvements delivered through the implementation of the '60 minute plan' have been impacted upon with further pressure in the CAH ED due to medical staffing pressures – 2 vacant consultant posts (one due to be filled early May 2015 with the other relating to new long-term sick leave); and gaps at middle grade level, which the department have been unable to cover through agency;
- Improvement work focused on throughput in the minor stream, to ensure early assessment, prompt treatment post assessment and escalation to Band 6 clinical sister has been initiated and ED is working to a culture whereby 'no minor patients should breach;
- The daily patient flow processes in CAH have been amended with the objective of pulling discharges forward and working towards having the hospital settled by 8.00pm. This is to avoid a build-up of admissions in the ED in the evening which impact on the patient experience and cause longer waiting times. Monday - Friday calls continue with Alamac, assessing performance against the 4 hour standard and highlighting areas for further improvement.
- From April 2015 an Expeditor Role in CAH ED is to be introduced from 12 midday to 11.00pm, 7-days a week, for a period of 6-months, initially. This is to be progressed through existing resources; and
- The Trust is working with the Commissioner on an Unscheduled Care Plan to address 5 key areas (as identified by HSCB/PHA) and also the medical bed capacity problem in CAH.




Graph 2 – Number of Admissions and % of Admissions via CAH ED for the period 21/12/14 to 11/3/15

| Site | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| Trust 4-Hour | 77.6% (10182 out of 13120) | 84.2% (10882 out of 12922) | 81.5% (11039 out of 13539) | 86.7% (11537 out of 13309) | 86.7% (10849 out of 12510) | 86.1% (11240 out of 13052) | 86.6% (10925 out of 12615) | 89.1% (10517 out of 11797) | 85.8% (10295 out of 11994) | 83.3% (9751 out of 11699) | 78% (8983 out of 11520) | | R | ↑ |
| Trust 6-Hour | 91.4% (11996 out of | 96% (12406 out of | 94.3% (12765 out of | 96.2% (12808 out of | 96.4% (12055 out of | 95.7% (12487 out of | 95.5% (12050 out of | 96.7% (11408 out of | 95.7% (11484 out of | 94.1% (11011 out of | 91.9% (10584 out of | | | ↑ |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 13120) | 12922) | 13539) | 13309) | 12510) | 13052) | 12616) | 11797) | 11994) | 11699) | 11520) | | | |
| **Site** | **Monthly Position:** | | | | | | | | | | | | **Cum Assess** | **Trend** |
| | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | | |
| **CAH 4-Hour** | 70% (4588 out of 6553) | 76.7% (4986 out of 6503) | 72.6% (4838 out of 6665) | 81.7% (5348 out of 6544) | 82.3% (5004 out of 6078) | 80.4% (5168 out of 6430) | 83% (5268 out of 6349) | 86% (5403 out of 6284) | 82.2% (5462 out of 6645) | 79% (5032 out of 6371) | 72.2% (4408 out of 6103) | | **R** | ↑ |
| **CAH 6-Hour** | 88.4% (5794 out of 6553) | 93.8% (6099 out of 6503) | 91.2% (6077 out of 6665) | 94.7% (6194 out of 6544) | 95.1% (5778 out of 6078) | 93.8% (6029 out of 6430) | 93.7% (5947 out of 6349) | 95.6% (6005 out of 6284) | 94.5% (6281 out of 6645) | 92.2% (5876 out of 6371) | 89.9% (5486 out of 6103) | | | ↑ |
| **DHH 4-Hour** | 75.1% (2934 out of 3907) | 86.4% (3318 out of 3840) | 83.1% (3298 out of 3971) | 85.7% (3459 out of 4035) | 84.5% (3209 out of 3796) | 85.8% (3316 out of 3866) | 83.7% (3111 out of 3719) | 88.6% (3109 out of 3508) | 86% (3174 out of 3689) | 83.1% (2984out of 3593) | 75.9% (2658 out of 3500) | | **R** | ↑ |
| **DHH 6-Hour** | 90.7% (3542 out of 3907) | 97.1% (3728 out of 3840) | 95.3% (3785 out of 3971) | 96.3% (3884 out of 4035) | 95.9% (3641 out of 3796) | 95.8% (3702 out of 3866) | 95.6% (3555 out of 3719) | 96.9% (3398 out of 3508) | 96.1% (3544 out of 3689) | 94.6% (3400 out of 3593) | 90.9% (3181 out of 3500) | | | ↑ |
| **Regional Ave (Peer)** | 77% | 77% | 79% | 82% | 79% | 79% | 79% | 80% | 77% | 75% | No update | | | |

**CP 7: UNSCHEDULED CARE: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services**

**From April 2014, no patient attending any Emergency Department should wait longer than 12 hours.**

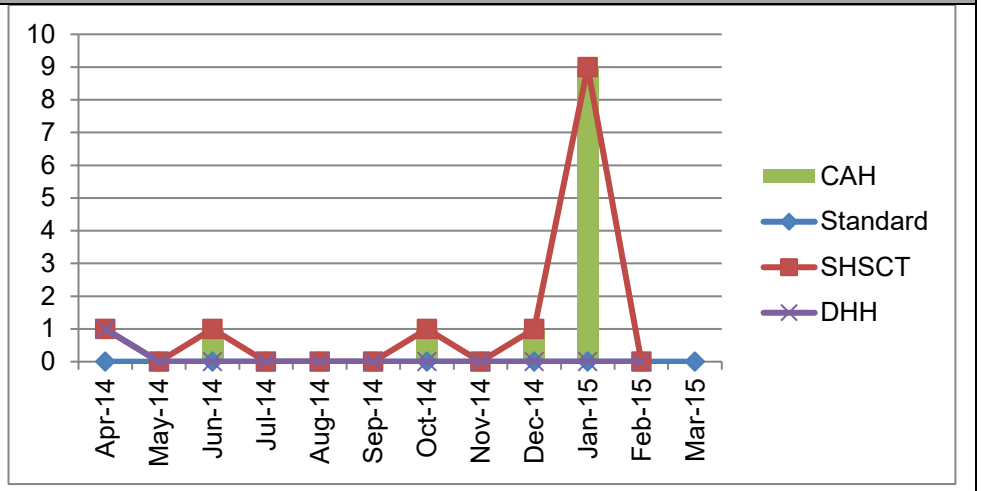
**Baseline:** 96 (2013/2014)
**TDP Assessment:** Likely to be achieved with some delay / partially achieved

**Standard:** 0

**Comments:**

There have been 9 further breaches of the 12-hour standard, on three consecutive days, in January when volumes of attendances and admissions remained high. Regionally pressures on EDs remained high in this period with 380 breaches, ranging from 7 (WHSCT) to 237 (SEHSCT).

From April to January 205 there was a total of 1919 breaches of the 12-hour standard in the Region, with SHSCT only accounting for 4 of these (0.7%).




| Site | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **Trust** | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 9 | 0 | | **R** | ↓ |
| **CAH** | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 9 | 0 | | **R** | ↓ |
| **DHH** | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | **G** | ↔ |

| GP OUT OF HOURS: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care | |
|---|---|
| GP Out of Hours Standards are:<br>Urgent triage (UT) 90% within 20 minutes<br>Urgent face to face (UF2F) appointment 90% within 2-hours | Routine triage (RT) 90% within 60 minutes<br>Routine face to face (RF2F) appointment 90% within 6-hours |

**Comments:**

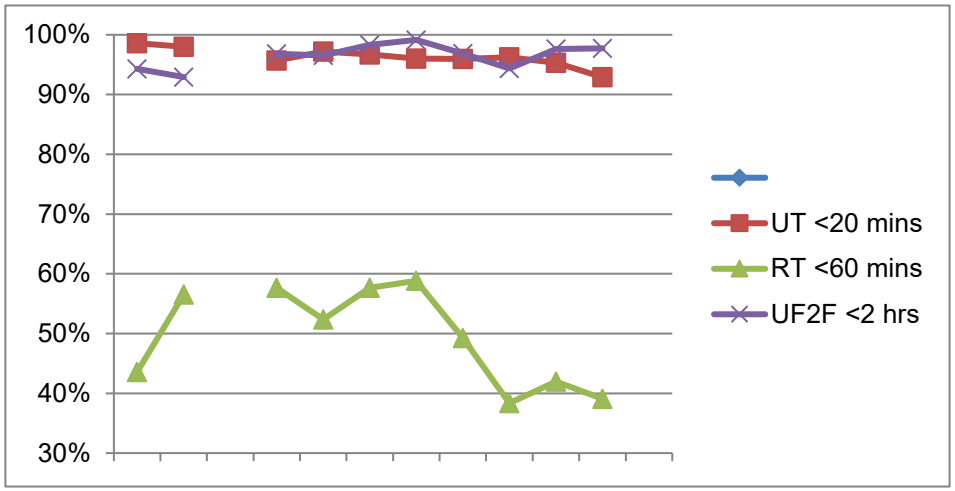
In order to reflect the totality of pressures on the 'unscheduled system' information on GP Out of Hours performance has been included. Whilst this is not a Commissioning Plan Standard or Indicator of Performance its activity / performance can have a direct relationship to ED.

- Urgent triage – of the 127 patients not triaged within 20-minutes, 7 patients waited in excess of 60 minutes for urgent triage.
- Routine triage – of the 3577 patient not triaged within 20-minutes, 167 patients waited 10 + hours for routine triage.
- Urgent face to face base attendance – of the 9 patients not seen within 2-hours, 1 patient waited 5-6 hours for an urgent face to face base appointment.
- Routine face to face base attendance – of the 78 patients not seen within 2-hours, 1 patient waited 16-18 hours for a routine face to face base appointment.

The ability to maintain adequate service provision and standards for triage relate to ongoing challenges presented in filling vacant GP shifts. Efforts to recruit additional GPs and Locum staff have not been successful.

**Actions to Address:**

- To supplement the current service, for triage, the Trust has recruited 30 nurses to undertake triage. The first cohort to staff are beginning their IT training in the middle of February and will follow with shadowing current staff. The second cohort of staff will begin training at the end of February.
- The Trust has also concluded interviews for Advanced Nurse Practitioners and 5 staff have accepted the posts and are awaiting their IT training.
- A pilot has been developed to enable Pharmacists to undertake triage, at weekends, for medication related calls. The recruitment process is completed and 9 applicants have been appointed and are attending Induction in mid-February. The staff will shadow the GPs for a period and then will begin shifts on Sunday, 1 March with shifts covering 11am



| | |
|---|---|
| – 4pm Saturday; Sunday; and Bank Holidays.<br>• Through additional funding secured for Winter Pressures additional GP shifts have been offered Monday – Thursday (4 hour shift); Friday (5 hour shift); Saturday and Sunday (20 hours in 4 shifts), with over 50% uptake on these shifts.<br>• Trust is exploring pilot of enabling IT equipment to support Out of Hours processes. | |

| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **UT <20 mins** | 98.6% | 97.99% | No Update | 95.67% | 97.19% | 96.7% | 96.04% | 95.95% | 96.21% | 95.31% | 92.91% | | G | ↓ |
| **No. >20 mins** | 23 | 30 | | 52 | 35 | 36 | 50 | 64 | 75 | 92 | 127 | | | ↓ |
| **RT <60 mins** | 43.57% | 56.53% | | 57.69% | 52.34% | 57.67% | 58.83% | 49.28% | 38.36% | 41.99% | 39.09% | | R | ⇔ |
| **No. >60 mins** | 4391 | 3514 | | 2576 | 2913 | 2293 | 2309 | 3296 | 4498 | 3839 | 3577 | | | ⇔ |
| **UF2F <2 hrs** | 94.28% | 92.93% | | 96.83% | 96.55% | 98.34% | 99.15% | 96.89% | 94.36% | 97.6% | 97.74% | | G | ↑ |
| **No. >2 hrs** | 31 | 36 | | 11 | 10 | 5 | 3 | 14 | 26 | 10 | 9 | | | ↑ |
| **RF2F <6 hrs** | 98.38% | 98.18% | | 98.73% | 98.20% | 98.69% | 98.48% | 98.97% | 96.86% | 97.38% | 96.98% | | G | ⇔ |
| **No. >6 hrs** | 45 | 49 | | 35 | 43 | 34 | 43 | 34 | 107 | 80 | 78 | | | ↓ |

**CP 9: HOSPITAL RE-ADMISSIONS: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services**

**By March 2015, secure a 5% reduction in the number of emergency re-admissions within 30 days (using the 2012/2013 data as the baseline).**

**Baseline:** To be confirmed
**TDP Assessment:** To be confirmed

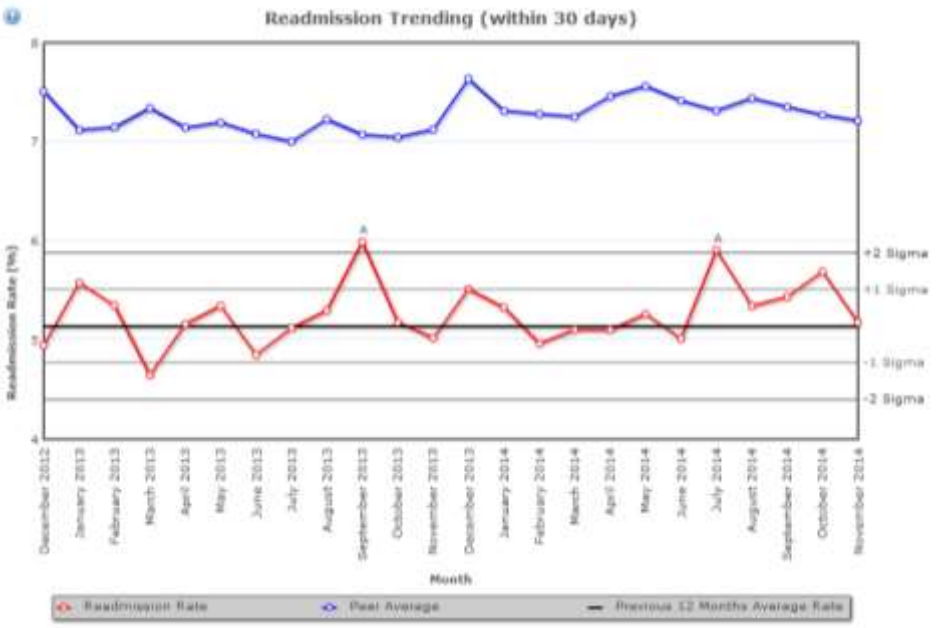
**Target:** 5% reduction

**Comments: Reporting three months in arrears.**
Based on April to October 2014 data provided by the HSCB, demonstrates a re-admission rate of 14% for the SHSCT against the baseline position of 2012/2013. Performance across the Region varies from 14% (SHSCT) to 55% (BHSCT).

CHKS, the comparative benchmarking system, measures re-admissions against the top hospital peers. Whilst this definition and the comparators are slightly different from those used by HSCB this is a useful guide to performance against our peers and in providing assurance regarding appropriate patient care. CHKS indicates the Trusts re-admission rate at 5.4% (April – November 2014) which is below the peer average of 7.4%.

The chart demonstrates the average % of re-admissions for the SHSCT over the last two years (December 2012 to November 2014) against the mean position for the previous 12 months. This red line shows some variability however it is significantly below the peer average performance which is represented by the blue line.

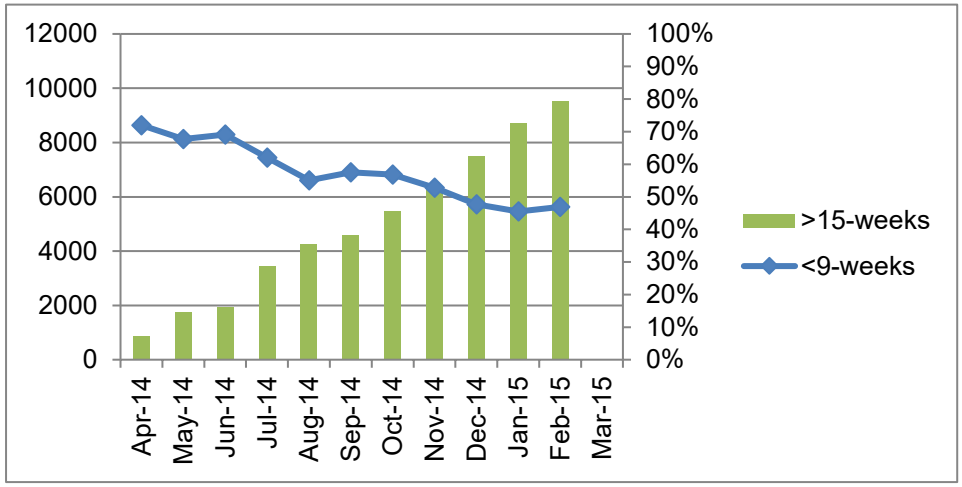
A detailed analysis of re-admissions has been undertaken which identifies that whilst the level of re-admissions in CAH is slightly higher than in DHH the collective position across the Trust is still lower than the Top Hospital peer group. Analysis by the top 10 condition groups, which represent 30% of total re-admissions to the Trust, indicates the Trust is below the Top Hospital peer for all areas; which provides assurance.




| Monthly Position: | | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Target** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | | |
| **Cumulative Position** | 2658 | | | | | | | | | | | | | |
| **Target Position** | 2335 | | | | | | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Variance Against Baseline** | +14% (+324) | | | | | | **R** | |

Note: Data sourced from Regional HSCB Board Performance Report

| CP 10: ELECTIVE CARE – OUT-PATIENTS: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services | |
|---|---|
| **From April 2014, at least 80% of patients wait no longer than 9-weeks for their first out-patient appointment and no patient waits longer than 15-weeks.** | |
| **Baseline:** 79.43% <9-weeks (2013/2014)<br>1454 >15-weeks (@ 31 March 2014)<br>**TDP Assessment:** Achievable, dependent upon additional funding being available | **Standard:** 80% <9-weeks<br>0 >15-weeks |
| **Comments:**<br>Regionally, January average performance against the % waiting less than 9-weeks was 46% with performance varying from 35% (BHSCT) to 53% (WHSCT). The total waiting in excess of 15-weeks regionally was 69,428 with SHSCT accounting for 13% of these patients.<br><br>At the end of February the following specialties were in excess of the maximum backstop of 15 weeks:<br><br>• Dermatology (inc ICATS) – 1688 patients, longest wait 40-weeks; *(SBA underperforming)*<br>• Urology (inc ICATS) – 1020 patients, longest wait 53-weeks *(SBA underperforming)*<br>• Ortho-Geriatrics – 41 patients, longest wait 46-weeks; *(SBA over performing)*<br>• Neurology – 450 patients, longest wait 29-weeks; *(SBA underperforming)*<br>• Orthopaedic (Consultant Led), 770 patients – longest wait 36-weeks; *(SBA underperforming)*<br>• Cardiology (Consultant Led) – 470 patients, longest wait 31-weeks*(SBA over performing)*<br>• Orthopaedic ICATS – 445 patients, longest wait 42-weeks (1 patient waiting 42 weeks booked in month – next longest wait is 28-weeks); *(SBA over performing)*<br>• ENT (Consultant Led) – 672 patients, waiting 25-weeks; *(SBA over performing)*<br>• General Surgery – 261 patients, longest wait 21-weeks; *(SBA underperforming)* |  |

| | |
|---|---|
| • Pain Management – 219 patients, longest wait 22-weeks; *(SBA over performing)*<br>• Endo-Diabetes – 125 patients, longest wait 37-weeks; *(SBA over performing)*<br>• Respiratory – 167 patients, longest wait 25-weeks; *(SBA underperforming)*<br>• Rheumatology - 447 patients, longest wait 38-weeks; *(SBA over performing)*<br>• Paediatric – 4 patients, longest wait 17-weeks; *(SBA over performing)*<br>• Gynaecology – 568 patients, longest wait 27-weeks; *(SBA over performing)*<br>• Gastroenterology (including General Medicine) – 148 patients, longest wait 27-weeks. *(SBA underperforming)*<br>• Breast Family History – 1 patient, longest wait 26-weeks (due to cancellation of clinics due to Consultant bereavement leave) *(SBA over performing)*<br>• Haematology – 7 patients, longest wait 17-weeks *(SBA over performing)*<br><br>In respect of patients waiting in excess of 9-weeks at end of February there are a total of 16,053 patients (14,941 consultant-led and 1,112 ICATS). 9,534 (8,254 consultant-led and 1,100 ICATS) of these relate to specialty areas that require to achieve 9-weeks.<br><br>The decision taken in July by HSC to temporarily "pause" sending any additional patients to the Independent Sector for assessment or treatment, revised levels of in-house additional capacity in Q1/2 and no allocation for additional outpatient capacity in Q3/4 has resulted in increased gaps between demand and capacity which will continue to grow and contribute to deteriorating access standards. The Trust is monitoring the performance against SBA to ensure that this is optimised and does not account for growth in access times.<br><br>Discussions are on-going with the Commissioner in respect of the future management of Ophthalmology. In the meantime SHSCT will | |

still report on the two visiting specialties of Ophthalmology and Paediatric Cardiology for completeness.

Two external (visiting specialties) in excess of 15 weeks were Ophthalmology – 2,404 patients, longest wait 49-weeks; and Paediatric Cardiology – 109 patients, longest wait 52-weeks.

A summary of projected access times for month-end January and year-end March is attached in Appendix 2.

**Action to Address:**

- Focus remains on the delivery of core SBA activity with the bi-weekly Director level performance meetings undertaken with the Acute Services Directorate. These meetings review and challenge the SBA performance and access delivery and are utilised to agree remedial action required to improve the areas of underperformance.
- Head of Service level performance meetings are held with Paediatrics fortnightly to review both Acute and Community performance. Agreed SBAs are reviewed at these meetings, with remaining SBAs under review.
- Discussions have commenced to develop a project plan to review chronological management practices within the Acute Services Division. This project will review current chronological management practices and will also identify underlying issues ie. consultant practice; administrative errors; short notice booking etc. An action plan will then be developed to implement necessary changes to improve the chronological management, where required.

| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **<9-weeks** | 72% (13633) | 67.7% (14316) | 69.1% (15232) | 62% (14738) | 55.1% (13461) | 57.5% (14090) | 56.8% (14521) | 52.8% (13625) | 47.7% (12692) | 45.5% (12504) | 46.9% (13327) | | R | ↓ |
| **>15-weeks** | 4.53% (859) | 8.34% (1763) | 8.76% (1930) | 14.5% (3453) | 17.3% (4236) | 18.7% (4578) | 21.4% (5473) | 24.7% (6378) | 28% (7477) | 32% (8731) | 34% (9527) | | R | ↓ |

**OUT-PATIENT REVIEWs –Patient waiting beyond their clinically indicated timescales: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services**

**Comments:**

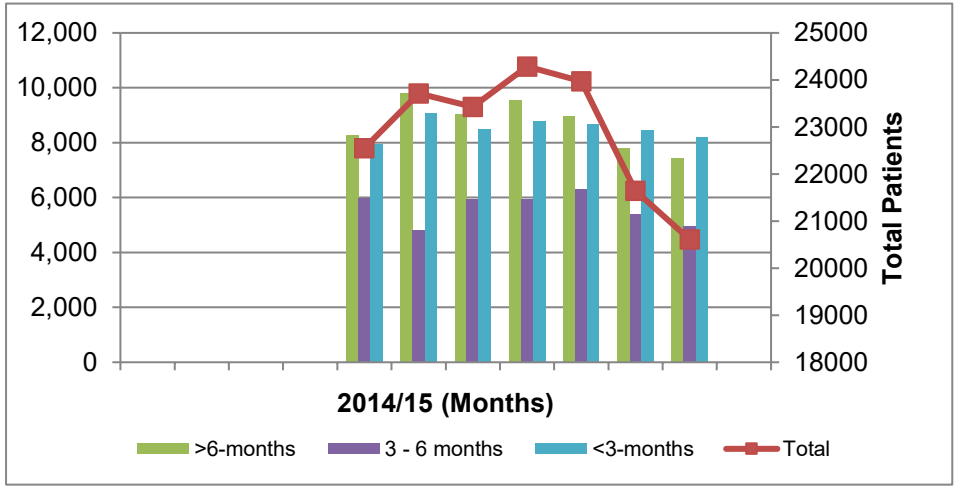
Of the 20,608 patients waiting for review appointments beyond their clinically indicated date :

- 36% (7455) of these are waiting in excess of 6-months;
- 24% (4958) of these are waiting between 3 – 6 months; and
- 40% (8195) waiting less than 3-months.

Focus on the longest waiters, with validation and additional capacity created via internal funding initiatives, has seen the cohort of patients waiting over 6 months decrease by over 1500 from December to February as per the red line on the chart.

**Action to Address:**

- Arrangements in place to minimise risk and ensure reviews with high clinical priority take place in accordance with the clinically indicated timescale;
- Discussion paper submitted to HSCB and SLCG to highlight ongoing issues (July);
- Trust has sought engagement with Primary Care via the SLCG to consider potential solutions in the absence of additional funding options to address backlog;
- Trust has commenced a validation programme to review patients waiting beyond their clinically indicated date. This plan includes both data and patient validation. This has been funded by Trust until March 2015; and
- Funding has in additional been provided by the Trust to provide addition capacity for patients waiting beyond their clinically indicated date. This temporary additional capacity will be directed towards



| | |
|---|---|
| the longest waiting review patients over the next three months. | |

| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **Total** | | | | | 22552 | 23715 | 23431 | 24286 | 23970 | 21645 | 20608 | | R | ↑ |
| **>6-months** | | | | | 8284 | 9811 | 9028 | 9563 | 8970 | 7798 | 7455 | | | |
| **3 – 6 months** | | | | | 5970 | 4823 | 5919 | 5944 | 6325 | 5384 | 4958 | | | |
| **<3-months** | | | | | 7931 | 9081 | 8484 | 8779 | 8675 | 8463 | 8195 | | | |
| **No timescale listed** | | | | | 367 | 259 | 272 | 238 | 240 | 231 | 258 | | | |

**CP 11: ELECTIVE CARE – DIAGNOSTICS: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services**

**From April 2014, no patient waits longer than 9-weeks for a diagnostic test and all urgent diagnostic tests are reported on within two-days of the test being undertaken.**

**Baseline:** Diagnostic Testing – 740> 9 weeks (@ 31 March 2014 – 665 Imaging and 75 Non-Imaging)
Endoscopy – 103> 9 weeks (@ 31 March 2014)
Imaging DRTT – 87% < 2 days (2013/2014)
Non-Imaging DRTT – 94% < 2 days (2013/2014)

**TDP Assessment:** Likely to be achieved with some delay / partially achieved

**Standard:** Diagnostic Testing 9-weeks
Endoscopy 9-weeks
DRTT 2 days

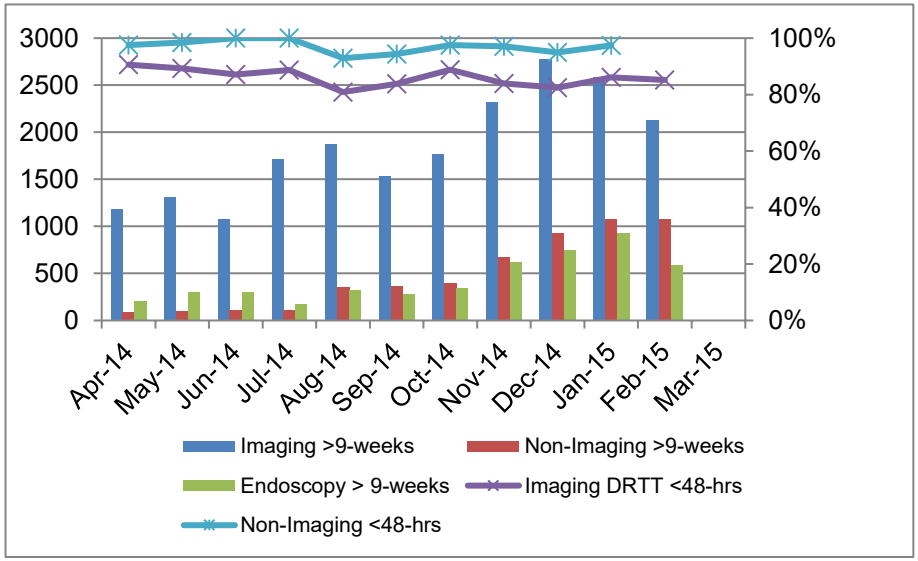
**Comments:**

- **Imaging** – Demand continues to increase with greater capacity gaps presenting. Whilst diagnostic imaging continues to perform well, against the SBA, capacity is not sufficient to provide for all routine examinations and focus is therefore on in-patients, red flag and urgent patients. HSCB has confirmed additional non-recurrent funding for additional capacity for MRI, CT, non-obstetric ultrasound and plain film reporting in Q3/4.

  Additional capacity will not be sufficient to see the achievement of 9 weeks by March. The estimated best position, subject to no increase is demand is
  - CT: General 13-weeks; CTC 33-weeks
  - MRI: 13-15-weeks
  - Non-Obstetric Ultrasound: 15-17-weeks

  **Action to Address:**
  - o Trust has secured the continuation of the leased MRI mobile facility to accommodate the additional volumes funded non-recurrently by HSCB for Q3/4 and until at least the end of April 2015. It is estimated that the new MRI scanner will be commissioned and in place by June 2015 which should increase capacity for 15/16;
  - o Trust has confirmed the allocation of funding and additional activity it can undertake in Q3/4 to HSCB and additional work has commenced; and
  - o The Trust has secured capacity within the Independent Sector to increase the volume of CT that can be undertaken; and
    The Trust is developing an investment proposal for additional CT capacity and is in liaison with HSCB re options for an interim mobile solution in 15/16 funded non-recurrently

- **Non-Imaging** – Of the 1084 patients in excess of 9-weeks at the end of February



there are 105 within Urodynamics (Urology) and 979 Cardiac Investigations.

Within Cardiac Investigations it is Echocardiogram examinations, both general (TTE) and Stress (DSE) that are in excess of the 9-week access standard. Whilst the volumes in excess of 9-weeks are increasing, associated with a general demand for cardiology input, it should be noted that at the end of January the SBA was over-performing.

The longest waiter at the end of February was 50-weeks in Urodynamics and it is anticipated that the access time will be 52-weeks at end March 2015.

**Actions to Address**

- Trust has committed additional funding in year to increase capacity for a range of cardiac investigations which should see an improvement in this position.
- Trust has highlighted increase demand related to cardiac investigations to the commissioner; the commissioner has agreed a capacity gap exists in this service. The Trust awaits confirmation of next steps.

January performance across the Region demonstrates a total of 22,299 waiting in excess of 9-weeks for Imaging and Non-Imaging, ranging from 735 (WHSCT) to 8,911 (BHSCT). The SHSCT has 3,661 which equates to 16.4% of the total waiting in excess of 9-weeks.

- **Endoscopy** – HSCB confirmed a level of additional capacity for endoscopy in Q3/4 which will decrease the routine wait but will not see achievement of 9 weeks. The Trust has committed further funding for additional capacity which will see the access time reduce to an estimated 18-weeks by March 2015. Demand continues to present challenges in maintaining waits for urgent patients and those waiting for repeat procedures.

  **Action to Address:**

  - Whilst the Trust had previously submitted an IPT for a Nurse Endoscopist, following discussion with HSCB / SLCG and in light of an agreed revised capacity gap the Trust has submitted, at the end of September, a high level proposal paper to meet the gap with 2 Nurse Endoscopists and additional medical-led sessions. Outcome of potential in-year investment is awaited; and
  - Trust has secured capacity both in-house and in the Independent Sector to provide additional capacity in-year funded by HSCB and internally.

A summary of <u>projected</u> access times for month-end February and year-end March is attached in Appendix 2.

- **Diagnostic Reporting** – **Imaging** – **see table below**
- **Diagnostic Reporting – Non-Imaging** – Update not available

January performance across the Region varies from 87% (SHSCT) to 97% (NHSCT and SEHSCT), with an average of 92%.

| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **Imaging >9-wks** | 1190 | 1307 | 1075 | 1720 | 1876 | 1535 | 1769 | 2326 | 2772 | 2583 | 2130 | | R | ↓ |
| **Non-Imaging >9-wks** | 91 | 104 | 112 | 115 | 359 | 366 | 396 | 672 | 925 | 1079 | 1084 | | R | ↓ |
| **Endos. >9-wks** | 210 | 300 | 304 | 170 | 321 | 285 | 348 | 623 | 752 | 933 | 594 | | R | ↓ |
| **Imaging DRTT Urgents <48-hrs** | 90.6% (2468 out of 2724) | 89.3% (2548 out of 2853) | 87.1% (2572 out of 2953) | 88.7% (2843 out of 3205) | 80.9% (2249 out of 2779) | 83.9% (2608 out of 3108) | 88.8% (2701 out of 3042) | 84% (2417 out of 2877 | 82.5% (2412 out of 2924 | 86.1% (2792 out of 3242) | 85.2% (2546 out of 2988) | | R | ↓ |
| **Non-Imaging DRTT Urgent <48-hrs** | 97.6% (160 out of 164) | 98.5% (130 out of 132) | 100% (156 out of 156) | 100% (136 out of 136) | 92.9% (130 out of 140) | 94.4% (151 out of 160) | 97.6% (202 out of 207) | 97.1% (136 out of 140) | 94.9% (168 out of 177) | 97.4% (189 out of 194) | N/A | | Y | ↔ |

Note: Amendment to January data

**CP 12: ELECTIVE CARE – IN-PATIENTS AND DAY CASES: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services**

**From April 2014, at least 80% of in-patients and day-cases are treated with 13-weeks and no patient waits longer than 26-weeks.**

**Baseline:** 69% <13-weeks (@ 31 March 2014)
252 >26-weeks (@ 31 March 2014)

**TDP Assessment:** Achievable, dependent upon additional funding being available

**Target:** 80% <13-weeks
0 >26-weeks

**Comments:**

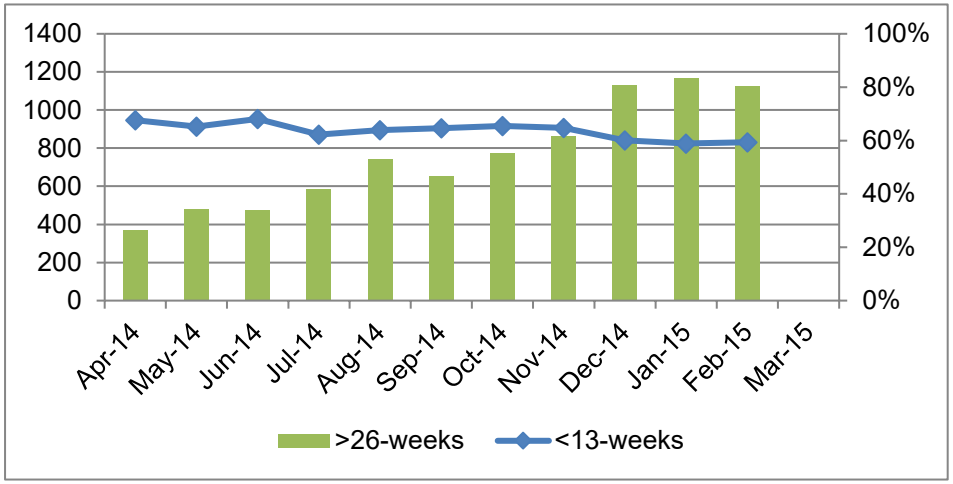
In respect of patients waiting in excess of 13-weeks there is a total of 2,973 patients at end February. 358 of these relate to specialty areas that require to achieve 13-weeks by March 2015, whilst the remaining 2,615 relate to specialty areas where the backstop target has been agreed as a maximum of 26-weeks.

Regionally, January average performance was 54% with performance varying from 42% (BHSCT) to 77% (NHSCT) of patients waiting less than 13-weeks. January performance across the Region demonstrates a total of 11,090 patients waiting in excess of 26-weeks with SHSCT accounting for 10.6% (1,173) of those waiting.

At the end of February the following specialties were in excess of the maximum 26-week backstop:

- General Surgery – 302 patients – longest wait 45-weeks; *(SBA underperforming)*
- Breast Surgery – 3 patients – longest wait 36-weeks; *(SBA over performing)*
- Gynaecology – 29 patients – longest wait 40-weeks; *(SBA underperforming)*
- Pain – 170 patients – longest wait 40-weeks; *(SBA over performing)*
- Urology – 269 patients – longest wait 82-weeks; *(SBA underperforming)*
- Orthopaedics – 355 patients – longest wait 59-weeks. *(SBA underperforming)*
- Gastroenterology – 5 patients – longest wait 29-weeks

One external (visiting specialty) in excess of 26 weeks was Opthalmology – 1 patient, longest wait 29-weeks.



The decision taken in July by HSC to temporarily "pause" sending any additional patients to the Independent Sector for assessment or treatment, revised levels of in-house additional capacity in Q1/2 and no allocation for additional outpatient capacity in Q3/4 has resulted in increased gaps between demand and capacity which will continue to grow and contribute to deteriorating access standards. The Trust is monitoring the performance against SBA to ensure that this is optimised and does not account for growth in access times. HSCB has made arrangements for patients waiting for treatment in the Independent Sector, previously paused, to continue their treatment.

A summary of projected access times for month-end February and year-end March is attached in Appendix 2.

**Actions to Address:**

- Focus remains on the delivery of core SBA activity with the bi-weekly Director level performance meetings undertaken with the Acute Services Directorate. These meetings review and challenge the SBA performance and access delivery and are utilised to agree remedial action required to improve the areas of underperformance; and
- Discussions have commenced to develop a project plan to review chronological management practices within the Acute Services Division. This project will review current chronological management practices and will also identify underlying issues ie. Consultant practice; administrative errors; short notice booking etc. An action plan will then be developed to implement necessary changes to improve the chronological management, where required.

| | Monthly Position (Excluding Scopes): | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **<13-weeks** | 67.6% (4336) | 65.2% (4161) | 68.1% (4239) | 66.2% (4061) | 63.9% (3858) | 64.6% (3977) | 65.5% (4155) | 64.7% (4132) | 60.1% (3904) | 58.9% (3829) | 59.4% (3872) | | R | ↓ |
| **>26-weeks** | 5.75% (369) | 7.6% (482) | 7.6% (473) | 9.5% (585) | 12.3% (742) | 10.6% (653) | 12.2% (776) | 9% (864) | 17.4% (1130) | 17.9% (1167) | 17.3% (1128) | | R | ↓ |

**CP 13: HEALTHCARE ACQUIRED INFECTIONS: Lead Director – Mr John Simpson, Medical Director**

**By March 2015, secure a further reduction of x% in MRSA and Clostridium Difficile infections compared to 2013/2014.**

**Baseline:** MRSA – 5
C Diff – 31

**TDP Assessment:** To be confirmed

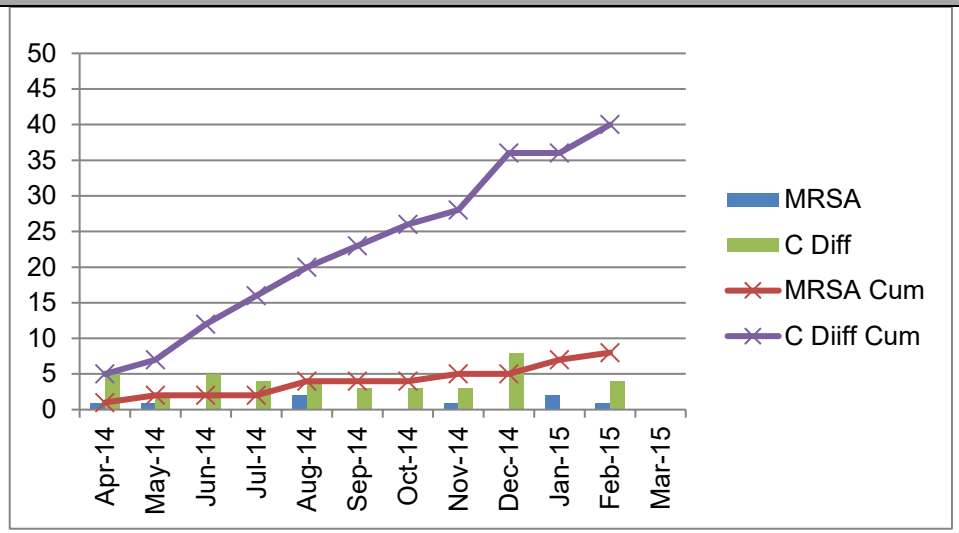
**Target:** MRSA - 3
C Diff - 32

**Comments:**

**MRSA:**
Cumulative Regional performance, April to January, demonstrates +11 (+26%) actual cases against target (42) with 53 cases in total recorded Regionally. 4 out of 5 Trusts are demonstrating levels beyond their profiled target.

**C Diff**:
Cumulative Regional performance, April to January, demonstrates +83 (+34%) actual cases against target (242) with 325 cases in total reported Regionally. All Trusts are demonstrating levels beyond their profiled target.

Further information on the HCAI rates is provided within the Medical Director's Trust Board Report.




| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **MRSA Actual** | 1 | 1 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 2 | 1 | | R | ↓ |
| **MRSA Cum** | 1 | 2 | 2 | 2 | 4 | 4 | 4 | 5 | 5 | 7 | 8 | | | |
| **C Diff Actual** | 5 | 2 | 5 | 4 | 4 | 3 | 2 | 3 | 8 | 0 | 4 | | R | ↓ |
| **C Diff Cum** | 5 | 7 | 12 | 16 | 20 | 23 | 25 | 28 | 36 | 36 | 40 | | | |

## CP 15: SPECIALIST DRUGS: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services

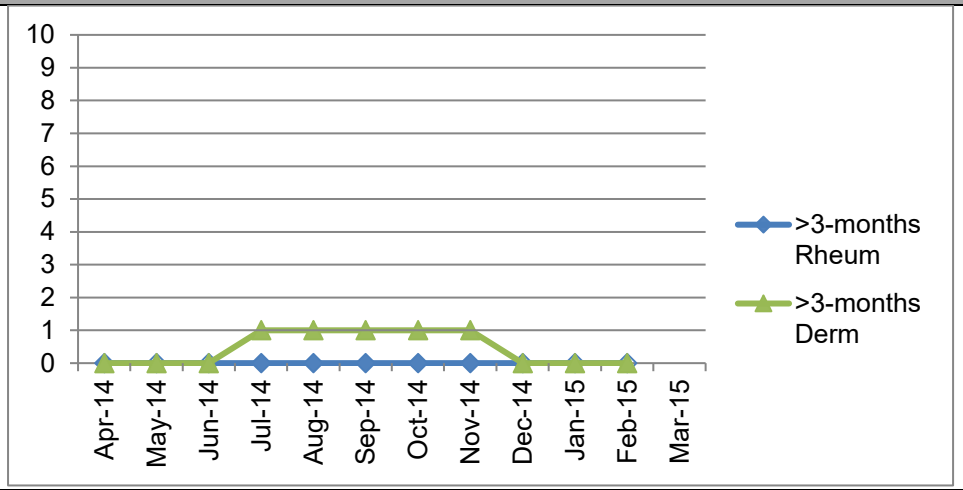
**Baseline:** Rheumatology – 0 >3-months (@ 31 March 2014)
Dermatology – 0 >3-months (@ 31 March 2014)

**TDP Assessment:** Achievable, dependent upon additional funding

**Comments:**

**Rheumatology & Dermatology** – A revised offer against the joint IPT for Biologic Therapies and the recurrent elective Rheumatology gap has been received and a plan for implementation is currently being developed.

**Inflammatory Bowel Disease (IBD)** – Whilst not contained within the Commissioning Plan Targets and Standards there is another specific are of funding for Anti-TNF treatments that the Trust participates in. This is for IBD ie. Crohn's disease and Ulcerative Colitis. At present there are 47 patients on Anti-TNF treatment for Crohn's disease and 20 patients on Anti-TNF treatment for Ulcerative Colitis.




| | Apr | | | | | | | | | | | Mar | | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **>3-months Rheum** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | **G** | ↔ |
| **>3-months Derm** | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | | **Y** | ↔ |

**CP 16: STROKE PATIENTS: Lead Director – Mrs Deborah Burns, interim Director of Acute Services**

**From April 2014, ensure that at least 12% of patients with confirmed Ischaemic stroke receive thrombolysis.**

**Baseline:** 10.5% (April to December 2013)
**TDP Assessment:** Achievable

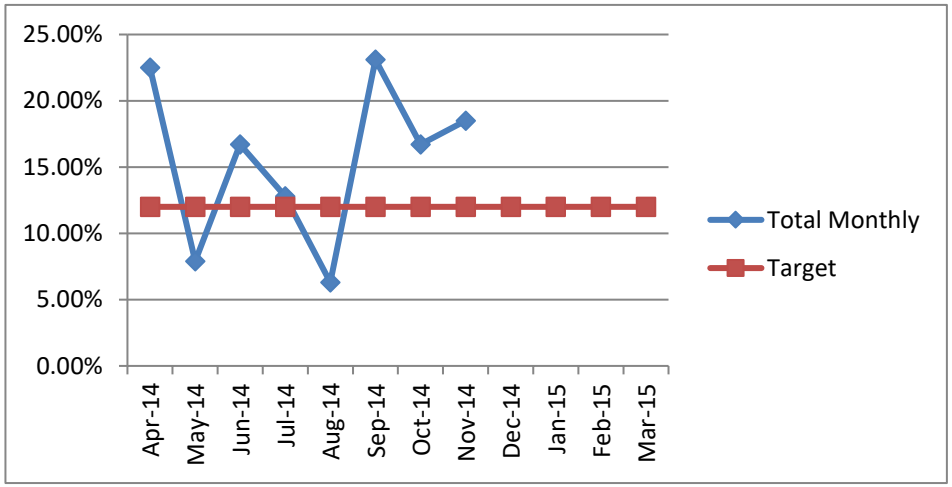
**Target:** 12%

**Comments: Reporting three months in arrears.**
Up to the end of November 15.3% of patients with confirmed ischaemic stroke received thrombolysis which is above the target of 12% at this point of the year.

Monthly performance against this target is impacted by the variable presentation of strokes, which is affected both seasonally and geographically. It should be noted that as strokes vary in type they will vary in time presentation and whilst no patient has been missed, clinical decisions will determine whether the drug is to be delivered considering the risks and benefits. Reviewing the performance data on an annual basis will demonstrate the performance taking into consideration the seasonal differences and atypical presentations.

Regionally, cumulative performance (April to October) varies from 14% (SEHSCT and NHSCT) to 29% (WHSCT) with a Regional average of 17%.

**Actions to Address:**
- A 24/7 Consultant-led service is in place;
- Review of time from scanning to reporting with a view to reducing this ongoing;
- Close monitoring of door to need time out of hours; and
- Seeking improvement in communication with and feedback to NIAS.




| Site | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Trust** | 22.5% | 7.9% | 16.7% | 12.8% | 6.3% | 23.1% | 16.7% | 18.5% | | | | | **G** | ⇔ |
| **Trust Admissions** | A 40 T 9 | A 38 T 3 | A 30 T 5 | A 39 T 5 | A 32 T 2 | A 26 T 6 | A 30 T 5 | A 27 T 5 | | | | | | |
| **Trust Cumulative** | - | - | - | - | - | - | - | 15.3% | | | | | | |
| **CAH** | 13.3% | 3.6% | 12.5% | 4.3% | 11.8% | 10.5% | 9.5% | 15.8% | | | | | **Y** | ⇔ |
| **CAH Admissions** | A 30 T 4 | A 28 T 1 | A 24 T 3 | A 23 T 1 | A 17 T 2 | A 19 T 2 | A 21 T 2 | A 19 T 3 | | | | | | |
| **CAH Cumulative** | - | - | - | - | - | - | - | 9.9% | | | | | | |
| **DHH** | 50% | 20% | 33.3% | 25% | 0% | 57.1% | 33.3% | 25% | | | | | **G** | ⇔ |
| **DHH Admissions** | A 10 T 5 | A 10 T 2 | A 6 T 2 | A 16 T 4 | A 15 T 0 | A 7 T 4 | A 9 T 3 | A 8 T 2 | | | | | | |
| **DHH Cumulative** | - | - | - | - | - | - | - | 27.2% | | | | | | |

**Note:** September / October data updated, based on updated clinical coding levels

**Note:** Stroke: A = Stroke Admissions / T = Patients Who Had Thrombolysis Administration

**CP 17: PRESSURE ULCERS: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services**

**By March 2015, secure a 10% reduction in pressure ulcers in all adult in-patient wards.**

**Baseline:** 63
**TDP Assessment:** Achievable

**Target:** 10% reduction (57)

**Comments: Reporting quarterly – (Quarter 3 data not available until 26/2/15 in line with HSCB reporting schedule)**

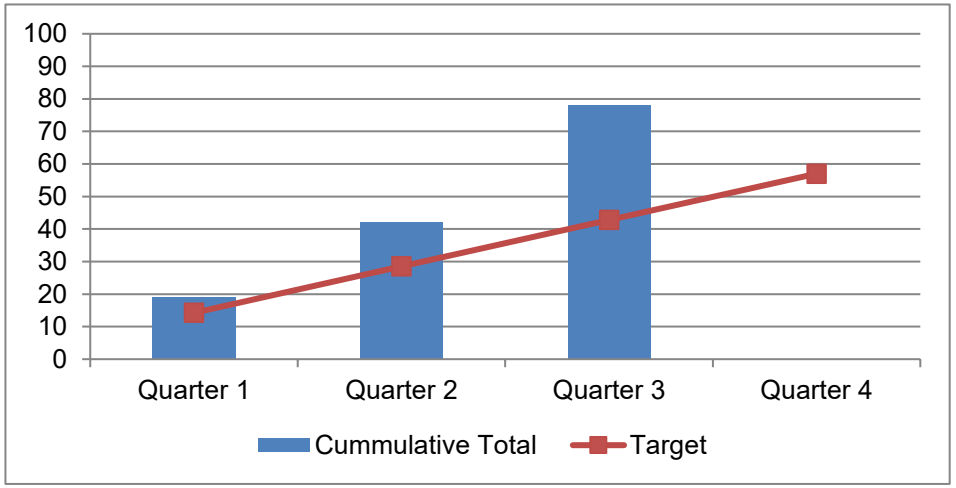
The Trust has 35 reported cases of pressure ulcers above the profiled target of 43 at the end of December 2014.

Regional cumulative performance at the end of Quarter 3 reflected 139 cases beyond the profile, equating to + 28%. 3 out of 5 Trusts reflected a position above the profiled target reduction.

It is recognised regionally that an expected increase in pressures ulcers reported is anticipated associated with increased awareness.

**Actions to Address:**

- The 'Patient Safety Cross' tool along with appropriate nursing documentation, relating to pressure ulcers, is in use in all Acute and Non-Acute wards since October 2014.
- Nursing education/training has been implemented to support the use of the patient safety cross tool and documentation via a series of workshops focused on recognition, grading and management of pressure ulcers.
- The Trust is considering spread of the project into key adult mental health wards in 2015/16 which is beyond the regional requirements.




| | Quarterly Position: | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|
| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | | |
| **Trust Quarterly** | 19 | 23 | 36 | | R | ↑ |
| **Trust Cumulative** | 19 | 42 | 78 | | | |

| CP 18: MEDICINES FORMULARY: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services | |
|---|---|
| **From April 2014, ensure that all therapeutic areas relevant to primary care are included in the NI Medicines Formulary and 70% prescribing compliance is achieved in each area.** | |
| **Baseline:** To be confirmed<br>**TDP Assessment:** To be confirmed | **Target:** 70% |

**Comments:**

Resources and systems are not available to permit a full audit of compliance, however, the Trust is complying with the Regional Formulary and PCE Guidance and by way of assurance has undertaken in-patient prescribing audits on six key areas between April – October 2013 and provided a report on the position to HSCB.

The Trust has, in agreement with HSCB, undertaken to submit audit data on a Chapter of the Formulary once per quarter, for in-patients only with Quarter 1 and 2 2014/15 data now submitted. In addition some small targeted audits of outpatient prescribing/recommendations are taking place. To date all the audits submitted have achieved above the HSCB target of 70% compliance.

| Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| Not Available | | | | | | | | | | | | | |

**MINISTERIAL PRIORITY: TO IMPROVE THE MANAGEMENT OF LONG-TERM CONIDIONS IN THE COMMUNITY, WITH A VIEW TO IMPROVING THE QUALITY OF CARE PROVIDED AND REDUCING THE INCIDENCE OF ACUTE HOSPITAL ADMISSIONS FOR PATIENTS WITH ONE OR MORE LONG-TERM CONDITIONS**

**CP 19: ALLIED HEALTH PROFESSIONALS: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care**

**From April 2014, no patient waits longer than 9-weeks for referral to commencement of AHP treatment.**

**Baseline:** 234 (@ 31 March 2014)
**TDP Assessment:** Unlikely to be achieved / affordable

**Standard:** 0

**Comments:**

In line with new regional guidance reporting was re-instated for AHPs focusing on Physiotherapy, Occupational Therapy (OT) and Dietetics in July. In October full AHP reporting was re-instated for all professions. New reporting arrangements are being embedded in line with revised regional definitions to ensure robust reporting.

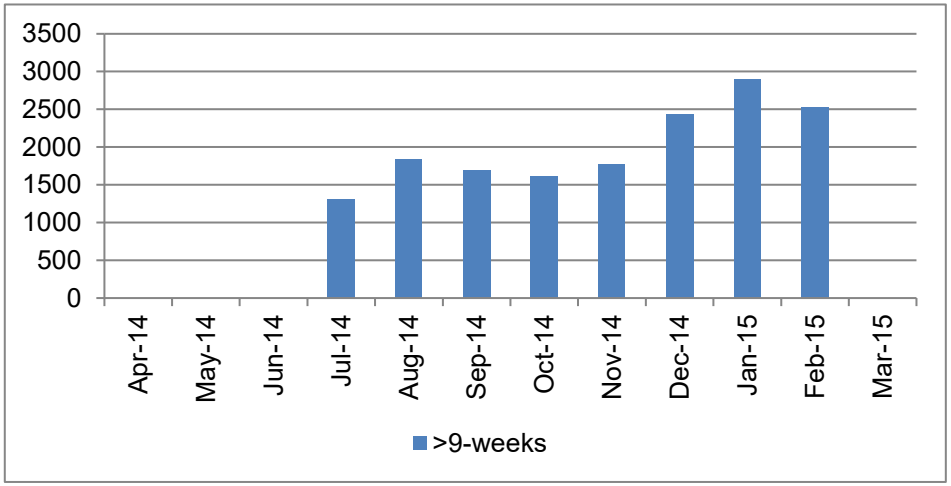
January performance across the Region varies with a total of 18,006 patients in excess of 9-weeks, ranging from 664 (SEHSCT) to 5,625 (BHSCT). SHSCT account for 16% (2,879) of the Regional total of patients waiting in excess of 9 weeks.

At the end of February the following professions were in excess of the 9-week access standard:

- Dietetics – 40-weeks (249 (10%) patients waiting >9 weeks)
- Occupational Therapy (OT) – 31-weeks (370 (15%) patients waiting >9 weeks)
- Physiotherapy – 21-weeks (327 (13%) patients waiting >9 weeks)
- Podiatry – 22-weeks (828 (33%) patients waiting >9 weeks)
- Speech and Language Therapy (SLT) – 28-weeks (748 patients (30%) >9 weeks)
- Multidisciplinary Team AHPs – 11-weeks (5 patients > 9 weeks)

Areas of particular note include:

- Paediatric specialist areas, including OT, dietetics and SLT where manpower issues coupled with demand/demography is particularly




Note: Data represented in graph is for all AHP professions

affecting access times;
- Podiatry services are also challenge by demand beyond capacity; and
- Reviews and treatments beyond their clinically indicated timescale has become an increasing challenge throughout a range of AHP areas and arrangements have been established for reporting of these patients monthly to ensure visibility.

**Actions to Address:**
- Monthly AHP performance meetings in place with representative from Operational Directorates;
- Additional capacity has been funded by Trust to target review and treatments beyond the clinically indicated timescales and additional temporary staff are in place in Paediatric SLT, OT, Dietetics and podiatry
- Plans focused on reducing longest waits in paediatric and learning disability OT are in place and options to secure additional capacity to reduce longest waits in other areas continue to be explored.
- Internal review of AHP on-going with fortnightly Director-led meetings. Actions plan in place focusing on corporacy, benchmarking staffing and highlighting areas of un-commissioned activity; and
- Trust has sought an update from HSCB/PHA on work to establish capacity, in the form of new SBA, and capacity/demand analysis which has been completed, in order to identify and agree capacity gaps and consider next steps.

| Monthly Position: | | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| >9-weeks* (3 Professions) | Reporting suspended | | | 606 | 700 | 627 | Reporting all Professions from October onwards | | | | | | | |
| >9-weeks# (All Professions) | Reporting suspended | | | 1304 | 1837 | 1696 | 1611 | 1773 | 2437 | 2890 | 2527 | | R | ↓ |

* Note: Reported volumes for July, August and September includes only 3 professions ie. Physiotherapy; Occupational Therapy and Dietetics.
# Note: Reported volumes from October onwards includes all Professions and MDTs

**CP 20: TELEHEALTH: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care**

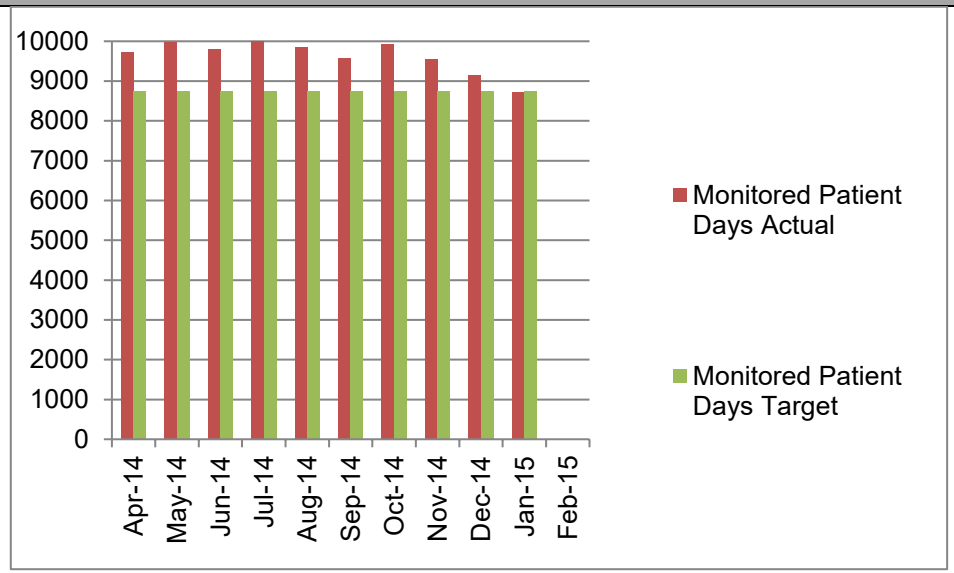
**By March 2015, deliver 500,000 Monitored Patient Days Regionally (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI Contract.**

**Baseline:** 94,797
**TDP Assessment:** To be confirmed

**Target:** To be confirmed

**Comments: Reporting one month in arrears.**

For the first time this year, the target for monitored patients' days was not delivered.




| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **Actual Monitored Patient Days** | 9718 | 9978 | 9805 | 10056 | 9842 | 9586 | 9922 | 9541 | 9143 | 8715 | | | G | ⇔ |
| **Target Monitored Patient Days** | 8750 | 8750 | 8750 | 8750 | 8750 | 8750 | 8750 | 8750 | 8750 | 8750 | | | | |

**CP 21: UNPLANNED ADMISSIONS: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care**

**By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions (using 2012/2013 data as the baseline).**

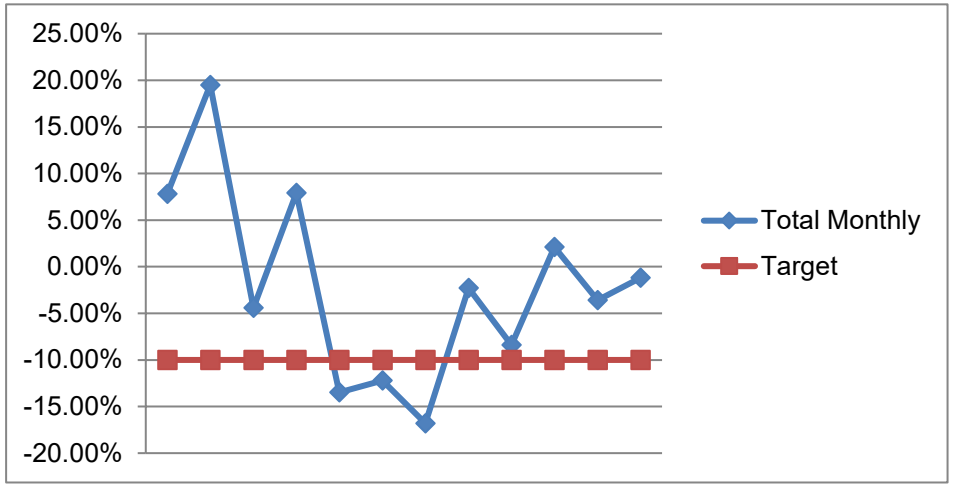
**Baseline: 1931 admissions**
**TDP Assessment:** Achievable

**Target:** 5% reduction
1834 admissions

**Comments: Reporting three months in arrears.**
As of 1 April 2014 the total conditions specified within this target include COPD, diabetes, heart failure, asthma; and stroke.

The projected level of admissions, based on the cumulative admission to date is 1737. This level appears to be on track to achieve the target of 1834 when profiled on a straight line, however this position is likely to be affected by seasonal variation. Admission for the specific conditions are likely to up to 10% greater between Dec – March than over the rest of the year.

Individually COPD, Asthma and Stroke are on track to meet the -5% reduction at this stage.




| | Monthly Position: *(Note: Long-term conditions admissions figures: T = Target / A = Actual In-Year)* | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **Total Actual Admissions** | 141 | 137 | 119 | 129 | 141 | 146 | 159 | 161 | | | | | | |
| **Target Admissions (to achieve -5% below baseline)** | 155 | 148 | 136 | 125 | 146 | 136 | 157 | 155 | | | | | | |
| **Cumulative & % variance against the Target Volume** | - | - | - | - | - | - | T 1003<br>A 972 | T 1158<br>A 1133 | | | | | **R** | |

**MINISTERIAL PRIORITY: TO PROMOTE SOCIAL INCLUSION, CHOICE, CONTROL, SUPPORT AND INDEPENDENCE FOR PEOPLE LIVING IN THE COMMUNITY, ESPECIALLY OLDER PEOPLE AND THOSE INDIVIDUALS AND THEIR FAMILIES LIVING WITH DISABILITIES**

## CP 22: CARERS' ASSESSMENT: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care

**By March 2015, secure a 10% increase in the number of carers' assessments offered.**

**Baseline:** 704 offered (@ March 2014)
**TDP Assessment:** Achievable

**Target:** Increase by 10% (774 offered)

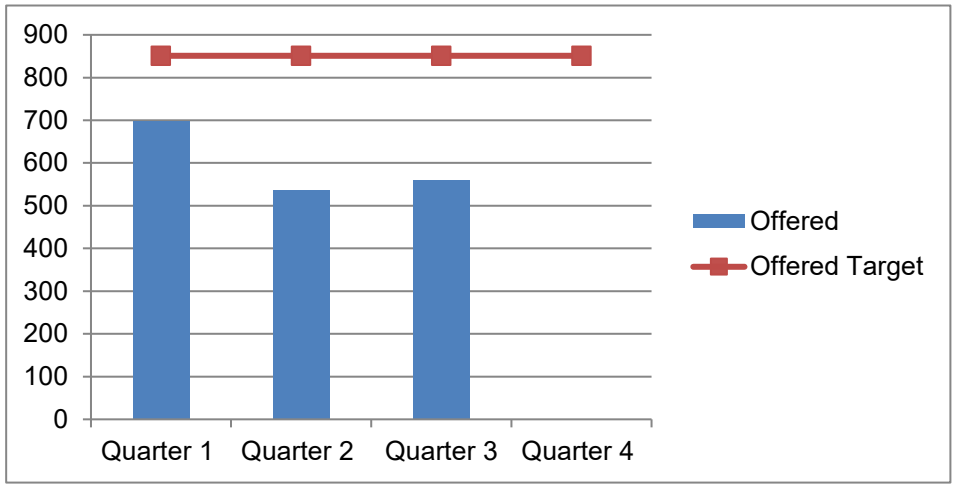
**Comments: Reporting quarterly.**

It is of note that the target is particularly challenging for the Trust. The target was set on the QE March baseline of 704 offers, however, this was the highest quarterly position achieved in the previous two years (at least 119 higher than any other period) and is unlikely to be representative. The achievability of this target is questionable and all areas are struggling to achieve. The only area on track to achieve the target is children's services where the baseline was initially lower.

Regional performance at Quarter 3 demonstrates a 14.3% decrease (2513) in the number of carers assessment offered in comparison to Quarter 4 2013/2014 (2933).

**Actions to Address:**

- The Trust has established a 'Carers Reference Group' at which each Directorate is represented by a 'Champion'.
- The CYPS Directorate has further established a 'Young Carers Group'.
- On-going awareness raising with relevant staff about requirements regarding Carers Assessments.




| | | | | | | Trend |
|---|---|---|---|---|---|---|
| | | | | Quarter 4 (January to | | |
| Offered | 697 | 537 | 560 | No update | | ↓ |

**CP 23: DIRECT PAYMENTS: Lead Director – Mr Miceal Crilly, Interim Director of Mental Health and Disability**

**By March 2015, secure a 5% increase in the number of direct payments across all programmes of care.**

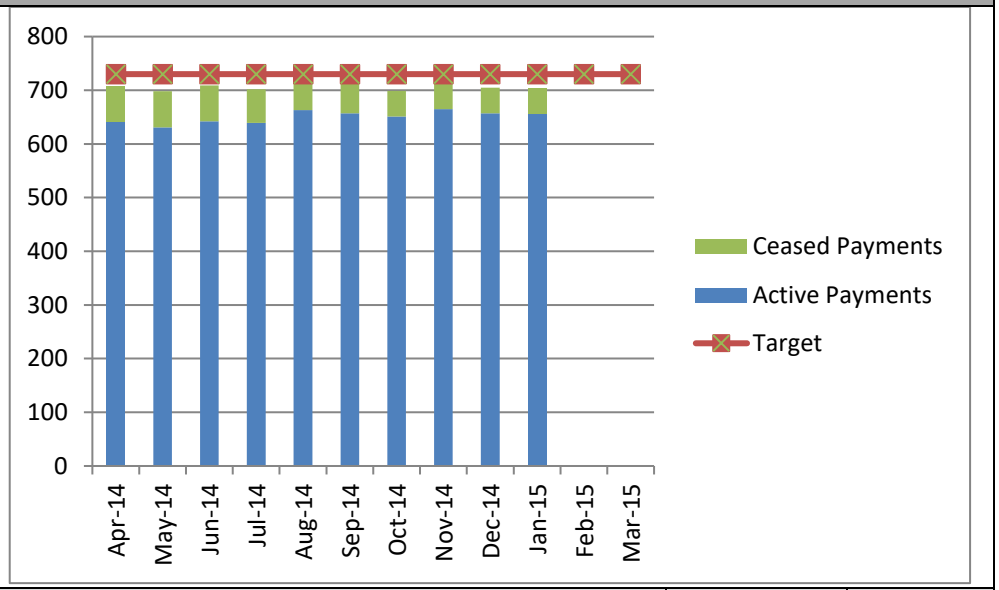
**Baseline:**631 active + 64 ceased payment = 695 (March 2014 CC8)
**TDP Assessment:** Achievable

**Target:** Increase by 5% (730)

**Comments: February update not available**
This target is made up of active payments and payments which were previously made and ceased within the quarter.

Information is available monthly on the active payments, however is only available at the quarterly point for ceased payments. Therefore the performance can accurately be measured at each quarter end.

Regionally there were 2,895 direct payments against the target at the end of Quarter 3, with the SHSCT accounting for 24% of this volume. Only 1 (WHSCT) out of 5 Trusts are on track at this stage to achieve the profiled target.




| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **Trust total** | 708 | 698 | 709 | 702 | 726 | 720 | 699 | 713 | 707 | 703 | No update | | Y | ↔ |
| **Trust Ceased (Quarterly only)** | 67 | | | 63 | | | 48 | | | Using Q3 as proxy for Q4 (48) | | | | |
| **Trust Active (Monthly)** | 641 | 631 | 642 | 639 | 663 | 657 | 651 | 665 | 657 | 655 | No update | | | |

| Breakdown by Programme of Acute Payments | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Primary Health & Adult Community** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| **Physical & Sensory Disability** | 176 | 167 | 176 | 173 | 176 | 174 | 173 | 177 | 174 | 173 | | | | |
| **Mental Health** | 50 | 49 | 50 | 51 | 51 | 52 | 50 | 52 | 54 | 53 | | | | |
| **Learning Disability** | 251 | 250 | 251 | 255 | 264 | 267 | 264 | 269 | 265 | 270 | | | | |
| **Elderly** | 164 | 165 | 165 | 160 | 172 | 164 | 164 | 167 | 164 | 169 | | | | |

**CP 24: TELECARE: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care**

**By March 2015, deliver 800,000 Telecare Monitored Patient Days (equivalent to approximately 2,300 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract.**

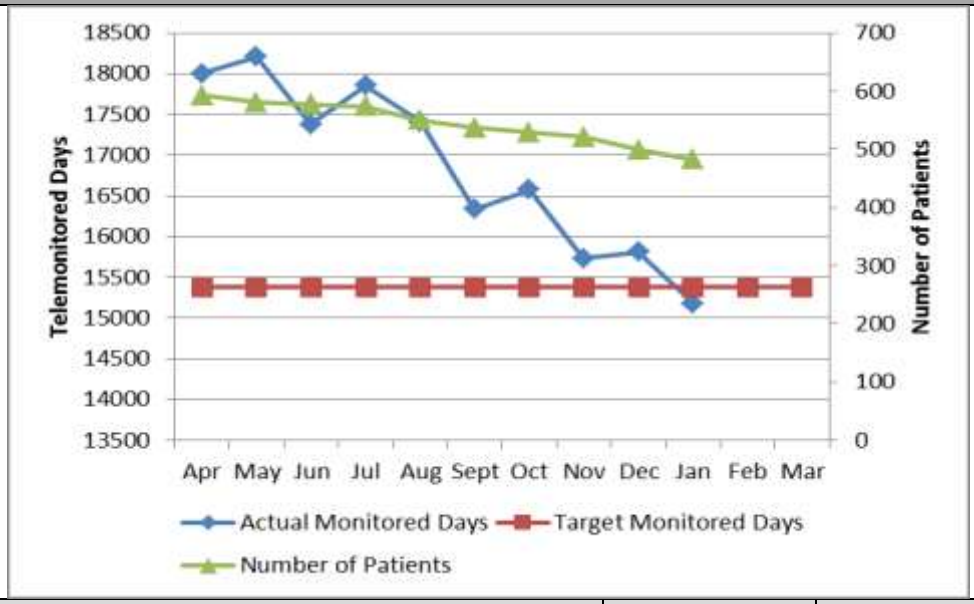
**Baseline:** To be confirmed
**TDP Assessment:** To be confirmed

**Target:** 184,506 monitored patient days (507 patients)

**Comments: Reporting one month in arrears.**
Information provided by Older Persons and Primary Care Directorate as outlined below.

Information to monitor this target is sourced from Fold, the contracted provider. Work is ongoing to try and improve the timeliness of information flows from this third party.

The Southern Trust share of Regional Target equates to 184,506 monitored patient days which is equivalent to 507 patients.




| Monthly Position: | | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| Actual Monitored Days | 18000 | 18206 | 17375 | 17852 | 17408 | 16336 | 16576 | 15729 | 15809 | 15180 | | | G | ↓ |
| Target Monitored Days | 15376 | 15376 | 15376 | 15376 | 15376 | 15376 | 15376 | 15376 | 15376 | 15376 | | | | |
| Number of Patients | 593 | 581 | 578 | 574 | 550 | 537 | 529 | 521 | 499 | 482 | | | | |

**CP 29: UNNECESSARY HOSPITAL STAYS: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services**

**By March 2015, reduce the number of excess beddays for the Acute Programme of Care by 10% (using 2012/2013 data as the baseline).**

**Baseline:** To be confirmed
**TDP Assessment:** To be confirmed

**Target:** Reduce by 10%

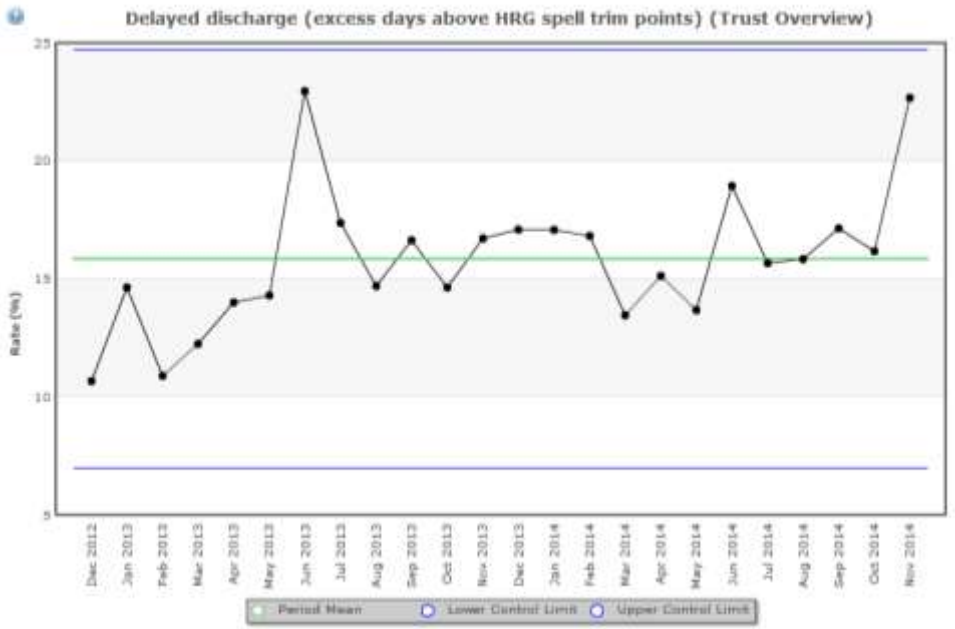
**Comments: Reporting three months in arrears.**

HSCB information against this target demonstrates April to October performance with a Regional average of -1% with performance varying across the Trusts from +45% (SHSCT) to -22% (SEHSCT).

CHKS, the comparative benchmarking system, measures excess beddays against the Top Hospital peers. Whilst this definition and the comparators are different from that used by HSCB as it is based on expected length of stay at condition level calculated for the payment by results (PbR) methodology adopted in England, it is a useful guide to peer performance. CHKS utilises information on 'spells' which will include the aggregated length or stay (beddays) in a patients total journey in the hospital system, including acute and non-acute hospital episodes and transfers across hospital sites.

Information available using CHKS data, April to November 2014, demonstrates the Trust with excess beddays of 16.5% against the HES Peer Average of 15.1%. Peer benchmarks against the 25th Percentile and 75th Percentile are 17.1% and 12%.

The chart opposite demonstrates a timeline analysis of excess beddays at Trust level over the last two years.




| Monthly Position: | | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| HSCB Data | +45% (3,274 excess beddays) | | | | | | R | |

| CP 30: CANCELLED CLINICS: Lead Director – Mrs Deborah Burns, Interim Director of Acute Services | |
|---|---|
| **By March 2015, reduce the number of hospital cancelled consultant-led out-patient appointments by 17%.** | |
| **Baseline:** 15235 (2012/2013)<br>**TDP Assessment:** Likely to be achieved with some delay / partially achieved | **Target:** Reduce by 17% (12645) |

**Comments:**

Regional performance, April to January demonstrates a significant increase in the number of cancelled appointments, with a total of 144,016 cancellations, which equates to +20% above the profiled reduction target. In January the SHSCT volume of cancellations equated to 9.95% of the Regional total.

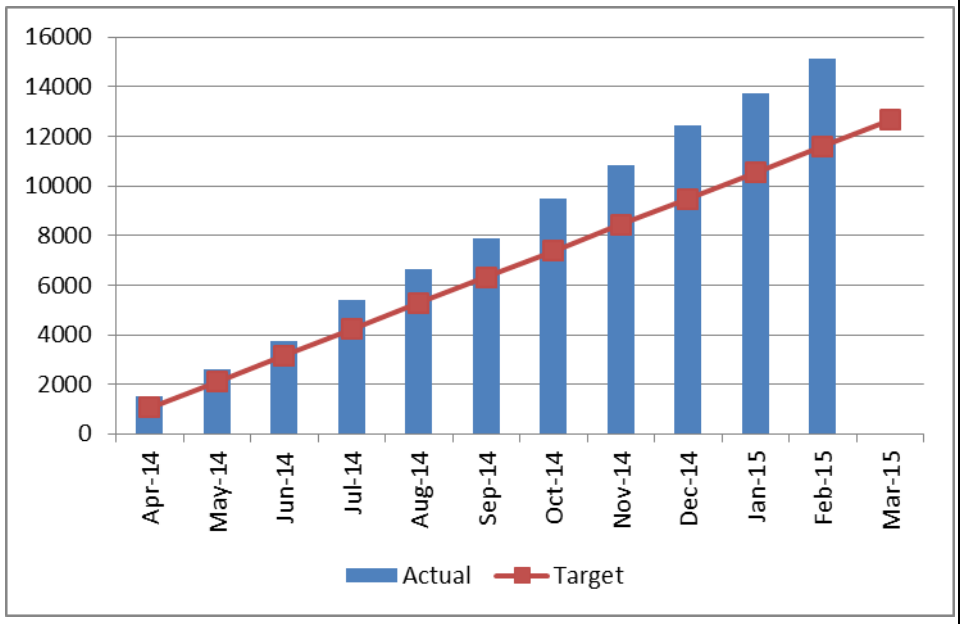
As an outcome of a Short Life Working Group, at the request of the Health Committee, work has been undertaken to ascertain the level of cancellations that had a direct impact on patients.

April to January demonstrated that 65,208 out of 144,016 cancellations had a direct impact on patients. This equates to 45.3% of the total cancellations. The SHSCT volume of cancellations equated to 10% (6,786) of the total 65,208 cancellations.

The SHSCT volume of cancellations that had a direct impact on patients (6,786) equated to 47.4% of the total SHSCT cancellations (14,330).

**Action to Address:**

- Analysis to be undertaken related to the reasons for cancellations to inform action planning; and
- Key actions to be agreed to enable reduction of cancellations and install best practice in clinic management.



| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **Trust Monthly Cancellations** | 1531 | 1086 (Cum 2617) | 1101 (Cum 3718) | 1662 (Cum 5380) | 1245 (Cum 6625) | 1251 (Cum 7876) | 1618 (Cum 9494) | 1350 (Cum 10884) | 1593 (Cum 12437) | 1268 (Cum 13705) | 1404 (Cum 15109) | | R | ↔ |
| **Total Attendance** | 18085 | 18174 | 19762 | 18231 | 16780 | 21794 | 20888 | 18982 | 18061 | 20202 | 19141 | | | |
| **% Cancellation in Month** | 7.8% | 5.6% | 5.3% | 8.4% | 6.9% | 5.4% | 7.2% | 6.6% | 8.1% | 5.9% | 6.8% | | | |

Note: Amendments to June, August, September, October, November and December data

**CP 31: PATIENT DISCHARGE: Lead Director – Mr Miceal Crilly, Interim Director of Mental Health & Disability**

**From April 2014, ensure that 99% of all learning disability and mental health discharges take place within 7-days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.**

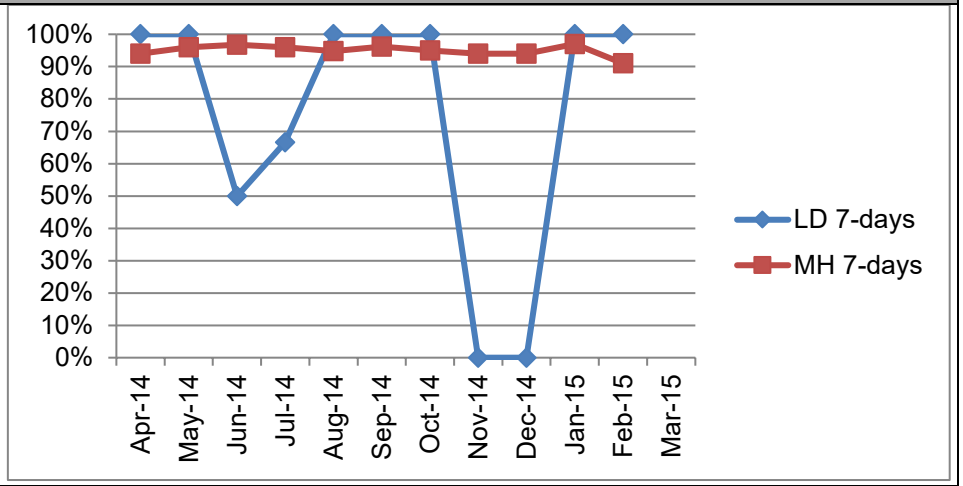
**Baseline:** LD – 72% (2013/2014)
MH – 95% (2013/2014)
**TDP Assessment:** To be confirmed

**Standard:** 99% 7-days
0 > 28-days

**Comments:**

**Learning Disability –** Regional performance in December demonstrates an average performance of 56% with performance varying across the Trusts from 0% (SHSCT) to 75% (NHSCT).

**Mental Health –** Regional performance in December demonstrates an average performance of 97% with performance varying across the Trusts from 94% (SHSCT) to 100% (NHSCT and SEHSCT).




| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **LD 7-days** | 100% (2 out of 2) | 100% (3 out of 3) | 50% (1 out of 2) | 66% (2 out of 3) | 100% (2 out of 2) | 100% (1 out of 1) | 100% (0 out of 0) | 0% (0 out of 2) | 0% (0 out of 1) | 100% (3 out of 3) | 100% (1 out of 1) | | **G** | ↔ |
| **LD >28-days** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | | **A** | ↔ |
| **MH 7-days** | 94% (75 out of 80) | 96% (104 out of 108) | 97% (122 out of 126) | 96% (118 out of 123) | 94.8% (111 out of 117) | 96.2% (126 out of 131) | 95% (95 out of 100) | 94% (120 out of 127) | 94% (94 out of 100) | 97% (108 out of 111) | 91% (80 out of 88) | | **Y** | ↔ |
| **MH >28-days** | 4 | 1 | 2 | 2 | 1 | 2 | 1 | 1 | 3 | 2 | 3 | | **A** | ↔ |

**CP 31: PATIENT DISCHARGE: Lead Directors – Mrs Deborah Burns, Interim Director of Acute Services and Mrs Angela McVeigh, Director of Older People & Primary Care**

**From April 2014, ensure that 90% of complex discharges from an Acute Hospital take place within 48-hours, with no complex discharge taking more than 7-days; and all non-complex discharges from an Acute Hospital take place within 6-hours.**

**Baseline:** Non-Complex 6-hours – 93.3% (2013/2014)
Complex 48-hours – 98.1% (2013/2014)
All Discharges 7-days – 99.7% (2013/2014)

**TDP Assessment:** Achievable

**Standard:** Non-complex 6-hours 100%
Complex 48-hours 90%
All discharges 7-days 100%

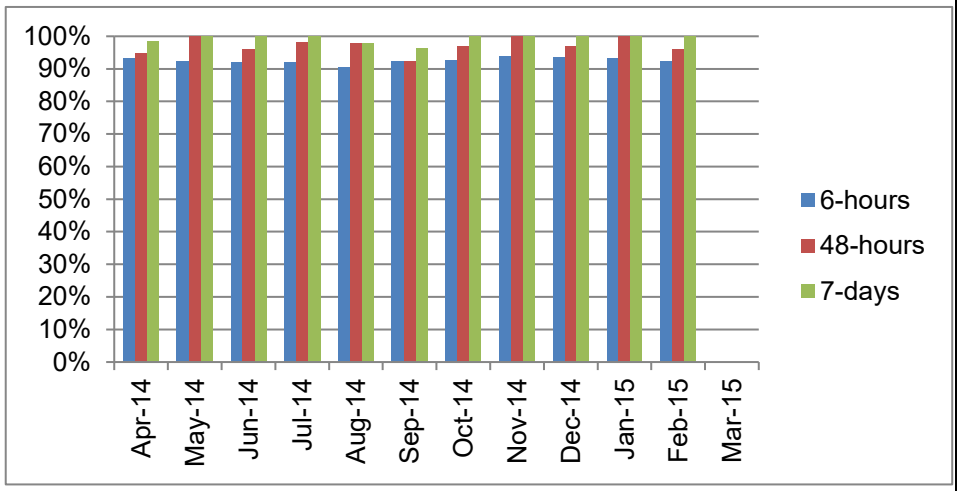
**Comments:**

**Non-Complex Discharges** – Performance against the 6-hour standard remains challenging and is affected by a number of challenges:

- Conflicting pressures on staff, causing delays in discharge letters and discharge scripts;
- Delays in discharge transportation;
- Issues with re-starting community packages;
- Issues with delivery of community equipment;
- Families being able to collect relatives or be at home to receive them

**Actions to Address:**

- An Admission & Discharge Steering Group has been established with a work plan focussing on 3 main areas:
  - Use of the Information Hub, so that Acute and Community staff are aware of existing services to patients;
  - Medication; and
  - Equipment.
- An increased focus on discharges before 1.00pm, which will in-turn assist with improving the 6-hour performance.



| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| 6-hours | 93.2% (1999 out of 2146) | 92.2% (1950 out of 2114) | 92% (1804 out of 1960) | 92% (1924 out of 2087) | 90.6% (1807 out of 1994) | 92.1% (1929 out of 2095) | 92.5% (2023 out of 2186) | 93.8% (1894 out of 2019) | 93.6% (1984 out of 2119) | 93.1% (1668 out of 1792) | 92.3% (1647 out of 1784) | | A | ⇔ |
| 48-hours | 94.9% (56 out of 59) | 100% (51 out of 51) | 96.1% (49 out of 51) | 98.2% (55 out of 56) | 97.9% (49 out of 50) | 92.9% (52 out of 56) | 96.8% (61 out of 63) | 100% (56 out of 56) | 96.7% (87 out of 89) | 100% (84 out of 84) | 96% (72 out of 75) | | G | ⇔ |
| 7-days | 98.31% (58 out of 59) | 100% (51 out of 51) | 100% (51 out of 51) | 100% (56 out of 56) | 97.9% (49 out of 50) | 96.4% (54 out of 56) | 100% (63 out of 63) | 100% (56 out of 56) | 100% (90 out of 90) | 100% (84 out of 84) | 100% 75 out of 75) | | Y | ⇔ |

Note: Amendment to July, December and January data

**MINISTERIAL PRIORITY: TO ENSURE THE MOST VULNERABLE IN OUR SOCIETY, INCLUDING CHILDREN AND ADULTS AT RISK OF HARM ARE LOOKED AFTER EFFECTIVELY ACROSS ALL OUR SERVICES**

**CP 32: LEARNING DISABILITY / MENTAL HEALTH: Lead Director – Mr Miceal Crilly, Interim Director of Mental Health & Disability**

**By March 2015, resettle the remaining long-stay patients in learning disability and psychiatric hospitals to appropriate places in the community.**

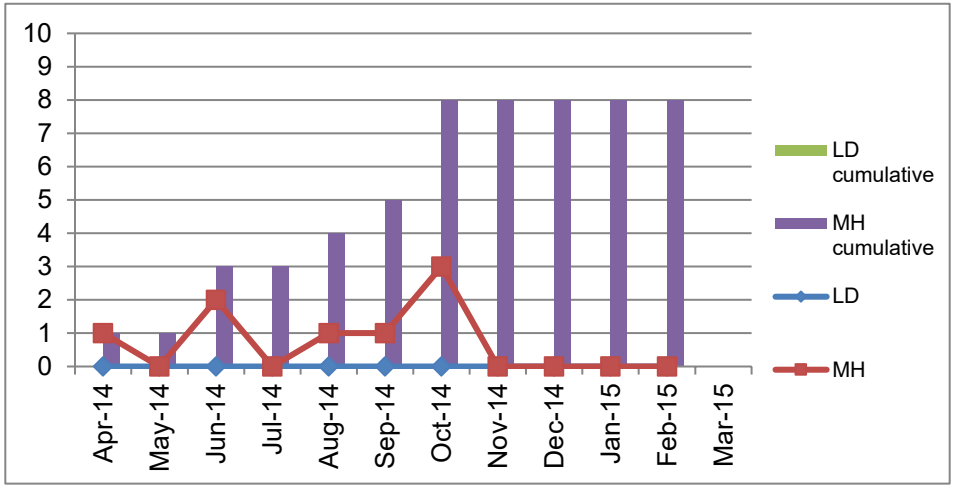
**Baseline:** Learning Disability – 30 (2013/2014)
Mental Health – 6 (2013/2014)
**TDP Assessment:** Learning Disability – Achievable
Mental Health – Achievable

**Target:** Learning Disability - 1
Mental Health – 10 ( 7 SHSCT & 3 Non-SHSCT)

**Comments:**

2014/15 targets for resettlement confirmed as 1 for Learning Disability and 10 for Mental Health. The Mental Health target relates to 7 SHSCT patients & 3 SHSCT residents currently residing in SEHSCT facilities.

- **Learning Disability** – One single target patient remains to be resettled, from Muckamore.
- **Mental Health** – The end of March 2015 target has been adjusted and is now reduced to 8 patients to be resettled. All 8 patients have now been resettled and the target for March 2015 is fully achieved.




| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| LD | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | |
| LD Cumulative | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | Y | ↔ |

| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **MH St Lukes** | 1 | 0 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | | | |
| **MH Downshire** | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | | | |
| **MH Cumulative** | 1 | 1 | 3 | 3 | 4 | 5 | 8 | 8 | 8 | 8 | 8 | | **G** | ⇔ |

**CP 33: MENTAL HEALTH SERVICES: Lead Director – Mr Miceal Crilly, Interim Director of Mental Health & Disability**

**By April 2014, no patient waits longer than 9-weeks to access child and adolescent mental health services; 9-weeks to access dementia services; and 13-weeks to access psychological therapies (any age).**

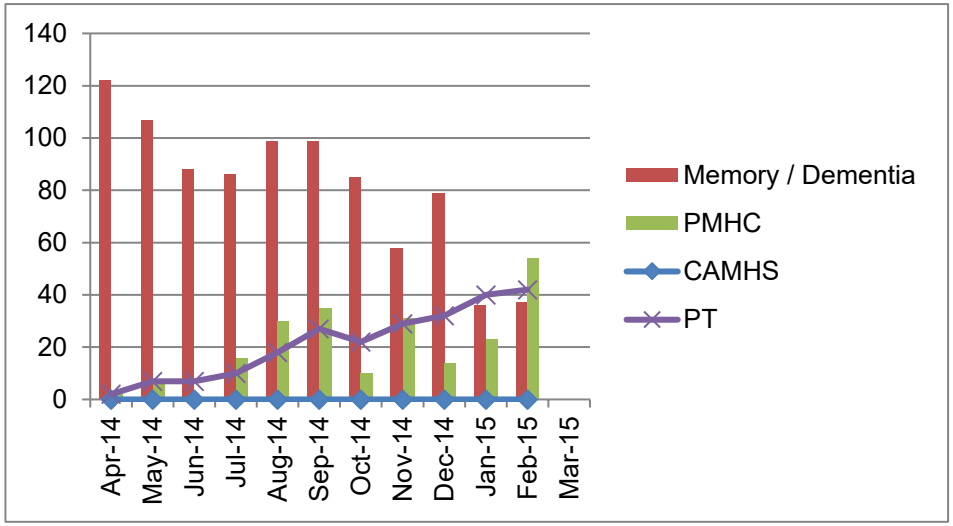
| | | | |
|---|---|---|---|
| **Baseline:** | CAMHS – 0 (@ 31 March 2014)<br>PMHC – 0 (@ 31 March 2014)<br>Dementia Services – 74 (@ 31 March 2014)<br>Psychological Therapies – 0 (@ 31 March 2014) | **Target:** | CAMHS 9-weeks<br>PMHC 9-weeks<br>Dementia Services 9-weeks<br>Psychological Therapies 13-weeks |
| **TDP Assessment:** | CAMHS – Achievable<br>PMHC – Achievable<br>Dementia Services – To be confirmed<br>Psychological Therapies – Achievable | | |

**Comments:**

- **Primary Mental Health Care –** Key issues relate to an increase in referrals equating to 33% over the past 6 months, with a 50% rise in referrals prioritised as "urgent" within this cohort. In addition the service is facing capacity issues associated with sickness absence. The service anticipates an increase in access time with 97 patients in excess of 9 weeks by end of March 2015.

  **Action to Address**
  - Service have undertaken analysis and prepared an action plan to mitigate as far as possible the anticipate impact on performance which includes
    - Refocus of internal resources with additional capacity established to try and mitigate the increase in referrals.
    - Procurement of additional capacity in the Independent Sector (post March 2015 due to procurement lag time
  - Position escalated to Commissioner.

- **Memory/Dementia Services** –New reporting arrangements have been established in January to bring reporting into line with regional definitions. The longest waits are for those patients triaged as requiring to access to the Consultant element of the multi-disciplinary service. Additional capacity for consultant activity has been put in place temporarily funded internally.



January performance across the Region demonstrates a total of 41 patients in excess of 9-weeks. 88% (36) of these relate to SHSCT patients with 12% (5) relating to WHSCT patients.

**Action to Address:**

- Whilst reporting has been revised there is ongoing work to look at recording and flows of information throughout the service. Work to establish capacity has been initiated. This will link into regional implementation of the Dementia Strategy which will look at capacity and demand issues.
- Additional temporary capacity has been put in place in the community response service and for consultant activity, funded by Trust..

- **Psychological Therapies** – Recruitment for the vacancies has been successful with 2 members of staff to commence in January and 1 further member of staff to commence in March.

  January performance across the Region demonstrates a total of 831 patients in excess of 13-weeks, ranging from 40 patients (SHSCT) to 477 patients (SEHSCT).

  **Action to Address:**

  - Head of Service level performance meetings are held with Mental Health Directorate monthly to review performance against the access standards. SBAs are under review for this area and when agreed a monitoring process will require to be implemented.

| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **CAMHS** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | G | ↔ |
| **Memory / Dementia** | 122 | 107 | 88 | 86 | 99 | 99 | 85 | 58 | 79 | 36 | 37 | | R | ↔ |
| **PMHC** | 3 | 7 | 1 | 16 | 30 | 35 | 10 | 31 | 14 | 23 | 54 | | R | ↓ |
| **PT** | 2 | 7 | 7 | 10 | 18 | 27 | 22 | 29 | 32 | 40 | 42 | | R | ↓ |

**OUT-PATIENT REVIEWs –Patient waiting beyond their clinically indicated timescales: Lead Director – Mr Miceal Crilly, Interim Director of Mental Health & Disability**

**Comments:**

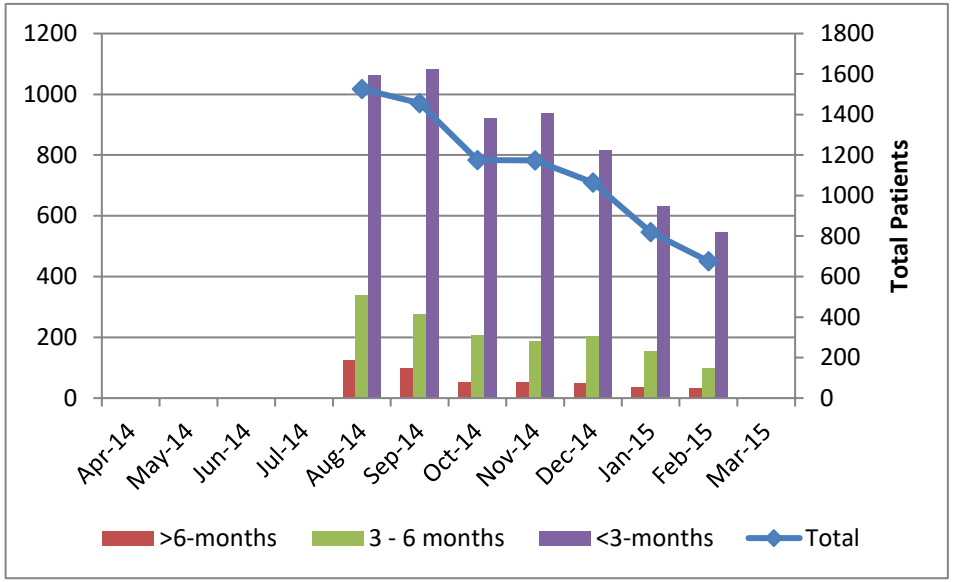
Of the 819 review patients waiting beyond their clinically indicated timescales:

- 4% (36) of these are waiting in excess of 6-months;
- 19% (155) of these are waiting between 3 – 6 months;
- with the remaining 77% (630) are waiting less than 3-months.

Focus on the longest waiters, with validation and additional capacity created via internal funding initiatives, has seen the cohort of patients waiting over 6 months decrease by over 700 from August to February as per the blue line on the chart.

**Action to Address:**

- Discussion paper submitted to HSCB and SLCG to highlight ongoing issues (July);
- Trust has sought engagement with Primary Care via the SLCG to consider potential solutions in the absence of additional funding options to address backlog; and
- Trust has ring-fenced additional temporary funding for additional capacity to be established in MHD to target patients beyond their clinically indicated timescale. Work is ongoing to consider how this can be put in place.




| | Monthly Position: | | | | | | | | | | | | Cum Assess | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | | |
| **Total** | | | | | 1526 | 1456 | 1176 | 1174 | 1064 | 819 | | | R | ↑ |
| **>6-months** | | | | | 125 | 97 | 51 | 50 | 48 | 36 | | | | ↑ |
| **3 – 6 months** | | | | | 339 | 277 | 206 | 188 | 202 | 153 | | | | ↑ |
| **<3-months** | | | | | 1062 | 1082 | 919 | 936 | 814 | 630 | | | | ↑ |

**CP 34: CHILDREN IN CARE: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services**

**From April 2014, increase the number of children in care for 12 months or longer with no placement change to 85%**

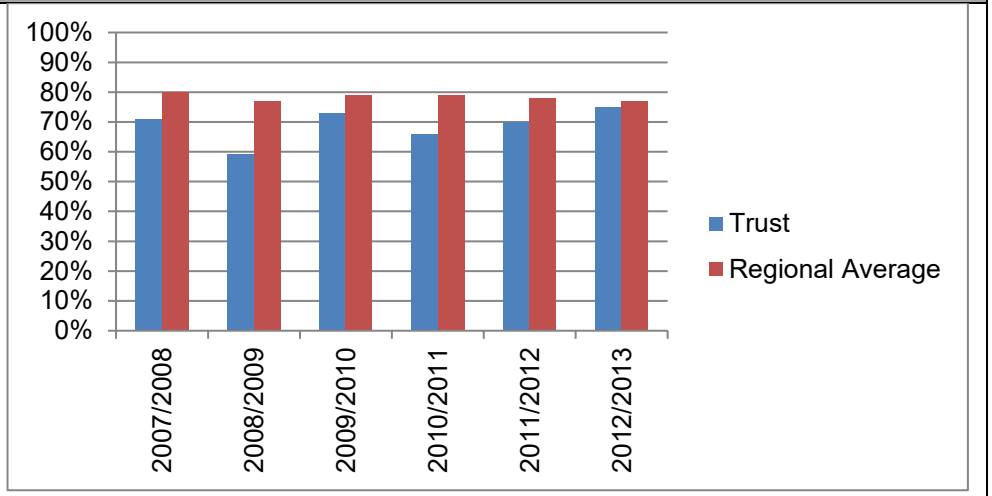
**Baseline:** To be confirmed
**TDP Assessment:** Achievable

**Standard:** Increase to 85%

**Comment/Actions:**

Information reported annually and therefore, will not be available until Quarter 1 2015/2016.

Detailed below is Trust and Regional performance (sourced from HSCB Trust Board Performance Report), against this standard, from 2007/2008 to 2012/2013. Trust performance in 2012/2013 was at its highest, for this 6-year period, at 75%. Trust performance is below the Regional average during all 6-years.



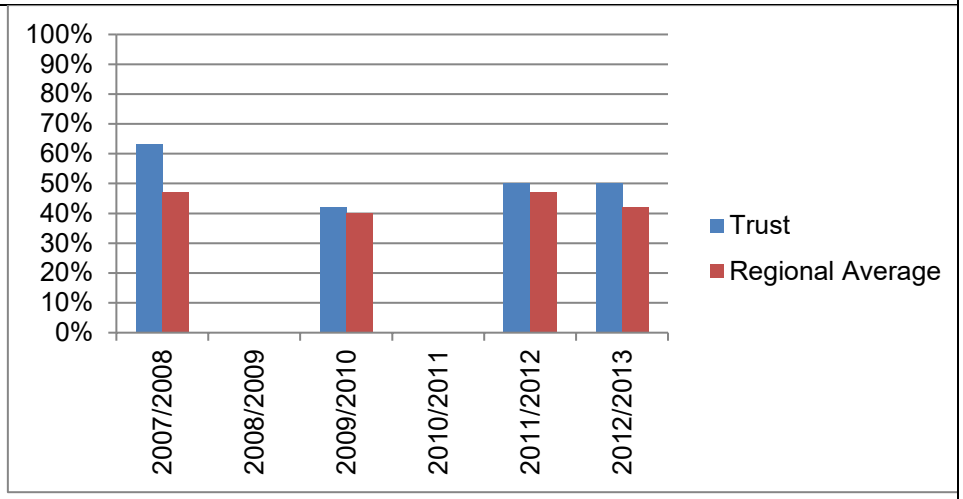

| | Yearly Trend Position: | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2007/2008** | **2008/2009** | **2009/2010** | **2010/2011** | **2011/2012** | **2012/2013** | **Trend** |
| **Trust** | 71% | 59% | 73% | 66% | 70% | 75% | ⇔ |
| **Regional Average** | 80% | 77% | 79% | 79% | 78% | 77% | ⇔ |

| CP 35: CHILDREN IN CARE: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services | |
|---|---|
| **By March 2015, ensure a 3-year time frame for 90% of children who are to be adopted from care.** | |
| **Baseline:** To be confirmed<br>**TDP Assessment:** Achievable | **Standard:** 3-Year Timeframe for 90% |
| **Comment/Actions:** Information reported annually and therefore, will not be available until Quarter 1 2015/2016. | |

**Comment/Actions:**

Information reported annually and therefore, will not be available until Quarter 1 2015/2016.

Detailed below is Trust and Regional performance (sourced from HSCB Trust Board Performance Report), against this standard, from 2007/2008; 2009/2010; 2011/2012; and 2012/2013. Trust performance during these 4-years has been in excess of the Regional average.




| | Yearly Trend Position: | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2007/2008** | **2008/2009** | **2009/2010** | **2010/2011** | **2011/2012** | **2012/2013** | **Trend** |
| **Trust** | 63% | No data | 42% | No data | 50% | 50% | ⇔ |
| **Regional Average** | 47% | No data | 40% | No data | 47% | 42% | ⇔ |

| CP 36: CHILDREN IN CARE: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **From April 2014, ensure that all school-age children who have been in care for 12-months or longer have a Personal Education Plan (PEP).** | | | | | | | | | | | | | | |
| **Baseline:** To be confirmed<br>**TDP Assessment:** Achievable | | | | | | | | **Standard:** 100% for 12-Months or Longer | | | | | | |
| **Comment/Actions:** Information reported annually and therefore, will not be available until Quarter 1 2015/2016. | | | | | | | | | | | | | | |
| **Monthly Position:** | | | | | | | | | | | | | **Cum Assess** | **Trend** |
| **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | | | |
| Not available until Quarter 1 2015/2016 | | | | | | | | | | | | | | |

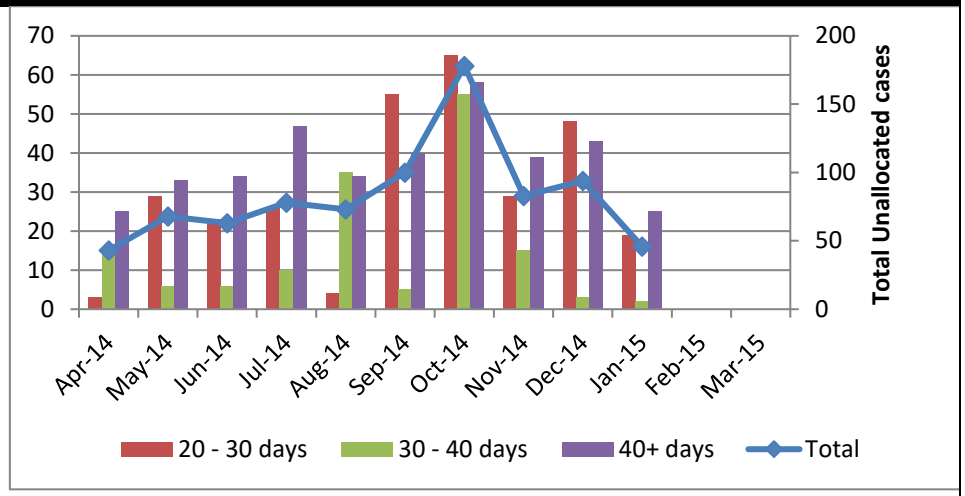
## UNALLOCATED CHILD CARE CASES: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services

**Comment/Actions: February Update not available**

At 31 January 2015 there are a total of 46 unallocated child care cases in excess of 20-days, represented by the blue line, which is a significant improvement from the peak reported in October of 178.

41% (19) of these are waiting between 20 and 30 days; 4% (2) between 30 and 40 days; with 54% (25) in excess of 40-days.

Further information on the Unallocated Child Care Cases is provided within the Director of CYPS Trust Board Report.




| | Monthly Position | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Trend |
| **Total** | 43 | 68 | 63 | 78 | 73 | 100 | 178 | 83 | 94 | 46 | No update | | ↑ |
| **>20 - <30-days** | 3 | 29 | 23 | 26 | 4 | 55 | 65 | 29 | 48 | 19 | | | |
| **>30 - <40-days** | 15 | 6 | 6 | 10 | 35 | 5 | 55 | 15 | 3 | 2 | | | |
| **>40-days** | 25 | 33 | 34 | 47 | 34 | 40 | 58 | 39 | 43 | 25 | | | |

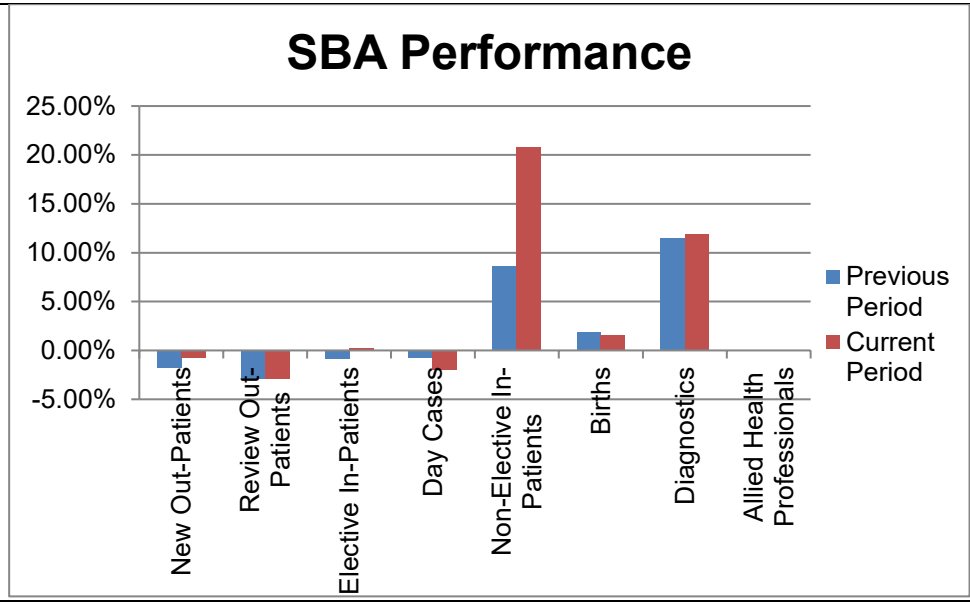
**SBA PERFORMANCE SUMMARY FOR TRUST BOARD – MONTH END JANUARY 2015** **APPENDIX 1**

**Total SBA Performance Per Activity Type (inclusive of newly agreed in-year uplifts):**
Table 1 below provides a summary of the total performance against elective and non-elective SBA; this excludes visiting services where the Trust is not responsible for the SBA, a number of areas in Mental Health Directorate where SBAs require to be updated/agreed and activity related to daycentres and bedday contracts. AHPs are currently excluded from SBA analysis pending input from HSCB/PHA on new baselines.

This position as at end of January 2015 reflects a fairly static position in all areas with all areas performing above the - 5% tolerance limit. February data not yet available

**Table 1**

| Activity Type* | Performance** | Trend |
|---|---|---|
| New Out-Patients | -0.75% (-500) | ↓ |
| Review Out-Patients | -2.87% (-3290) | ↓ |
| Elective In-Patients | -0.28% (-15) | ↑ |
| Day Cases | -1.98% (-524)[1] | ↓ |
| Non-Elective In-Patients | +20.80% (+5431) | ↑ |
| Births | +1.54% (+75) | ↓ |
| Diagnostics | +11.94% (+23785) | ↑ |
| Allied Health Professionals | SBA not yet agreed | - |




* **Note:** SBA performance includes ASD; CYPS; and OPPC specialties, where robust SBAs are in place. MHD is excluded as robust SBAs are not yet developed.
** **Note:** SBA Performance 1/4/14 – 31/12/14.

| RAG Status: | On SBA or Over performing on SBA | Underperformance of up to -4.9% | Underperformance of -5.0 to -9.9% | Underperformance of -10% and above |
|---|---|---|---|---|

[1] Note: Cardiology Cath Lab January activity not yet available – therefore, SBA performance will be subject to change

## ANTICIPATED ACCESS TIMES
## OUTPATIENTS

| | | Actual Access Time and Volume of Waits (by Time Band) at end of February 2015 | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Specialty** | **Access Standard or Backstop** | **Actual End of February 2015 position** | **Actual Volume of patients waiting in excess of backstop** | **Timebands (in weeks)** | | | | **Estimated End of March 2015 position** |
| | | | | **15 - 20** | **21 - 30** | **31 - 40** | **41 - 50** | **50 +** | |
| Anti-Coagulant | 9-weeks | 9-weeks | - | - | - | - | - | - | 9-weeks |
| Breast Family History | 9-weeks | 26-weeks | 1 | - | 1 | - | - | - | 9-weeks |
| Cardiology | 9-weeks | 31-weeks | 470 | 310 | 159 | 1 | 0 | 0 | 32-weeks |
| Cardiology ICATS | 9-weeks | | | | | | | | |
| Cardiology – Rapid Access Chest Pain | 2-weeks | 3-weeks | - | - | - | - | - | - | 2/3-weeks |
| Chemical Pathology | 9-weeks | 9-weeks | - | - | - | - | - | - | 13-weeks |
| Colposcopy | 9-weeks | 5-weeks | - | - | - | - | - | - | 4-weeks |
| Community Paediatrics | 9-weeks | 30-weeks | 27 | 9 | 18 | 0 | 0 | 0 | 9-weeks |
| Dermatology | 15-weeks | 40-weeks | 1688 | 556 | 760 | 372 | 0 | 0 | 42-weeks |
| Dermatology ICATS | 15-weeks | | | | | | | | |
| Endocrinology / Diabetes | 9-weeks | 37-weeks | 125 | 65 | 56 | 4 | 0 | 0 | Diabetes 40-wks Endo 30-wks |

| Specialty | Access Standard or Backstop | Actual End of February 2015 position | Actual Volume of patients waiting in excess of backstop | Timebands (in weeks) | | | | | Estimated End of March 2015 position |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 15 - 20 | 21 - 30 | 31 - 40 | 41 - 50 | 50 + | |
| ENT | 9-weeks | 25-weeks | 673 | 663 | 9 | 0 | 0 | 0 | 29-weeks |
| ENT ICATS | 9-weeks | | | | | | | | |
| Gastro-enterology | 9-weeks | 27-weeks | 148 | 136 | 12 | 0 | 0 | 0 | 24-weeks |
| General Medicine | 9-weeks | | | | | | | | |
| Geriatric Medicine | 9-weeks | 9-weeks | - | - | - | - | - | - | 9-weeks |
| Geriatric Medicine – OrthoGeriatric | 9-weeks | 46-weeks | 41 | 13 | 10 | 13 | 5 | 0 | 45-weeks |
| General Surgery | 9-weeks | 21-weeks | 262 | 236 | 26 | 0 | 0 | 0 | 24-weeks |
| Gynaecology | 9-weeks | 27-weeks | 568 | 551 | 17 | 0 | 0 | 0 | 28-weeks |
| Haematology | 9-weeks | 17-weeks | 7 | 7 | 0 | 0 | 0 | 0 | 22-weeks |
| Nephrology | 9-weeks | 9-weeks | - | - | - | - | - | - | 9-weeks |
| Neurology | 9-weeks | 29-weeks | 450 | 213 | 237 | 0 | 0 | 0 | 34-weeks |
| Orthopaedics | 13-weeks | 36-weeks | 770 | 318 | 390 | 62 | 0 | 0 | 38-weeks |
| Orthopaedics ICATS | 9-weeks | 42-weeks | 445 | 421 | 23 | 0 | 1 | 0 | 24-weeks |
| Paediatrics | 9-weeks | 17-weeks | 4 | 4 | 0 | 0 | 0 | 0 | 9-weeks |
| Pain Management | 9-weeks | 22-weeks | 219 | 190 | 29 | 0 | 0 | 0 | 24-weeks |

| Specialty | Access Standard or Backstop | Actual End of February 2015 position | Actual Volume of patients waiting in excess of backstop | Timebands (in weeks) | | | | | Estimated End of March 2015 position |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 15 - 20 | 21 - 30 | 31 - 40 | 41 - 50 | 50 + | |
| Rheumatology | 15-weeks | 38-weeks | 447 | 156 | 210 | 81 | 0 | 0 | 42-weeks |
| Symptomatic Breast Clinic | 9-weeks | 2-weeks (Red Flag) & 12-weeks (routine) | - | - | - | - | - | - | 2-weeks (Red Flag) & 9-weeks (routine) |
| Thoracic Medicine | 9-weeks | 25-weeks | 167 | 142 | 25 | 0 | 0 | 0 | 30-weeks |
| Urology | 9-weeks | 53-weeks | 1020 | 210 | 387 | 362 | 60 | 1 | 46-weeks |
| Urology ICATS | 9-weeks | | | | | | | | |

## IN-PATIENTS / DAY CASES

| Specialty | Access Standard or Backstop | Actual End of February 2015 position | Actual Volume of patients waiting in excess of backstop | Timebands (in weeks) | | | | Estimated End of March 2015 position |
|---|---|---|---|---|---|---|---|---|
| | | | | 26 - 40 | 41 - 60 | 61 - 80 | 80 + | |
| Breast Surgery | 26-weeks | 36-weeks | 3 | 3 | 0 | 0 | 0 | 27-weeks |
| Cardiology | 13-weeks | 26-weeks | 1 | 1 | 0 | 0 | 0 | 18-weeks |
| Community Dentistry | 13-weeks | 14-weeks | - | - | - | - | - | 13-weeks |
| Dermatology | 13-weeks | 17-weeks | - | - | - | - | - | 16-weeks |
| ENT | 13-weeks | 22-weeks | - | - | - | - | - | 28-weeks |
| Gastro-enterology | 13-weeks | 29-weeks | 5 | 5 | - | - | - | TBC |
| General Surgery | 26-weeks | 45-weeks | 302 | 289 | 13 | 0 | 0 | 50-weeks |
| Gynaecology | 13-weeks | 40-weeks IP & 13-weeks DC | 29 | 29 | 0 | 0 | 0 | 38-weeks IP & 13-weeks DC |
| Haematology | 13-weeks | 13-weeks | - | - | - | - | - | 13-weeks |
| Orthopaedics | 26-weeks | 59-weeks | 355 | 218 | 137 | 0 | 0 | 62-weeks |
| Pain Management | 26-weeks | 40-weeks | 170 | 170 | 0 | 0 | 0 | 40-weeks |
| Rheumatology | 26-weeks | 24-weeks | - | - | - | - | - | 16-weeks |
| Urology | 26-weeks | 82-weeks | 269 | 113 | 110 | 45 | 1 | 84-weeks |

## DIAGNOSTICS

| Specialty | Sub Specialty | Access Standard or Backstop | Actual End of February 2015 position | Actual Volume of patients waiting in excess of backstop | Timebands (in weeks) | | | | Estimated End of March 2015 position |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 9 - 13 | 13 - 21 | 22 - 26 | 26 + | |
| Endoscopy | - | 9-weeks | 28-weeks (routine) *(Actual 35-weeks)* 15-weeks (urgent) | 594 | 224 | 264 | 83 | 23 | 18-weeks |
| Non Imaging | Audiology | 9-weeks | 9-weeks | - | - | - | - | - | 9-weeks |
| | Cardiac Investigations | | Total 9-weeks | 979 | 550 | 420 | 89 | 0 | TBC |
| | Echo | | Echo 16-weeks | 867 | 448 | 411 | 8 | 0 | 22-weeks |
| | Neurophysiology | | 9-weeks | - | - | - | - | - | 9-weeks |
| | Respiratory Physiology | | 9-weeks | - | - | - | - | - | 9-weeks |
| | Urodynamics (Urology) | | 50-weeks | 105 | 22 | 36 | 11 | 36 | 46-weeks |
| | Urodynamics (Gynae) | | 9-weeks | - | - | - | - | - | <9-weeks |
| | Sleep Studies | | 9-weeks | - | - | - | - | - | 9-weeks |

| Specialty | Sub Specialty | Access Standard or Backstop | Actual End of February 2015 position | Actual Volume of patients waiting in excess of backstop | Timebands (in weeks) | | | | Estimated End of March 2015 position |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 9 - 13 | 13 - 21 | 22 - 26 | 26 + | |
| Imaging | Plain Film | 9-weeks | < 9-weeks | - | - | - | - | - | < 9-weeks |
| | CT | | CT (excl CTC) 23-weeks | 801 | 294 | 368 | 125 | 14 | CT:13-weeks CTC:34-weeks |
| | CTC | | CTC 35-weeks | | | | | | |
| | USS | | 13-weeks | 788 | 761 | 27 | 0 | 0 | 15-weeks |
| | Dexa | | 15-weeks | 325 | 229 | 96 | 0 | 0 | 16-weeks |
| | MRI | | 22-weeks | 178 | 81 | 95 | 2 | 0 | 13-weeks |
| | Fluoroscopy | | | 24 | 23 | 1 | 0 | 0 | 15-weeks |
| | Barium Enema | | | 1 | 1 | - | - | - | 9-weeks |
| | Gut Transit Studies | | | - | - | - | - | - | 9-weeks |
| | Obstetrics Ultrasound | | | - | - | - | - | - | 9-weeks |
| | Radio Nuclide | | | - | - | - | - | - | 9-weeks |

## MENTAL HEALTH AND DISABILITY

| Specialty | Sub Specialty | Access Standard or Backstop | Actual End of February 2015 position | Actual Volume of patients waiting in excess of backstop | Timebands (in weeks) | | | | | Estimated End of March 2015 position |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 9 - 13 | 13 - 18 | 18 - 26 | 26 - 39 | 39 + | |
| Adult Mental Health Services | Primary Mental Health Care | 9-weeks | 13-weeks | 54 | 53 | 1 | 0 | 0 | 0 | 12-weeks |
| | Memory / Dementia Services | | 29-weeks | 37 | 16 | 8 | 6 | 7 | 0 | 39-weeks |
| CAMHS | - | 9-weeks | 9-weeks | - | - | - | - | - | - | 9-weeks |
| Learning Disability | - | 9-weeks | 9-weeks | - | - | - | - | - | - | 9-weeks |
| Psychiatry of Old Age | - | 9-weeks | 9-weeks | - | - | - | - | - | - | 9-weeks |
| Autism | - | 13-weeks | 13-weeks | - | - | - | - | - | - | 13-weeks |
| Psychological Therapies | - | 13-weeks | 27-weeks | 42 | 28 | 12 | 2 | 0 | 0 | 28-weeks |

## ALLIED HEALTH PROFESSIONALS

| Specialty | Access Standard or Backstop | Actual End of February 2015 position | Actual Volume of patients waiting in excess of backstop | Timebands (in weeks) | | | Estimated End of March 2015 position |
|---|---|---|---|---|---|---|---|
| | | | | 9 - 13 | 13 - 26 | 26 + | |
| Dietetics – Acute | 9-weeks | 9-weeks | - | - | - | - | 9-weeks |
| Dietetics – Elderly and Primary Health Care | 9-weeks | 11-weeks | 1 | 1 | 0 | 0 | 12-weeks |
| Dietetics – Paediatrics | 9-weeks | 39-weeks | 282 | 36 | 145 | 101 | 42-weeks |
| Occupational Therapy – Acute | 9-weeks | 23-weeks | 9 | 7 | 2 | 0 | 9-weeks |
| Occupational Therapy – Elderly and Primary Health Care | 9-weeks | 27-weeks | 172 | 66 | 105 | 1 | 29-weeks |
| Occupational Therapy – Paediatric | 9-weeks | 34-weeks | 136 | 39 | 77 | 20 | 35-weeks |
| Occupational Therapy – Physical Disability | 9-weeks | 18-weeks | 56 | 24 | 32 | 0 | 28-weeks |

| Specialty | Access Standard or Backstop | Actual End of February 2015 position | Actual Volume of patients waiting in excess of backstop | Timebands (in weeks) | | | Estimated End of March 2015 position |
|---|---|---|---|---|---|---|---|
| | | | | 9 - 13 | 13 - 26 | 26 + | |
| Occupational Therapy – Learning Disability | 9-weeks | 14-weeks | 9 | 8 | 1 | 0 | 9-weeks |
| Orthoptics | 9-weeks | 9-weeks | - | - | - | - | 9-weeks |
| Physiotherapy – Adult | 9-weeks | 17-weeks | 321 | 306 | 13 | 2 | 21-weeks |
| Physiotherapy – Paediatrics | 9-weeks | 18-weeks | 20 | 15 | 4 | 1 | 15-weeks |
| Podiatry – Adult | 9-weeks | 25-weeks | 710 | 255 | 455 | 0 | 21-weeks |
| Podiatry – Paediatrics | 9-weeks | 20-weeks | 118 | 45 | 73 | 0 | 21-weeks |
| Speech & Language Therapy Elderly & Primary Health | 9-weeks | 21-weeks | 2 | 1 | 1 | 0 | 9-weeks |
| Speech & Language Therapy Paediatrics | 9-weeks | 29-weeks | 751 | 137 | 589 | 25 | 30-weeks |

| Specialty | Access Standard or Backstop | Actual End of February 2015 position | Actual Volume of patients waiting in excess of backstop | Timebands (in weeks) | | | Estimated End of March 2015 position |
|---|---|---|---|---|---|---|---|
| | | | | 9 - 13 | 13 - 26 | 26 + | |
| Speech & Language Therapy Physical Disability | 9-weeks | 9-weeks | - | - | - | - | 9-weeks |
| Speech & Language Therapy Learning Disability | 9-weeks | 16-weeks | 1 | 0 | 1 | 0 | 9-weeks |

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

# GOVERNANCE COMMITTEE

**Minutes of a meeting of the Governance Committee of the Southern Health and Social Care Trust held on Tuesday, 10th May 2011 at 9.30 a.m. in the Boardroom, Trust Headquarters**

**PRESENT**:

Mrs D Blakely, Non Executive Director (Chairman)
Mr E Graham, Non Executive Director
Mr A Joynes, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director

**IN ATTENDANCE**:

Mrs M McAlinden, Chief Executive
Dr P Loughran, Medical Director
Dr G Rankin, Director of Acute Services
Mrs P Clarke Director of Performance and Reform
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs D Burns, Assistant Director, Clinical and Social Care Governance
Dr T Boyce, Head of Pharmaceutical Services (item 3)
Mrs S Judt, Committee Secretary (Minutes)

**APOLOGIES**:
None

1. **MINUTES OF MEETING HELD ON 8TH MARCH 2011**

The Minutes of the meeting held on 8th March 2011 were agreed as an accurate record and duly signed by the Chairman.

2. **MATTERS ARISING FROM PREVIOUS MINUTES**

There were no matters arising from the previous meeting.

3. **MEDICINES GOVERNANCE REPORT**

Dr Boyce presented the Medicines Governance Report for the fourth quarter of 2010/11 and highlighted the key aspects as follows:-

i) 165 medication incidents were reported during this period. The average number of reported medication incidents each month was 55, representing a decrease from 76 per month in the previous quarter. Most reported incidents were of insignificant or minor impact on patients.
ii) Medicines management training for domiciliary care staff continues and the success of this training is reflected in the increasing trend of reporting of medication incidents from this group of staff.
iii) Work on the development of Medicines management procedures and guidelines has been widened to include Medicines Management in the supported living sector and also addressing specific issues raised by the Managers of the Children's Residential facilities in the Trust.

Non Executive Directors asked a number of questions about medicines management and Dr Boyce outlined the steps taken as per the Trust's Medicines Management approach.

Dr Boyce advised that following Internal Audit's verification of the Trust's compliance with the Medicines Management Controls Assurance Standard, the Trust met the DHSSPS requirement for substantive compliance. It is expected that a benchmark report comparing the five Trusts' compliance will be available in May 2011.

The Chief Executive referred to the increase in broad spectrum antibiotic usage. Dr Boyce stated that the usage was in paediatrics and not on the adult side. The Chief Executive asked Dr Boyce and Dr Loughran to monitor the situation and reference in the report to the next meeting. Mr Graham asked about the steps to be taken to reduce costs and Dr Boyce confirmed that these were happening. The Chief Executive asked that Dr Rankin and Mr McNally reiterate the increased costs associated with the antibiotic policy to the Commissioner.

4. **WH&SCT GOVERNANCE REVIEW/PERFORMANCE REPORT – ASSESSMENT OF SH&SCT COMPLIANCE AGAINST RECOMMENDATIONS**

Members discussed the Trust's assessment of compliance against the recommendations made by the HSCB following the Western H&SCT performance/governance review. The Chief Executive stated that this demonstrates that the Trust is well placed against the recommendations. Gaps had been previously identified and are largely included in the Cinical and Social Care Governance Review Implementation Plan. Mrs Blakely stated that the Non Executive Directors, together with the Chairman, had provided input into the self-assessment and one of the key issues raised was the risk associated with transition to the new clinical and social care governance systems. The Chief Executive acknowledged this concern and stated that Mrs Burns would be highlighting some of the actions to manage key risks under the next agenda item.

5. **UPDATE ON CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW IMPLEMENTATION PLAN**

Mrs Burns drew members' attention to the following key issues in the Implementation Plan:-

- 3 of the 8B posts have been filled. A potential secondment opportunity is being explored to fill the Acute Directorate post.

- Job Descriptions have now been completed for the other posts within the new structure and pooling has commenced. Agreeing the substantive bandings of posts has been time consuming. Mrs Mahood expressed her concern that timescales were slipping and Mr Joynes asked if there were other risks other than timescales. The Chief Executive advised that she has met with Directors and discussed concerns such as workload and timescales. She assured members that the underlying systems and processes to identify, record and assess risk remain. Changing those systems that require improvement is being worked on and contingency arrangements have been agreed with Directors.

- A workshop has been arranged for 20th May 2011 for the professional governance fora;

- A review and redesign of the Mortality and Morbidity (M&M) meetings is underway and Mrs Burns reported on the recent meeting held on 6th May 2011. At that meeting, it was noted that most specialties' meetings were Trust wide and across sites, but, for example, the Medicine specialty is still organised on a single site basis. Dr Loughran stated that the review of the M&M process is aimed at focusing the discussions towards 'lessons learned' and discussions to reduce the risk of avoidable deaths and improve patient safety.

  Mrs Mahood and Mr Joynes stressed the importance of the Governance Committee being made aware of the M&M outcomes and being assured that the M&M process is robust. Mr Donaghy suggested that the reassurance to Governance Committee is that M&M meetings are taking place and that the process is robust, rather than the specific details of individual patient outcomes. Mrs Burns undertook to consider how assurance around M&M processes are fed back to the Governance Committee

  RCA reports were then discussed. The Chief Executive stated that current practice is to share RCA reports with the Coroner and asked if there was any risk in doing so. Dr Rankin stated

that it was important to note that Consultants are not aware that this is current practice and raised the dilemma of this for medical staff in terms of constructive learning. Mrs Burns stated that this issue was raised with the clinical leadership when it was agreed that Mrs Burns would undertake a piece of work on RCA methodology and this will be included in the implementation plan.

- Assurance reports for the Executive Directors of Nursing, AHP, Social Work and Medicine will be brought to the Governance Committee in September 2011.

6. **CAWT GOVERNANCE ARRANGEMENTS**

The Chief Executive stated that as a partner organisation within CAWT (Co-operation and Working Together), the Trust has a responsibility for the CAWT governance arrangements to ensure proper control of public funds and provision of safe care. To that end, she referred members to a paper setting out the proposed governance arrangements for CAWT and sought members' approval. She drew to members' attention a particular governance issue which the Trust has raised in respect of professional staff employed by the Trust with CAWT/Interrag funding working in another jurisdiction. Mr Rice has been working with nursing registration arrangements in the RoI so that nurses within the Trust can work cross border as has Mr Morgan in terms of social work staff. Dr Loughran and Mrs Clarke are working through the complexities associated with medical staff. In response to a question from Dr Mullan on the finance and audit function, the Chief Executive stated that the Department oversees the internal CAWT systems.

The Non Executive Directors requested a briefing session on CAWT at a future workshop.

Members approved the proposed CAWT governance arrangements.

## 7. CORPORATE RISK REGISTER

The Chief Executive presented the updated Corporate Risk Register and advised of changes. She advised that the Corporate Risk Register had been recently reviewed by SMT Governance when a number of potential risks were identified for consideration at the next SMT Governance meeting.

### i) Records Action Plan to address areas of risk May 2011

Mrs Clarke advised that areas of risk are those where sensitive and personal client/patient/staff records are held in unsecured premises. An audit was carried out in 2009/10 to identify records held in unsecured premises and Mrs Clarke took members through the detail of an action plan to address the areas of risk.

Mr Joynes stated that it would be useful to consider the security of closed records in the event of a fire or flood. Mrs Clarke agreed to take this forward.

## 8. INCIDENTS AND COMPLAINTS MANAGEMENT REPORT

Mrs Burns presented the above-name report for the period January – March 2011 in a revised format.

### Incidents

Mrs Burns drew members' attention to the grading of incidents and stated that, in conjunction with DHSSPS guidance, the SMT has agreed that when reporting an incident the actual outcome is recorded, together with the potential consequence of the incident. The potential consequence will then be used to calculate an overall grading when multipled by the likelihood of re-occurrence.

Mrs Burns then referred to the current volume of ungraded incidents and advised that a significant proportion of these incidents have

already been graded by the service teams when they reported the incident. The SMT has agreed to provide some additional administrative support to enter these onto Datix with the grading assigned by the service teams at the time of reporting.

There was a short discussion on the Top 10 incidents (frequency of occurrence) by Directorate in March 2011compared to March 2010. Fall on level ground remains the top incident in Acute and Mr Joynes stated that it would be useful if future reports provided detail on the action the Trust is taking to address some of those incidents with a high level of occurrence. Mrs McVeigh outlined the considerable work underway within the Trust on Management of Falls and Mr Joynes reflected that this intelligence would be useful in future reports.

Mr Joynes asked what was happening at a regional level as regards grading. Mrs Burns advised that the DHSSPS had indicated that all Trusts should use the same grading matrix, but is not seeking complete consistency across the region.

Mr Joynes asked that consideration be given to Internal Audit undertaking a review of how incidents are graded.

**Complaints**

Mrs Burns stated that returns to both the DHSSPS and the HSCB are made on the number of issues of complaint received as opposed to the number of complaint letters received. She drew members' attention to a table in the report detailing the numbers of complaint subjects received by Directorates. She went on to say that complaints graded statistics are based on the number of letters received as are those statistics concerning the 20 day response target.

9. **OMBUDSMAN UPDATE**

Mrs Burns provided members with an update position on cases with the Ombudsman as at 27th April 2011. During the period 1st April 2010 – 31st March 2011, 4 cases were closed by Ombudsman.

10. **MEDICAL DIRECTOR'S REPORT**

Dr Loughran presented an overview of the key issues within the Medical Director's area of responsibility.

**HCAI**

Dr Loughran advised that the regional PfA targets from April 2011 requireTrusts to secure a reduction of 14% in the number of MRSA and C.difficile cases compared to 2010/11. He reported that there have been a cluster of MSSA cases in April and Dr Damani and the HCAI team are completing the RCAs in each case to see if a worrying trend is emerging.

*Dr Mullan left the meeting at 11.30 a.m.*

**Patient Safety Interventions**

Dr Loughran referred to the 13 Patient Safety Interventions which are a mixture of internal Trust and PfA targets. This current report looks at 2 of the 13 interventions. Dr Loughran advised that work is progressing in relation to the Stroke Collaborative. Dr Rankin stated that it is important to recognise that the Stroke Collaborative had only recently commenced and the Trust was awaiting the appointment of a Specialty Doctor and further rota changes to support the speedy responses required for effective thrombolysis. Dr Loughran noted that the Trust is providing thrombolysis for a significant number of patients (high numbers per capita).

**Indicators of Safety and Quality**

Dr Loughran advised that whilst the clinical coding of patients who have died is slow, but accurate, the final statistics are helpful and the overall Trust Risk Adjusted Mortality Index (RAMI) is within normal limits (peer reviewed). The Chief Executive stated that the Regional mortality figures will be issued in June 2011.

*The Chief Executive and Mrs Clarke left the meeting at 11.40 a.m.*

**Litigation**

Dr Loughran provided members with details of costs relating to litigation cases associated with medical negligence closed and settled during 2010/11.

**Medical Appraisal and Revalidation**

Mr Joynes stated that he found the low level of completed appraisals for the calendar year 2010 unacceptable and suggested that the timescales for completion be looked at. Dr Loughran agreed to discuss this issue with Medical staff.

11. **SERIOUS ADVERSE INCIDENTS REPORT FOR THE PERIOD 1.4.2010 – 31.3.2011**

Mrs Burns presented a summary of the SAIs reported during 1st April 2010 to 31st March 2011. One cases remains outstanding from 2007-2008 and three cases remain outstanding from 2009-2010.

13. **UPDATE ON REVIEW OF TRUST LITIGATION SYSTEMS AND PROCESSES**

This item was deferred to the Governance Committee meeting on 6th September 2011.

14. **OUTPATIENT REVIEW BACKLOG – PROGRESS REPORT**

Dr Rankin provided members with a short progress report. From the analysis, members noted a reduction in the number of patients in the review backlog from over 2,000 to 344 waiting from 2008; a reduction from 7,000 to 2,000 in those waiting from 2009 and a reduction from over 8,000 to 7,000 waiting from 2010. In relation to the urgent/top of list patients, Dr Rankin spoke of the considerable progress made from May 2010 to end of March 2011 in the 5 specialties, but acknowledged that there is more work to be done.

Mrs Mahood asked if there was a risk that the trend would go upwards. Dr Rankin stated that the reduction in the outpatient review backlog was achieved partly due to resources from the

HSCB, but also as a result of clarifying to all staff the Trust's approach to reviews.

14. **PUBLIC INQUIRY INTO OUTBREAK OF C.DIFFICILE IN NORTHERN H&SCT**

Dr Loughran informed members that the Chief Medical Officer has written to ask each Trust to review HCAI arrangements in light of the 12 recommendations of the Public Inquiry. He provided assurance that the recommendations have been reviewed and embedded into the HCAI Workstreams strategy. A detailed report will be presented at the June Trust Board meeting.

15. **FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REQUESTS – SUMMARY REPORT FOR THE PERIOD JANUARY – MARCH 2011**

Members noted the content of the summary report for the period January – March 2011. A total of 55 requests were responded to in this period. Of these responses, 45 were processed within the 20 day deadline and 10 were processed outside of the 20 day deadline.

16. **DRAFT STATEMENT ON INTERNAL CONTROL**

Mr McNally presented the draft Statement on Internal Control as submitted to the NI Audit Office with the year-end accounts on 6th May 2011. He stated that of 23 Internal Audit reports, 9 had received limited assurance. He advised that Internal and External Audit continue to work with the Trust with regard the balance of managing risk within available resources. Mr Joynes, as Chair of the Audit Committee, stated that he would be concerned that the issue of resources would weaken an independent audit opinion. It was agreed that this discussion be deferred to the Audit Committee.

17. **RQIA REVIEWS STATUS UPDATE**

Members were provided with an update on the following RQIA Reviews:-

i) **Review of Readiness for Medical Revalidation**

Dr Loughran advised that the Review Team had concluded that the Trust has made good progress in preparing for medical revalidation and enhanced appraisal.

Members discussed the action plan and Dr Loughran noted that on completion of these actions, the Review Team had concluded that the Trust could consider application to be an early adopter site for revalidation. In response to a request from Mr Joynes, Dr Loughran undertook to include timescales in the action plan. Mrs Blakely referred to recommendation 1 on the linkage of Responsible Officer to the new Clinical and Social Care Governance arrangements and asked what action was being taken to address the issues raised. Dr Loughran advised that as responsibility for clinical and social care governance transferred from the Medical Director to the Chief Executive on 1st April 2011, discussions are ongoing between the Chief Executive and Medical Director to agree a suite of reporting information. This will provide the Responsible Officer with the 'window' into the clinical and social care governance structures.

ii) **Review of Child and Adolescent Mental Health Services (CAMHS)**

Mr Morgan advised that the final report of the RQIA Review was published on 22nd February 2011 and he referred members to the summary report in their papers. Mr Morgan went on to advise that there were 21 regional recommendations and these are being taken forward by a regional group on which Mr Peadar White, Head of Service for CAMHS, is the Trust's representative. He stated that there were 2 recommendations specific to the Southern Trust for which an action plan is currently being progressed. Both these recommendations have been addressed successfully and the action plan will be brought to the Governance Committee meeting in September 2011.

iii) **Review of Radiology**

Dr Rankin reminded members that the draft report had been presented to Trust Board and that an action plan is in place. On receipt of the final report, the action plan will be brought to the Governance Committee.

iv) **Review of Blood Safety**

Dr Rankin drew members' attention to the Trust's action plan to implement the recommendations of the Blood Safety Review undertaken by the RQIA on 22nd April 2009. She was pleased to report that all of the recommendations have now been completed.

v) **Review of Intrapartum Care**

Dr Rankin noted that the Trust's capacity to deliver the high quality standards of maternity care as defined by the RQIA report remains on its Corporate Risk Register. Whilst a substantial number of actions have been taken, such as the appointment of a Risk Midwife and consultant cover to Ward 3, the additional anaesthetic rota for Craigavon Area Hospital Labour Ward remains outstanding and it is hoped that this will be addressed from August 2011.

vi) **Unannounced Hygiene Inspections**

Dr Rankin referred members to the summary report which provided an update on the 7 RQIA Unannounced Hygiene Inspection visits during May – July 2010. She advised that out of a total 190 recommendations, 157 (83%) have been completed and 33 (17%) are ongoing.

18. **UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE**

Mrs Brownlee joined the meeting for this item and updated members on the meeting of the Patient and Client Experience

Committee held on 10th February 2011. This meeting was attended by a representative of the Patient Client Council Advisory Committee. The key areas discussed were complaints, commendations and the PPI strategy.

Southern Health and Social Care Trust
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# GOVERNANCE COMMITTEE

**Minutes of a meeting of the Governance Committee of the Southern Health and Social Care Trust held on Tuesday, 6th September 2011 at 9.30 a.m. in the Boardroom, Trust Headquarters**

**PRESENT**:

Dr R Mullan, Non Executive Director (Chairman)
Mr R Alexander, Non Executive Director
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs S Rooney, Non Executive Director

**IN ATTENDANCE**:

Mrs M McAlinden, Chief Executive
Dr J Simpson, Medical Director
Dr G Rankin, Director of Acute Services
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs D Burns, Assistant Director, Clinical and Social Care Governance
Mrs S Judt, Committee Secretary (Minutes)

**APOLOGIES**:

Mrs P Clarke Director of Performance and Reform
Dr Boyce, Head of Pharmaceutical Services

Dr Mullan welcomed everyone to the meeting, particularly the two newly appointed Non Executive Directors, Mrs S Rooney and Mr R Alexander. He also welcomed Dr J Simpson to his first Governance Committee meeting. Dr Mullan paid tribute to Mrs D Blakely for her Chairmanship of the Governance Committee to date.

For the benefit of the new members, Mrs McAlinden gave a brief overview of the role and remit of the Governance Committee.

1. **MINUTES OF MEETING HELD ON 10th MAY 2011**

The Minutes of the meeting held on 10th May 2011 were agreed as an accurate record and duly signed by the Chairman.

2. **MATTERS ARISING FROM PREVIOUS MINUTES**

Members noted the progress updates from Directors to address those matters arising from the previous meeting.

Mrs Mahood asked that members receive a copy of the written response provided to Mr Joynes following his query on records storage in terms of potential fire/water damage.

***Action: Mrs P Clarke***

Mr McNally confirmed that the draft Statement of Internal Control and the potential Internal Audit assignment in relation to the grading of incidents will be discussed at the Audit Committee meeting on 13th October 2011.

***Action: Mr S McNally***

3. **MEDICINES GOVERNANCE REPORT**

In the absence of Dr Boyce, Dr Rankin presented the Medicines Governance Report for the first quarter of 2011/12 and highlighted the key aspects as follows:-

i. 192 medication incidents were reported during this period. The average number of reported medication incidents each

month was 64, representing an increase from 55 per month in the previous quarter. This remains less than the highest average of 114 reports per month achieved during 2008/09. Dr Rankin assured members that there were no trends of specific concern amongst the reports and referred members to the actions resulting from medication incident monitoring to prevent re-occurrence. Figure 2 in the report demonstrates that most of the reported incidents were of insignificant or minor impact on patient. One incident had a catastrophic impact and Dr Rankin agreed to bring the report on the Root Cause Analysis of this incident to the next Governance Committee meeting.

***Action: Dr Rankin***

ii. Work on the Medicines Management procedures and guidelines for Domiciliary Care, Day Care and Supported Living continues. Mr Graham stated that this should be noted as being on the Trust's Corporate Risk Register. It was agreed that all reports should reference links to the Corporate Risk Register.

iii. In terms of the National Patient Safety Agency (NPSA) Patient Safety Alert 'Reducing harm from omitted and delayed medicines in hospitals', Dr Rankin advised that an initial audit has been completed within the Trust and she undertook to bring the results to a future Governance Committee meeting.

***Action: Dr Rankin***

Mrs McAlinden referred to the NPSA Patient Safety Alert 'Oxygen safety in hospitals' and advised that implementation of this alert was raised at the Trust's Year End Accountability Review meeting with the Department. Mrs Kelly asked about oxygen administration to patients in the community.
Mrs McVeigh stated that this would be the responsibility of the COPD team or the District Nurse depending on the patient's needs. Mrs Blakely stated that increased antibiotic usage by young people is an issue and asked what systems the Trust had in place. Dr Rankin advised that patients are asked to advise of their medication on admission to hospital and this is

cross-checked with the GP. The emergency care record is available to the GP Out of Hours Service and A&E would also hold this information. However, patients need to disclose their conditions.

4. **UPDATE ON CLINICAL AND SOCIAL CARE GOVERNANCE (C&SCG) REVIEW IMPLEMENTATION PLAN**

Mrs Burns provided an update on progress in relation to the population of the agreed C&SCG structure; the underpinning systems and processes and the information requirements.

Discussion ensued on the review and redesign of the Mortality and Morbidity (M&M) meetings which is underway. Mrs Burns explained that these meetings will be multi-disciplinary and the M&M process will be a much more comprehensive process. Major risks to patient safety will be brought to the attention of the Governance Committee via the Corporate Risk Register.

Mrs Burns gave an update on the implementation of DATIX web and it was agreed that a progress report will be circulated to members. Mrs Burns agreed to arrange a short demonstration on DATIX web for Non Executive Directors.

***Action: Mrs D Burns***

It was agreed that the consultation document on the Clinical and Social Care Governance Review 'A System of Trust' will be circulated to Mrs Rooney and Mr Alexander.

***Action: Mrs D Burns***

Mrs Burns agreed to provide a summary paper on the progress of the Clinical and Social Care Governance Review for the next Governance Committee meeting.

***Action: Mrs D Burns***

5. **INCIDENTS AND COMPLAINTS MANAGEMENT REPORT AND UPDATE ON OMBUDSMAN CASES**

Mrs Burns presented the above-named report for the period April – June 2011.

**Incidents**

Mrs Burns began by advising that work continues to address the backlog of logging incidents. Mrs Mahood asked for details on those incidents graded as catastrophic and Mrs Burns gave some examples and agreed to provide this in future reports. In response to a question from Mr Alexander as to the definitions of minor and moderate, Mrs Burns stated that these are Trust definitions in the absence of regional guidance. She went on to say that the Department and HSCB are leading on a piece of work to harmonise these definitions.

***Action: Mrs Burns***

Mrs Burns referred members to the update in their papers on the actions being taken on falls and falls prevention. Members noted the wide range of activities in place which contribute to falls prevention.

**Complaints**

Mrs Rooney commented that staff attitude and behaviour is the second top complaint subject after quality of treatment and care. Mrs Burns stated that work has been done with the view to reducing the number of complaints in this area and she agreed to include examples of this for the next meeting.

***Action: Mrs D Burns***

Members noted the progress update on Ombudsman cases.

6. **SERIOUS ADVERSE INCIDENTS REPORT FOR THE PERIOD 1.4.2011 – 30.6.2011**

Mrs Burns began by advising of work being taken forward regionally on the definition and process for SAIs and the role of the Designated Review Officer (DRO). Table 1 in the report details those SAIs that remain open from 1 April 2007 to 31 March 2011 and Mr Alexander queried the elongated process in relation to two of these cases. Mrs Burns explained that some of the issues identified require resolution by the Commissioner. Mrs McAlinden advised that all SAI investigation reports are approved at SMT Governance meetings to ensure collective agreement that the Trust can deliver on the recommendations identified.

7. **CORPORATE RISK REGISTER**

Mrs McAlinden presented the Corporate Risk Register updated as at August 2011 and in a revised format. She stated that this version has been shared with the Department and the HSCB. In presenting the report, Mrs McAlinden highlighted the 5 red risks facing the organisation and provided a summary of the actions being taken. Two new risks have been added in relation to a fully embedded appraisal scheme and the management and monitoring of procurement and contracts. The Corporate Risk Register is reviewed and updated monthly at SMT Governance.

8. **PROFESSIONAL GOVERNANCE REPORTS**

**i. Medical Director**

Dr Simpson presented his first Medical Director's report and welcomed comments on its content and format. He highlighted the key issues within his area of responsibility.

- **Medical Appraisal and Revalidation**

There is a continued focus to complete medical appraisals in a timely manner. A robust appraisal scheme is in place and Mrs McAlinden stated that it was important to note that the RQIA

review team had concluded that the Trust had made good progress preparing for medical revalidation and enhanced appraisal. Within the appraisal scheme, it is now agreed that the appraiser and the appraisee will get a list of complaints and incidents in which the consultant (appraisee) had been mentioned.

- **HCAI**

Members noted the Trust's response to the increased number of cases of C difficile in April 2011. Dr Simpson updated members on any recent episodes.

- **Patient Safety Interventions**

Dr Simpson referred members to the update on progress with each intervention in their papers. Dr Rankin updated on the Stroke Collaborative.

Mrs Blakely stated that it would be helpful if Dr Simpson included a synoposis of the key issues he considered to be pertinent in future reports to the Governance Committee.

**ii. Social Work and Social Care**

Mr Morgan presented his report and summarised progress against the key areas of activity in relation to social work and social care governance. A discussion ensued on training and Mr Morgan acknowledged that releasing staff to undertake training is an ongoing issue due to service pressures. He commented that research is actively promoted within the Directorate. Mrs Rooney asked if there were any difficulties in meeting the DHSSPS requirement on UNOCINI training. Mr Morgan advised that the Trust has been delivering this training for the past 3 years and it is kept under review by the Trust's R.I.T. Project Board. All social workers have received this training and mulit-disciplinary training programmes continue to run throughout 2011/12 to ensure that all staff who require the training can avail of it.

### iii. Nursing and AHP

Mr Rice presented the report summarising progress against key areas of activity in relation to nursing, midwifery and allied health professions. He began by advising that the nursing, midwifery and AHP professions are currently developing a range of indicators to evidence the quality of the care delivered within the Trust. The first report on the Quality Indicators will be available in December 2011.

## 9. ACCOUNTABILITY REPORT FOR STANDARDS AND GUIDELINES

Mrs McAlinden advised that this report was shared with the Department at the Trust's Year End Accountability Review Meeting 2010/2011 and subsequently with the HSCB. The Senior Management Team has agreed that where full compliance is not achievable due to financial constraints, this will be highlighted to the HSCB.

## 10. FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REQUESTS – SUMMARY REPORT FOR THE PERIOD APRIL – JUNE 2011

Members noted the content of the summary report for the period 1st April – 30th June 2011. A total of 46 requests were responded to in this period. Of these responses, 35 were processed within the 20 day deadline and 11 were processed outside of the 20 day deadline. Mrs McAlinden noted that requests are received from a variety of sources, including members of the public, Trust staff and the media. Details of the individual requests for information are included in the report.

## 11. PUBLIC INQUIRY INTO OUTBREAK OF C.DIFFICILE IN NORTHERN H&SCT- SH&SCT ACTION PLAN

Dr Simpson advised that the Trust continues to monitor progress against the recommendations of the Inquiry. He referred members to the detailed report on the Trust's position as at 2nd August 2011 and stated that there were no major outstanding issues.

12. **OUTPATIENT REVIEW BACKLOG – PROGRESS REPORT**

Dr Rankin began by advising that considerable progress has been made in reducing the outpatient review backlog. She presented a snapshot of the position as at end August 2011 which includes the action being taken by each acute specialty to address the backlog. Progress continues to be made to achieve the target that by end of 2011, the 2010 backlog will have been triaged/seen/discharged and by end of March 2012, the 2011 backlog will have been triaged/seen/discharged. Concerns remain in two specialties, Urology and Ophthalmology and agreement has now been reached for additionality from Belfast Trust Consultants to help to address some of the issues in Ophthalmology. A locum Consultant has been appointed in Urology to commence in October 2011.

Mrs Mahood asked about continued sustainability of the position to which Dr Rankin advised of the range of actions being taken to prevent a backlog occurring. She stated that the HSCB is reviewing capacity for each acute specialty in Northern Ireland and will only fund against the targets set for new to review ratios.

13. **MORTALITY REPORTS**

The quarterly Mortality Reports for January – March 2010 and April – June 2010 were discussed. Mrs McAlinden asked if a longer longitudinal period is required to reflect trends across quarterly reports and also asked if there is a level of independence in reviewing the information on deaths when above peer average. Dr Simpson provided assurance that there is a level of independence, different from the treating clinician, but this requires ongoing development to embed.

14. **RQIA REVIEWS STATUS UPDATE**

Members were provided with written updates on the progress made in implementing the recommendations from the following RQIA Reviews:-

i) Review of Readiness for Medical Revalidation

ii) Review of Child and Adolescent Mental Health Services (CAMHS)

iii) Review of Blood Safety

iv) Review of Intrapartum Care

v) Unannounced Hygiene Inspections

Mrs McAlinden welcomed the significant progress made in implementing a key recommendation of the RQIA Review of Intrapartum Care, with a dedicated anaesthetic rota for maternity now in place in Craigavon Area Hospital.

15. **FINDINGS FROM PATIENT CLIENT COUNCIL FOOD FOR THOUGHT: VIEWS OF PATIENTS AND PUBLIC ON HOSPITAL MEALS- SH&SCT ACTION PLAN**

Dr Rankin presented the Trust's action plan to address the findings from the Patient Client Council's Food for Thought: Views of Patients and Public on hospital meals. She advised that at its recent meeting, the Trust's Patient and Client Experience Committee had discussed the outcome of a survey of patients in hospitals across the Trust to find out their views on the quality of food within hospitals. Mrs Kelly commented on a visit Dr Mullan and herself had made to the Catering Department in Craigavon Area Hospital and stated how impressed they were that the nutritional needs of patients were being met.

***Dr Rankin left the meeting at 12.30 p.m.***

16. **DENTAL HOSPITAL INQUIRY**

Mrs McAlinden explained the background and context of this Inquiry. She referred members to the Executive Summary in their papers and advised that the recommendations have not yet received Ministerial endorsement. In the interim, the Trust is internally looking at any

compliance issues and this work will be completed within the coming months, led by Mrs D Burns.

17. **CORPORATE MANDATORY TRAINING AND COMMUNICATION STRATEGY**

Mr Donaghy provided a finalised list of Corporate Mandatory Training, together with a draft communications strategy. Mrs Mahood asked if there were any concerns in staff being able to access training due to financial constraints. Mr Donaghy advised that the main difficulty is releasing staff to attend training courses due to service pressures and more imaginative ways of delivering training are being explored, including e-learning. In response to a question from Mrs Kelly in relation to the domiciliary care workforce, Mrs McVeigh advised that their compliance with mandatory training requirements is very good.

18. **STATEMENT OF INTERNAL CONTROL**

Mr McNally advised of recent correspondence from the Department proposing to replace the format of the current Statement of Internal Control with a wider statement. He agreed to prepare a short briefing paper for discussion at the Audit Committee meeting on 13th October 2011.

***Mrs Blakely left the meeting at 12.45 p.m.***

19. **MINUTES OF ACCOUNTABILITY REVIEW MEETING**

Mrs McAlinden stated that the minutes of the Year End Accountability Review Meeting 2010/2011 will be produced by the Department and circulated to the Trust. These will be brought to the Governance Committee, when available.

20. **UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE**

Mr Graham updated members on the meeting of the Patient and Client Experience Committee held on 16th June 2011. Key agenda items included:-

Examples of learning from two complaints in Mental Health and Disability and Older People and Primary Care Directorates;
Launch of the PPI toolkit;
Complaints and commendations;
Monitoring of Patient/Client Experience Standards – report on 6th phase.

The next meeting is scheduled for 15th September 2011 and Mr Graham will replace Mrs Brownlee as Chair of the Committee.

21. **PROPOSED MEETING DATES FOR 2012**

Members approved the schedule of meeting dates for 2012.

***The next meeting of the Governance Committee will take place on Tuesday, 6th December 2011 9.30 a.m. in the Boardroom, Trust Headquarters, Craigavon***

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**Minutes of a meeting of the Governance Committee held on Tuesday, 5th February 2013, at 9.30 a.m. in the Boardroom, Trust Headquarters**

**PRESENT**:

Dr R Mullan, Non Executive Director (Chairman)
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs S Rooney, Non Executive Director

**IN ATTENDANCE**:

Mrs M McAlinden, Chief Executive
Mrs P Clarke, Director of Performance and Reform
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Mr S McNally, Director of Finance and Procurement
Mrs A McVeigh, Director of Older People and Primary Care Services
Dr J Simpson, Medical Director
Dr G Rankin, Director of Acute Services
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs D Burns, Assistant Director, Clinical and Social Care Governance
Dr T Boyce, Head of Pharmaceutical Services
Mr A Metcalfe, Assistant Director of Estates (Item 4 only)
Mr T Burns, Fire Safety Manager (Item 4 only)
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary (Minutes)

1. **APOLOGIES**:

Apologies were recorded from Mr R Alexander, Non Executive Director, Mrs D Blakely, Non Executive Director and Mr E Graham, Non Executive Director.

## 2. DECLARATION OF INTERESTS

Dr Mullan asked members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

## 3. CHAIRMAN'S BUSINESS

There was no Chairman's Business.

## 4. FIRE SAFETY ACTION PLAN

Mrs Clarke began by setting in context the Departmental correspondence and subsequent Trust response regarding Fire Safety included within the papers. She stated that the response had included a Statement of assurance, explaining that the Trust's overall fire safety strategy is to ensure that the outbreak of fire does not occur but if it does, that robust processes and key management arrangements are in place. Mrs Clarke advised members that work on a prioritised action plan was underway.

*Mrs Rooney and Mr Rice arrived at the meeting at 9.45 a.m.*

Mr Metcalfe, Assistant Director of Estates and Mr Burns, Fire Safety Manager, were welcomed to the meeting. Mr Burns began his presentation by demonstrating a comparison of the Trust's position, in terms of progress in a number of key areas, from April 2010 to January 2013 and beyond. Members were afforded a short time to ask questions. Dr Mullan raised investment in building infrastructure to address Fire Safety issues. Mrs Clarke acknowledged the current funding deficit of around £4.9M but noted the ongoing prioritisation and bidding process for capital. Mrs Mahood asked with regards to Fire evacuation plans and a position on those facilities which remain outstanding in having relevant evacuation plans in place. Mr Burns advised that foundation work has been carried out with relevant staff and communication with wards/departments had taken place. He reported that since April 2010 when approximately 500/600 staff undertook the nominated fire officer training this figure had risen to 1800 staff and that a rise in general fire training had also been recorded. Mrs McVeigh confirmed that in keeping with the Trust's

Governance Arrangements, Mr Rice and herself had agreed lead persons within their Directorates to manage fire safety. Mr Burns highlighted the area of Fire risk assessments and stated that approximately 271 were required to be carried out annually. He advised that with much of the work complete at Craigavon Area Hospital, the focus would now shift to Daisy Hill Hospital and the possibility of engaging external contractors to assist with this work. Following a question from Dr Mullan, Nominated/Deputy Nominated Fire Officer roles were discussed. Mr Rice explained that these roles would be carried out alongside any normal daily duties and that no protected time was made available to undertake these responsibilities. Dr Rankin highlighted the requirement to have fire officers on Wards at all times. Dr Mullan asked if staff had been made aware of the responsibility these positions held. In responding, Mr Rice stated that staff were fully aware of their responsibilities and the Nominated Fire Officers are well supported by their Deputies.

The Chief Executive asked in relation to the storage of waste in lobby/basement areas and the associated fire risk. In responding, Mrs Clarke stated that this issue remains problematic but assured members that spot checks are undertaken and staff are provided with information/advice on all aspects of fire safety and reminded of their responsibility.

In response to a question from Mrs Mahood about priorities for Fire Safety, Mr Burns envisaged that work would be undertaken on the Daisy Hill site, with funding available for the upgrade of fire alarm systems, bed escape lifts and fire compartmentation works. The Chief Executive stated that in terms of the older estate, it was recognized that some deficiencies may exist but compared to April 2010, the Trust has now a greater understanding of the risk areas. In conclusion, Dr Mullan thanked Mr Burns and Mr Metcalfe for attending the meeting and stated that the presentation had provided members with assurance that structures and processes are in place to continually review fire safety.

*Mr Metcalfe and Mr Burns left the meeting at 10.15 a.m.*

## 5. MINUTES OF MEETING ON 4TH DECEMBER 2012

The Minutes of the meeting held on 4th December 2012 were taken as read and agreed as an accurate record. The Minutes were duly signed by the Chairman.

## 6. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates from Directors to address those matters arising from the previous meeting.

## 7. CORPORATE RISK REGISTER

Mrs McAlinden presented the Corporate Risk Register and stated that of the 17 Corporate Risks, 6 are high level and 11 are moderate. Mrs McAlinden informed members that the Corporate Risk Register was last reviewed and updated at the Senior Management Team meeting on 30th January 2013 and is monitored on a monthly basis. She gave a brief summary of the discussion at that meeting when it was agreed that 'Implementation of new regional on-call arrangements' would be removed from the Corporate Risk Register and managed at Directorate level. Mr Morgan stated that the anticipated date for commencement of the new service was 1 May 2013 and the recruitment process was already underway. Members were advised that to date, no specific issues were emerging in the transition to this new regional approach.

Mrs McAlinden advised of the decision by SMT to escalate the financial risk of breakeven in 2013/14 from moderate to high risk. Mrs McAlinden then referred to the BSTP Programme Board meeting which had taken place the previous day. Due to the delays and contractual difficulties experienced by the Human Resources Payroll, Travel and Subsistence (HRPTS) side of the project, a re-plan is expected in seeking to move the new system forward. Mr Donaghy advised that he will be negotiating with the Business Services Organisation (BSO) with regards to the shared service implementation. Dr Mullan asked if the Trust was aware of any particular risk to the service at present. Mrs McAlinden stated that no major issues were emerging to date and that the ability to balance the

departure of displaced staff with the appointment of temporary staff to backfill these positions was working well.

Mrs McAlinden outlined a number of queries Mrs Blakely had submitted for discussion. These were discussed in detail and it was agreed that responses would be provided to Mrs Blakely by Directors. Following discussion on lack of compliance with RQIA recommendations in relation to the supervision and administration of medication, the Chief Executive asked Dr Boyce to draft a letter to the HSCB on this matter.

***Action – Dr Boyce***

## 8. MEDICINES GOVERNANCE REPORT

Dr Boyce presented the Medicines Governance Report for the second quarter of 2012/13 and highlighted the key aspects. 230 medication incidents were reported during this quarter. The average number of reported medication incidents each month was 77, representing a slight increase from 71 in the previous quarter. During the quarter there were no major catastrophic incidents.

Mrs Mahood referred to her recent visit to a Children's Home and raised concern about Controlled Drugs within the Community. Dr Boyce advised that members of the PSNI Drugs Squad had discussed this with Pharmacists and had offered to hold an information/awareness session for Ward managers.

## 9. THE FRANCIS INQUIRY REPORT

Members noted the short summary, included for information purposes. The Chief Executive advised that once a full transcript of the report was released, work would commence to review the Trust's position against the key themes of the Report and this would be brought to a future meeting for discussion.

10. **SIRO REPORTING INFORMATION GOVERNANCE REQUIREMENTS TO BOARD**

Mrs Clarke explained that the report was a brief summary setting out how the Trust seeks to move forward with the series of actions requested by the DHSSPS in 2010 with regards to Personal Identifiable Data (PID) and Personal Sensitive Data (PSD). Mrs Clarke drew members' attention to the requirement that an assurance report be presented covering the level of compliance and progress against action plans to the Trust Board by the Senior Information Risk Officer (SIRO) on at least a quarterly basis. Mrs Clarke reminded members that Information, Communication and Technology along with Records Management are reported through the Controls Assurance Standards mechanism, in place to address any areas where the organizational performance falls short or is weak, but that it would be appropriate in keeping with the required Departmental actions, to provide a quarterly update to Governance Committee as a committee of the Trust Board. Dr Mullan asked if many data breaches had been recorded. Mrs Mahood stated that progress has been made, in particular with regard to correct protocol procedures and commended the work undertaken by Mrs Graham, Head of Information Governance. Mrs Clarke spoke of the need to educate staff in the following areas: the role of the SIRO, Information Security and training. Following a brief discussion, it was agreed that Mrs Judt would email a link to the Trust CETIS e-learning tool to non-executive directors.

***Action – Mrs Judt***

Mrs Rooney referred to the Internal Assurance Statement, Appendix 3 and asked if the Trust would be in a position to complete this by 31 March 2013. In responding, Mrs Clarke referred to Appendix 2 which sets out the phases for implementation and stated that she was confident that the Trust was in a good position to provide assurance at the conclusion of each phase.

*Mr Donaghy left the meeting at 10.55 a.m.*

11. **FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REQUESTS – SUMMARY REPORT FOR PERIOD OCTOBER – DECEMBER 2012**

Mrs Clarke presented the summary report for the period 1 October – December 2012. A total of 62 requests were received and responded to in this period and of these 50 were processed within the 20 day deadline and 12 processed outside of the 20 day deadline. Members noted that the majority of requests were received from members of the public, businesses and the media. Details of the individual requests for information are included in the report.

Mrs Clarke spoke of the complexity of some of the FOI Requests received by the SHSCT and advised that members of the SMT and Non-Executive Director colleagues had recently attended a number of successful FOI Awareness Sessions. In concluding, Mrs Clarke stated that the FOI process would be kept under review.

12. **CLINICAL AND SOCIAL CARE GOVERNANCE UPDATE**

Dr Simpson began by updating members on the Governance Working Body which had been established one year ago, comprising of 45 members from across the Trust, including Clinicians, Management, Litigation and HR. Dr Simpson updated on the progress of the 4 working body sub groups and referred to the Trust being well placed ahead of its counterparts with regards the implementation of National Early Warning Scores (NEWS). Dr Simpson spoke of the launch of work with Urinary Catheter Associated Infections and advised that a bid had been lodged with the Public Health Agency (PHA) to secure a Band 6 to support the project.

Dr Simpson provided feedback from the most recent Governance Working Body meeting, reporting that this meeting had been led by Clinicians and added that it was hoped to further encourage Clinicians to take the lead in the area of Clinical Governance in the future. Dr Simpson spoke about incident reporting and the differing levels and approaches and acknowledged that Clinicians and junior doctors require further training in the IR1 reporting system. Mrs Rooney asked if gaps in incident reporting existed. In responding to

her, Mrs Burns acknowledged that there was a level of under reporting within the medical community but that steps were been taken to address this. The Chief Executive spoke about the need to ensure Clinicians confidence in the system and to communicate the benefits to be gained in learning from incidents.

*The Chief Executive and Mrs Clarke left the meeting at 11.15 a.m.*

13. **INCIDENTS AND COMPLAINTS MANAGEMENT REPORT AND UPDATE ON OMBUDSMAN CASES**

Mrs Burns presented the report for the period 1 September – 30 November 2012. A total of 2,837 incidents were reported during this period. Mrs Burns drew members' attention to an error within the report and stated that an updated version would be sent out to members via her office.

Falls were discussed and Mrs Burns advised of a pilot exercise within the Acute and OPPC Directorates. Members asked a number of questions to which Mrs Burns responded.

Mrs Rooney highlighted page 9 of the report and asked for further information on the 5 choking incidents recorded within the MHD Directorate in October 2012. Mr Rice agreed to provide these details. Mrs Burns emphasized that the snap shot of incidents highlighted those most frequently recorded but these were not the most serious and assured members these were being monitored continually. In concluding, Mrs Kelly referred to the category of physical abuse, assault or violence and asked if the Trust had any staff absent from work on sick leave because of violent behavior. In responding, Mrs Burns advised that these incidents were recorded on the reporting system RIDDOR, through the HR Directorate.

***Action – Mr Rice***

Complaints were discussed and members noted that for the period 1 September 2011 – 30 November 2012 a total of 981 complaints were reported. Mrs Rooney drew attention to the complaint subjects and the huge impact on resources required to deal with these.

Members noted the Update on Cases with N.I. Commissioner for Complaints as at 30 November 2012. Four new cases were received from the Ombudsman's Office, 3 existing cases remain on-going and 1 case was closed by the Ombudsman during the period.

Following a short discussion, Mrs Burns agreed to include the outcome of cases closed by the Ombudsman within future reports.

***Action – Mrs Burns***

14. **INCIDENT POLICY AND IMPLEMENTATION PLAN**

Mrs Burns presented the Incident Management Procedure and outlined its purpose as being a guide to all employees of the Trust in the consistent identification, reporting, monitoring and review of incidents. Mrs Rooney made a number of suggestions which Mrs Burns agreed to take onboard.

15. **SERIOUS ADVERSE INCIDENTS REPORT FOR THE PERIOD 1.4.2012 – 30.11.2012**

Mrs Burns presented a summary of the SAIs reported during the quarter 1 September 2012 – 30 November 2012 and those that remain open from 1 April 2007 – 30 November 2012. She reported a total of 9 new notified SAIs during 1 September 2012 – 30 November 2012. Mrs Burns advised members that the Designated Review Officer (DRO) continues to query case SAI ID27891, which occurred in 2009.

16. **STROKE COLLABORATIVE PRESENTATION**

By way of introduction Dr Rankin welcomed Dr McCaffrey, Clinical Director of Older People to the meeting and commended her as being instrumental in leading the way on these issues. Dr McCaffrey welcomed the opportunity to present Stroke collaborative to the Board and update on the use of Thrombolysis treatment within the Trust and highlight some areas for improvement within the service model. In responding to Dr Mullan's query on the national median figure of 413 patients admitted with stroke per site between 1 April 2011 – 31 March 2012 compared to 347 patients admitted to

Craigavon Area Hospital and 167 admitted to Daisy Hill Hospital, Dr Rankin advised that this figure was based on the size of unit dealing with specialist services and that as part of the direction set out in TYC an implementation strategy would come to Trust Board in March 2013 and this would include consideration as to how improvement of inpatient stroke services can be made. Following questions from Dr Mullan and Mrs Rooney around staffing, Dr Rankin advised that a Consultant is available 24/7 but in the event that this is not the case, knowledge and assistance is sought from specialists at the Belfast Trust. Dr Rankin confirmed that the Trust had 2 stroke teams, 1 based on each of the Acute hospital sites and thereafter an out-of-hours service was available. Dr Simpson assured members that the Trust was well on target to deliver this high quality service based upon the 4 measures Dr McCaffrey had referred to. Mrs Kelly made reference to the increasing number of stroke patients presenting and in particular those within the younger population. In responding, Mrs McVeigh emphasized that once the first signs of stroke present a quick response in contacting the emergency services was paramount to help a successful outcome and advised that the Ambulance service have been involved with the regional development of this service model. Dr Mullan thanked Dr McCaffrey for her very informative presentation.

17. **RQIA REVIEW STATUS UPDATE**

Members noted the above named report which recorded that during the period May 2010 – December 2012, RQIA carried out 29 Announced/Unannounced Hygiene Inspections at various locations around the Trust. Mrs Mahood asked if it would be possible that future reports could include the changes from the previous quarter in red font. Mrs Judt agreed to take this action forward.

***Action – Mrs Judt***

**Review of care for Under 18s on adult acute wards on 12 October 2011**

Dr Rankin advised members that the Trust had received the RQIA inspection report on the review of care for under 18s on adult acute wards and added that she had received correspondence from the

Department of Health, Social Services and Public Safety (DHSSPS) that the Health and Social Care Board (HSCB) would lead in moving forward with the recommendations from the RQIA baseline assessment. Dr Rankin added that the Trust needed to do some work locally but welcomed the recommendations.

**Ardaveen Manor, Beesbrook**

Members noted the update provided on RQIA concerns in relation to a number of regulations. Mr Rice advised that at present a list of suitably skilled and experienced persons is held within the bank system but the Trust would like to see this information being held centrally. Mr Rice stated that the Trust will seek to meet with RQIA and added that Mr Donaghy continues to move forward with these issues.

**Radiology Review Phase 2**

Dr Rankin confirmed that the DHSSPS will undertake a review of Radiology but due to other work commitments this has not taken place to date. In seeking to move forward Dr Rankin advised that she had contacted colleagues within the Directorate of Secondary Care but has not as yet received a response.

18. **PROFESSIONAL GOVERNANCE REPORTS**

i) **Appraisal and Revalidation Annual Report 2010/2011**

Dr Simpson presented the above named report. He advised that the Trust Revalidation Support Team had been established and during the next 12 months it was anticipated that 250 Doctors would complete their revalidation. Dr Simpson spoke about the development of support for Appraisers and Appraisees and the intention to audit this going forward. Dr Simpson advised that the Trust has been continuously developing systems to improve availability of supporting information for medical staff to support the appraisal process. Dr Mullan drew attention to the appraisal participation audit round in 2011 and the 63 per cent completion rate of medical appraisals within surgery and elective care. Dr Simpson

acknowledged the low percentage rate compared to 97 per cent completed in the previous year. He stated that doctors were being encouraged to embrace the appraisal system and assured members that those who have not engaged are followed up. Mrs Kelly asked if a regional register was in place. In responding, Dr Simpson advised that the General Medical Council (GMC) have launched GMC Connect, which is an area of the GMC website where responsible officers can view and manage the list of doctors who have a prescribed connection to their designated body. He went on to explain that the Trust closely monitor clinicians when they join the organization. Mrs Kelly asked how long doctors can practice without completing revalidation. Dr Simpson explained that Doctors must follow an extremely detailed procedure and gave assurance that if they did not adhere to this they would not be able to practice.

ii) **HCAI Update**

Dr Simpson presented this report and confirmed that the RCA process was now in place with initial feedback indicating excellent clinical engagement and enhanced accountability.

Priorities for Action targets (PfA) for 2012-13 have been set at: MRSA Infections 10 and 22 C.difficile infections. Southern Trust performance figures year-to-date (28 January 2013), record 1 MRSA infection and 38 cases of C.difficile. In concluding Dr Simpson added that the HCAI action plan would help to reduce these figures.

iii) **Social Work and Social Care Report**

Mr Morgan spoke to this report, which summarizes progress against 6 key areas of activity. Within these 6 areas, are 22 sub-sections of activity, he asked members to note the significant progress made towards compliance in that 17 are green, 5 are amber and there are no red areas. Mr Morgan drew members' attention to the amber compliance against the Protection of Vulnerable Adults and updated on a number of training elements completed by staff. Mr Morgan advised that the Trust is working towards the implementation of the Vulnerable Adult module on Soscare and all appropriate staff

have been trained to use the module. He added that this training would be signed off regionally. Mr Morgan reported that until the consultation process takes place on the NIASP training work stream draft regional training strategy, in the interim the Trust have devised an Adult Safeguarding Training Programme, for all levels of the workforce. Mr Morgan stated that he felt it would be beneficial to include figures against each of the 6 workforce levels to show the number of staff who have received training in these elements. Members noted the amber compliance against Case Management Reviews (CMRs). Mr Morgan advised that work was ongoing in this area and stated that all legacy CMRs had been signed off. In concluding, Mr Morgan said that a number of sub-sections could move from amber compliance to green and he would include this within a future report. Mrs Rooney asked if all appropriate staff had completed UNOCINI training. In responding to Mrs Rooney, Mr Morgan said that staff had received sufficient training and should be equipped to use this tool. He went on to say that modules 2 and 3 are currently being reviewed but that good progress has been achieved.

iv) **Report on Compliance of Core and Profession Specific Quality Indicators for AHP**

Mr Rice took members through the detail of the report for the period ending 31 December 2012 and advised that the report demonstrated good progress. While acknowledging some professional supervision issues Mr Rice advised that these were progressing under the QIs identified. Members noted 3 new QIs added to the report under the following AHP professions: Orthoptics, Podiatry and Radiography. Mr Rice highlighted Nutrition and Dietetics and advised that under phase 2 of the QI it was proposed to extend the protocol to include the Nutrition and Dietetic service delivery of education and training to other professional/staff groups, to enable them to be au fait with protocols and procedures in different areas, for example, the SAI on choking referred to earlier. In concluding Mr Rice drew members' attention to the excellent achievement in Radiography and highlighted the actual

compliance of 99.85 per cent compared to the regional agreed expected compliance of 95 per cent.

19. **LEADERSHIP WALKABOUTS SUMMARY REPORT FOR THE PERIOD APRIL – DECEMBER 2012**

Dr Mullan presented the above named report for the period 1 April 2012 – 31 December 2012 and advised that 29 leadership walk arounds were undertaken. He explained that as part of the ongoing 'Board to Ward' governance assurance process within the Southern Trust, a framework for leadership 'walk arounds' had been developed and implemented since July 2011. Dr Mullan stated that the walk arounds were an informal process of engagement with staff, enabling Board members to assess the experience of patients and discuss any issues staff may raise. Members noted the guidance tool attached at Appendix 1.

Mrs Mahood commented that a substantial number of visits had been carried out around the Trust as part of the Excellence Awards scheme for 2012 and asked if these could be included within the report in future. Mrs Judt agreed to raise this with Mrs Brownlee.

***Action – Mrs Judt***

20. **ANY OTHER BUSINESS**

There was no further business for discussion.

***The next meeting of the Governance Committee will take place on Tuesday, 14th May 2012 at 9.30 a.m. and will be held in the Boardroom, Trust Headquarters.***

***SIGNED:*** _____

***DATED:*** _____

Health and Social Care Board

Public Health Agency

# Learning Report

# Serious Adverse Incidents

## April 2011 – September 2011

## October 2011

# INDEX

# SECTION 1

## Introduction

A Serious Adverse Incident is defined as, any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation,[1] arising during the course of the business of an HSC organisation / Special Agency or commissioned service.

These incidents occur in all health systems and can be the result of system failures, human error, intentional damaging act, rare complications or other causes.

An organisation with a culture of safety will not only report these incidents but will have a process by which learning from these incidents is shared both locally and regionally.

This report aims to identify key regional learning, action taken and proposed from SAIs reported during the period to September 2011.

The aim is to improve the care and treatment of patients and clients, to improve safety and ensure respectful management of the incident.

## Background

Responsibility for management of Serious Adverse Incident (SAI) reporting transferred from the DHSSPS (Department) to the Health and Social Care Board (HSCB) working in partnership with the Public Health Agency (PHA), with effect from 1st May 2010.

In April 2010, following consultation with key stakeholders, the HSCB issued the procedure for the „Reporting and Follow up of Serious Adverse Incidents" for full implementation on 1 May 2010. The procedure sets out the arrangements for reporting, managing, investigating and reviewing of all SAIs occurring during the course of business of an HSC organisation, special agency or commissioned service. It also sets out the arrangements of how SAIs are managed within Primary Care Services in conjunction with the adverse incident system in place within the Integrated Care Directorate in the HSCB.

The procedure details arrangements for internal management of SAIs by HSCB and PHA staff which are supported by an additional internal protocol in relation to the nomination and role of a HSCB/PHA Designated Review Officer (DRO).

Appendix A of this report sets out the definition of an adverse incident and the criteria of an SAI.

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

## Current Arrangements to manage the SAI Process

The arrangements to manage the SAI process by the HSCB and PHA include:

1. Regional reporting system to the HSCB for all SAIs.

2. The nomination of a Designated Review Officer (DRO) to review and scrutinise reports.

3. Regional SAI Group meeting held on a bi-monthly basis to consider reports, identify learning and agree actions.

4. Escalation process through normal performance management arrangements if required in respect of:
    a. deadlines for Investigation reports
    b. assurances for action being taken forward by Trusts following the investigation

In addition, the HSCB Senior Management Team receives and considers all SAIs on a weekly basis.

## SAIs Received April 2011 – September 2011

During the period 1 April to 30 September 2011, the HSCB received 145 SAIs. A breakdown of these by Trust and programme of care is detailed at Appendix B.

### *SAI Categories*

SAIs are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

***De-escalation***

Trusts are encouraged to report SAIs but it is accepted that SAI reports can be based on limited information at the time of reporting. This can result in occasions where following further investigation the incident does not meet the criteria of an SAI. If this happens a request can be submitted by the reporting organisation to de-escalate the report. This information is considered by the HSCB/PHA Designated Review Officer who advises on approval for any de-escalation.

During the reporting period five SAI notifications received were de-escalated.

## SECTION 2

## Learning from Serious Adverse Incidents

The purpose of any adverse incident reporting system is to improve patient safety. Reporting is only of value if it leads to a constructive response therefore each organisation has a role in identifying learning.

The Regional SAI Group has a role in meaningful analysis, identifying learning between organisations, making recommendations for change and informing the development of solutions.

Learning opportunities can be identified in a number of ways:

- Through individual investigations and root cause analysis.
- Aggregation of similar incidents over time identifying common underlying causes.
- Systematic reviews of areas of concern.

When learning is identified, both Providers and the Regional SAI Group have a role in identifying actions which will makes changes to practice through, for example, prioritisation, training or dissemination of information and in the implementing and sustaining these changes in practice.

In taking forward this work, the Regional Group recognises that there are many barriers to learning as identified in „An Organisation with a Memory".[2]

- An undue focus on the immediate event rather than on the root cause of problems
- A tendency towards scapegoating and finding individuals to blame rather than acknowledging and addressing deep rooted organisational problems
- Lack of corporate responsibility
- Organisational culture

In meeting its objectives the Regional Group will be exploring new methods of learning to maximise the impact on patient safety.

[2] An Organisation with a memory (2000) Department of Health England.

## Current Learning Initiatives

These current initiatives were identified as part of the SAI review process and relate to both learning for trends, reviews and individuals cases. Some of the learning identified may relate to SAIs reported in the previous period as part of ongoing work.

***Mental Health***

During this reporting period there have been 64 SAIs reported in Mental Health Services, the majority associated with suicides or unexpected deaths. (Appendix B)

The Regional SAI group commissioned an independent consultant through the Beeches Management Centre to analyse all SAIs related to suicides over a period.

The review was asked to complete an analysis from a regional perspective of:

- Trends emerging from the reports submitted
- Areas were practice could be improved
- Issues which require a regional approach
- Lessons regarding the SAI process from both a HSCB/PHA and HSC Trust perspective.

The report was considered by the Regional SAI group in June 2011 and key priority learning issues agreed.

A Professional Practice Workshop was held on the 13 October 2011, to share key findings and agree actions. The Programme is included in Appendix C. This event was attended by approximately 130 participants, including Directors of Mental Health, Executive Medical and Nursing Directors, Clinical Governance Leads and Front Line Practitioners.

The outcome of the workshop and follow up actions will be included in the next SAI report.

***Early Warning Scores***

Trusts have made significant progress with the introduction of Early Warning Scores and systems of early clinical alerts. These Early Warning Scoring Systems (EWS) are evidence based tools designed to assist with the detection of changes in clinical deterioration at an early stage, making it easier to intervene and correct.

The Regional SAI Group, in partnership with the DHSSPS, felt that good practice needed to be reinforced as a number of SAIs have been associated with a failure to recognise a deteriorating patient, resulting in a delay of failure to act.

The regional learning focuses on the careful observation and monitoring of individual patients to detect signs of clinical deterioration.

The PHA in collaboration with the DHSSPS, have organised a PEWS (Physiology Early Warning Scores) Workshop targeting an audience of Chief Executives, Lead Clinicians and Governance Officers. The programme will be delivered by expert clinicians from the other UK Countries and will also include local solutions. This event will be followed with a "rolling" training programme of half day workshops targeted at front line staff.

The event was scheduled for 5 October but has had to be rescheduled due to the industrial action. The programme for the workshop is attached at Appendix D.

***Breathing Masks***

A small number of SAIs highlighted an issue related to the use of breathing masks in the acute hospital sector. This issue was highlighted to the Regional SAI Group by the DRO. Concerns were raised about the product and the potential for users error in application.

The Regional SAI Group convened a working group to consider the issue and identify the action required.

The outcome of this work was:

- A revised specification for procuring specific masks, including a revised training programme.
- The learning arising from reviewing this incident was disseminated regionally via the Resuscitation Officers Forum (R.O.F.) and the DHSSPS were requested to issue an Alert letter.
- This Alert letter was issued jointly by the DHSSPS and the Northern Ireland Adverse Incident Centre (NIAIC).
- Arrangements were made to recall all masks that did not have the required safety vents. Regional Supplies Service has implemented the recall.

***Syringe Drivers***

An SAI was received which highlighted an issue of concern related to variations in equipment used between the statutory sector and voluntary sector. This issue was discussed by the Regional SAI Group with the DRO.

Actions following the Regional Group include:

- Advice and guidance should be issued regionally on the need to check types, brands, and specification of similar type equipment.

- Plans are being progressed to move to standardisation of syringe drivers, thus reducing, or if possible, eliminating risks. The PHA are progressing this work through the Regional Palliative and End of Life Care Steering Group in partnership with BSO colleagues.

***Maternal & Child Health***

An SAI was reported relating to the care and treatment of an individual with diabetic ketoacidosis (DKA). This was highlighted to the Regional SAI Group by the DRO as having regional implications for the delivery of services.

The Regional Group considered this and recommended that the CMO issue a letter to the service on this issue, which has now been actioned.

***Primary Care***

*General Medical Services (GMS)*

Learning is disseminated via the circulation of Alert letters across the 4 professions. Some services such as community pharmacy also produce newsletters. The development of trend analysis will enable Primary Care to focus on specific areas with the aim of disseminating learning.

*Pharmacy*

A small number of SAIs involving community pharmacy have been reported to the HSCB. These include:

- Prescriptions not being received by a community pharmacy from a GP practice;

- A pharmacy prescribing medication in the absence of prescriptions being supplied by the patient"s GP**.**

As a result of these incidents, the HSCB has issued letters to GPs and community pharmacists reminding them of their legal obligation regarding written prescriptions and the supply of medicines.

## SECTION 3

## Next Steps

The management and review of SAIs is an ongoing process with the following identified as key actions for the Regional SAI Review Group.

***Review of SAIs related to Care of Older People***

Following discussions at the Regional SAI Group and subsequently with the chair of the Regional Complaints Group, it has been agreed to conduct an analysis of SAIs and complaints relating to care of older people.

This review will commence in December 2011.

***Review of SAI Procedure***

Following a number of stakeholder events to monitor the effectiveness of the current regional procedure, plans are in place to introduce amendments and consult upon the revised procedure prior to full implementation. This will include a review of the SAI process as it related to integrated care.

***Review of the role of the DRO***

A DRO workshop has been planned for November 2011. The aim of the workshop is to review the role and function of a DRO, following which revised guidance for DROs will be issued. The workshop will also assist in informing the review of the SAI procedure.

***Regional Adverse Incident and Learning (RAIL) System***

The PHA working closely with the HSCB and all other HSC organisations have a responsibility to ensure the Regional Adverse Incident Learning System is successfully designed and implemented and evaluated. The overall aim of the project is to implement agreed proposals for an integrated system that will support a culture of learning from adverse incidents and the effective implementation of that learning across the HSC and Primary Care services.

The established project team have a responsibility to:

- Develop a work plan to achieve the delivery of the projects aims and objectives, supported by a business case.
- Take agreed action to support the delivery of the projects aims.
- Quality assures all deliverables in line with the projects terms of reference.

Considerable progress has already been made:

- Project structure has been put in place;

A project team has been established to take forward the preparation of an outline business case with options which will be submitted to the Project Board by December 2011.

# Appendix A

## Definition of an Adverse Incident

„Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation, [3] arising during the course of the business of an HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

### SAI Criteria

- serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self harm*) of :
    - A service user
        - A service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two [4] years)
    - A staff member in the course of their work
    - A member of the public whilst visiting an HSC facility.

- Unexpected serious risk to a service user and/or staff member and/or
    - member of the public

- Unexpected or significant threat to provide service and/or maintain business
    - continuity

- Serious assault (*including homicide and sexual assaults*) by a service user
    - on other service users,
    - on staff or
    - on members of the public

  Occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years).

- Serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

[3] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

[4] Mental Health Commission 2007 UTEC Committee Guidance

**Appendix B**

## Total SAI Activity April 2011 – September 2011

The HSCB has received 145 SAIs from across Health and Social Care (HSC) for the above period. The information below has been aggregated into summary tables / commentary to prevent the identification of individuals.

Table 1 below gives an overview of all SAIs reported by organisation.

**Table 1 – Trust**

| SAIS REPORTED | BHSCT | NHSCT | PCARE | SEHSCT | SHSCT | WHSCT | NIAS | HSCB | Total |
|---|---|---|---|---|---|---|---|---|---|
| Totals: | 50 | 27 | 1 | 29 | 25 | 12 | 0 | 1 | 145 |

### *SAI De-escalation*

SAI reports can be based on limited information at the time of reporting. If on further investigation the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate. In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation provides information on why the incident does not warrant further investigation under the SAI process. This information is considered by the HSCB/PHA Designated Review Officer prior to approving any de-escalation. During the reporting period 5 SAI notifications received were subsequently de-escalated.

## SAIs by Programme of Care

### *Acute Services*

**Table 2 – Acute Services**

| SAIS REPORTED | BHSCT | NHSCT | SEHSCT | SHSCT | WHSCT | Total |
|---|---|---|---|---|---|---|
| Totals: | 19 | 2 | 1 | 3 | 1 | 26 |

26 incidents relating to Acute Services were reported during the period under the following categories, with less than 5 incidents being reported in any one category.

**Categories:**

- Slips, trips and falls
- Diagnosis
- Medication error
- Equipment failure
- Treatment / Procedure
- Failure to act / monitor

- Cardiac arrest
- Controlled drugs missing / unaccounted
- Healthcare acquired infection
- Physical abuse, assault or violence
- User error
- Other

- There were no major themes emerging from the SAIs. The largest group (n=4) were associated with the category, „trips, slips and falls."
- SAIs related to diagnosis were identified in 3 SAIs

### *Maternity & Child Health*

Four SAIs relating to maternity and child health were reported during the period.

### *Family & Child Care*

**Table 3 – Family & Child Care**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Totals:** | **6** | **3** | **1** | **7** | **0** | **17** |

17 SAIs relating to family and childcare were reported during the period.

10 SAIs were related to suspected cases of abuse. The remaining seven SAIs were reported under the following categories with less than five incidents being reported in any one category.

**Categories:**

- Access, admission, transfer, discharge other
- Documentation (including records, identification) other
- Other
- Self harm
- Suicide (completed), whether proven or suspected
- Unexpected/Unexplained death

### *Older People Services*

**Table 4 – Older People Services**

| SAIS REPORTED | BHSCT | NHSCT | SEHSCT | SHSCT | WHSCT | Total |
|---|---|---|---|---|---|---|
| **Totals:** | **1** | **1** | **2** | **2** | **1** | **7** |

Seven SAIs relating to older people services were reported during the period under the following categories, with less than five incidents being reported in any one category.

**Categories:**

- Falls from a bed or chair
- Alleged abuse/assault
- Proven, alleged or suspected theft
- Transfer – delay/failure
- Fire - accidental

### *Mental Health*

**Table 5 – Mental Health**

| SAIS REPORTED | BHSCT | NHSCT | SEHSCT | SHSCT | WHSCT | Total |
|---|---|---|---|---|---|---|
| **Totals:** | **16** | **19** | **22** | **9** | **9** | **75** |

75 SAIs relating to mental health were reported during the period

- 64 related to suspected/attempted suicides* or unexpected deaths

The remaining eleven SAIs were reported under the following categories, with less than five incidents being reported in any one category.

**Categories:**

- Self harm
- Homicide (whether proven or suspected)
- Violence / aggression
- Sexual abuse
- Missing patient
- Access, admission, transfer, discharge to/from service
- Other / Other medication incident
- Fire – Accidental

**Suspected suicide – suicide (completed) whether suspected or proven. It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.*

### *Learning Disability Services*

Seven SAIs relating to learning disability services were reported during the period under the following categories, with less than five incidents being reported in any one category:

- Asphyxiation
- Sexual Abuse
- Lifting or moving a patient or other person
- Homicide (whether proven or suspected)
- Accident
- Other

There were no specific trends noted

***Primary Care***

One SAI relating to primary health was reported during the period

***Physical Disability and Sensory Impairment***

One SAI relating to physical and sensory impairment was reported during the period

**Appendix C**

***Professional Practice Event***

***"Sharing the Learning .....SAIs and Suicides in Mental Health"***

THURSDAY 13 OCTOBER 2011 9AM -1.30PM

KNOCKBRACKEN HALL, KNOCKBRACKEN HEALTHCARE, BELFAST

| Time | Item |
|---|---|
| **9.00 – 9.30 am** | **Registration & refreshment** |
| **9.30 – 9.45 am** | Setting the scene "Purpose of new review process" - Mrs Mary Hinds, Public Health Agency |
| **9.45 – 10.10 am** | "Serious Adverse Incidents – identifying the common causes and learning the lessons"<br>Key Speaker – Dr Colin Dale, Caring Solutions |
| **10.10 – 10.30 am** | "Learning from PSNI Experience" – Sharon Beattie<br>& Alison Conroy PSNI |
| **10.30 – 10. 50 am** | Mental Health Order & Role of RQIA in Serious<br>Adverse Incidents – Mr Patrick Convery, RQIA |
| **10.50 – 11.10 am** | **Refreshments** |
| **11.10 - 11.30 am** | Report on Review of Mental Health Serious<br>Adverse Incidents within Health & Social Care<br>Trusts – Mr Brendan Mullan, Independent Consultant |
| **11.30 – 11.55 pm** | "What makes a good review?" – Dr Gerry Waldron,<br>Public Health Agency |
| **11.55 – 12.15 pm** | Trust Perspective on SAI Review process –<br>**To be confirmed** |
| **12.15 – 12.20 pm** | Issues Log |
| **12.20 – 1 pm** | Group work and discussion |
| **1 - 1.20 pm** | Feedback , Summary & Close – Mrs Mary Hinds |
| **1.20 pm** | **Lunch** |

## Appendix D

**EARLY WARNING SCORES**

**AND THE**

**MANAGEMENT OF THE DETERIORIATING PATIENT – WORKSHOP**

**5 OCTOBER 2011, 9.30 – 4.00**

**CASTLEVIEW SUITE, THE PAVILION, STORMONT ESTATE, BELFAST**

**PROGRAMME**

| | | |
|---|---|---|
| 8.30 | Registration<br>Tea / Coffee | |
| **Co Chairs** | **Dr Michael McBride, Chief Medical Officer, DHSSPSNI** | |
| | **Mrs Mairead McAlinden, Chief Executive, Southern HSCT** | |
| 9.30 | Welcome and Opening Remarks | Dr Michael McBride |
| 9.40 | Purpose of the day | Mrs Mary Hinds |
| 9.50 | GAIN - The N.I. Perspective | Dr John Trinder, GAIN |
| 10.10 | The Salford Experience<br>Mr David Dalton, CEO<br>Mr Peter Murphy, DNS Salford Royal NHS Foundation Trust | |
| 10.40 | Why quality improvement in healthcare is hard and how to get it work?<br>Professor Mary Dixon-Woods, Leicester University | |
| 11.00 | **COFFEE** | |
| 11.20 | Identifying patient deterioration – which track and trigger system should I use?<br>Professor Gary Smitm | |
| 11.40 | Local Solutions | |

- Children — Ms Bernie McGibbon
- Critical Care Outreach: Working with wards to benefit patients — Joanna McCormick
- E Learning Programme for PEWS — Mr Padraig Dougan

| | | |
|---|---|---|
| | • Assisted Technology ? | Mr Roy Harper |
| 12.40 | Panel Discussion | Mrs Mairead McAlinden |
| 1.00 | **LUNCH** | |
| **Co Chairs** | **Mrs Angela McLernon, Chief Nursing Officer (Acting), DHSSPSNI** | |
| | **Mr Sean Donaghy, Chief Executive, Northern HSCT** | |
| 1.45 | Introduction to afternoon session | Sean Donaghy |
| 1.50 | Regional Learning Case Scenarios<br>Gavin Lavery/Mary McElroy<br>• Complexity in Care<br>• Maternity / Obstetrics<br>• General | |
| 2.50 | Group work and Feedback - Gavin Lavery / Mary McElroy | |
| 3.50 | Summary and Key Learning | Angela McLernon |
| 4.00 | Closing remarks<br>Way Forward | Sean Donaghy |

Southern Health and Social Care Trust

*Quality Care - for you, with you*

| | |
|---|---|
| **Risk Management Strategy**<br>Author | Mrs Margaret Marshall<br>Interim Assistant Director of Clinical and Social Care Governance |
| **Date of Issue** | January 2014 |
| **Date of Approval by Trust Board** | |
| **Date of Review** | |

# January 2014

# Contents

## Foreword

The Southern Health & Social Care Trust (the Trust) seeks to deliver high quality care in all aspects of its services to patients/clients, staff, visitors, and the local communities. Risks occur daily in most activities undertaken within the Trust. Failure to manage these risks can result in injury to patients/clients, staff or visitors, claims against the Trust and resources lost from patient care. It is therefore vital to implement a strategy to effectively manage risks, which will result in better quality of care.

The strategy is based on best, statutory requirements, national guidance and complies with the following:

- Circular HSS (PPM) 13/2002 – Governance in the HPSS – Risk Management
- Circular HSS (PPM) 3/2002 – Corporate Governance: Statement of Internal Control
- Circular HSS (PPM) 5/2003 - Governance in the HPSS – Risk Management
- Circular HSS (PPM) 8/2004 – Governance in the HPSS: Controls Assurance standards – update
- Clinical Governance: in the new NHS – HSC 1999/065
- Establishing an Assurance Framework – March 2009
- Governance in the New NHS - Controls Assurance Statements 1999/2000: Risk Management and Organisational Controls
- HSC Controls Assurance Standards – Governance and Risk Management
- Integrated Governance Handbook, DOH, February 2006
- Standards Australia Risk Management – AS/NZS 4360:2004

This document helps us understand what might prevent us from achieving our objectives (the risk) it also assists in responding to our risks. This means trying to reduce the chance of each risk happening, or reducing the consequences if it does occur. It is not about totally eliminating risk, as this is not possible within a health and social care environment. Therefore we must then decide which risks are urgent and more likely to occur, and the importance of their consequences.

We live in a constantly changing environment, with circumstances evolving both within and outside the Trust this strategy reflects current best practice across the National Health Service (NHS) and Health & Social Care (HSC) and the guidance's in Departmental circulars and

related areas such as risk management, controls assurance and clinical and social care governance.

The Trust is fully committed to the effective management of risks in all areas. This strategy provides the tools to make our risk management systems robust and systematic. Please use it to help you understand and appreciate why your job is so important in the management of risk.

**Section 1 - Definitions of Risk and Risk Management**
This section of the Strategy provides a definition of risk and risk management. It also establishes the Trust's risk management policy statement and associated objectives.

**Definition of Risk**
Risk is the chance, great or small, that damage or an adverse outcome of some kind will occur as a result of a particular hazard. It is the threat that an event or some action will adversely affect the Southern Trust's ability to successfully execute its strategies and achieve its objectives. Risk also includes failing to exploit opportunities and maintain organisational resilience.

**Risk Management**
Management of risk is an integral part of the Southern Trust's management processes. Risk management involves the identification of risk at strategic and operational levels (including service delivery and corporate functions). It is a process of continual improvement which requires the identification, assessment, analysis, evaluation, treatment, monitoring and communication of risk.

**Risk Appetite**
Risk Appetite can be defined as the amount of risk that an organisation is willing to take in the pursuit of its corporate objectives. Factors such as the external environment, relative benefit, stakeholders, innovation, policies and business systems will all influence an organisation's Risk Appetite.

This strategy explains the framework used within the Trust to ensure risk is clearly identified, considered and managed within the context of organisations 'Risk Appetite' at all levels of the organisation.

## Risk Registers

In order to develop and be aware of its risk profile and to identify the key areas for investment in risk reduction/management, the Trust has developed a framework for risk registers. This comprises both Corporate and Directorate risks. The Risk Registers will enable the Trust to identify the totality of its risk and quantify those that are deemed as acceptable or present significant risks that may affect the objectives of the Trust.

A Risk Register is a log of significant risks (clinical, non-clinical, financial etc.) that threaten the Trust's success in achieving its aims and objectives. It is populated through the various risk assessments undertaken within the organisation, together with external reviews and reports. This enables risk to be quantified and ranked to inform the Trust Board and aid decision-making and resource allocation processes.

## Risk Management Policy Statement

It is the policy of the Trust that a proactive approach to risk management is taken in order to:

- Bring about the desired continual improvements in the care/services the Trust provides;
- Ensure the Trust does its reasonable best to ensure the safety of staff and the security of Trust premises for those that visit, live or work in them;
- Improve the way the Trust conducts its business;
- Enhance the services, reputation and efficient management of resources of the Trust; and
- Comply with the statutory and public duties placed upon the Trust.
- To ensure that there is a consistent approach to the assessment and recording of risk across the organisation

## Trust Vision and Key Objectives

The Risk Management Strategy has been developed in line with the Trust vision and key objectives.

## Vision and Purpose

The Trust's vision is to deliver safe, high quality 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 it. 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

Our vision and values guide all that we do and will do in the future. Alongside this we want to be very clear about what we want to achieve. The Trust's priorities are set out in our six key objectives:

- Provide safe high quality care
- Maximise independence and choice for our patient and clients
- Support people and communities to live healthy lives and to improve their health and wellbeing
- Being a great place to work, valuing our people
- Make best use of resources
- Be a good social partner within our communities

**Aims and Objectives**

The aims and objectives of the Risk Management Strategy underpin the vision and corporate objectives of the Trust, and are outlined below.

The aim of the Trust Risk Management Strategy is to:
Cultivate and foster an 'open and fair' culture in order to encourage openness, honesty, reporting and facilitate learning for all staff

Ensure a systematic approach to the identification, assessment and analysis of risk, and the allocation of resources to eliminate, reduce and control risk

Mitigate risks and/or manage those risks which are deemed as acceptable

The objectives of the Risk Management Strategy which underpin the above aims are to:

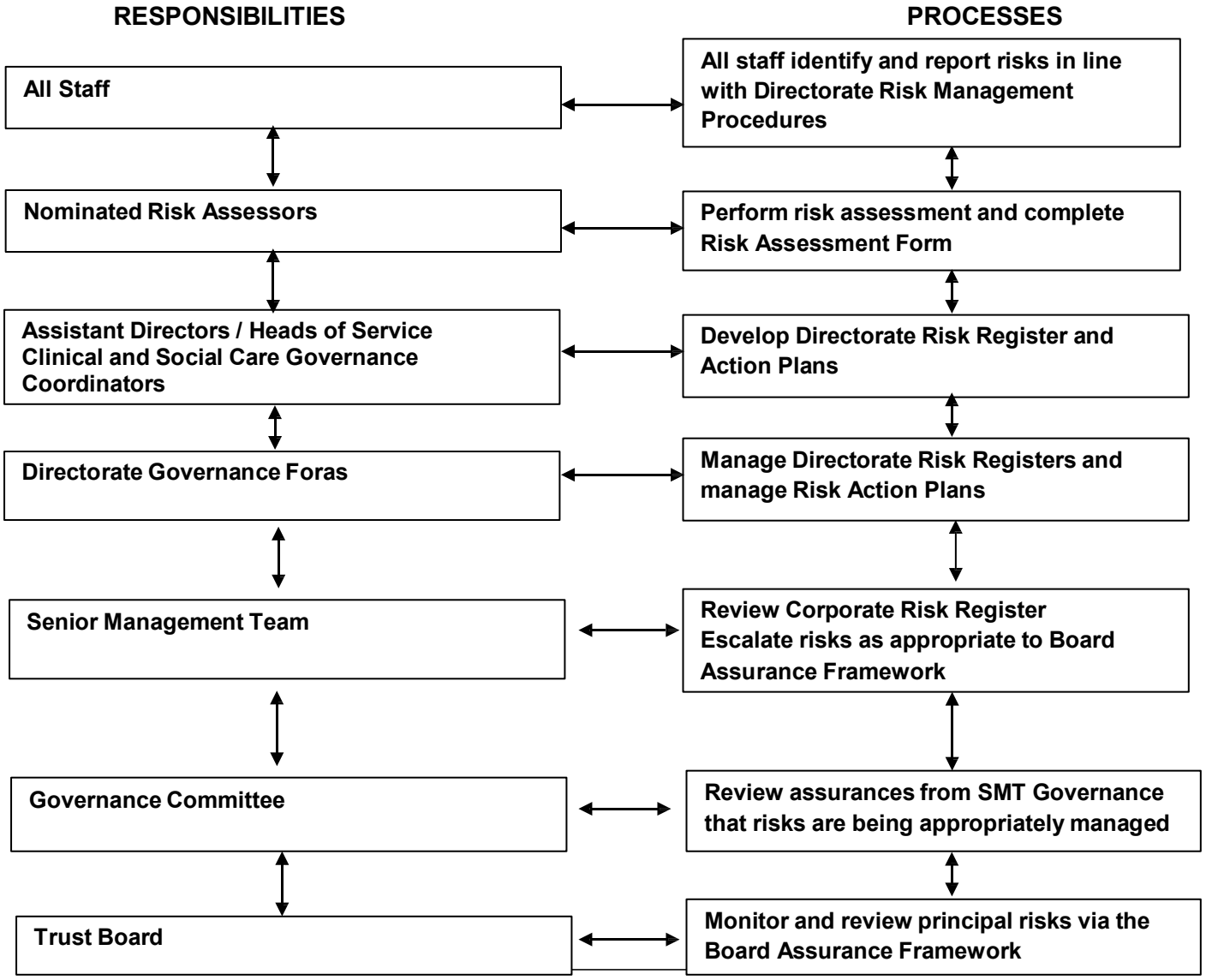
- Manage risks to the quality of services provided and the safety of patients, clients, visitors and staff

- Manage risks associated with the corporate functions of Human Resources, Finance and Informatics
- Manage risks associated with service continuity
- Manage risks associated with the reputation, community expectation and equity of services of the Trust
- Minimise damage and financial losses that arise from avoidable, unplanned events

## Section 2 - Governance Arrangements in place to manage risk in the Trust

The specific governance arrangements relating to the Risk Management Strategy are described in the sub-sections which follow. A summary of the responsibilities and processes associated with risk management in the Trust is illustrated in Figure 1.

***Figure 1***



## Trust Board

The Board of Directors (Executive and Non-Executive) are responsible for ensuring that the organisation consistently follows the principles of good governance applicable to HPSS organisations. This includes the development of systems and processes for financial control, organisational control, clinical and social care governance and risk management. In the context of this Strategy the Board of Directors will:

- Demonstrate its commitment to risk management through the endorsement of the Risk Management Strategy
- Ensure, through the Chief Executive, that the responsibilities and structure for risk management outlined in this document are fully introduced
- Oversee risk assurance processes
- Consider strategic and corporate level risks, including agreeing the related risk control measures and monitoring implementation of same
- Assess and consider the provision of financial support for any necessary risk management requirements
- Demonstrate and support model behaviour throughout the Trust, consistent with good governance and an 'open and fair culture'.

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

## Governance Committee

The remit of the Governance Committee is to ensure that:

- There are effectively and regularly reviewed structures in place to support the effective implementation and development of integrated governance across the Trust
- Risk management is a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective
- Principal risks and significant gaps in controls and assurances are considered by the Trust Board
- Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services
- There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance.

- Recommendations considered appropriate by the Governance Committee are made to the Trust Board recognising that financial governance is primarily dealt with by the Audit Committee.

Within the context of this Strategy the Governance Committee will receive assurances from the Trust Senior Management Team (SMT) that risks are being effectively managed.

**Senior Management Team (SMT)**
It is the remit of the Senior Management Team to:

- Ensure that the Trust has an effective Corporate Risk Register
- Review the Corporate Risk Register and ensure and that all significant risks are escalated to the Board Assurance Framework
- Receive completed investigation reports of serious adverse events
- Receive completed reports of findings of Root Cause Analyses
- Implement and keep under review the Integrated Governance Strategy
- Receive assurance of the adequacy of systems for quality assurance, managing risk and the control of the environment
- Receive assurance regarding the implementation of activities associated with action plans for Controls Assurance Standards, HPSS Quality Standards and RQIA Recommendations
- Accept and approve reports and strategy documents for presentation to the Governance Committee
- Assess the adequacy of the Governance Sub Committees to provide accountability and assurance that governance arrangements are effective

**The SMT is constituted from the following membership**:

- Chief Executive (Chair)
- Medical Director
- Director of Human Resources
- Director of Finance
- Director of Performance and Reform
- Director of Mental Health & Disability
- Director of Acute Services
- Director of Older People & Primary Care
- Director of Children & Young People
- Board Secretary

Other senior staff members will be required to attend meetings as the SMT Governance Group considers necessary.

**Operational Directorate Governance Foras**

Operational Directorate Governance Foras are responsible for reviewing and managing Directorate Risk Registers. Directorates will be supported in this function by the Clinical and Social Care Governance (CSCG) Co-ordinators and Governance Officers aligned to each of the directorates. Directorate Governance Foras meet monthly and are reflective of all speciality interests/service areas across Directorates/Divisions.

Membership of Directorate Governance Foras should be drawn from (though not limited to) Associate Medical Directors, Clinical Directors, Assistant Directors, Heads of Service and the Clinical and Social Care Governance (CSCG) Coordinators and Governance Officers aligned to the Directorates of Acute, Children & Young People, Older People & Primary Care and Mental Health & Disability, as appropriate.

Within the context of this strategy, the Directorate Governance Foras manage the processes associated with developing, assessing and evaluating risk and developing Risk Registers within the Directorates as outlined in Section 3 of this Risk Management Strategy.

The Directorate Governance Foras through the appropriate Director present those risks which cannot be managed at Directorate level and/or may require consideration in respect of addition to the Corporate Risk Register to the Senior Management Team.

The processes associated with developing, assessing and evaluating risk and developing Risk Registers is documented in Section 4 of this Risk Management Strategy.

## Section 3 - Roles and Responsibilities

**Chief Executive**

The Chief Executive is the Accountable Officer of the Trust and as such has overall accountability and responsibility for ensuring the Trust meets its statutory and legal requirements, and adheres to the guidance issued by DHSSPS in respect of governance. This responsibility encompasses Risk Management, Health and Safety, financial and organisational controls and Clinical and Social Care Governance.

The Chief Executive will ensure that the responsibilities for the management and co-ordination of risk are clear and that the strategy for Risk Management outlined in this document is implemented. The Chief Executive will ensure that risk management is included on the agenda of SMT governance meetings and committee meetings.

**Directors**

Whilst the Chief Executive has overall responsibility for Risk Management, Trust Directors are required to ensure that the Risk Management processes outlined in this Strategy are applied and working effectively in their own relevant areas. With the support of Assistant Director of Clinical and Social Care Governance and the Clinical and Social Care Governance Coordinators' aligned to Directorates, Trust Directors are required to:

- Ensure local Risk Management procedures are established for their area of responsibility based on the Trust-wide strategy including Risk Assessment, adverse incident reporting and Risk Registers
- Ensure that risk is a standing agenda item at team meetings
- Ensure there is a system for monitoring the application of risk management within the Directorates and that risks are actioned in accordance with the risk grading action guidance
- Provide reports that contribute to the Trust-wide monitoring and auditing of risk
- Ensure staff attend relevant mandatory and local training programmes and training in risk management
- Ensure there is a system in place to facilitate feedback to staff on risk management issues and the outcome of adverse incident reporting
- Ensure the specific responsibilities of managers and staff in relation to risk management and controls assurance are identified within the job descriptions of posts and that objectives are reflected in the individual performance review/staff appraisal process

**Directors of Medicine, Nursing & AHP and Social Work**

Those Directors with accountability for professional governance are responsible for ensuring effective risk management and governance arrangements are in place across the Trust in respect of their professional group. The Directors will be supported by professional

governance leads in ensuring that professional standards of care and practice are maintained

**Managers**
Managers at all levels in the Trust must encourage, support and facilitate staff in the application of good risk management practice and ensure staff are provided with the education and training to allow them to do so.

Managers must be fully conversant with the Trust's approach to risk management and where applicable Controls Assurance and the Quality Standards for Health and Social Care. Managers will be supported in this role by the Clinical and Social Care Governance Co-ordinators and Governance Officers aligned to their directorates.

**All Staff**
All staff of the Trust are responsible for providing each patient/client with the highest possible quality of care/services and for taking all appropriate action to promote patient and staff safety by minimising risk where possible.

Issues of concern should be highlighted through existing professional and or line management lines of accountability. Where individual staff continue to have specific concerns of risks which may impact on the delivery of safe and effective care, they have a duty to highlight them through the Trust's Whistle Blowing Policy.

All members of staff should:

- Demonstrate and awareness of risk and its consequences at all times
- Consider the risks involved in what they do and minimise those risks where possible to an agreed acceptable level
- Practice in accordance with their professional Codes of Conduct
- Comply with the Risk Management Strategy and associated procedures for example The Incident Management Procedure
- Notify line managers of any hazard or risk identified in their area of work which cannot be managed and requires attention
- Participate in the Trusts Risk Management training and education programmes
- Accept personal responsibility for maintaining a safe working environment

**Assistant Director of Clinical and Social Care Governance**
Is accountable to and reports to the Chief Executive and is responsible for the delivery of the strategic and operational management agenda for Risk Management, incorporating both clinical and non-clinical risk.

**Clinical and Social Care Governance Co-ordinators'**
The Key role of the CSCG Co-ordinator is to, on behalf of the Director, ensure that there are processes in place to support the implementation of this strategy and they must challenge and support the Directorate in the regular review of:

- Directorate/department Risk Registers
- Support the Assistant Directors and Heads of Service Directorate in preparation of actions plans to manage and minimise risk
- To monitor the progress of action plans and escalate barriers to progress to the appropriate directorate and Governance Fora
- Support and assist the Directorates in reviewing adverse incident trends
- Co-ordinate investigations into serious adverse incidents, medium to extreme incidents
- Support and monitor the Directorates in implementing recommendations arising from investigations on behalf of the Director
- Ensure that there are systems and processes in place to provide feedback to staff reporting risks and adverse incidents

**Internal Audit**
The internal audit function is responsible for providing independent advice to the Trust Board that risk management systems are in place, fit for purpose and meeting Trust objectives.

**Patients, Service Users and the Public**
The Trust understands the potential value of risk reporting from patients and or members of the public, and adopts a positive approach to the complaints or comments from which potential risks are identified. The Trusts processes to manage and investigate complaints and comments include mechanisms for the sharing and management of risk identified through these channels.

## Organisations working in partnership with the Trust

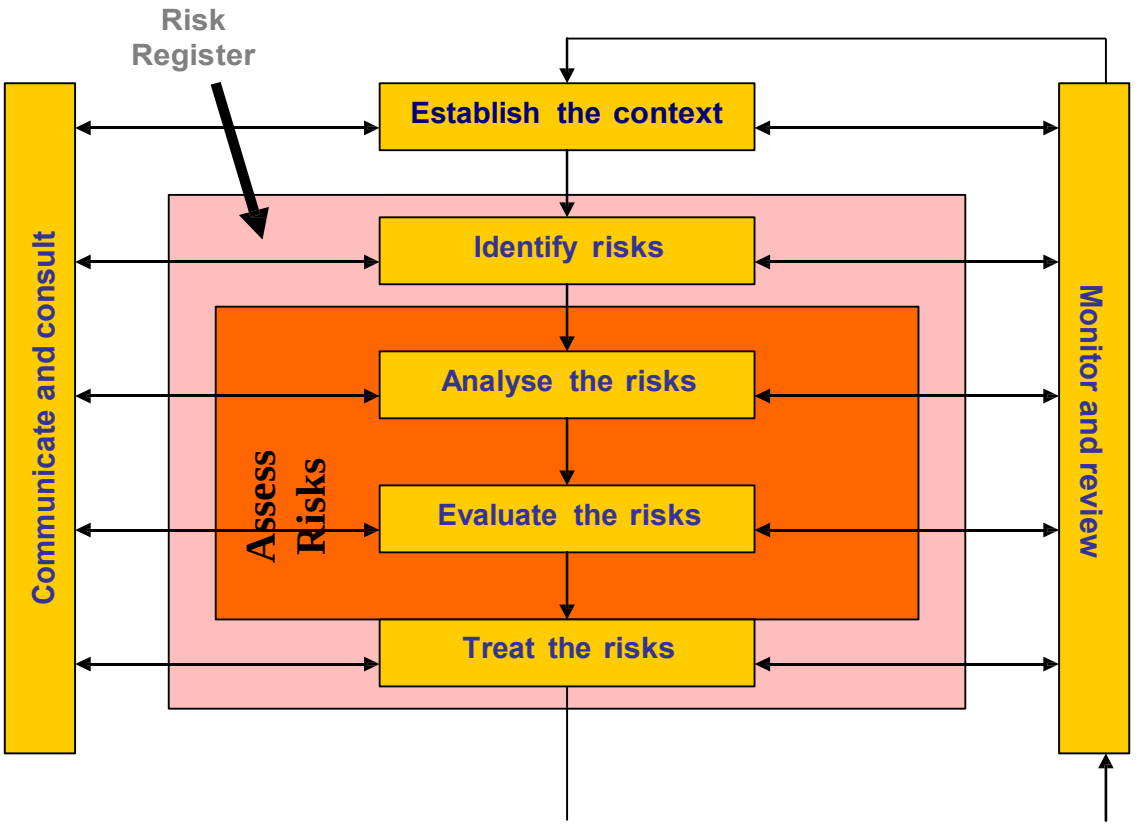
### Contractors and Agency Staff

It is essential that Contractors and agency staff are advised of their responsibilities to work safely within the Trust and acknowledge that the management of risk is an individual as well as a collective responsibility. They should be informed of the reporting mechanisms in the local area they are working in for reporting any hazards, risks and incidents whether they impact upon the contractor, agency staff, patient, client, staff or visitor. All Service Level Agreements and Contracts will include a section on Risk Management.

## Section 4 - The Risk Management System adopted by the Trust

The Trust's Risk Management Model is based on the Risk Management Australian/New Zealand Standards AS/NZS4360:2004 and is illustrated in Figure 2.

***Figure 2:*** AS/NZS 4360, 2004



Each aspect of the model as applied to the Trusts systems is described in the sub-sections which follow.

**Establish the Context**

The Trust objectives for Risk Management are identified in Section 2 of this document. The following risk impact assessment criteria have been derived from the risk management objectives and will be used for the assessment of risks as part of the impact grading in the Trust's Risk Grading Matrix:

- Risks to people (impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)
- Risks to quality and professional standards/guidelines (Meeting quality/professional standards/statutory functions/responsibilities and Audit Inspections)
- Risks to reputation (Adverse publicity, enquiries from public representatives/media Legal/Statutory requirements)
- Risks to Finance, Information and Assets (Protect assets of the organisation and avoid loss)
- Risks to resources (Service and business interruption, problems with service provision, including staffing (number and competence), premises and equipment)
- Risks to the environment (air, land, water, waste management)

**Risk Identification**

There are several aspects to risk identification, all of which need to be present in an effective risk management system. Risks should be assessed anytime when there is the potential for unexplored and unidentified issues diverting the organisational resources from its objectives and goals. The risk management process should be applied to business planning at all levels and risk management issues should be communicated to key stakeholders where necessary.

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

***Figure 3***

## The key elements for risk identification are detailed below:-

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

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

- Data review – review of adverse incidents, complaints, lessons learned from investigations, user views and claims data
- Workplace Risk Assessment – review of current risk assessments to identify trends and recurrent risks across the organisation
- External Review(s) – examine review reports to identify risks identified by the external review team

Using the above identification methods risks should be identified and recorded in Risk Registers.

A risk assessment form (Appendix 1) should be applied to this risk assessment process.

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

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

***i) Step 1 - Determining Risk Likelihood***
In assessing likelihood it is important to consider the nature of the risk being assessed. On the one hand, risk may be scored in relation to probability of future occurrence. However, in using likelihood scores reactively, for example, when reviewing adverse incidents a more appropriate perspective might be 'How likely is this to occur again? / How frequently has this occurred?'

Figure 4 should be used to assign a descriptor for this perceived risk. This should be determined by **either** frequency or **likelihood.**

***Figure 4***

| Risk Likelihood Scoring Table | | | |
|---|---|---|---|
| **Likelihood Scoring Descriptors** | **Score** | **Frequency (How often might it/does it happen?)** | **Time framed Descriptions of Frequency** |
| Almost certain | 5 | Will undoubtedly happen/recur on a frequent basis | Expected to occur at least daily |
| Likely | 4 | Will probably happen/recur, but it is not a persisting issue/circumstances | Expected to occur at least weekly |
| Possible | 3 | Might happen or recur occasionally | Expected to occur at least monthly |
| Unlikely | 2 | Do not expect it to happen/recur but it may do so | Expected to occur at least annually |
| Rare | 1 | This will probably never happen/recur | Not expected to occur for years |

### *ii) Step 2 – Determining the Risk Impact/Consequence*

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

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

All risks should be assessed **across each** of the 5 consequence / impact categories. The highest value attained against any one of the categories will be the impact / consequence grade will be used to indicate the level of risk.

Figure 5

## HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

| DOMAIN | IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential] | | | | |
|---|---|---|---|---|---|
| | **INSIGNIFICANT (1)** | **MINOR (2)** | **MODERATE (3)** | **MAJOR (4)** | **CATASTROPHIC (5)** |
| **PEOPLE**<br><br>*(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)* | • Near miss, no injury or harm. | • Short-term injury/minor harm requiring first aid/medical treatment.<br>• Any patient safety incident that required extra observation or minor treatment e.g. first aid<br>• Non-permanent harm lasting less than one month<br>• Admission to hospital for observation or extended stay (1-4 days duration)<br>• Emotional distress (recovery expected within days or weeks). | • Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year).<br>• Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days).<br>• Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required | • Long-term permanent harm/disability (physical/emotional injuries/trauma).<br>• Increase in length of hospital stay/care provision by >14 days. | • Permanent harm/disability (physical/ emotional trauma) to more than one person.<br>• Incident leading to death. |
| **QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES**<br><br>*(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)* | • Minor non-compliance with internal standards, professional standards, policy or protocol.<br>• Audit / Inspection – small number of recommendations which focus on minor quality improvements issues. | • Single failure to meet internal professional standard or follow protocol.<br>• Audit/Inspection – recommendations can be addressed by low level management action. | • Repeated failure to meet internal professional standards or follow protocols.<br>• Audit / Inspection – challenging recommendations that can be addressed by action plan. | • Repeated failure to meet regional/ national standards.<br>• Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities.<br>• Audit / Inspection – Critical Report. | • Gross failure to meet external/national standards.<br>• Gross failure to meet professional standards or statutory functions/ responsibilities.<br>• Audit / Inspection – Severely Critical Report. |
| **REPUTATION**<br><br>*(Adverse publicity,*<br><br>*enquiries from public representatives/media*<br><br>*Legal/Statutory Requirements)* | • Local public/political concern.<br>• Local press < 1day coverage.<br>• Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS). | • Local public/political concern.<br>• Extended local press < 7 day coverage with minor effect on public confidence.<br>• Advisory letter from enforcing authority/increased inspection by regulatory authority. | • Regional public/political concern.<br>• Regional/National press < 3 days coverage. Significant effect on public confidence.<br>• Improvement notice/failure to comply notice. | • MLA concern (Questions in Assembly).<br>• Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined.<br>• Criminal Prosecution.<br>• Prohibition Notice.<br>• Executive Officer dismissed.<br>• External Investigation or Independent Review (eg, Ombudsman).<br>• Major Public Enquiry. | • Full Public Enquiry/Critical PAC Hearing.<br>• Regional and National adverse media publicity > 7 days.<br>• Criminal prosecution – Corporate Manslaughter Act.<br>• Executive Officer fined or imprisoned.<br>• Judicial Review/Public Enquiry. |
| **FINANCE, INFORMATION & ASSETS**<br><br>*(Protect assets of the organisation and avoid loss)* | • Commissioning costs (£) <1m.<br>• Loss of assets due to damage to premises/property.<br>• Loss – £1K to £10K.<br>• Minor loss of non-personal information. | • Commissioning costs (£) 1m – 2m.<br>• Loss of assets due to minor damage to premises/ property.<br>• Loss – £10K to £100K.<br>• Loss of information.<br>• Impact to service immediately containable, medium financial loss | • Commissioning costs (£) 2m – 5m.<br>• Loss of assets due to moderate damage to premises/ property.<br>• Loss – £100K to £250K.<br>• Loss of or unauthorised access to sensitive / business critical information<br>• Impact on service contained with assistance, high financial loss | • Commissioning costs (£) 5m – 10m.<br>• Loss of assets due to major damage to premises/property.<br>• Loss – £250K to £2m.<br>• Loss of or corruption of sensitive / business critical information.<br>• Loss of ability to provide services, major financial loss | • Commissioning costs (£) > 10m.<br>• Loss of assets due to severe organisation wide damage to property/premises.<br>• Loss – > £2m.<br>• Permanent loss of or corruption of sensitive/business critical information.<br>• Collapse of service, huge financial loss |
| **RESOURCES**<br><br>*(Service and Business interruption,* | • Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. | • Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. | • Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. | • Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. | • Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. |

| DOMAIN | IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential] | | | | |
|---|---|---|---|---|---|
| | **INSIGNIFICANT (1)** | **MINOR (2)** | **MODERATE (3)** | **MAJOR (4)** | **CATASTROPHIC (5)** |
| *problems with service provision, including staffing (number and competence), premises and equipment)* | • No impact on public health social care.<br>• Insignificant unmet need.<br>• Minimal disruption to routine activities of staff and organisation. | • Short term impact on public health social care.<br>• Minor unmet need.<br>• Minor impact on staff, service delivery and organisation, rapidly absorbed. | • Moderate impact on public health and social care.<br>• Moderate unmet need.<br>• Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention.<br>• Access to systems denied and incident expected to last more than 1 day. | • Major impact on public health and social care.<br>• Major unmet need.<br>• Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations. | • Catastrophic impact on public health and social care.<br>• Catastrophic unmet need.<br>• Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations. |
| **ENVIRONMENTAL**<br><br>*(Air, Land, Water, Waste management)* | • Nuisance release. | • On site release contained by organisation. | • Moderate on site release contained by organisation.<br>• Moderate off site release contained by organisation. | • Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc). | • Toxic release affecting off-site with detrimental effect requiring outside assistance. |

### *iii) Step 3 – Determining the Risk Rating*

Following the identification of the level of likelihood and impact/consequence of the identified risk, a risk rating will be calculated using the matrix in Figure 6. This rating will prioritise and inform the further management of the risk identified.

***Figure 6***

| | Impact (Consequence) Levels | | | | |
|---|---|---|---|---|---|
| **Likelihood Scoring Descriptors** | **Insignificant(1)** | **Minor (2)** | **Moderate (3)** | **Major (4)** | **Catastrophic (5)** |
| **Almost Certain (5)** | **Medium** | **Medium** | **High** | **Extreme** | **Extreme** |
| **Likely (4)** | **Low** | **Medium** | **Medium** | **High** | **Extreme** |
| **Possible (3)** | **Low** | **Low** | **Medium** | **High** | **Extreme** |
| **Unlikely (2)** | **Low** | **Low** | **Medium** | **High** | **High** |
| **Rare (1)** | **Low** | **Low** | **Medium** | **High** | **High** |

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

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

### *iv) Step 4 - Risk Action Planning*

As part of the process, those carrying out the risk assessment exercise should also develop proposals for management of the risks identified. This should be documented in the risk action plan. All options should be considered including accepting a higher level of risk if doing so increases the quality of life for a patient/client. It is unlikely that proposals to completely eliminate all risks impacting on the organisation will always be feasible. Proposals should strike a balance between improving the risk situation, the level of resource input required and a realistic timescale in which to bring the risk faced to an acceptable level.

All action plans should clearly set out the action required to manage the identified risk. The Trust recognises it is not always possible to eliminate or reduce risks to the lowest level of rating and that some risks will have to be accepted at a high level. The process for acceptance of these risks is outlined in the Risk Acceptance Framework, Section 5.

In developing risk action plans consideration should be given where: -

- There are no control measures at all;
- Current control measures are ineffective; or
- Additional control measures are required to the existing effective controls in place.

An individual with explicit responsibility must be identified for ensuring the action is taken. The name of this person together with a target date for completion of the action must be recorded against the proposed action in the plan.

A planned date for the first review of the risk assessment, to assess progress initially, should be agreed and recorded in the action plan. This date should be determined by the initial risk rating.

A **predicted** risk rating once all control measures are implemented should be determined.

If there are anticipated resource implications associated with the action plan, details and costs should be recorded.

The relevant Trust manager should sign off each action plan and ensure the risk is managed according to the process outlined in the Risk Acceptance Framework.

The management of the risk must then be reviewed on an ongoing basis to:

- Monitor whether the risk profile is changing; and
- Gain assurance that the risk action plan is effective and to identify when further action is necessary.

Details of subsequent reviews should be recorded in the action plan, including the date of the review, a summary of the current position and a re-assessment of the risk rating. The risk rating may change as actions are completed and this should be recorded.

## Section 5: Risk Acceptance Framework

### Risk Acceptance Framework

The Trust recognises that it is impossible, and not always desirable, to eliminate all risks especially in the delivery of care to patients/clients. A

mark of good risk management is the innovative and imaginative use of resources in finding ways to avoid or reduce risks whenever possible.

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

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

Despite thorough risk assessment and management action plans, things can still go wrong and it is therefore essential that there are controls in place to deal with this situation. It is crucial that Business Continuity Plans/local emergency plans are in place for the management of situations in which control failure leads to material realisation of risk.

**Risk Acceptance Framework Categorisation**

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

**Green Risks (Low)**

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

**Yellow Risks (Medium)**

Identified risks which fall in the yellow area are deemed medium risk to the Trust but require action to reduce the risk. Responsibility for taking

action would normally remain at a local level within the appropriate Directorates / Service Areas and be entered on the Team / Service Risk Register.

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

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

**Amber Risks (High)**
Identified risks which fall in the amber area are deemed high risk to the Trust and require prompt action to reduce the risk to an acceptable level. When risks cannot be reduced locally they should be submitted to the Directorate Governance Fora for consideration and recommended action, i.e. further local action, resourcing or acceptance.
Where these risks cannot be managed within the Directorate they should be referred to the Senior Management Team for consideration and/or addition to the Corporate Risk Register.

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

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

SMT will be the gate keepers of the Corporate Risk Register and will use the following criteria to inform their decision making in escalating risks to the Corporate Risk Register.

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

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

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

**Definition of Acceptable Risk**
As a guide the Trust considers green (low and medium) risks to be acceptable (as defined by the risk rating matrix, Figure 6).

This definition is to be used as a guide only and managers are encouraged to take action on green and yellow (low and very low) risks identified particularly when these risks can be easily eliminated or reduced.

**Definition of Unacceptable Risk**
The Trust considers all amber (high) and red (extreme) risks to be unacceptable (as defined by the risk rating matrix, Figure 6). Managers are expected to take immediate action on amber (high) and red (extreme) risks identified and document action taken.

**Definition of Significant Risk**
Those red (extreme) risks, which have been identified as potentially threatening the achievement of the Trust's objectives or represent significant gaps in controls/assurances are escalated by the SMT Governance to the Board Assurance Framework.

In addition to these guidance notes, Directors, Directorates, Service Areas etc. should consider notifying the Governance Committee and Trust Board of frequently occurring lower graded risks.

The Corporate Risk Register will be reviewed monthly by the SMT. Trust Board review the Board Assurance Framework bi-annually in conjunction with the Corporate Risk Register.

The Corporate Risk Register is also shared with the Department of Health mid-year and year end at the Trusts accountability meetings.

Where the resolution of a risk includes funding implications that cannot be contained within the available budgets, a business case should be developed as part of the Trust's business planning process.

## Risk Registers and Action Plans

### Risk Registers

It is the responsibility of Clinical and Social Care Governance Co-ordinators for the Acute, Children and Young People, Older People and Primary Care and Mental Health and Disability Directorates to maintain Directorate level risk registers in conjunction with relevant Directors/Senior Managers/Heads of Service.

The Chief Executive, as the Chair of SMT Governance, is responsible for maintenance of the Corporate Risk Register.

With regard to both Directorate/Departmental and Corporate Risk Registers risks will be entered in accordance with the risk rating and action guidance. Risk registers should be developed using the proforma attached in Appendix 1.

- Risk ID Number
- Source
- Risk title and description (including location and local details)
- Potential for harm
- Summary of current control measures
- Initial risk rating
- Action plan
- Nominated person responsible for each action
- Review date
- Monitoring arrangements
- Lead individual

### Risk Action Plans

A risk action plan should be developed to document the management actions and controls to be adopted.

It is the responsibility of the Clinical and Social Care Governance Co-ordinators for the Directors of Acute, Children and Young People, Older People and Primary Care and Mental Health and Disability to develop and maintain risk action plans for Directorate/Departmental risk registers

in conjunction with relevant Directors/Senior Managers/Heads of Service.

On the delegated authority of the Chair (the Chief Executive) of SMT Governance, the Board Secretary, is responsible for maintaining risk action plans for the Corporate Risk Register.

Risk action plans should be developed using the proforma (and maintained in a suitable electronic format) incorporating the following information:

- Risk ID Number
- The action to be taken and the risks such actions address.
- Identified individual(s) responsible for implementing the plan.
- Budgetary allocation (where appropriate)
- Timetable for implementation
- Details of mechanism and frequency or review of action plan

**Risk Strategy Education and Training**

The Trust is committed to the education and training of all staff which ensures the welfare and health and safety of patients, clients and the public.

Risk management training will be assessed and delivered by the Directorate Governance Teams based on organisational/staff needs. Directorates are required to maintain risk management training records, monitor attendance of staff at training, and report on risk management training to SMT Governance as required. Trust induction programmes will include standardised risk management training.

**APPENDIX 1 – TRUST RISK ASSESSMENT FORM**

| **SOUTHERN HEALTH & SOCIAL CARE TRUST** | | |
|---|---|---|
| **RISK ASSESSMENT FORM** | | **Risk ID No** |
| **Directorate:** | **Facility/Department/Team:** | **Date:** |
| **Where is this being carried out?**<br>**(e.g. Trust premises/home of client/staff/ private nursing home etc)** | **Objective(s) i.e. Corporate, Legislative requirements etc.** | |
| **Risk Title: (Threat to achievement of objective)**<br><br>**Description of Risk:**<br>*(Describe the risk being assessed identifying who is at risk e.g. patient/staff/other care provider)*<br><br>**Outline the potential for harm:** *(Consider injury to client, staff, litigation, etc)* | | |

**Summary of current control measures: (Consider equipment, staffing, environment, policy/procedure, training, documentation, information - this list is not exhaustive).**

**Are these controls: (a) Effective or (b) Require Further Action** ***(if [b], complete Action Plan)***

**Please list control measures considered but discounted and why (where appropriate):**

| **Assessment of Risk** | **Likelihood** e.g. Likely | **Consequence/ Impact** e.g. Moderate | **Risk Rating** L and C = RR e.g. Likely and Moderate = AMBER |
|---|---|---|---|
| | | | |

**ACTION PLAN OF FURTHER CONTROL MEASURES REQUIRED (risk treatment):**

| **Action/Treatment** | **Action Lead** | **Start Date** | **Target Date** | **Progress/Review Date** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Date of first review (to be determined by risk rating)** | | | | |

| **Predicted Risk Assessment once all control measures are implemented** | **Likelihood** e.g. Likely | **Consequence/ Impact** e.g. Moderate | **Risk Rating** L and C =RR e.g. Likely and Moderate = AMBER |
|---|---|---|---|
| | | | |

Southern Health and Social Care Trust

# LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

| | |
|---|---|
| Name: | Roberta Brownlee |
| Visit To: | Thorndale Unit (Urology), Craigavon Area Hospital |
| Date and time of visit: | 23 May 2012 at 10.30 am |
| Accompanied By: | Kate O'Neill, Urology Specialist Nurse |

** Please note: you may not wish to complete all questions during your visit – the following are suggested questions.*

1.

a. What works well for you?

Small select unit. Very personalised for patients. We engage well with the patients. Many patients afraid – need a lot of reassurance. Small effective team and very adaptable. Highly skilled and competent team. Specific nurses who lead in different areas and development opportunities are available and accepted. Good communication. Good flexible and responsive staff. Supportive Consultants.

b. **What doesn't work well?**

**Short of middle grade doctors for support (Registrar level).** *There is a recognised shortage of middle grade doctors nationally within Urology. The Trust has advertised on a number of occasions without success. However we have recently advertised and we have had three applicants – interviews due to take place mid-August and we are hopeful that we will be successful in appointing. Also last year we only were successful in getting one registrar through training but from August 2012 we are getting 2 Registrars which will assist with this support. Last week we were advised that the Trust had secured funding from Board Liaison Group for an additional Specialty Doctor and we are hopeful that we will appoint another doctor from the interviews in August.*
**Limitations of the size of the building.** *These limitations have been recognised and there are plans being put in place to move the 'Thorndale Team' to main outpatients.*
**Small team so if one staff member off sick impacts greatly**. *As part of the Review of Adult Urology there is funding for a further 2 Specialty Nurses and we have been involved in discussions on how best to utilise this funding. Also the Unit depends on the General Practitioner with Specialist Interest (GPwSI) and when he is off sick this impacts on the activity. However it is hoped to address this through the appointment of more Specialty Doctors.* **Two patients and staff raised concerns of no car parking spaces. The length of walk for older patients and their family members**. *It is anticipated that both these points will be addressed through the move from the current location to main outpatients.*

2.

a. What would you like to change or see different?

**Expansion of the team** *this is in process with the additional 2 new Consultants and 1 replacement Consultant commencing 1 August, 1 September and 1 October. Also the appointment of the 2 new Specialty Doctors, 2 Specialty Nurses and the successful securement of 2 Registrars*
***Non-stock and requisitions – the process i.e. consumables – e.g. can these be stock items to enable more cost effective purchasing? I have asked for this to be looked at on several occasions – to date no response.** *This is currently with Head of Purchasing and Supplies. Although we have been advised that the items alluded to can only be moved to stock items once they have gone through the tendering process which is governed by BSO. A list and appropriate documentation has been completed in preparation of this tendering process.*

## b. What challenges do you face?

**Expansion of the area 'South'. Limited medical cover. Not always a medical member available in this unit.** *As per above this will be addressed with the additional medical staff (Consultants, Specialty Doctors, Registrars) that are coming to the Trust. The plan is that one or more of these will be based each day in Thorndale Unit.*

****Access to the main hospital for emergencies is not possible – what we have to do is call 999 to get Emergency Department. Needs to be noted for future reference. The present link corridor not passable**** *the corridor was planned to link the Thorndale Unit with the main hospital but the only access was through the Paediatric Outpatients area which has security risks in that only staff can use this when paediatric outpatients is not taking place. Also part of the corridor is open so therefore not suitable if accessible for patients during inclement weather. This issue will be addressed when the Unit is incorporated in main outpatients.*

## c. Have you any ideas for improvement?

**Privacy at reception – for phone calls**. *This will be addressed when the Unit moves to main outpatients as they will have a 'closed in' reception area*. **Formalisation of link corridor – how to use – great corridor but of no benefit.** *It has been very difficult to progress the use of this corridor due to child protection issues. We have been able to use it for moving equipment through from main hospital to Thorndale Unit.*

## d. Have you made any improvements you are particularly proud of?

- One stop clinic - Haematuria and prostate diagnosis – these patients seen within 1 or 2 weeks and offered biopsy on the day of visit. Most flexible cystoscopy done on same day of clinic.
- Decontamination purposes – used to only have one probe now bought 4 and formalised a protocol for decontamination– excellent outcomes – Band 7 lead the MDT approach to safe practice, completing this task is nursing auxiliary.
- Harmonisation of prostate biopsy service – Band 7 used the opportunity of her post graduate diploma in specialist nursing to standardize all patients to get appropriate local analgesia.

3.

a. How many commendations have you received in the past 3 months?

| |
|---|
| Feedback from community services very good and have many commendations. Staff impressed with high levels of satisfaction.<br><br>Could patient satisfaction survey and the questionnaires be completed at this unit? |

b. How many complaints have you received in the past 3 months?

| |
|---|
| None. |

c. What are you doing to respond to/learn from the issues raised?

| |
|---|
| If any complaints I would share locally and listen and learn. Engage with all staff. |

4. How do you engage with users?

| |
|---|
| We do 1:1- we have used service users to improve haematuria documentation. Daily engagement with all patients and ask for feedback before they leave the clinic. Open honest 1:1. Availability of documentation used. |

5. Do you have regular team meetings?

a. What**'s on you**r team meeting agenda?

| |
|---|
| Band 7 goes to Sisters meeting weekly – I find this excellent. Good links with the wards. I bring back and share information weekly. Formal meetings 2-3 times per year. We look at Assistant Director meeting outcomes, HR, Training, Governance and Infection Prevention Control. |

6. Any staffing issues?

| |
|---|
| Only middle grade doctors. *As per response to 1 (b).* No other staffing issues. |

7. **Is your Team's mandatory training up**-to-date?

Basic life support up-to-date.
M&H – 100%
Fire Awareness – all staff booked for May 12 – all previously trained.
Infection Control – annual – 100% up-to-date. Excellent and up-to-date. Good opportunity for development.

8. Do you have arrangements in place for regular supervision?

I do this twice yearly with staff (one Band 7 responsible for this) and KSF completed by other Band 7.

9. Tell me about your safety audits (on dashboard/other)

Bedpan/fridge/hand hygiene audits – learning outcomes shared with staff for display in patient waiting area.

10. Is there a good understanding of when and how to report an incident/error?

Good understanding by staff. Sharing Datix report/process to all other staff.

11. What areas of risk are you concerned about in your ward/facility/team?

None raised but highlighted isolation from main hospital. Could have two collapses per month and have to go via 999 call. *This is a recognised concern and one of the reasons to having Thorndale relocated to main outpatients*.

12. When you escalate risks that are beyond your control, do you get a timely response?

No concerns – can raise concerns and gets a timely response.

13. Are you getting the support you need to manage risks that you are accountable for?

| |
|---|
| Yes – no issues. |

14. Do you have any problems with infection control (if applicable)? (Non Executive Directors to comment on environment and general observation for infection control)

| |
|---|
| None. Fresh and new unit. Extremely clean. Spoke to three patients and all very complimentary of the service provided. Commended staff's friendliness, helpfulness and privacy. |

15. When had you last an MRSA; MSSA; C. Diff or other problem?

| |
|---|
| None. |

16. Any other comments? (*Record any additional information noted during visit*)

| |
|---|
| This is an excellent facility. Very person centred. Patients like the privacy. Spoke to two S/Ns and audio typist. Both S/Ns highly skilled nurses – no concerns raised. Confirmed the high quality outcomes. Phone area very open and poor privacy. *To be addressed and to be taken into account when Thorndale is relocated*. Staff have had 'other teams' come to look at Thorndale as it appears Urology may move from this Unit. *The discussions about a potential move were only at a very early initial stage and had been tentatively discussed with the Urologists and Specialty Nurses and nothing had been agreed or that there would be a definite move. However, the other team that have been provisionally told that there may be a potential for them to move to Thorndale if Urology moved went to visit the Unit without notifying, Assistant Director/Head of Service and arrived unannounced. However, Head of Service addressed this immediately with the Staff in Thorndale*. Staff not really aware of any planned changes. Staff need to be kept informed and involved in the planning e.g. Urodynamics Room – extremely hot and no air conditioning. If Urology moving to another area the name 'Thorndale Unit' needs to go with this specialty because of how and why it was named this. It's important that this request is noted at this stage please. *The proposed move has been discussed with Consultants and Specialty Nurses and they all had been given an opportunity to advise on any areas that they wanted to have included. This is still only at the planning stage and it will not be progressed without their involvement including a clinical room suitable for urodynamics/biopsies etc. We have also noted the request to keep the Thorndale name for the area when it is relocated.* |

Signature _____ Date _____

** This report should be completed within 7 days of your visit and returned to the Chair**'s Office. The Chair's PA will then forward to the** Chief Executive and person(s) who conducted/assisted in your walk-around.*

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Southern Health and Social Care Trust

# Incident Management Procedure

## October 2014

## *Procedure Checklist*

| | |
|---|---|
| **Name of Procedure:** | Incident Management Procedure |
| **Purpose of Procedure:** | To describe the Trusts systems and processes in relation to Incident Management |
| **Directorate responsible for Procedure:** | Corporate Governance, Office of the Chief Executive |
| **Name & Title of Author:** | Mrs Margaret Marshall, Interim Asst Director CSCG |
| **Does this meet criteria of a Procedure?** | Yes |
| **Trade Union consultation?** | No |
| **Equality Screened by:** | |
| **Date Procedure submitted to Policy Scrutiny Committee:** | |
| **Members of Policy Scrutiny Committee in Attendance:** | |
| **Policy Approved/Rejected/ Amended** | |
| **Policy Implementation Plan included?** | |
| **Any other comments:** | |
| **Date presented to SMT** | |
| **Director Responsible:** | Chief Executive |
| **SMT Approved/Rejected/ Amended** | |
| **SMT Comments** | |
| **Date received by Employee Engagement & Relations for database/Intranet/Internet:** | |
| **Date for further review** | |

## *Contents*

### *1.0 Introduction:*

The consistent identification, monitoring and review of incidents is central to the Trust"s strategic and operational processes to ensure it can achieve its vision for safe and effective care. As recommended in the document „Safety First: a Framework for Sustainable Improvement in the HPSS" (HPSS 2006) the Trust recognises that incident reporting is a fundamental element of its Risk Management Strategy.

### *1.1 Purpose:*

The purpose of this procedure is to guide all employees of the Trust in the following:

- Identification, reporting, review, monitoring and learning from all incidents which have resulted in or had the potential to result in injury or harm to a person or damage to property or the environment, or a breach of security, confidentiality, policy or procedure.
- Analyse incident trends, root causes, associated costs and to develop appropriate action plans to eliminate or minimise exposure to associated risks.
- Enable staff to participate in, and effect change by ensuring that mechanisms are in place to learn from incidents which occur and that resulting changes in care, policy or procedures are embedded in local practice.
- Notification and recording of incidents from third party organisations from which the Trust commissions services.
- Notification of incidents where appropriate to other relevant agencies, for example the Regional Health and Social Services Board (RHSCB), Regulation Quality and Improvement Authority (RQIA), Department of Health, Social Services and Public Safety (DHSSPS) via appropriate Early Alerts, HM Coroner, Northern Ireland Adverse Incident Centre (NIAIC), Health & Safety Executive Northern Ireland (NIHSE), Police Service of Northern Ireland (PSNI), etc. Please see **Appendix 2.**

### *1.2 Scope of the Procedure:*

The following procedure applies to all employees of the SHSCT. Some aspects, including reporting a serious adverse incident, also applies to independent providers / contractors commissioned or engaged by the Trust. It addresses the Trust's governance responsibilities in relation to incidents and is one element of the Trust's Risk Management Strategy.

## *2.0 The Roles and Responsibilities:*

### *2.1 Chief Executive:*

The Chief Executive is the responsible Officer for the Trust"s statutory duty of quality and is required to drive the delivery of the Trust"s corporate priorities, particularly the priority to provide safe, high quality care. Through the overview of this Trust Policy and Procedure, the Chief Executive will seek to embed the Trust"s corporate values throughout the organisation, to promote the Trust"s values of all staff being open and honest and acting with integrity, to listen and learn and to embrace change for the better.

The Assistant Director for Clinical and Social Care Governance (AD CSCG) reports directly to the Chief Executive and will provide the Chief Executive, Trust Board, Senior Management Team (SMT) and Governance Committee with an on-going overview of this Policy and Procedure through the continuous corporate review and monitoring of Incidents and Serious Adverse Incidents (SAIs).

### *2.2 Assistant Director of Clinical and Social Care Governance (AD CSCG):*

The AD CSCG will provide leadership to ensure a systematic and organisation-wide approach to the reporting of clinical and social care incidents and near misses and will work with SMT to embed a culture of appropriate and timely reporting, analysis and learning across the organisation.

The Assistant Director will participate in monthly meetings with the Clinical and Social Care Governance Coordinators in order that there is a corporate oversight in relation to incidents, risks, trends and learning within the organisation.

It is the responsibility of the AD CSCG to present a trend analysis report quarterly of all incidents reported in the Trust to:

- Senior Management Team (SMT)
- the Governance Committee
- CSCG Working Body

This report will be used by the SMT to inform organisational risk management and governance priorities and will escalate concerns in relation to trends and /or learning.

On behalf of the Chief Executive and SMT, the AD CSCG will provide assurance reports to Governance Committee in relation to the adoption and implementation of procedures relating to incident reporting, monitoring and learning. This includes evidence of cross organisational learning through appropriate forums including the Trust Governance Working Body.

The AD CSCG will act as a conjugate between the Directorates and the Chief Executive, appraising the latter of all major and catastrophic incidents, internal reviews and Serious Adverse Incidents. They will also liaise on behalf of the Trust with the Department, the Public Health Agency (PHA) and the HSCB to ensure the Trust contributes to and is involved in any Regional opportunities for learning.

### *2.3 Directors:*

- Directors are responsible for leading a culture of openness, transparency and learning within their area of responsibility and for ensuring that the actions from any learning are appropriate and the most effective way to minimise risk and provide good care services
- Directors shall ensure that processes are in place to effectively identify, report, review, monitor and learn from all incidents within their Directorate and that the processes are as laid out within this procedure
- They shall ensure that the reviewing, learning from and monitoring of incidents is included on the agenda of all directorate, divisional and team governance meetings
- They shall ensure that action plans and learning to be implemented from incidents are an effective response with an appropriate timescale, prioritised and are reviewed on an on-going basis at directorate governance meetings
- Directors shall consider learning from moderate, major and catastrophic incidents and any trends identified from insignificant / minor incidents to inform directorate governance priorities, education, training and directorate and organisational learning. The latter should be identified through the Directorate Governance forum and be escalated to the AD CSCG for dissemination via the Trust Governance Working Body
- They shall ensure that all current risks recognised from this governance of incidents are considered for the Directorate / Corporate Risk Register
- Training – liaise with the appropriate Executive Directors with responsibility for professional and organisational training

### *2.4 Assistant Directors & Associate Medical Directors (AMD's for clinical incidents):*

All incidents recorded on Datix Web must be reviewed by an ***Incident Review Team*** on a ***weekly*** basis***.*** It is the responsibility of all Assistant Directors / Associate Medical Directors (AMDs) to put in place ***Incident Review Teams*** within their divisions/teams. The membership of an Incident Review Team should include a Head of Service / Senior Manager and an identified Clinician where ***clinical incidents*** are under review.

The Assistant Director / AMDs must also:

- Lead a culture of openness, transparency and learning within their area of responsibility and ensure that the actions from any learning are appropriate and the most effective way to minimise risk and provide high quality care and services

- Include the management, review, monitoring and learning from incidents on the agenda of divisional, service and team governance meetings
- Ensure that action plans and learning to be implemented from incidents are an effective response, appropriately time bound, prioritised and are reviewed on an on-going basis at divisional meetings
- Consider learning from moderate, major and catastrophic incidents and any trends highlighted from insignificant / minor incidents when identifying directorate and divisional governance priorities, education, training and organisational learning in a timely way
- Organisational learning should be identified through to the Directorate Governance forum and be escalated to the AD CSCG for dissemination via the Trust Governance Working Body
- Identify training needs to the appropriate Heads within the Trust
- Ensure through their Heads of Service that any barriers to implementing the learning from moderate, major or catastrophic incidents is risk assessed using the SHSCT risk assessment matrix, highlighted at Directorate Governance Fora and placed on the appropriate risk register if not immediately actioned

### *2.5 Head of Service/ Team Manager:*

It is the Head of Service/Team Manager"s responsibility to:

- Lead a culture of openness, transparency and learning within their area of responsibility and ensure that the actions from any learning are appropriate and the most effective way to minimise risk and provide high quality care and services
- Include the management, review, monitoring and learning from incidents on the agenda of service and team governance meetings
- Ensure that action plans and learning to be implemented from incidents are an effective response, appropriately time bound, prioritised and are reviewed on an on-going basis at team meetings
- Consider learning from moderate, major and catastrophic incidents and any trends highlighted from insignificant / minor incidents when identifying service and team governance priorities, education, training and organisational learning in a timely way
- Escalate any barriers to implementation of action plans relating to incidents to the appropriate Assistant Director and consider if they need to be placed on the appropriate Risk Register
- Ensure through the function of the ***Incident Review Team*** that feedback is provided to the incident reporter on the outcome of incident investigations for all moderate, major and catastrophic incidents

### *2.6 Incident Review Team:*

- The purpose of the ***Incident Review Team*** is to review all incidents, determine any learning from them, make recommendations as to what would constitute an effective response which will minimise risk and communicate this within their teams (and to Heads of Service / Team Manager if they are not part of the Incident Review Team). Learning / effective response to any risks highlighted should then be communicated to the appropriate Head of Service / Team Manager for action within the operational teams. Any barriers to implementation of action plans relating to incidents should be escalated by the appropriate Head of Service to the Assistant Director.

The Review Teams should also consider and review the following:

- The information submitted by the reporter including the incident grade
- Consider the need for additional internal and/or external reporting e.g. Health and Safety, RIDDOR, NIAIC, HSCB, RQIA, Adult Safeguarding (PVA). See **Appendix 2**
- Develop time bound and prioritised action plans as appropriate. All **moderate, major** and **catastrophic** incidents reported will require an action plan which **must** include relevant learning points
- Feedback the outcome of the review of **moderate, major and catastrophic** incidents to the incident reporter
- Inform Assistant Director of any immediate learning which could minimise the risk of further reoccurrence of incident
- Close all incidents following completion of the review process

All Incident Review Teams should adhere to the Datix Web User Guide for Managers/Reviewers which can be accessed from the Trust intranet site. See Hyperlink:

http://vsrintranet.southerntrust.local/SHSCT/documents/DatixWeb_InvestigatorsFinalApproversguidance2012.pdf

### *2.7 The Directorate CSCG Coordinator:*

The CSCG Coordinator will ensure that processes are in place for the recording, reviewing, monitoring and learning from incidents and will provide timely and appropriate information on incidents to the Directorate. Reports will be tailored for Directors, Assistant Directors, Heads of Service and Team Managers.

The CSCG Coordinator will also be responsible for interpreting and analysing incident information to identify risks and/or trends. They will feedback this information to the Directorate through the Directorate Governance structures.

The CSCG Coordinator will provide regular and timely information to the Directorate on the action plans and learning arising from incidents and SAI"s and the progression of these action plans.

On behalf of the Director, the CSCG Coordinator is responsible for monitoring that within each service team, incident information is being acted on appropriately in order to mitigate risk, improve quality of care and patient and client safety and facilitate teams to make any links required from issues identified in incident management to appropriate Risk Registers. They will also ensure that a process is in place to escalate any concerns relating to incidents to the appropriate Director, and that there are appropriate processes in place to identify SAIs in line with the Health & Social Care Board (HSCB) process.

The CSCG Coordinator will participate in monthly meetings with the Assistant Director of Clinical and Social Care Governance in order that there is a corporate oversight in relation to incidents, risks, trends and learning within the organisation.

### *2.8 All SHSCT Staff:*

All SHSCT staff are required to provide safe, high quality care and this includes the reporting of incidents for organisational learning and good risk management as defined below and further in **Appendix 1**, in accordance with this procedure and participate in any subsequent review if required.

## *3.0 Procedure for the Identifying and Reporting of Incidents – ALL STAFF*

### *3.1 Incident Identification:*

A useful definition of an incident is:

**"Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation."**

The incident may arise during the course of the business of the Trust or any of its commissioned / contracted services.

However this is not an exhaustive definition and using the incident reporting system specifically for clinical outcomes which are unexpected and / or unexplained, but are not believed to be associated with an adverse incident, is also encouraged by the Trust as a means of triggering a thorough review of such cases. These reviews are a beneficial mechanism of providing assurance to staff, patients, clients, carers and relatives that any learning related to any aspect of the case is sought and acted upon.

#### *3.1.1 Other Systems for Reporting:*

An incident can sometimes also be reported through other systems such as Adult Safeguarding, Case Management Review, Mortality and Morbidity meetings, etc.

The Trust mechanism for recording all incidents is **Datix Web** and the electronic incident form (IR1) should be completed as soon as possible after the incident occurs or is discovered to have occurred. Staff should then think through what other reporting systems, such as notifying their Line Manager, may need to be considered.

### *3.1.2 Incidents Occurring Within Services Contracted or Commissioned by the Trust:*

Incidents occurring in contracted / commissioned services which are not observed / witnessed by Trust staff and / or not reported to Trust staff are dealt with under the regional contractual arrangement with independent providers. This states that all incidents occurring within the regulated sector which are notifiable to RQIA will also be notified to the appropriate Trust via a central email. From here they will be distributed to the appropriate Directorate for review as per section 4 of this procedure.

If a member of Trust staff observes or witnesses an incident occurring within a service contracted or commissioned by the Trust or has an incident reported to them by a Trust client and / or their family / carers which relates to care provided by a contracted or commissioned service i.e. domiciliary care services, private nursing home, etc. then the member of staff has a duty to report the incident using the Trust Datix web system. The staff member will also instruct the contracted service to report the incident via their reporting mechanisms (which include notifying RQIA and Trust of significant incidents) and this instruction should be documented by Trust staff. If reported to the Trust by the contracted service the Datix incident reports should be merged by the appropriate governance team. **The original incident should be reviewed as per section 4 of this procedure.**

### *3.1.3 Immediate Action Checklist Following Identification of an Incident:*

When an incident is identified and before it is reported please complete the following **immediate action checklist:**

- The extent of injuries/damages to person(s) or property should be ascertained and a determination made regarding the need for emergency or urgent treatment / action. For patient / client care related incidents, contact the relevant medical team to assess where required. The situation must be made safe
- Appropriate obvious treatment / actions should be taken to minimise the likelihood of the incident recurring
- Any equipment involved in the incident should be removed from use and clearly labeled, “Do not use”, until appropriate checks can be carried out. Do not dispose of equipment involved in an incident
- **The patient/client and/or their relatives / carers** should be informed, as soon as possible of the incident and of any treatment that may be necessary taking into consideration any consent issues and referring to the Trust‟s “Being Open” guidance in **Appendix 4**

- Any incident involving a patient or client, and the action taken, should be recorded in their healthcare record
- If the incident is major or catastrophic and requires an immediate action plan to prevent further harm the line manager ( if out of hours, the Senior Out of Hours Manager) should be informed
- For incidents requiring further in-depth investigation e.g. SAIs/Internal Root Cause Analysis (RCA"s) / Reviews, patient/client records should be returned as soon as is practical to the Directorate Governance Coordinator to ensure all recorded information is available for review. Retrospective notes are permitted as long as these are clearly marked as being made in retrospect
- Where appropriate and where it would be beneficial to assist in the investigation of the incident, photographs should be taken and retained as evidence – this is particularly useful in Health and Safety type incidents or where damage had occurred to property
- CCTV footage should be sourced and a copy made for all cases which would be subject to PSNI investigation.
- Security staff and/or the PSNI should be informed where appropriate
- Consideration should also be given to the need to activate site based emergency / contingency plans if necessary (in line with current emergency procedures)

### *3.2 Reporting an Incident:*

**Where:** All incidents must be recorded electronically via the Datix Web based form (IR1 form) which can be accessed as follows from the Trust intranet site. **(Trust intranet/ useful links/ other useful links and scroll down to click on „Datix Web")**

**By Whom:** This form must be completed by either the member of staff involved in or who has witnessed the incident, or by the person the incident has been reported to.

**When:** All incidents should be reported via the electronic reporting form (IR1 form), no later than the end of the working shift or day during which it occurred **or** its occurrence became known.

**How:** Information concerning the incident must be accurate, complete and factual. The description of the incident should not contain opinions, conclusions, subjective or speculative statements. The following instructions should be followed when filling in the electronic incident form. *See Hyperlink below:*

http://vsrintranet/SHSCT/documents/DatixWebIR1FormUserGuidance_000.pdf

Incidents given an initial severity rating of major or catastrophic (as a minimum) will automatically be triggered to the appropriate Head of Service/Team Manager, relevant Assistant Director and the Assistant Director of Governance in an email via Datix Web.

In circumstances where the incident is considered as a potential **Serious Adverse Incident (SAI),** *(see **Appendix 1** for the definition of an SAI)* immediate telephone contact should be

made to the relevant Head of Service/ Line Manager or Out of Hours Manager if appropriate. They will notify the appropriate Director, Assistant Director/Associate Medical Director and Clinical and Social Care Governance Coordinator at the earliest opportunity. The incident will then be reviewed by the latter group against the HSCB SAI criteria and the DHSSPS Early Alert criteria. This group must complete a major/catastrophic incident checklist for all incidents screened as possible SAIs. This checklist, regardless of the outcome of the screening process, will be held by the Directorate CSCG Coordinator and copied to the Assistant Director of Governance via the Corporate Governance Office**. (**See **Appendix 6)** In the event of the incident meeting the Serious Adverse Incident criteria; **section 5.0** of this procedure should be followed and where appropriate, the Director should brief the Chief Executive on SAIs as soon as possible.

### *4.0 Procedure for Reviewing, Monitoring and Learning from Incidents:*

All incidents are to be reviewed on a weekly basis by the service area‟s Incident Review Team. As indicated earlier the purpose of the Incident Review Team is to undertake a local assessment / review of the incident in a timely manner. This review should include:

- Quality assure the information submitted via the Datix system and the initial severity rating given to the incident. Where the review team believes the severity rating should be changed – the incident reporter should be contacted and this should be discussed and agreed
- Calculate the actual and potential risk rating for the incident using the Risk Grading Matrix and impact Table – this is explained on the Datix screen and also in **Appendix 3**
- Consider the need for additional internal and /or external reporting e.g. RIDDOR, NIAIC, HSCB, RQIA, Vulnerable Adults (PVA), Fire **(See Appendix 2 for guidance on advisory contacts re: these additional reporting routes)**
- If the incident is also an adult safeguarding review (this will be recorded on Datix) then the Incident Review team should link with the adult safeguarding Designated Officer (DO) for that incident. If the incident is proceeding to a safeguarding investigation the Incident Review Team should participate in that or at a minimum, review the learning from that investigation and implement as appropriate
- Develop and agree learning and action plans as appropriate. All **moderate, major** and **catastrophic** incidents reported will require a time bound action plan which **must** include relevant learning points. This learning should be communicated and actioned within teams
- Feedback the outcome of the review of **moderate, major and catastrophic** incidents to the incident reporter
- Inform the Assistant Director of any immediate learning which could minimise the risk of further reoccurrence of the incident
- Any barriers to implementation of action plans relating to incidents should be escalated to the appropriate Head of Service and the Assistant Director

- Close all incidents following completion of the review process

### *4.1 Incident Review:*

The following risk assessment process should be applied to all incidents at the time of occurrence in order to decide what level of investigation is required and at what level within the Trust the investigation should be conducted.

## ***Step One* – What was the impact of the incident at the time of the incident? (Actual Harm)**

4.1.1 The person reporting the incident should undertake this stage of the assessment, entering it on the IR1 form (DIF1). Based on the actual impact of the incident at the time of occurrence (taking into account psychological as well as physical harm) a judgment is made as to the incident"s severity in the range Insignificant to Catastrophic.

4.1.2 Incidents assessed as causing actual **major** or **catastrophic** harm at the time of the incident must be given immediate consideration for further in depth analysis.

4.1.3 For incidents causing lesser levels of actual harm further questions need to be asked to decide on the level of investigation required.

## ***Step Two* – What might the impact be if the incident happens again? (Potential harm)**

4.1.4 Where the potential harm of the incident is being considered, staff must ask the following in the context of "if no further action was taken".

- Was the harm caused by a chance happening?
- Could the actual harm caused realistically have been a lot worse?
- How many people might be hurt if it happened again?
- How seriously might someone be hurt if it happened again?
- What are the control measures already in place, today?

4.1.5 It is important that grading on actual harm and potential harm are completed as separate exercises. This will ensure that the most severe incidents where the level of actual harm is higher are dealt with as a priority. All incidents with a lower level of actual harm but with a potential for a higher level of harm must be managed appropriately.

| | |
|---|---|
| **Step one** | Deciding what was the impact / harm of the incident today **(actual)** |
| **Step two** | Where there is insignificant to moderate actual impact/harm, deciding what might the realistic impact/harm be if the incident were to happen again under similar circumstances. **(potential impact)** |
| **Step three** | Decide what are the chances of the incident happening again under similar circumstances. At this stage consideration should also be given |

| | |
|---|---|
| | to reviewing similar incidents that have happened in the past. **(Likelihood)** |
| **Step four** | Decide what the overall risk grading for the event is by plotting: **Impact** multiplied by **likelihood = risk grading** |

The level of review applied to an incident is determined by the actual severity (impact) of the incident and/or the potential impact and is as follows:

**INSIGNIFICANT AND MINOR –** These incidents will usually not require detailed review, however the following questions should be asked to establish any learning:

- What happened?
- Did what happened vary from what should have or was expected to happen?
- If so, why?
- What is the learning from this incident?

**However,** these incidents could be subject to detailed review if similar incidents are found to occur frequently i.e. where there is a trend. It is the review team"s responsibility to identify such trends and advise the appropriate Head of Service/Team Manager or Assistant Director regarding improvements or action plans required if a trend is identified. Heads of Service and Assistant Directors should also be identifying and analysing trends through their Team / Service / Divisional Governance meetings. Action plans and lessons learnt from this trend analysis should be discussed and actions recorded in the notes of team, service and divisional governance meetings.

**MODERATE –** These incidents **must** be reviewed as part of the incident review process on a weekly basis. The review team must ensure that an investigation is completed within four weeks and that there is a documented action plan and learning points recorded on Datix Web. These actions and the learning should then be reviewed by the team, division and directorate with respect to progress of implementation.

In undertaking a Moderate Incident review the following questions should be answered **as a minimum:**

- What happened?
- Did what happened vary from what should have or was expected to happen?
- If so, why?
- What is the learning from this incident?

Further guidance on incident review is available in **Appendix 7.**

The Heads of Service and Assistant Directors are responsible for reviewing implementation of any actions and learning following an investigation. Action plans and implementation of learning should also be reviewed at the Directorate Governance forum by the Director.

**MAJOR AND CATASTROPHIC -** This level of incident will, as previously described, have been automatically notified by the Datix system to the Head of Service, relevant Assistant Director and the Assistant Director of Governance at the time of reporting. It is the responsibility of the relevant Assistant Director to inform the Director and Associate Medical Director (AMD) (in the case of clinical incidents) and the appropriate CSCG Coordinator for that area of the incident.

The incident must be considered against the HSCB (October 2013) criteria for a Serious Adverse Incident (SAI) by the relevant Director, Assistant Director, AMD and CSCG Coordinator. This review of the incident should be documented by the CSCG Coordinator on the major / catastrophic incident checklist which must be completed by the group. Regardless of the outcome of the screening, the completed checklist should be shared with the Assistant Director of Governance via the Corporate Governance Office. In the event of the incident meeting the SAI criteria, **section 5.0** of this procedure should be followed.

If the incident does not meet the SAI criteria the relevant Director may either appoint an independent internal team to review the incident using a Root Cause Analysis methodology (the method used to review an SAI -see section 5) or the incident may be reviewed by the service Incident Review Team. **(**See **Appendix 7)**

Whatever the method of reviewing the incident – either as an SAI, an internal review by an independent team within the Trust or by the clinical review team within the division itself, the service team involved in the incident **must** be informed of the decision regarding how the incident is to be reviewed at the earliest opportunity, by the Assistant Director / Associate Medical Director, and **before** the review commences.

Where an incident is to be reviewed internally by an independent team or if it is the subject of an SAI, the patient /client and/or family/carer must be informed of this review at the earliest opportunity (as per the HSCB SAI guidance April 2014) as should the coroner where the case has previously been referred to them. This action forms part of the major / catastrophic incident checklist and should be documented. In exceptional cases where it is not appropriate to share this decision with the patient /client and/or family/carer, the reasons for this decision **must** be documented on the checklist and on the SAI notification form.

The findings and recommendations of the review - irrespective of how it is carried out, will be discussed and documented at relevant team, service, division, Morbidity and Mortality meetings and directorate governance meetings.

The Heads of Service and Assistant Directors are responsible for reviewing implementation of any actions and learning following an investigation.

Action plans and implementation of learning will also be reviewed at the Directorate Governance forum by the Director.

Cross Directorate learning points should be escalated to the Assistant Director of Governance by the CSCG Coordinators when they meet monthly.

The findings and recommendations of an internal review of an incident or an SAI should be shared with the patient / client and/or family / carer, RQIA and the coroner (if previously referred) at the earliest opportunity.

### *5.0 Procedure for Reporting and Completing a Review of a Serious Adverse Incident (SAI):*

Following the review meeting of the relevant Director, Assistant Director, AMD and CSCG Coordinator where it is agreed to report an incident as a SAI, the SAI notification should be electronically reported to the HSCB, via the Corporate Governance Office, as per the HSCB Procedure for the Reporting of SAIs (HSCB October 2013)

*See Hyperlink:*
http://www.hscboard.hscni.net/publications/Policies/102%20Procedure_for_the_reporting_and_followup_of_Serious_Adverse_Incidents-Oct2013.pdf

The Directorate CSCG Coordinator will populate the HSCB SAI notification form on behalf of the appropriate Director and forward to the Corporate Governance Office for the attention of the Assistant Director of Governance. All SAI notification forms **must** be fully completed and accurate with an appropriate Datix ID number when submitted to the Corporate Governance Office and should be done so **within 72 hours** of the incident occurring. The Director / their designate should also report the SAI to the Chief Executive.

If the SAI concerns the death of a patient and the death has been reported to the Coroner by the appropriate medical professional this will have been recorded on the major/catastrophic review checklist and the SAI Notification. In this case the Corporate Governance Office will automatically inform Litigation (litigation generic email account) of the SAI review and this will on completion be submitted to the Coroner.

Where the SAI notification form indicates that the RQIA should be informed the Corporate Governance Office will automatically share the notification and report (when finalised) with the RQIA.

If the SAI requires an Adult Safeguarding Investigation, the Adult Safeguarding Investigation will inform the SAI process. The PVA Designated Officer will liaise with the appropriate Governance Coordinator, relevant HoS, and a representative from the Adult Safeguarding Team to compose the Adult Safeguarding Investigation review team membership. That review team must be approved by the Director, Assistant Director, and where appropriate AMD. The PVA Investigation Officer will produce an Adult Safeguarding Investigation report which will be submitted to HSCB/RQIA and to the Coroner if appropriate etc as the SAI report.

## *5.1 Procedure for Conducting a SAI Review (This procedure should also be applied when conducting an Independent Internal Review):*

| Timescale | Action | Lead |
|---|---|---|
| 0 -72hrs | Discuss with Director, Assistant Director, AMD and CSCG Coordinator. Consider the incident against HSCB (Oct 2013) definition of a SAI and using the Major/Catastrophic incident checklist. | Director / CSCG Coordinator |
| 0-72hrs | If above group decides the incident is an SAI they will inform the service team involved in the incident of their decision and the patient/client and/or their relatives. This group should identify nominations for the SAI review team including a Chair. (Advice for Chairpersons - see Appendix 8) Those nominated should have had no involvement in the incident for review, should be from another site / team and should be available to participate during the subsequent 12 weeks.<br>There is the option to nominate external independent persons from other organisations onto the review team – this is done via the Director and Chief executive. This option may be useful when there is a need to engage the appropriate expertise, the incident is particularly distressing for staff involved or is particularly sensitive, where carers and relatives have expressed significant dissatisfaction with a service team or the organisation at an early stage, where a service team is small and based on one site only, where the case may be subject to external or legal scrutiny at a later stage or at any other time where it may be deemed to offer a benefit. | Director / AD/AMD/CSCG Coordinator |
| 0-72hrs | Following confirmation of their involvement all review group nominees will receive an email with the following information:<br>• Notification of their nomination and who nominated them.<br>• Membership and Chair of the group<br>• A brief description of the incident<br>• Timescale for completion of the report<br>• Guide to RCA methodology.<br>The relevant A/D will check and ensure the case note /records have been forwarded to the CSCG Coordinator. | CSCG Coordinator |
| Week 1 | CSCG Coordinator and Chair of review group will agree draft terms of reference for the review.<br>Draft terms of reference and a copy of the case note / records will be circulated with potential dates for meeting 1 of the review.<br>All relevant information will be distributed to the group for consideration prior to meeting 1 of the group. | Chair/CSCG Coordinator |
| Week 2-3 | Meeting 1 will take place. This meeting will normally agree a terms of reference – including the scope of the review. The timeline of events will be discussed - and all relevant points for further analysis identified together with any points needing further clarity from the professional team involved in the incident. It is often useful and appropriate to meet with some / all of the staff involved in the incident so they can give their account to the review team in person, indicate their thought processes at the time and clarify any | Review Team |

| | | |
|---|---|---|
| | **outstanding issues. The appropriate members of the review can meet those of similar profession from the team involved in the incident.** | |
| **Week 3-6** | **Actions from meeting 1 will be completed, including follow up meetings with staff involved in the incident and all information can be forwarded to CSCG Coordinator.** | **Review team** |
| **Week 6** | **Meeting 2 can take place. It may be appropriate in less complex cases to have Draft 1 of the report tabled at this meeting for further discussion. However this meeting is more likely to pull together all information received and to analyse the incident and make conclusions, recommendations and propose an action plan.** | **Review team / CSCG Coordinator** |
| **Week 7-9** | **A complete draft of the report will be prepared by members of the review team and circulated to all for comment.** | **Review team /CSCG Coordinator** |
| **Week 9-10** | **Comments from the review team will be reviewed by the Chair and CSCG Coordinator / review facilitator and a final draft agreed and then circulated to the review team.** | **Chair/ CSCG Coordinator** |
| **Week 10-12** | **The final draft will be circulated / shared with all members of the service team involved in the incident for factual accuracy checking and information. The Final Draft will then be forwarded to the appropriate Director, Associate Medical Director and Assistant Director for quality assurance prior to presentation at Directorate governance meetings.** | **Chair/CSCG Coordinator** |
| **Week 12** | **Following approval by AD CSCG the report will be submitted to HSCB/ RQIA via the Corporate Governance Office. The report may also be submitted to SMT for information sharing / discussion and if a case involves a death being reviewed by the Coroner it will be shared with their office also.** | **CSCG Coordinator / Corporate Governance** |

### *5.2 Points of Best Practice When Undertaking a SAI Review (Applicable when undertaking an Internal Review of an Incident also):*

- The service team involved in the incident are provided with support and assistance following the incident and during and after the review. See **Appendix 5**
- The patient / client and/ or relatives are informed of the review taking place, **BEFORE** it commences, to provide assurance to them that any learning related to the incident is identified and acted upon. See **Appendix 4**
- The service team involved in the incident are informed as soon as possible and **BEFORE** it commences how the incident will be reviewed. They are kept informed with respect to review progress and they can interface with the review team to provide additional information and or clarity when required. The draft review report should be shared with the service team involved in the incident for factual accuracy and information
- The review must be chaired by someone with relevant professional experience and expertise from another geographical area of the Trust who has had no involvement in the case or direct line management responsibility for any of the team involved in the incident

- The review team should be multidisciplinary and have the appropriate expertise to review the incident appropriately. They must be independent from being involved in the care and treatment provided to the patient / client
- There is the option of seeking external independent review team members and this should be considered at the outset by the Director, Assistant Director, and Associate Medical Director and CSCG Coordinator. This option can be used at any time throughout the review
- The facts, findings and recommendations from the review will be shared with the patient /client and /or family / carers. See **Appendix 4**
- Where the case has previously been referred to the Coroner, their office will receive a copy of the review report
- Learning and action plans from SAI"s will be managed in the same way as that from other incidents – **see section 4**

***(subject to service users consent)***

## *APPENDIX 1:*

## *KEY DEFINTIONS*

**Definitions**: The following terms describe events, which are defined as incidents and will be recorded and reported within the scope of this procedure and through Datix Web.

| Terminology | Definitions |
|---|---|
| Incident/ Near Miss | Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of an HSC organisation / Special Agency or commissioned service (including a breach of security or confidentiality). However this is not an exhaustive definition and using the incident reporting system specifically for clinical outcomes which are unexpected and / or unexplained, but are not believed to be associated with an adverse incident, is also encouraged by the Trust as a means of triggering a thorough review of such cases. These reviews are a beneficial mechanism of providing assurance to staff, patients, clients, carers and relatives that any learning related to any aspect of the case is sought and acted upon. |
| Near Miss | **Incidents** that do not lead to harm but could have, are referred to as near misses. |
| Serious Adverse Incident (SAI) | The following criteria will determine whether or not an adverse incident constitutes a Serious Adverse Incident (SAI)<br>**Serious Adverse Incident Criteria:-**<br>serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self-harm*) of :<br>a service user<br>a service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS)<br>or Learning Disability (LD) within the last two years)<br>a staff member in the course of their work<br>a member of the public whilst visiting an HSC facility.<br>unexpected serious risk to a service user and/or staff member and/or member of the public<br>unexpected or significant threat to provide service and/or maintain business continuity<br>serious assault (*including homicide and sexual assaults*) by a service<br>− on other service users,<br>− on staff or<br>− on members of the public<br>occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years).<br>- serious incidents of public interest or concern involving theft, fraud, information breaches or data losses. |
| Harm | Injury (physical or physiological), disease, suffering, disability or death. In most instance harm can be considered to be unexpected if it is not related to the natural cause of the service user"s illness or underlying harm („Doing Less Harm, National Patient Safety Agency) |
| Concern | A worry or "gut feeling" about something that could lead to an incident. To highlight a situation which could lead to a full blown incident or suboptimal standards of equipment, practice or performance. |

## *APPENDIX 2:*

### *When and How an Incident Should Also Be Reported To Other Sources*

All adverse incidents should initially be reported using the Datix Web incident management system. However some incidents should also be reported to other sources either internally within the Trust and / or externally to other agencies. The following table provides a list of types of incident and where they should be reported to following being recorded as an incident. There is also a list of useful contacts and Web links for additional advice and help.

| TYPE OF INCIDENT | WHERE ELSE IT SHOULD BE REPORTED TO | USEFUL CONTACTS AND LINKS ON HOW TO REPORT IT |
|---|---|---|
| **Potential Adult Safeguarding Incident** | Definition available on the link opposite | Info available from Trust Intranet: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/SAFEGUARDINGVULNERABLEADULTSPROCEDUREGUIDANCEVERSION4.pdf<br><br>Report form available on: http://vsrintranet/SHSCT/HTML/PandP/documents/PVA1BLANK.pdf |
| **Health and Safety Incident** | Via the Datix Web form Incidents should be automatically reviewed by Health and Safety | Contact: (Internal) Health & Safety Dept<br>Number: 028 3741 2671<br>Email:<br>http://vsrintranet.southerntrust.local/SHSCT/HTML/HR/documents/ReportableDiseases.pdf |
| **MHRA** | Should be notified (although voluntary) when an Adverse Drug Reaction occurs (ADR) | A paper form can be found in the back of every BNF or alternatively can be completed online at www.mhra.gov.uk/yellowcard |
| **RIDDOR** | An Incident is RIDDOR reportable if:<br><br>**1)**The injury sustained is major,<br>**2)** If a member of the public on Trust premises is killed or taken to hospital<br>**3)** If the injury is sustained is an „Over 3 day injury"<br>**4)** If there has been a Dangerous occurrence | Appropriate information should be completed on the Datix Web IR1 form which alerts the Trust"s Internal Health and Safety Dept.<br><br>The above department is also contactable on<br>**028 3741 2645** or<br>**028 3741 2671** |

| | | |
|---|---|---|
| | **5)** If a notification of a reportable work-related disease has been received<br><br>Further guidance available on Trust Intranet | |
| **SABRE**<br><br>**SHOT** | For adverse blood reactions and events the MHRA (above) has a web based system for reporting known as ***SABRE*** - ****Serious Adverse Blood Reactions and Events**** The hospital blood bank should be informed who will inform a member of the Trust Transfusion Team and the Haemovigilance practitioner will complete online reporting to SABRE. There is an option in the SABRE reporting system also to report to the ***Serious Hazards of Transfusions (SHOT)*** enquiry. All SABRE incidents are discussed at the Hospital Transfusion Committee meetings. | For further information on both SABRE and SHOT please visit<br><br>www.mhra.gov.uk |
| **CMR** | Case Management Review | *New processes have been put in place under Safeguarding Board NI.* |
| **Fire** | Relates to all fire Incidents: | An FPN 11 Form should be completed within 24 hours of the Fire Incident.<br>FPN 11 form is available on the Intranet at:<br>http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html<br>and should be sent to:<br>Fire Safety Department,<br>Meadowview,<br>Daisy Hill Hospital,<br>when completed. |
| **RQIA** | ***RQIA are notified about Incidents such as***<br>-serious injury to, or the unexpected/unexplained death<br>-unexpected serious risk to service user and / or staff member and / or member of the public<br>-unexpected or significant threat to provide service and / or maintain business continuity. | Corporate Governance Office to notify RQIA on receipt of appropriate SAI Notification form. |

| | | |
|---|---|---|
| | -serious assault (*including homicide and sexual assaults*) by a service user<br>-serious incidents of public interest or concern involving theft, fraud, information breaches and data losses | |
| **HM Coroner** | There is a general requirement under section 7 of the Coroners Act (Northern Ireland) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death. | Guidance on reporting a death to the coroner available at: http://www.courtsni.gov.uk/en-GB/Publications/UsefulInformationLeaflets/Documents/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland%20(PDF).pdf<br>and on the Trust Intranet at: http://vsrintranet.southerntrust.local/SHSCT/HTML/clinical_guidelines.html<br><br>Corporate Governance Office to also notify Coroner on receipt of SAI Notification form |
| **NIAIC** | An incident is NIAIC reportable if it relates to a Medical Device | Contact: Specialist Estates Services Dept (internal) Medical Devices Liaison Officer<br>Email:<br>Irrelevant information redacted by the USI<br>i.net |
| **DHSSPS Early Alert** | Guidance available on Early Alerts at: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html | Notification sent by Corporate Governance Office |
| **HSCB Early Alert** | As above - | Notification sent by Corporate Governance Office |

# Appendix 3

| DOMAIN | IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential] | | | | |
|---|---|---|---|---|---|
| | INSIGNIFICANT (1) | MINOR (2) | MODERATE (3) | MAJOR (4) | CATASTROPHIC (5) |
| **PEOPLE**<br>*(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)* | • Near miss, no injury or harm. | • Short-term injury/minor harm requiring first aid/medical treatment.<br>• Minimal injury requiring no/ minimal intervention.<br>• Non-permanent harm lasting less than one month (1-4 day extended stay).<br>• Emotional distress (recovery expected within days or weeks).<br>• Increased patient monitoring | • Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year).<br>• Increase in length of hospital stay/care provision by 5-14 days. | • Long-term permanent harm/disability (physical/emotional injuries/trauma).<br>• Increase in length of hospital stay/care provision by >14 days. | • Permanent harm/disability (physical/ emotional trauma) to more than one person.<br>• Incident leading to death. |
| **QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES**<br>*(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)* | • Minor non-compliance with internal standards, professional standards, policy or protocol.<br>• Audit / Inspection – small number of recommendations which focus on minor quality improvements issues. | • Single failure to meet internal professional standard or follow protocol.<br>• Audit/Inspection – recommendations can be addressed by low level management action. | • Repeated failure to meet internal professional standards or follow protocols.<br>• Audit / Inspection – challenging recommendations that can be addressed by action plan. | • Repeated failure to meet regional/ national standards.<br>• Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities.<br>• Audit / Inspection – Critical Report. | • Gross failure to meet external/national standards.<br>• Gross failure to meet professional standards or statutory functions/ responsibilities.<br>• Audit / Inspection – Severely Critical Report. |
| **REPUTATION**<br>*(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)* | • Local public/political concern.<br>• Local press < 1day coverage.<br>• Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS). | • Local public/political concern.<br>• Extended local press < 7 day coverage with minor effect on public confidence.<br>• Advisory letter from enforcing authority/increased inspection by regulatory authority. | • Regional public/political concern.<br>• Regional/National press < 3 days coverage. Significant effect on public confidence.<br>• Improvement notice/failure to comply notice. | • MLA concern (Questions in Assembly).<br>• Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined.<br>• Criminal Prosecution.<br>• Prohibition Notice.<br>• Executive Officer dismissed.<br>• External Investigation or Independent Review (eg, Ombudsman).<br>• Major Public Enquiry. | • Full Public Enquiry/Critical PAC Hearing.<br>• Regional and National adverse media publicity > 7 days.<br>• Criminal prosecution – Corporate Manslaughter Act.<br>• Executive Officer fined or imprisoned.<br>• Judicial Review/Public Enquiry. |
| **FINANCE, INFORMATION & ASSETS**<br>*(Protect assets of the organisation and avoid loss)* | • Commissioning costs (£) <1m.<br>• Loss of assets due to damage to premises/property.<br>• Loss – £1K to £10K.<br>• Minor loss of non-personal information. | • Commissioning costs (£) 1m – 2m.<br>• Loss of assets due to minor damage to premises/ property.<br>• Loss – £10K to £100K.<br>• Loss of information.<br>• Impact to service immediately containable, medium financial loss | • Commissioning costs (£) 2m – 5m.<br>• Loss of assets due to moderate damage to premises/ property.<br>• Loss – £100K to £250K.<br>• Loss of or unauthorised access to sensitive / business critical information<br>• Impact on service contained with assistance, high financial loss | • Commissioning costs (£) 5m – 10m.<br>• Loss of assets due to major damage to premises/property.<br>• Loss – £250K to £2m.<br>• Loss of or corruption of sensitive / business critical information.<br>• Loss of ability to provide services, major financial loss | • Commissioning costs (£) > 10m.<br>• Loss of assets due to severe organisation wide damage to property/premises.<br>• Loss – > £2m.<br>• Permanent loss of or corruption of sensitive/business critical information.<br>• Collapse of service, huge financial loss |
| **RESOURCES**<br>*(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)* | • Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service.<br>• No impact on public health social care.<br>• Insignificant unmet need. | • Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service.<br>• Short term impact on public health social care.<br>• Minor unmet need.<br>• Minor impact on staff, service delivery | • Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service.<br>• Moderate impact on public health and social care.<br>• Moderate unmet need.<br>• Moderate impact on staff, service | • Loss/ interruption 8-31 days resulting in major damage or loss/impact on service.<br>• Major impact on public health and social care.<br>• Major unmet need.<br>• Major impact on staff, service delivery | • Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service.<br>• Catastrophic impact on public health and social care.<br>• Catastrophic unmet need.<br>• Catastrophic impact on staff, service |

| DOMAIN | IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential] | | | | |
|---|---|---|---|---|---|
| | INSIGNIFICANT (1) | MINOR (2) | MODERATE (3) | MAJOR (4) | CATASTROPHIC (5) |
| | • Minimal disruption to routine activities of staff and organisation. | and organisation, rapidly absorbed. | delivery and organisation absorbed with significant level of intervention.<br>• Access to systems denied and incident expected to last more than 1 day. | and organisation - absorbed with some formal intervention with other organisations. | delivery and organisation - absorbed with significant formal intervention with other organisations. |
| **ENVIRONMENTAL** *(Air, Land, Water, Waste management)* | • Nuisance release. | • On site release contained by organisation. | • Moderate on site release contained by organisation.<br>• Moderate off site release contained by organisation. | • Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc). | • Toxic release affecting off-site with detrimental effect requiring outside assistance. |

**Risk Likelihood Scoring Table**

| Likelihood Scoring Descriptors | Score | Frequency (How often might it/does it happen?) | Time framed Descriptions of Frequency |
|---|---|---|---|
| Almost certain | 5 | Will undoubtedly happen/recur on a frequent basis | Expected to occur at least daily |
| Likely | 4 | Will probably happen/recur, but it is not a persisting issue/circumstances | Expected to occur at least weekly |
| Possible | 3 | Might happen or recur occasionally | Expected to occur at least monthly |
| Unlikely | 2 | Do not expect it to happen/recur but it may do so | Expected to occur at least annually |
| Rare | 1 | This will probably never happen/recur | Not expected to occur for years |

| | Impact (Consequence) Levels | | | | |
|---|---|---|---|---|---|
| **Likelihood Scoring Descriptors** | **Insignificant(1)** | **Minor (2)** | **Moderate (3)** | **Major (4)** | **Catastrophic (5)** |
| **Almost Certain (5)** | **Medium** | **Medium** | **High** | **Extreme** | **Extreme** |
| **Likely (4)** | **Low** | **Medium** | **Medium** | **High** | **Extreme** |
| **Possible (3)** | **Low** | **Low** | **Medium** | **High** | **Extreme** |
| **Unlikely (2)** | **Low** | **Low** | **Medium** | **High** | **High** |
| **Rare (1)** | **Low** | **Low** | **Medium** | **High** | **High** |

## *APPENDIX 4:*

***Guidelines on being open with patients, service users, families and carers when things go wrong or outcomes are unexpected and /or unexplained***

- Any incident involving a service user should be discussed with this individual as soon as is appropriate by a senior member of the service team and preferably the lead professional. If the service user is a child or is unable to give consent due to their physical condition or mental capacity the incident should be discussed with their named next of kin contact. If the service user is able to provide consent and wishes the incident to be discussed with another carer or relative, the service team should facilitate this request.

- Specifically those incidents graded moderate, major and catastrophic should be discussed immediately with the service user and/or their relatives / carers, with consent. Those incidents of an insignificant and minor nature which occur out of hours can be discussed with those required at the most appropriate time within the next 24 hours.

- When discussing an incident with a service user and / or designated relatives / carers, the lead professional should outline the facts of the incident as known, the actual and potential consequences for the service user and how the team will review the incident for future learning. If the service user and/or designated carers / relatives wish to have the outcome of the incident review fed back to them the service team should consider this as good practice and should be conducted with consent of the service user if applicable. These interactions should be documented and attached to the incident report on Datix.

- If an incident meets the criteria for notification as an SAI or internal RCA, (**refer to Section 5**) the service user and / or designated relatives / carers must be informed of this decision before the SAI / RCA review begins. Where possible this should be undertaken by the Lead professional involved in the service user"s care. Where this is not possible to due relations being strained or it is judged to be inappropriate the Chair of the SAI /RCA review group supported by the Directorate CSCG Coordinator will undertake this role. This

individual will continue as the point of contact for the service user and / or designated relatives / carers throughout the period of the review and until the findings have been fed back.

- When an SAI / RCA review is completed and has been approved by the Directorate the point of contact for the service user and / or designated relatives / carers should offer to feed back the factual findings and recommendations of the review. This can include a meeting between parties and / or giving the review document to the service user and / or designated relatives / carers. How this process of review feedback is managed should be guided as far as possible by the wishes of the service user and / or designated relatives / carers.

## *APPENDIX 5:*

### *Guidance on Support for Staff following an Incident*

The Trust promotes an open, honest and participatory culture in which adverse incidents can be reported, discussed and reviewed to enable lessons to be identified, active learning to take place and the necessary changes made to improve our services and practices. A key part of that culture involves the need to support staff when an adverse incident occurs and during its review.

Depending upon the nature and circumstances of an adverse incident the levels of support required by staff will vary. Such support can be provided by line managers in a number of ways, for example:

- Providing immediate assistance/aid if required.
- Contacting the relevant staff member(s) as soon as possible following the incident to discuss.
- Facilitating an immediate informal and/or formal debrief of the staff / team involved in the incident. This should include providing staff with the opportunity to discuss their involvement and/or the circumstances leading up to the incident and how they feel about it. It is usually best to do this in a team setting with all those involved in the incident present.
- Informing staff of the Directorate"s processes in relation to incident review; keeping staff informed of likely next steps in that process and informing staff of who they can contact for advice including the Directorate Governance Office who coordinate all serious adverse incident reviews.
- At any time staff can seek advice from outside their team, for example from Directorate and Corporate Governance Offices, the Trust Litigation Department, Trust Legal Advisors or via the appropriate professional bodies.
- Line managers should be visible to all staff members. Physical presence by line managers post-incidents helps decrease anxiety related to an review and provides an accessible resource for clarification of any issues staff may have.
- Providing information on the Trust and external support systems currently available for staff who may be distressed by incidents. This includes counselling services offered by professional bodies; stress management courses; Occupational Health Services, Carecall or Hospital Chaplains.

## *APPENDIX 6:*

### Major / Catastrophic Incident Checklist

| | |
|---|---|
| Directorate: | |
| Reporting Division: | |
| Date of Incident: | |
| Incident (IR1) ID: | |
| Grade of Incident: | |
| If Incident involved the death of a service user, was the coroner informed: | |
| Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)* | |
| Brief Summary of Incident: | |
| Summary of discussions re SAI / RCA/ Major / Catastrophic incident review: | |
| Decision on Level Review Type AND rationale for this: | |
| Nominated Review Team: *(Consider need / benefit of independent external expertise)* | |

| | |
|---|---|
| Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing? | ☐ YES ☐ NO |
| Contact for service user and / or designated relatives / carers:*(Either Lead Professional or Chair of Review)* | |
| Date and by whom service user and / or designated relatives / carers informed of review taking place:*(If there is an exceptional case where this is inappropriate rationale must be documented):* | |
| If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review : | |
| *(Corporate Governance Office / Litigation to complete)* Date and by whom Trust Litigation Dept informed: | |
| Does this incident meet the DHSSPS Early Alert Criteria including rationale: | |
| **POST REVIEW COMPLETION:** Date and by whom and how Review is shared with the service user and / or designated relatives / carers: *(In exceptional cases where this is inappropriate rationale should be documented)* | |
| Date and by whom and how Review is shared with the Coroner: | |

***This form once completed, regardless of Outcome, should be shared with the AD of Governance via Corporate Governance Office***

## *APPENDIX 7:*

### *Incident Review Guidance*

A key principle of the CSC governance framework is that incidents are reviewed and analysed to find out what can be done to prevent their recurrence. Therefore, a key principle of the incident review is that when an incident occurs the important issue is not „who is to blame for the incident?" but „how and why did it occur?

Although there will be some incidents which require review using methodologies as contained within e.g. individual agency reviews, adult safeguarding reviews, health and safety reviews, the majority of incidents can be reviewed using the National Patient Safety Agency (NPSA) Root Cause Analysis Tools. Nonetheless all incident reviews will ask the core questions of:

- What actually happened? *(The facts)*
- How did what happened vary from what should have or was expected to happen?
- Why did it happen in that way? *(The causes)*
- Is there any learning to share with the team or wider Trust services to minimise the likelihood of recurrence?

The above can be expanded to include where appropriate:

- Was there anything about the task/procedure involved?
- Was there anything about the way that the team works together or perceives each other's roles?
- Was there anything about the equipment involved?
- Was there anything related to the working environment or conditions of work?
- Was there anything about the training and education of the staff in relation to their competence to:-

  **(a)** provide the care/service required, and

**(b)** manage the incident when it occurred?

- Was there anything relating to communication systems between individual members of the team, departments, or electronic communications, for example, test results via computer?
- Was there anything about the availability, or quality of any guidance notes, polices or procedures?
- Was there anything about the Trust"s strategy, its strategic objectives and priorities?

Further detailed advice in relation to incident review techniques including Root Cause Analysis (RCA) Methodologies can be sought from the Directorate Governance Coordinators or visiting the NPSA RCA toolkit resource here.

## *APPENDIX 8*

### *Brief Guidance on the Role and Responsibilities of an SAI Review Chairperson*

The Chairperson leads an SAI Review Team. The Chairperson's main aim is to ensure that the SAI Review Team explores in an open, fair and critical manner the circumstances surrounding the incident, and establishes what, if any, lessons arising need to be incorporated into practice in order to prevent or minimise the likelihood of reoccurrence of the incident. The review should identify not only areas for improvement but also areas of good practice. The Chairperson will be assisted by the relevant Governance Coordinator or their nominated review facilitator.

**The main responsibilities of the review Chairperson are:**

**1.0 Prior to the Review**

1.1 Reviewing all relevant case notes, statements, synopsis of care reports and relevant sections of policies and procedures related to the incident to enable them to lead the initial meeting of the Review Team.

1.2 In conjunction with the Governance Coordinator, prepare a draft Terms of Reference for consideration by the Review Team at the initial meeting.

**2.0 During the Review**

2.1 Ensuring that all attendees at the review are introduced to each other and are aware of their role.

2.2 Facilitating a process that is conducive to learning and analysis without interference from personal disagreements, criticisms, perceptions or dissatisfaction.

2.3 Ensuring that the review is open, fair and participative. That if required appropriate members of the Review Team are delegated to meet members of the service team involved in the incident to obtain clarity on events.

2.4 Chairing the Review in a manner which ensures that: all salient facts, a clear chronology of events and interventions, areas of strength/weakness of policy or practice are identified and clear action plans are formulated and agreed.

2.5 Ensuring that Review Team members, service teams and patients / clients and /or relatives and carers are kept informed with respect to the review and its progress as required. See **Appendix 4** and **section 5.**

## 3.0 Following the Review

3.1 Liaising with the Governance Coordinator to ensure that a comprehensive report with recommendations / action points and timescales (where relevant) is produced and agreed ensuring that the service team involved in the incident are given an opportunity to check the information they have contributed to the report for factual accuracy. The Chairperson should sign off/approve the report prior to it being sent to the AMD /Assistant Director / Director.

3.2 If there are queries / comments raised by the AMD / Assistant Director/ Director following their review of the draft report, the Chair should consider these and reconvene the Review Team if necessary to address same.

3.3 Report practices, systems or other issues which the Review Team feel require immediate attention to the relevant Assistant Director, Head of Service and AMD, where appropriate.

3.4 If the Chairperson is the nominated contact with the patient/client and or family/ carers, they will be responsible for sharing the facts/ recommendations and action plan with them as outlined in **Appendix 4.**

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Minutes of a meeting of the Board of Directors held on Thursday, 24th February 2011 at 9.30 a.m. in the Boardroom, Craigavon Area Hospital

## PRESENT:

Mrs E Mahood, Non Executive Director (Interim Chairman)
Mrs M McAlinden, Chief Executive
Mrs D Blakely, Non Executive Director
Mrs R Brownlee, Non Executive Director
Mr E Graham, Non Executive Director
Mr A Joynes, Non Executive Director
Mrs H Kelly, Non Executive Director
Dr R Mullan, Non Executive Director
Mr B Dornan, Director of Children and Young People's Services/Executive Director of Social Work
Dr P Loughran, Medical Director
Mr S McNally, Director of Finance and Procurement

## IN ATTENDANCE:

Mrs P Clarke, Director of Performance and Reform
Mr K Donaghy, Director of Human Resources and Organisational Development
Dr G Rankin, Director of Acute Services
Mrs J Holmes, Board Secretary
Mrs R Rogers, Head of Communications
Mrs S Cunningham, Area Manager, Patient and Client Council
Mrs S Judt, Committee Secretary (Minutes)

## 1. CHAIRMAN'S WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting. A particular welcome was extended to Councillor George Savage. Apologies were recorded from Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing and Mrs A McVeigh, Acting Director of Older People and Primary Care Services.

## 2. MINUTES OF MEETING HELD ON 27TH JANUARY 2011

The Minutes of the meeting held on 27th January 2011 were agreed as an accurate record and duly signed by the Chairman.

## 3. MATTERS ARISING FROM PREVIOUS MEETING

### i) Communicating with patients with sight difficulties

In response to a query raised by Personal Information redacted by USI at the previous meeting, the Chief Executive referred members to a briefing in their papers. This outlines the various methods used by both the Southern Trust and by Trusts regionally to communicate with people with sight difficulties. Personal Information redacted by USI welcomed this information and stated that she was encouraged that much work is being done locally, as well as regionally, to improve access for people with sight difficulties. Mrs Blakely welcomed the establishment of the Access Working Group within the Trust and encouraged voluntary sector involvement and advocacy input into this group. Mrs Mahood referred to the RQIA Review of Sensory Services in N. Ireland and the recent Trust inspection. She advised that initial feedback was positive. Mr Graham commended the Trust on this inspection and made reference to the fact that this highlighted that there are a small number of patients who are both blind and deaf in the Trust area and asked how the needs of this particular group will be addressed. The Chief Executive advised that this recommendation will be followed through in the Trust's action plan.

## 4. STRATEGIC ISSUES

### i) Update on Changing for Children

Mrs Clarke advised that discussions are ongoing with the Commissioner to progress the proposals and these have been productive. However, in the context of the draft Budget decision, there are affordability issues around both revenue and capital requirements.

Agreement has been reached to explore how revenue investment could be progressed, alongside the business case process, to secure capital funding. Mr Dornan spoke of the engagement with senior professional staff at the HSCB in terms of ambulatory paediatric care.

ii) **Trust response to Budget consultation (ST 297/11)**

Mr McNally presented the Trust's response to the draft Budget for 2011-2015. He stated that the proposed settlement represents a significant challenge, with a £828m gap over the four-year period and a £346m gap in 2011/12. Mrs Clarke stated that the demand for Trust services is continuing to grow and the Trust provided examples of this in its response. The Trust has demonstrated, throughout the current CSR period, that it is one of the two most efficient providers in Northern Ireland and, in light of this, the proposed settlement is particularly challenging. The themes identified by the Trust are common with other organisations who have responded. Members endorsed the response and expressed concern at the extreme challenges. Following Trust Board approval, the response will be shared with staff. Mr Joynes referred to the funding pressures on health and social care and the recent media coverage in relation to the Budget debate.

**The Board of Directors approved the Trust's response to the Budget consultation (ST 297/11)**

5. **PATIENT/CLIENT SAFETY AND QUALITY OF CARE**

i) **Unallocated Child Care Cases**

Mr Dornan reported that referrals were now at a consistent level, of around 800 in January 2011, as in previous years. He explained that 120 referrals represents 3 days flow into the Gateway system. Mr Dornan provided assurance that there continue to be no unallocated Child Protection Cases and that Heads of Service, the APSW and Team Managers

regularly monitor, review and prioritise unallocated cases for allocation. The situation is closely monitored and he emphasised that it is imperative that these services do not take a service reduction.

Mr Joynes queried the term 'unallocated child care cases' and asked if the report came under scrutiny by the media, would it be understood without accompanying narrative. He stated that he felt narrative would add more measure and balance to the figures. Mr Dornan stated that this terminology was adopted regionally, but he agreed to raise Mr Joynes' comments at the next Association of Directors meeting.

Mrs Blakely referred to the number of internal movements of staff with a total of 22 staff moving between teams and sought assurance that there is consistency in terms of supervision and record keeping. Mr Dornan advised that there are very clear protocols for supervision and professional support and a new supervision policy has been introduced. He went on to say that Senior Social Work staff undertake file audits and Team Leaders are aware of consistency of case workload management. He also outlined the various ways senior social work staff strengthen the system.

In terms of workforce, an action plan in relation to sickness and absenteeism will be provided at the Trust Board meeting in April 2011.

ii) **X-Ray issue**

Mrs Mahood referred to the intense scrutiny by the media the previous week and she welcomed Dr S Hall, Consultant Radiologist/Associate Medical Director and Mr S O'Reilly, Consultant in Emergency Medicine, Craigavon Area Hospital, to the meeting to discuss the issues raised.

Dr Hall began by welcoming the opportunity to address the Board on radiology services and specifically on the processes for reporting on plain film x-rays. He

outlined the comprehensive imaging service that is run on multiple sites across the Trust area. This includes MRI, CT scans, ultrasound, nuclear medicine, vascular and non-vascular interventional procedures, endoscopic ultrasound, as well as involvement in cancer diagnostics and colonic cancer stenting. The total number of these radiological diagnostic tests is approximately 250,000 every year of which around 170,000 are plain film x-rays. All of these vital diagnostic tests, with the exception of certain categories of plain film x-rays are reported on only by the radiology staff. The majority of plain film x-rays are reported on by consultant radiologists including the following

All GP plain film x-ray requests
All outpatient plain film x-ray requests
All inpatient and A&E Chest x-rays
All Minor Injury Unit Plain Films
All under 16 plain film x-ray requests

The Trust practice is carried out in accordance with guidance from the Royal College of Radiologists, recognising that the skills of specialist radiology staff should be directed to the more complex diagnostic services. These arrangements comply with the Trust's obligations under the IRMER reporting regulations.

Dr Hall advised that the Trust introduced NIPACS in April 2010 and took this opportunity to review which x-rays were reported by consultant radiologist. It was agreed that the Radiology Department should read all chest x-rays and implementing this change required additional capacity.

Dr Hall assured members that at all times, the management of the x-ray workload is directed to ensure that patient safety is paramount. There are currently routine plain film x-rays that have been viewed by the referring clinician, but not formally reported on by a radiologist although a radiology opinion is available on request. As there is insufficient capacity within the Trust's Radiology Department to

manage the current level of demand within a 28 day reporting timeframe, the Trust has secured additional in-house capacity and a contract with the independent sector with the aim of reporting all outstanding plain films within 28 days by 28th February 2011.

Dr Hall advised of the limited availability of radiologists both in Northern Ireland and beyond. Dr Mullan expressed his concern at the shortage of radiologists and asked what action the Trust could take to address this. Dr Hall suggested the progression of skill mix and the use of independent sector in the short term. Dr Rankin augmented Dr Hall's response regarding skills mix.

Mrs Blakely stated that she was reassured by the governance and risk management approach taken by the Trust and the recognition of what the gaps/risks are. Mr Graham expressed his concern at the damage done to the Trust's reputation by the negative media coverage and queried how the Trust can rebuild public confidence.

The Chief Executive stated that an important issue for the Trust is how IRMER regulations are applied as there are varying practices across Trusts in N. Ireland and the United Kingdom.

Mrs Cunningham stated that from a public perspective, there is a good level of public confidence in the safety of care provided by the Trust and it was important to get the key messages across to counter the negative reporting. She added that the role of GPs is key. The Chief Executive spoke of the support from Dr P Beckett, Associate Medical Director for Primary Care and the wider GP community. Dr Loughran stated that it was important to note that there were no errors or omissions of care. In terms of staff morale, the Chief Executive advised that she had issued a global e-mail to staff and had received positive feedback.

Mr O'Reilly endorsed Dr Hall's comments and explained x-ray reporting within the A&E Department at Craigavon and Daisy Hill Hospitals. He referred to the serious allegations made by an anonymous former employee about how x-ray reports are managed within the Department and assured the Board that there was absolutely no substance to any of these allegations. Mr O'Reilly described the quality assurance processes in A&E and he reassured members that the checking and reporting systems carried out by senior clinical staff are robust to ensure patient safety.

Dr Rankin provided an update on outpatient review delays. She stated that there has been a capacity gap over recent years with increased demand and the delivery of access targets. Whilst the vast majority of review patients are seen within the timescale identified for their review, there has been an increase in the numbers of patients whose review appointment has gone past the date they were due to be seen. Dr Rankin assured members that this situation is being actively managed, with actions progressed over the past 12 months and a process has been put in place whereby each speciality determines their clinical priorities.

Dr Rankin advised that the Trust has established a process to particularly address routine review patients waiting for the longest periods.

Mrs Mahood asked about the allegation about the Trust prioritising patients in alphabetical order. In response, Dr Rankin assured members that the Trust books outpatient review patients on the basis of clinical priority and the urgency of the individual patient's condition. Patients are assessed by the clinical teams and their review appointments are allocated on this basis. Within the system, patients requiring a review within 6 weeks will be seen first. Patients who may be on, for instance, drug regimes and are required to be seen within a particular timeframe, will be allocated review appointments next.

The remaining non-urgent/routine patients are then selected for booking in chronological (date) order and then by alphabetical order.

The Chief Executive spoke of the concerns raised publically by staff and stated that the Trust will seek to learn from what had happened and will work to improve understanding of the channels of communication for all staff. Mr Donaghy referred members to the Trust's Whistleblowing Policy and advised that there are a number of ways for staff to raise concerns. The Chief Executive advised that some staff choose to raise their concerns anonymously and this makes it difficult to investigate and resolve the matter. Sufficient information is required in order for the Trust to be able to respond and this message should be reinforced in the revised policy. Mr Joynes suggested the inclusion of a flow chart to demonstrate the mechanisms within the Trust for raising concerns.

In response to a question from Mrs Blakely as to how the Trust will communicate to staff how they can raise concerns, the Chief Executive advised that a short briefing note is being prepared and this will be made available to staff via the next staff e-brief. Mrs Kelly asked how this information would be disseminated to domiciliary care workers. The Chief Executive advised that this would be done through the existing line management arrangements. Mrs Brownlee raised the importance of staff feeling that their concerns are being listened to and that they are supported. She reported that the Patient and Client Experience Committee is discussing how the Trust could capture 'soft information' given by either staff members, service users etc. who do not plan to go through the formal complaints route. Mr Joynes suggested that the Board consider nominating a Non Executive Director to act as a named contact and their details included in the Whistleblowing Policy. Mr Donaghy stated that the Whistleblowing Policy is due for review in March 2011 and members were asked to forward any additional comments to Mr Donaghy in advance of this date.

Members asked that the policy is presented to a future Board meeting.

Mrs Mahood asked Dr Loughran to provide assurance to members that the concerning issues raised in a letter from a number of medical staff to Dr Loughran in relation to x-rays were appropriately addressed. Dr Loughran confirmed that in discussion with Dr Hall and Dr Rankin at the time, he was assured that appropriate actions were being taken to ensure the clinical safety of the system.

Mrs Mahood, on behalf of the Non Executive Directors, thanked Dr Hall, Mr O'Reilly and Dr Loughran for volunteering to speak to the media on behalf of the Trust and for the work they did to allay public concern and maintain confidence in services. She paid tribute to the Chief Executive for her leadership, to the senior management team, to the communications team and to staff for their professionalism and their efforts to support the Chief Executive.

6. **OPERATIONAL PERFORMANCE**

i) **Performance Report (ST 298/11)**

Mrs Clarke presented the Corporate Performance Management report for January 2011 and the supplementary Corporate Performance Dashboard report. She summarised the key areas which continue to present challenges as follows:-

i) A&E – there is high pressure on the system, particularly in Craigavon Area Hospital, however it remains the highest performer in the region. Significant plans are in place to improve performance, pending Commissioner approval.

ii) The waiting time for AHP treatment has increased during January above the 9 week position. This is primarily attributable to orthoptics due to the inability to recruit suitably qualified personnel.

iii) Outpatient Review Backlog. As previously discussed, plans are in place to address the backlog across all specialties. A further breakdown of the figures will be provided in future dashboard reports.

Mrs Brownlee queried the access time for Neurology outpatients given recent media coverage of this issue. Mrs Clarke confirmed that the Trust's position was that Neurology patients would be seen within the 9 weeks by March 2011 with the current waiting time approximately 20 weeks. In terms of the access position for all inpatient, day case and outpatient targets, Mrs Clarke advised that backstop positions have now been agreed with the HSCB and will be signed off this week.

**The Board of Directors approved the Performance Report (ST 298/11)**

ii) **Finance Report (ST 299/11)**

Mr McNally presented the Finance Report for approval. He advised that as at 31st January 2011, the Trust has generated a modest in-month surplus of £28k. He reminded members that as at the end of December 2010, the Trust was forecasting a year end deficit of £1.5m, based on expenditure trends to date and also in the knowledge that discretionary spend was being held back until the last few months of the financial year. He reported that the Trust has now received verbal confirmation that it will be receiving non-recurrent RRL support to cover this position and this funding, together with slippage on development allocations issued during January 2011, will allow the Trust to break-even in year.

In relation to the CSR efficiency target, a £8m underlying deficit remains which although a significant challenge, is a tremendous achievement. The Chairman acknowledged this achievement and paid tribute to staff.

**The Board of Directors approved the Finance Report (ST 299/11)**

iii) **Human Resources Report (ST 300/11)**

Mr Donaghy presented the Human Resources report and highlighted some of the key aspects. He advised that the report focuses on the NHS HR High Impact Change 'Promote Staff Health and Manage Sickness Absence.' The Chief Executive drew attention to Agenda for Change and the high number of outstanding leavers' arrears payments. In response, Mr Donaghy advised that there is a small team working on this backlog, but acknowledged that it is a slow process. An update on progress will be given at the next meeting. The Chief Executive advised that the CSR VER/VR funding comes to an end at the end of March 2011 with no indication of further funding.

**The Board of Directors approved the Human Resources Report (ST 300/11)**

7. **BOARD ASSURANCE FRAMEWORK (ST 301/11)**

The Chief Executive presented the updated Board Assurance Framework and associated Corporate Risk Register. She stated that the corporate risks are kept under regular review by the Senior Management Team and the Corporate Risk Register is reviewed by the Governance Committee on a quarterly basis. Members were advised of a recent Media request for a copy of the Trust's Corporate Risk Register. Mr Joynes suggested that the release of this information should be accompanied by a written narrative to provide context.

Mrs Holmes highlighted the changes to some of the strategic risks facing the Trust since the Framework was last presented to Trust Board in November 2010. Mrs Brownlee referred to the high risk in relation to the supervision/administration of medication by Domiciliary Care Workers and stated that she would welcome a report/update on the Trust's monitoring and supervision structures within Domiciliary Care. Directors then explained how they review their Directorate Risk Registers and Mrs Blakely stated that it would be useful to include narrative on the process. Mrs Holmes agreed to incorporate the changes suggested to the Corporate Risk Register before its release.

**The Board of Directors approved the Board Assurance Framework (ST 301/11)**

8. **IMAS REPORT AND PROGRESS UPDATE**

Dr Rankin presented the NHS Interim Management and Support (IMAS) Report. She advised that the Trust engaged with the IMAS team who provided support and expertise for ongoing service improvement initiatives in three key areas of work, namely:-

Urology Services
Elective Pathway, focusing on outpatient booking processes
Introduction of the Perfect Operating Theatre project

Members noted the progress update against action plans.

9. **BOARD REPORTS**

i) **Information Technology Annual Report 2010 and progress to date (ST 302/11)**

Mrs Clarke presented the Information Technology Annual Report which sets out the Trust's position with regard to IT Controls Assurance during the year 1st January 2010 to 31st December 2010. She summarised the key points and the actions taken to progress and improve the Trust's IT infrastructure during this year. In response to a query from Dr Mullan as to staff's awareness on their own responsibilities in

relation to I.T. security, data protection etc. Mrs Clarke advised that policies and procedures have been developed to provide guidance and direction to staff and are available on the Trust's Intranet and at staff induction training. An e-learning package, CETIS, is also available and is mandatory for all staff to complete. Staff were issued with a message from the Chief Executive some months ago on the importance of data security and a further e-mail to reinforce this message will be issued to staff next week.

**The Board of Directors approved the I.T. Annual Report 2010 (ST 302/11)**

10. **BOARD COMMITTEES**

i) **Governance Committee – Minutes of meeting held on 7th September 2010 (ST 303/11)**

Mrs Blakely presented the Minutes of the 7th September 2010 meeting for approval. Members were advised that the Assistant Director, Clinical and Social Care Governance, has now been appointed.

Recruitment of the 8b Directorate posts is underway.

**The Board of Directors approved the Governance Committee Minutes dated 7th September 2010 (ST 303/11)**

iii) **Endowments and Gifts Committee – Minutes of meeting held on 13th September 2010 (ST 304/11)**

Mrs Kelly presented the Minutes of the 13th September 2010 meeting for approval. She advised that she had attended three presentations recently where donations were made to the Trust and she spoke of the ongoing work to encourage and promote donations into a general fund.

The low uptake of the Trust's Gift Aid Scheme is also being addressed.

**The Board of Directors approved the Endowments and Gifts Committee Minutes dated 13th September 2010 (ST 304/11)**

iv) **Patient and Client Experience Committee – Minutes of meeting held on 16th September 2010 (ST 305/11)**

Mrs Brownlee presented the Minutes of the 16th September 2010 meeting for approval. She advised that the Committee had held a further meeting in February 2011 which was attended by a representative of the Patient Client Council Local Advisory Committee. At its next meeting in June 2011, the Committee will be provided with examples of where there has been learning from complaints.

**The Board of Directors approved the Patient and Client Experience Committee Minutes dated 16th September 2010 (ST 305/11)**

v) **Audit Committee – Minutes of meeting held on 14th October 2010 (ST 306/11)**

Mr Joynes presented the Minutes of the 14th October 2010 meeting. He advised that the Committee had held a further meeting in February 2011 when the Internal Audit of Income from Private Medical Practice was discussed. He asked Dr Loughran for his support in moving this forward. The two audits which were provided with limited assurance, namely Gifts and Hospitality and Fostering and Adoption Payments were followed up at the recent meeting. Mr Joynes suggested that it would be useful to have a representative from the Communications Team in attendance at Audit Committee meetings.

**The Board of Directors approved the Audit Committee Minutes dated 14th October 2010 (ST 306/11)**

11. **CHAIRMAN AND NON-EXECUTIVE DIRECTORS' BUSINESS**

A list of the Chairman's and Non Executive Directors' business was noted.

12. **INTERNAL VISITS - CHIEF EXECUTIVE**

A list of the Chief Executive's visits with Directors to meet with front line staff was noted.

13. **ANY OTHER BUSINESS**

i) The Interim Chairman informed Board members that Craigavon Area and Daisy Hill Hospitals have been designated 'Queen's University teaching hospitals.' In partnership with Queen's University Belfast, the designation specifically recognises the important contribution acute hospitals make in providing high quality clinical placements to medical students.

ii) The Board extended congratulations to the COPD team who have been shortlisted for an award at the 2011 Advancing Healthcare Awards Finals.

iii) **Regional Social Work Awards**

The Disability Service User Forum (Bannvale House) has been shortlisted in the first-ever Regional Social Work Awards which take place on Friday 25 February. The Forum has been entered in the Partnership Working category – one of four awards, three team awards and one for individuals.

***The next Board of Directors meeting will be held on Thursday, 21st April 2011 at 10.00 a.m. in the Boardroom, Craigavon Area Hospital***

Southern Health and Social Care Trust

# Minutes of a meeting of the Board of Directors held on Thursday, 29th April 2010 at 10.30 a.m. in the Boardroom, Craigavon Area Hospital

## PRESENT:

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

## IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources and Organisational Development
Dr G Rankin, Interim Director of Acute Services
Mrs A McVeigh, Acting Director of Older People and Primary Care Services
Mrs P Clarke, Acting Director of Performance and Reform
Mrs R Rogers, Head of Communications
Mrs S Cunningham, Southern Area Manager, Patient and Client Council
Mrs S Judt, Committee Secretary (Minutes)

## 1. CHAIRMAN'S WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting. There were no apologies.

## 2. MINUTES OF BOARD MEETING HELD ON 25TH MARCH 2010

The minutes of the meeting held on 25th March 2010 were agreed as an accurate record and duly signed by the Chairman.

## 3. MATTERS ARISING

### i) Strategic Action Plan for the promotion of Health and Wellbeing

Mrs McVeigh confirmed that the action plan has been updated to incorporate additional information as requested at the previous meeting.

## 4. STRATEGIC ISSUES

There were no strategic issues.

## 5. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

### i) Infection Control update

Dr Loughran presented the Public Health Agency's end of year report detailing both the Trust's and the Region's performance for MRSA, MSSA and C.difficile. Members noted the Trust's strong performance for MRSA and C.difficile. Dr Loughran advised that whilst the target for MSSA has not been achieved, the Trust has a comprehensive action plan in place. The region has decided not to set a target for MSSA for this year, however, the Trust will continue to monitor its performance internally.

Mr Joynes referred to the public perception of staff wearing uniforms outside the workplace. The Acting Chief Executive advised that there is no accepted evidence base to demonstrate an infection risk by staff wearing uniform outside the workplace, but acknowledged that public confidence in the HSC may be undermined. She advised that good practice guidelines are set out in the Trust's Uniform Policy as part of the Trust's commitment to strengthen infection control arrangements. She stated that substantial investment would be required to provide changing facilities for all uniformed staff.

In response to a question from Mrs Blakely in the context of record keeping and claims, Dr Loughran advised that there are currently no live claims in respect of patients who contracted a blood borne infection as a result of negligence. He confirmed that the Trust's ability to defend an accusation of negligence in respect of infection would, as in all other medical negligence cases, depend on our medical and laboratory records and the statements and evidence of staff.

ii) **Unallocated Child Care Cases**

Mr Dornan reported a significant increase in the volume of referrals into Gateway over the last four months and an increase in the number of unallocated cases from 100 as at 5th March 2010 to 170 as at 16th April 2010. Mr Dornan stated that whilst the system is under pressure, due to capacity issues relevant to this increased demand and staff vacancies, the situation is being managed including staff being redeployed to teams with higher numbers of unallocated cases. He provided assurance that Heads of Service, the APSW for Gateway and Team Managers regularly monitor, review and prioritise unallocated cases for allocation. He concluded by advising that easement in terms of staffing is expected in May/June 2010.

Members asked a number of questions to which Mr Dornan responded by outlining the process for the assessment of referrals, the robustness and careful scrutiny of the record keeping system, the benefits of the UNOCINI system, improved supervision arrangements and the audit work undertaken by the Governance team to ensure appropriate handling of cases.

iii) **Corporate PPI Action Plan and Progress Report 2009/2010 (ST 231/10)**

Mrs McVeigh presented the report which provides an overview of actions identified to enhance personal and public involvement within the Trust and the progress made against those actions for 2009/10. Mr Joynes asked about definitive timescales for work in progress to which Mrs McVeigh advised that specific dates will be inserted as the plan is reviewed and updated during the year. Mrs Brownlee stated that personal and public involvement is a substantive item on the Patient Client Experience Committee's agenda and she commended Mrs McVeigh and the Trust staff

involved on the significant progress they have achieved in this work to date.

**The Board of Directors approved the Corporate PPI Action Plan and Progress Report 2009/2010 (ST 231/10)**

iv) **Presentation: Clinical Indicators - Cardiology**

The Chairman welcomed Dr McEneaney, Consultant Cardiologist to the meeting for a presentation on Clinical Governance within the Cardiology Department. Dr McEneaney outlined the Cardiology Governance areas, one of which is the Patient Safety programme and he spoke of progress with the Acute Myocardial Infarction (AMI) and Cardiac Arrest bundles. He advised that the Southern Trust is the only Trust in Northern Ireland participating in the audit of the AMI bundle and the aim is to achieve 95% of bundle measures. Dr McEneaney stated that good progress is being made with a slight underperformance in thrombolysis being administered within 30 minutes from door to needle and in PCI (stent insertion) within 90 minutes. Mr McEneaney advised of a working group comprising Cardiology and A&E representatives looking at the patient's journey from the door of the hospital.

The Chairman thanked Dr McEneaney for a very informative presentation.

6. **OPERATIONAL PERFORMANCE**

i) **Performance Report (ST 232/10)**

Mrs Clarke presented the report summarising the Trust's performance in March 2010 against Priority for Action (PfA) 2009/10 standards and targets and key performance indicators of corporate performance. Mrs Clarke noted the Trust's strong performance advising of an 80% achievement rate across the range of targets, with only 9 out of almost 100 targets highlighted as red status. She drew members' attention to the risk areas as follows:-

- Diagnostic reporting urgent within 2 days: Progress has been made (82% for imaging within 2 days and 91% for imaging within 4 weeks) and the benefit of the implementation of NIPACS will be seen later in the year;
- IP/OP Access target: Agreement had been reached with the

HSCB that particular speciality areas (Urology, Endoscopy, T&O and MRI services) would not meet the 9 and 13 week targets, but would not exceed 17 weeks and this was largely achieved;
- Fractures: This is a capacity issue and the Trust is working with Commissioners to finalise agreement on investment for trauma operating sessions 7 days per week;
- Care leavers: 51% against a 71% target. The appointment of an Employability Worker will impact on this target over the coming year. The Acting Chief Executive referred to the Awards Ceremony within the Trust which recognises the successes of young people in care and she commented on the diversity of attainments, not all of which would be reflected in this performance measure. Mrs Mahood paid tribute to Trust staff for their efforts in making this event so successful;
- Renal dialysis by fistula: achieved 40% against a 60% target with work underway regionally to reassess this target;
- Family Support Pathway: Measures are currently being implemented to address capacity issues relative to staff vacancies.

Mr Joynes asked if the KPIs were being looked at sensibly in light of financial predictions. The Acting Chief Executive stated that some of the proposed targets for next year may be unaffordable and the Trust is putting that commentary back into the system. There are a number of KPIs that relate to the safety and quality of services and those are being as closely monitored as the access targets.

**The Board of Directors approved the Performance Report (ST 232/10)**

ii) **Human Resources Report (ST 233/10)**

Mr K Donaghy presented the Human Resources report, together with the Employment Law and Case Management Annual Report for 2009/10. He highlighted key aspects as follows:-

- Staff turnover rate of 3.4%;
- Sick leave rate of 5.06% at end January 2010;
- Steady progress continues to be made in relation to Agenda for Change reviews with 361 reviews cleared to date. The anticipated completion date for clearance of all reviews is 30th September 2010.

Mr Donaghy referred members to the information on cases on a range of employee relations issues as detailed in the Employment Law and Case Management Annual Report for 2009/10. The management of sickness absence was discussed and Mrs Blakely asked about the quality of sickness reporting. Mr Donaghy responded by acknowledging that there are areas for improvement, but he felt that with the actions the Trust is taking, including extensive training to managers, the quality of sickness absence reporting will continue to improve.

Mr Joynes stated that he would welcome information on workforce issues in the report such as employee relations/engagement etc. The Chairman asked that Mr Joynes and Mr Donaghy discuss this further outside the meeting.

**The Board of Directors approved the Human Resources Report (ST 233/10)**

7. **DRAFT STATEMENT ON INTERNAL CONTROL (ST 234/10)**

Mr McNally presented the Statement of Internal Control in draft format, pending the finalisation of some outstanding reports from Internal Audit. Mr Joynes drew attention to the fact that out of 33 Internal Audit reports, 8 received limited assurance. Mr McNally advised that discussions are underway with Internal Audit as to the most efficient and effective way of monitoring implementation of Internal Audit recommendations. The Senior Management Team will monitor the situation and a list of outstanding recommendations will be maintained and considered at each Audit Committee.

Mrs Mahood highlighted her concern that in some instances, Internal Audit recommendations were not being fully implemented and examples of good practice were not been shared. She referred, in particular, to Supported Living facilities. Mr Rice stated that this is a complex area advising that advice has been sought from the RQIA in relation to the obligations of the Trust. Mr Rice reported that he has meetings arranged with Finance and Audit Departments to explore the issues raised and resolve the current challenges in the system.

Mrs Mahood welcomed the involvement of the SMT in the process of following up Internal Audit recommendations. The Chairman stated that the Chair of the Audit Committee will report on progress to the Board of Directors on a six-monthly basis.

**The Board of Directors approved the draft Statement of Internal Control (ST 234/10)**

8. **BOARD COMMITTEES**

i) **Audit Committee – Minutes of meetings held on 10th December 2009 and 18th February 2010 (ST 235/10 and ST 236/10)**

Mrs Mahood presented the Minutes of the above meetings for approval and highlighted the main discussion points. She noted that the Committee has conducted a self assessment and produced a corresponding action plan.

**The Board of Directors approved the Minutes of the Audit Committee meetings (ST 235/10 and ST 236/10)**

9. **SEALED DOCUMENTS**

The Chairman advised that the provision of Consultancy Services in connection with Minor Works Schemes had been sealed in the name of the Trust.

10. **CHAIRMAN'S AND NON-EXECUTIVE DIRECTORS' BUSINESS**

A list of the Chairman's and Non Executive Directors' business was noted.

11. **ANY OTHER BUSINESS**

11.1 **RCN CNO Award for Patient Safety Finalist**

The Board of Directors congratulated Ruth Carroll who has reached the final for the above award for the work the Dungannon Health Visiting Team has undertaken with women from BME communities in relation to domestic violence.

***The next Board of Directors meeting will be held on Thursday, 27th May 2010 at 10.00 a.m. in Dungannon Council Offices***

**SIGNED:** _____

**DATED:** _____

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

# GOVERNANCE COMMITTEE

**Minutes of a meeting of the Governance Committee of the Southern Health and Social Care Trust held on Tuesday, 6th December 2011 at 9.30 a.m. in the Boardroom, Trust Headquarters**

**PRESENT**:

Dr R Mullan, Non Executive Director (Chairman)
Mr R Alexander, Non Executive Director
Mr E Graham, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs S Rooney, Non Executive Director

**IN ATTENDANCE**:

Mrs M McAlinden, Chief Executive
Mrs P Clarke, Director of Performance and Reform
Mrs A McVeigh, Director of Older People and Primary Care Services
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Dr G Rankin, Director of Acute Services
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr J Simpson, Medical Director
Mrs D Burns, Assistant Director, Clinical and Social Care Governance
Dr Boyce, Head of Pharmaceutical Services
Mrs S Judt, Committee Secretary (Minutes)

1. **APOLOGIES**

Apologies were recorded from Mrs D Blakely, Non Executive Director, Mrs H Kelly, Non Executive Director, Mr K Donaghy, Director of Human Resources and Organisational Development and Mr S McNally, Director of Finance and Procurement.

## 2. MINUTES OF MEETING HELD ON 6th SEPTEMBER 2011

The Minutes of the meeting held on 6th September 2011 were agreed as an accurate record and duly signed by the Chairman.

## 3. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates from Directors to address those matters arising from the previous meeting. In particular, the following issues were raised:-

**Grading of Incidents:** In the absence of Mr McNally, Mrs McAlinden advised that the Audit Committee had considered this area as a potential Internal Audit assignment at its recent meeting. At that meeting, it was noted that Internal Audit will not challenge clinical judgement, but will review the process and make comments on i) getting the grading done at source and ii) checking that the regional guidance re grading is applied. Internal Audit will liaise with Mrs D Burns in terms of this audit assignment.

**Review of Trust Litigation systems and processes.** In response to a query from Mrs Rooney, Dr Simpson stated that a progress update will be brought to the Governance Committee meeting on 7th February 2012.

***Action: Dr Simpson***

## 4. CORPORATE RISK REGISTER

Mrs McAlinden presented the Corporate Risk Register and advised that this document was most recently reviewed and updated by SMT Governance on 23rd November 2011. She stated that there are currently 19 risk areas on the Corporate Risk Register, 4 new risks having been added and 4 removed since the previous Governance Committee meeting.

Mrs McAlinden highlighted the 6 high risk areas facing the organisation and provided a summary of the actions being taken to mitigate the risks.

Mrs McAlinden advised that issues for further consideration at the next SMT Governance will include:-

- Impact of the Review of Health and Social Care
- Ongoing threat of Industrial Action
- RQIA Phase II Radiology Review
- RQIA Review of Under 18s in Adult Wards

Mrs McAlinden reminded members of the discussion at the recent Board Development Day on risk appetite and the areas to be captured on the Corporate Risk Register. She welcomed feedback from the Governance Committee on the Corporate Risk Register and the following comments/suggestions were made which will be taken on board:-

- A more detailed summary of the 'red' risks
- Use of abbreviations to be avoided
- Timescales for action to be included as required

5. **MEDICINES GOVERNANCE REPORT**

Dr Boyce presented the Medicines Governance Report for the second quarter of 2011/12 and highlighted the key aspects as follows:-

i. 230 medication incidents were reported during this period. The average number of reported medication incidents each month was 76, representing an increase from 64 per month in the previous quarter. This remains less than the highest average of 114 reports per month achieved during 2008/09. Dr Boyce stated that it was encouraging to note the increase in the reporting of medication incidents and that none had a major or catastrophic impact on the patient.

ii. Work on the Medicines Management procedures and guidelines for Domiciliary Care, Day Care and Supported Living continues. Mrs McAlinden noted that medicines management in domiciliary care remains on the Corporate Risk Register as the Trust is not fully compliant with the RQIA recommendations.

Mr Rice outlined the risk management approaches in place to mitigate risk and advised that issues with achievability of compliance have been raised at a regional level.
Mrs McAlinden asked that all reports to Governance Committee reference links to the Corporate Risk Register, where appropriate.

iii. Members noted the information on C.difficile related antibiotic usage and the good management of broad spectrum antibiotics.

Mrs Mahood raised the Audit Committee's concern at the Priority 1 finding in the Internal Audit assignment on Medicines Management. Due to the exceptionally high number of staff on maternity leave (15 out of 36 Pharmacists in Craigavon Area Hospital for a short period), the frequency of stock checks performed at Craigavon Area Hospital Pharmacy was not as per Trust's procedures. Dr Rankin acknowledged that the high number of staff on maternity leave in Pharmacy had resulted in a reduced service, but that the situation had much improved. She assured members that the situation is regularly reviewed with updates provided to the Senior Management Team.

Dr Rankin advised that a considerable amount of work is ongoing across Directorates on the Trust wide audit of omitted and delayed medicines. The audit results and associated action plan will be brought to a future Governance Committee meeting.

***Action: Dr Rankin***

6. **MEDICAL DIRECTOR REPORT**

Dr Simpson presented his report which provided a progress update on the key issues within the Medical Director's area of responsibility.

- **Junior Doctors Mandatory Training Competencies**

Concern was expressed that some junior doctors may not achieve some of the necessary competencies for working on wards and it

was felt that greater emphasis should be placed on ensuring that junior doctors attain all the required competencies. Dr Mullan undertook to raise this matter at the next Medical Education Committee meeting.

***Action: Dr Mullan***

- **PMETB/GMC Survey 2011**

  A report on the outcomes of the survey will be brought to the Governance Committee on 7th February 2012.

  ***Action: Dr Simpson***

- **HCAI**

  There have been 25 cases of C.difficile infections to date, against a PfA target of 22. Dr Simpson referred to the increased number of patients with Norovirus admitted to Craigavon Area Hospital in September 2011 and outlined the measures put in place.

  At this point, Dr Rankin updated on the Trust's performance on stroke lysis. She stated that the Trust is performing well, however, there are still issues about patients recognising they have a stroke, NIAS recognising this and acute services investigating and lysing within the 60 minute standard given the travel distances.

7. **MORTALITY REPORTS**

Dr Simpson presented the mortality reports for the periods July – September 2010 and October – December 2010. He stated that risk adjusted mortality is dependent on the completeness and depth of coding and the reports are run in arrears to reflect the almost complete coding for the periods, therefore improving the accuracy.

Dr Simpson advised that Hospital Standardised Mortality Ratios (HSMR) are an indicator of healthcare quality and trigger points for further investigation have been agreed. During the period July – December 2010, there were triggers in a number of specialties which required further analysis. This analysis has not raised any care

errors or omissions for the October – December data. There are ongoing reviews of deaths in colorectal and general surgery for the July – September period.

Mrs McAlinden and Dr Simpson are currently reviewing the format of these reports to make them more streamlined in future.

8. **MEDICAL APPRAISAL ANNUAL REPORT**

Dr Simpson spoke to the annual report on appraisals for the 2009 appraisal year. This demonstrates that 98% of Consultants; 78% of Locum Consultants and 79% of Speciality Grade Doctors have been appraised Trust wide.

Dr Simpson advised that during 2010/11, the Trust participated in the RQIA Review of Readiness for Revalidation and he referred members to the report and associated action plan in their papers.

9. **UPDATE ON CLINICAL AND SOCIAL CARE GOVERNANCE (C&SCG) REVIEW IMPLEMENTATION PLAN**

Mrs Burns provided a synopsis of progress on the Implementation Plan. She advised that in terms of populating the agreed C&SCG structure, all aspects have been completed with the exception of the Directorate Lead AHP posts. The pool for these posts has now been agreed and it is estimated that this will be completed by the end of January 2012. There was discussion on the 1 year Governance Training Officer post. Mrs Burns advised that this appointment will be progressed once the new systems and processes have been established. She envisaged a start date of 1st April 2012. Dr Mullan suggested that training could be delivered on an ad hoc basis and Mrs Burns agreed to consider this suggestion.

Mrs Burns informed members that the first meeting of the C&SCG Working Body took place on 18th November 2011. At that meeting, the group agreed its terms of reference and remit. She also advised that the review and redesign of the Morbidity and Mortality (M&M) meetings across the organisation has been completed. Mrs Mahood asked how the Governance Committee would be kept updated on progress of the M&M process. Mrs McAlinden stated that the

assurance for the Governance Committee is that a robust M&M process is in place and any major risks/issues to patient safety will be brought to the attention of the Governance Committee via the Corporate Risk Register. She agreed to discuss with Dr Simpson an integrated safety and quality report which would include the M&M process.

It was agreed that a copy of the review of the M&M process would be forwarded to Mrs Rooney.

***Action: Mrs Burns***

10. **PRESENTATION ON DATIX WEB**

Ms Joanne McEvoy, Project Manager, attended the meeting and gave a short demonstration on datix web for incident management. Members welcomed this very informative presentation.

11. **INCIDENTS AND COMPLAINTS MANAGEMENT REPORT AND UPDATE ON OMBUDSMAN CASES**

Mrs Burns presented the above-named report for the period July – September 2011. She noted the considerable progress made on the grading of incidents with no ungraded incidents in the period. Mrs Burns drew members' attention to the detail provided on catastrophic incidents as requested at the previous meeting.

Mrs Burns referred members to the ongoing work on falls and the work being taken forward on the Trust Falls Strategy in particular.

The information on complaints was discussed. As requested at the previous meeting, Mrs Burns provided information on staff attitude and behaviour which included initiatives being taken forward in the Older People and Primary Care Directorate . She stated that staff attitude and behavior is an area of focus by the Patient and Client Experience Committee.

Members discussed the summary of cases with the Ombudsman, together with a summary of the outcomes for the period. Mrs Burns reported that four cases had been closed by the Ombudsman in the

period and the Trust had been instructed to pay consolatory payments in respect of two of these cases.

12. **SERIOUS ADVERSE INCIDENTS REPORT FOR THE PERIOD 1.7.2011 – 30.9.2011**

Mrs Burns presented a summary of Serious Adverse Incidents reported during the above-name period, together with a summary of those that remain open from 1st April 2007 to 30th September 2011.

13. **10 ELEMENTS OF BOARD TO WARD ASSURANCE ON HEALTHCARE ASSOCIATED INFECTIONS**

Dr Simpson presented a compliance paper and explained that the '10 Elements' are statements describing infection prevention and control (IPC) in a high performing Trust and are intended as an aide-memoire to help Non Executive Directors focus on key aspects of IPC in order to strengthen board to ward assurance. He stated that the Trust is currently compliant with 6 out of the 10 elements and members discussed the Trust's position.

14. **UPDATE ON BUSINESS CONTINUITY PLANNING**

Dr Simpson provided an update on business continuity planning. He advised that the Trust has engaged a business continuity consultancy support and is recruiting a temporary business continuity manager to take forward this work. He went on to advise that a number of key milestones will be met by March 2012 including the development of a Corporate Business Plan.

15. **FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REQUESTS – SUMMARY REPORT FOR THE PERIOD JULY – SEPTEMBER 2011**

Mrs Clarke presented the summary report for the period 1st July – 30th September 2011. A total of 56 requests were responded to in this period and of these, 35 were processed within the 20 day deadline and 21 processed outside of the 20 day deadline.

Mrs McAlinden noted that the majority of requests were received from members of the public, businesses and the media. Details of the individual requests for information are included in the report.

16. **RQIA REVIEWS STATUS UPDATE**

Members noted the progress update in their papers. Mrs McAlinden stated that since the previous Governance Committee meeting, there has been a review of mixed gender accommodation in acute wards and a review of care for under 18s on adult acute wards. Both of these inspection reports are awaited.

17. **MINUTES OF ACCOUNTABILITY REVIEW MEETING**

The minutes of the Trust's Year End Performance and Accountability Review Meeting 2010/2011 were noted.

18. **EQUALITY SCHEME APPROVAL**

Members noted the content of a letter from the Equality Commission dated 14 September 2011 formally approving the Trust's Equality Scheme.

19. **UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE**

Mr Graham updated members on a meeting of the Patient and Client Experience Committee held on 1st December 2011. He spoke of good participation by members and user representatives at that meeting. It was noted that complaints are monitored through this Committee to ensure that processes are in place and working well and that learning from complaints is taken on board and shared across the organisation. As there is currently duplication of complaints information provided to the Governance Committee, Mrs McAlinden suggested that assurance on complaints remain the remit of the Patient and Client Experience Committee and issues regarding the complaints process and systems reported to the Governance Committee by exception only.

Mr Graham undertook to raise this suggestion at the next Patient and Client Experience Committee.

***Action: Mr Graham***

20. **UPDATE FROM TRUST LEGIONELLA CONTROL GROUP**

Mrs Clarke presented a briefing paper on the management of Legionella in water systems. Initial testing indicated the presence of Legionella in some samples and sampling is ongoing with further remedial measures being implemented as required. Areas deemed high risk, will have water sampling undertaken on a regular basis in accordance with Trust procedures.

Control measures continue to be implemented and results monitored by Infection Prevention and Control. A meeting of the Trust Legionella Control Group was held on 27th October 2011 and members noted receipt of the minutes.

21. **REVIEW OF GOVERNANCE COMMITTEE**

A questionnaire will be issued to members for completion.

***The next meeting of the Governance Committee will take place on Tuesday, 7TH February 2012 at 9.30 a.m. in the Boardroom, Trust Headquarters, Craigavon***

***SIGNED: _____***

***DATED: _____***

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# CORPORATE RISK REGISTER

# to Governance Committee

# 9th September 2014

# BRIEFING NOTE FOR GOVERNANCE COMMITTEE MEETING, 9TH SEPTEMBER 2014

There are currently **21** Corporate Risks, (13 high level 8 moderate level) as agreed by the Senior Management Team on 27th August 2014.

The Corporate Risk Register has been reviewed by the SMT on 3 occasions since the last Governance Committee meeting on 13th May 2014, most recently on 27th August 2014. Changes include:-

## Review of Risk Ratings

Risk ratings have been reviewed, but have not been amended since the Corporate Risk Register was last reviewed by the Governance Committee on 13th May 2014.

## Removal of Risks

Risk No. 9 - High Pressure Hot Water System, Craigavon Area Hospital

## New Risks

Risk No. 6 – Medicines Management compliance
Risk No. 7 - Medical Workforce – inability to recruit/retain Consultant medical staff for specific specialties
Risk No. 8 – Long Term Placements for clients with challenging behaviour resulting in delayed discharge from hospital
(*risk assessments attached for information)*

## Risks to be considered in detail at next monthly review by SMT (end September 2014)

Risk No. 19 – Implementation of Business Systems Transformation Programme (BSTP)

# Summary of Corporate Risks as at August 2014

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

| Risk No. | HIGH RISKS | * Corporate Objective | Risk Rating | Change to Status since April 2014 |
|---|---|---|---|---|
| **1.** | Ongoing achievement of Commissioning Plan Standards/Targets | **1** | **HIGH** | Unchanged |
| 2. | Outpatient Reviews in a number of specialties significantly beyond clinical review timescales | **1** | **HIGH** | Separated out from Risk No.1 on 30.4.14 |
| **3.** | Achievement of statutory duties/functions<br>- Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed | **1** | **HIGH** | Unchanged |
| 6. | Medicines Management compliance in domiciliary care | **1** | **HIGH** | New risk added on 9.7.14 |
| 7. | Inability to recruit/retain Consultant medical staff for specific specialties | **1** | **HIGH** | New risk added on 9.7.14 |
| 9. | Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement | **1** | **HIGH** | Unchanged |
| 11. | High Voltage capacity limit on electrical supply to Craigavon Hospital | **1** | **HIGH** | Unchanged |
| 12. | Pharmacy Aseptic Suite, CAH | **1** | **HIGH** | Unchanged |
| 15. | Accreditation status of Laboratory, Craigavon Area Hospital | **1** | **HIGH** | Unchanged |
| 17. | Financial Balance – risk in 2014/15 that the Trust will not achieve Financial balance in year | **5** | **HIGH** | Unchanged |
| 19. | Implementation of Business Systems Transformation Programme | **5** | **HIGH** | Unchanged |

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|---|---|---|---|---|
| 20. | GP Out of Hours Service - inability to attract adequate cover for GP shifts | 1 | HIGH | Unchanged |
| 21. | Health Visiting Service – impact on families due to decreased staffing levels | 1 | HIGH | Unchanged |

| Risk No. | MODERATE RISKS | | Risk Rating | Change to Status Since April 2014 |
|---|---|---|---|---|
| 4. | Achievement of statutory duties/functions: Robust Care Management processes | 1 | MODERATE | Unchanged |
| 5. | Systems of assessment and assurance in relation to quality of Trust services | 1 | MODERATE | Unchanged |
| 10. | Fire Safety | 1 | MODERATE | Unchanged |
| 8. | Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health | 1 | MODERATE | New risk added on 9.7.14 |
| 13. | HCAI | 1 | MODERATE | Unchanged |
| 14. | Risk of harm to patients from water borne pathogens | 1 | MODERATE | Unchanged |

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| 16. | Fully embedded Appraisal system | **4** | **MODERATE** | Unchanged |
| 18. | Management and monitoring of procurement and contracts | **5** | **MODERATE** | Unchanged |

## Corporate Objectives

1: Provide safe, high quality care.

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

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

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

5: Make the best use of resources.

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

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

| CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE | | | | | |
|---|---|---|---|---|---|
| **No** | **Risk Area and Principal Risks** | | **Action Planned/Progress update (August 2014)** | | **Status** |
| 1 | Achievement of Commissioning Plan Standards and Targets and review appointments to secure timely assessment and treatment<br>• A number of inpatient/day case/outpatient waiting times beyond access standards/targets (Acute,OPPC and Mental Health areas)<br>• AHP services across all programmes<br>• Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust<br>• Plain film X Ray reporting only maintained at current level of Ionizing Radiation Medical Exposure Regulations with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations | • Bi-weekly reporting to Senior Management Team<br>• Monthly reporting to Trust Board<br>• Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed.<br>• Fortnightly Elective Performance meetings with Health and Social Care Board<br>• Identification of capacity gaps to HSCB for non recurrent funding for additional capacity on a specialty basis | • On-going work with Health and Social Care Board to agree capacity gaps and associated recurrent funding requirements. Agreement reached on Gynae; ENT General Surgery, Cardiology and Trauma and Orthopaedics with implementation progressing. Agreement remains outstanding on rheumatology and endoscopy and discussions are being undertaken between Health and Social Care Board and the Trust.<br>• Initial Quarter 1 and 2 non-recurrent allocations provided by Health and Social Care Board to maintain end of March 2014 access positions in Quarter 1 and 2 are being regionally reviewed and subject to revision. which will not allow access position to be held.<br>• Independent Sector contracts secured, through mini-competitive tendering process, for 2014/15 for Pain Management and General Surgery. Independent Sector capacity for Orthopaedics and Endoscopy secured through existing regional tenders. A new regional exercise has been undertaken for Orthopaedics, however, the contracts associated with this process have not yet been awarded. HSCB approved extension of Mobile MRI and Modular Cardiac Cath Lab until end of September 2014. | Performance and Reform/ Operational Directors | HIGH |

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|---|---|---|---|---|---|
| | | | • The Trust has secured appointment of 5th permanent Consultant Urologist with additional supernumerary 6th Consultant Urologist approved by HSCB, commencing in August 2014.<br><br>• SHSCT Consultant Ophthalmologist left the Trust at the end of Quarter 3 2013/2014. SHSCT and Southern Local Commissioning Group (SLCG) agreed that SHSCT service would no longer be pursued. SLCG in discussion with WHSCT to undertake 'SHSCT service' element. Visiting service continues from BHSCT with BHSCT managing transfer of patients to the Independent Sector from 1/4/2014.<br><br>• The Trust continues to maximise available in-house additionally, in line with Waiting List Initiative rules, in preference to Independent Sector provision.<br><br>• HSCB have confirmed that no non-recurrent resources will be provided for AHP in Quarter 1/2 until the outcome of the PHA demand / capacity exercise. Significant progress on access standards were made in Quarter 3/4 2013/2014 due to non-recurrent funding provided by HSCB. Performance against the 9-week access standard will not be held in Quarter 1/2 without additional non-recurrent resources. | | |

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| | | | • The Trust has been retaining a number of staff at financial risk as approved by Trust Board in April 2014. However, these staff will be released at the end of August 2014, resulting in reduced access performance.<br><br>• Focus on SBA was well maintained in 2013/2014 with only a small number of specialties in Amber or Red within the HSCB RAG Status assessment. Focus remains on delivery of SBA as first priority with delivery of access standards following this.<br><br>Plain Film X Ray<br><br>• In 2013/2014, IS and IHA were utilised through recurrent funding from HSCB; use of Radiology MCN monies; and through a small element of non-recurrent funding. However, the level of plain film reporting was in excess of that projected through the funding so this additionality will have been unfunded. No funding has been agreed yet for 2014/2015 from HSCB for plain film reporting. This level of reporting remains within the Non-IR(MER)'d plain films.<br><br>• Phase 1 Action Plan in progress. Phase 2 report received and Action Plan developed. Action Plan sent by Chief Executive to Chief Medical Officer and Health and Social Care Board to seek clarification on timescales and process for regional actions. Response received and regional group now convened. | | |

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| | | | • Review of Imaging Services Terms of Reference adopted by Project Board of the Review and approved by the Minister – April 2014<br><br>• Proposal submitted to SLCG for plain film reporting by Radiographers of ED films. | | |
| | **Risk Area and Principal Risks** | **Key Controls** | **Action Planned/Progress update (August 2014)** | **Lead Director** | **Status** |
| 2 | Outpatient Reviews in a number of specialties significantly beyond clinical review timescales (Consultant led Outpatient Clinic Review s and AHP Review/Interventions) | • Bi-weekly reporting to Senior Management Team<br>• Monthly reporting to Trust Board<br>• Outpatients Review backlog action plan<br>• Review of administrative process and development of associated Standard Operating Procedure to ensure maintenance of validated 'clean' waiting list and removal of patients off the review backlog waiting list at appropriate times | Outpatient Review Backlog<br><br>• Whilst significant reduction in volume of review backlog achieved initially in the number of routine waits in Q3 and 4 of 2011/12, there has been an increasing trend in 2012/13 and 2013/14 as the system continues to bring in significant volumes of in-house additional new patients to meet access targets. The Outpatient Review Backlog at 1/8/2014 has increased to a total of 24,198 (patients past their clinically indicated review). NB this excludes Mental Health)<br><br>• Of the total patients on the review backlog list, only 1.5% of these date back to before 1/4/2012. The volume of patients backlogged before 1/4/14 equates to 52.5% of the total waiting list<br><br>• From Q3/4 in 2013/14, the Trust has only accepted non recurrent allocations for new outpatients that include sufficient capacity for the associated review appointments to assist in not adding to the backlog | | |

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| | | | • Work continues to cleanse lists and Specialist Nurses are working with relevant consultants to screen urgent reviews and longest waiters<br><br>• Outpatients Review backlog action plan being reviewed to reprioritise actions to be undertaken and ensure inclusion of all elements of patient care backlogged ie. Mental Health, AHPs<br><br>• The Trust has submitted review backlog discussion plan to HSCB (July) and has sought regional discussion on best practice and options to address in the absence of specific funding to create additional capacity to see additional review patients. Options include renewed interface with primary care around this issue and SLCG have been asked to facilitate this approach<br><br>• Review backlog discussion plan highlights emergent backlog in review/interventions in AHP services, specifically Podiatry and Speech & Language services. Options are being developed to address the governance risk created by these backlogs for discussion with commissioner. | | |

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

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|---|---|---|---|---|---|
| | | | **6. Mixed Economy of Provision**<br>– Controlled shift of work to IS Providers.<br><br>**Compliance with Review Target**<br><br>12 month annual review by 30.6.2014:-<br><br>– Domiciliary Care: - 86.8%<br>– Nursing Homes – 84.6%<br>– Residential Homes – 85.1%<br><br>Overall completion rate – 86.2%<br><br>Therefore, 13.8% have been waiting longer than 12 months to have their reviews carried out.<br><br>NB: Those clients whose reviews are outstanding are subject to a desktop risk assessment to ensure that the delay in having their review carried out is not detrimental to their care.<br><br>**Care Home Support Team**<br>- Commenced on 20th January 2014 with a phased approach. The service model developed will carry out reviews for all clients in Nursing/Residential Homes<br>**Adult Safeguarding Team**<br>- Further targeted vulnerable adults training for those staff in care management and involved in annual reviews. | | |

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
|---|---|---|---|---|---|
| 4 | Achievement of statutory functions/duties:<br><br>The Trust should have robust care management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Care Management process. | | • A project officer has commenced the implementation of the new care management guidance & (NISAT in Physical Disability/Learning Disability Teams.) The officer reports directly to the Head of Disability Services & Assistant Director of PDIS/LDIS who are also progressing restructuring within community teams. A monthly project oversight/accountability group has been set up to monitor progress. . | | **MODERATE** |
| **No.** | **Risk Area and Principal Risks** | **Key Controls** | **Action Planned/Progress update (August 2014)** | **Lead Director** | **Status** |
| 5 | Systems of assessment and assurance in relation to quality of Trust services<br><br>Specific risks include:-<br><br>4.1 Lack of compliance with Standards and Guidelines (DHSSPS/HSCB/other)<br><br>4.2 Lack of agreed indicators/measures of quality to provide assurance across all Trust services | • Standards and Guidelines report on compliance to Governance Committee and DHSSPS Accountability Review meetings<br>• Standards and Guidelines Risk Assessment and Prioritisation Group<br>• Clinical and Social Care Governance Review completed and new structures/processes embedded<br>• Governance Committee, Senior Management Team and Governance Working Body in place and operating to agreed | • New I.T. system to capture Standards and Guidelines now agreed and implementation planned for September 2014<br>• Web-based incident reporting (on Datix) rolled out across the Trust<br>• Review of Risk Management Strategy completed and approved by SMT on 17th April 2014<br>• Morbidity and Mortality Group have standardised M&M processes in the SHSCT, providing assurance that all deaths are being reviewed in the same way and to coordinate a standard approach to learning from M&M meetings which has a patient | Chief Executive<br><br>Medical Director | **MODERATE** |

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| | 4.3 Effectiveness of systemic process to review all intelligence from incidents, complaints, litigation and user feedback to identify and address service safety and quality issues<br><br>4.4 Effectiveness of process for learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning | remit<br>• Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee<br>• Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information<br>• Review of Specialty Mortality and Morbidity system completed.<br>• Mortality Reports to Governance Committee<br>• Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chair and Chief Executive<br>• Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs)<br>• Medical Director Report to Trust Board and Governance Committee includes Quality and Safety Indicators<br>• Serious Adverse Incident/Adverse Incident reporting system in place<br>• Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy<br>• Director, Children and Young People's Services, reports to Trust Board and Governance Committee including Roles and | safety focus.<br>• Quality Sub Group established to develop Quality Strategy<br>• Q2020 Strategy Regional Workstreams continue to develop regional quality indicators for reporting via Trust Quality Report | | |

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| | | Responsibilities on all Looked After Children and Child Protection services<br><br>• Trust Quality Report with limited range of indicators to Trust Board in January 2014<br><br>• For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning<br><br>• Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning<br><br>• Complaints assessed/screened for adverse incident review<br><br>• Litigation process now embedded to ensure early alert to operational Directors | • 4 issues arising from Serious Adverse Incidents brought to Governance Working Body and being taken forward for organisational learning. Implementation of NEWS has now been completed across Acute, Older People and Primary Care and Mental Health and Disability Directorates. Audit in place to monitor compliance. Falls Working Group ongoing Progress on the other 2 issues remain to be reported to Governance Committee on a rotational basis.<br>• Governance Working Body in the process of reviewing their workstreams | | |

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
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| 6 | Lack of compliance with RQIA Standards in relation to medicines management in domiciliary care | • Trust Medicines Management policy<br>• Review of operational procedures<br>• Incident reporting system in place<br>• Interim procedure on prescribing<br>• Trust Medicines Steering Group<br>• Trust representatives on regional group<br>• Themed Domiciliary Care Forum (IS) focused on safe administration of medication | • Trust response letter on medicines compliance/adherence sent to Mr Joe Brogan in June 2014<br>• Competency based training re medicines management for domiciliary care workers completed for 939 staff. Three 'mop up' sessions scheduled for October/November 2014. | Older People and Primary Care/Mental Health and Disability | HIGH |

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
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| 7 | Inability to recruit/retain Consultant medical staff for specific specialties<br><br>• Consultant Medical Staff in Dermatology, Emergency Medicine, Orthodontics, T&O, Haematology and Psychiatry Old Age<br><br>• SAS Medical Staff in Anaesthetics, GP Out of Hours, Urology, Dermatology, Emergency Medicine | • Recruitment campaigns<br>• Use of Locum agencies<br>• Risk Assessment<br>• Detailed Action Plan is held within the HROD Directorate. | • Workforce review completed in June 2014<br>• Risk Assessment (as attached) highlights controls in place/action | Human Resources & Organisational Development/ Medical Director | HIGH |

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
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| 8 | Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health | • Multidisciplinary Team Assessments<br>• Monthly Delayed Discharge meeting for all Mental Health Wards including Gillis | • Continue to explore the potential for existing homes to manage cases with an individualised bespoke package<br>• Potential to procure a specialist home for people with dementia and challenging behaviour discussed with Commissioners | Mental Health and Disability/Older People and Primary Care | **MODERATE** |
| **No.** | **Risk Area and Principal Risks** | **Key Controls** | **Action Planned/Progress update (August 2014)** | **Lead Director** | **Status** |
| 9 | Insufficient capital to maintain and develop Trust estate to support service delivery and improvement | • Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department<br>• Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk<br>• Strategic development plans in place for major projects and business cases submitted for highest risk areas<br><br>Specific examples:<br>• Fire Safety Action Plan in place | • On-going prioritisation and bidding process for capital in place<br>• Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment<br>• Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available<br>• £1.99m Maintaining Existing Services funding secured for 2013/14.<br>• Craigavon Area Hospital Main Theatres Refurbishment Project - the 4 theatres and recovery ward have been completed and are in | Performance and Reform | HIGH |

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| | | (see below)<br>• High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below)<br>• High pressure hot water system (HPHW) at Craigavon Area Hospital (see below)<br>• £2.9m secured to complete structural works to tower block at South Tyrone Hospital | use.<br>• Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2013/14.<br>• Structural repairs and replacement of external envelope to STH are progressing well.<br>• Strategic Outline Case completed for Major Redevelopment at CAH site and Outline Business Case to be progressed. | | |
| **No.** | **Risk Area and Principal Risks** | **Key Controls** | **Action Planned/Progress update (August 2014)** | **Lead Director** | **Status** |
| 10 | Fire Safety and compliance with Fire Safety Regulations (NI) 2010 | • Fire Safety Action Plan in place and to be monitored quarterly<br>• Local Fire Safety Management Arrangements in place<br>• Funding to resolve deficiencies – prioritised within Maintaining Existing Services<br>• Approximately £450k was invested in upgrade of fire alarm systems in 2013/14 which consisted of upgrading fire alarm systems to Hill Building, Trasna House, partial upgrade to South Tyrone Hospital and providing/upgrading fire alarm zone maps throughout the Trust | • Staff training on-going<br>• New methods for delivering mandatory fire training agreed and to be implemented and tested 2014/15<br>• Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out<br>• Firecode funding allocation from Maintaining Existing Services for 2014/15 c. £110k is for swing arm door closers in residential homes and alterations to fire alarm programme in Lurgan Hospital.<br>• Internal Audit Report in 2013/14 – limited assurance. Priority 1 issues relate to completion of the Fire Risk Assessment Programme; attendance at training and recording of housekeeping. Action Plan in place with majority of issues to be addressed by December 2014 | Performance and Reform | MODERATE |

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

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
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| 12 | The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified several issues:<br>• The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding).<br>• Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding)<br>• The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding) | • Increased environmental monitoring to check for failures of sterility in the unit<br>• Expiry dates of all products prepared has been reduced to a maximum of 24 hours.<br>• A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented<br>• Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved<br>• Additional environmental and function testing is being performed on both isolators to identify any sterility failures. | • Work is nearing completion on the business case for a new build aseptic suite co-located with the Mandeville Unit.<br>• The Capita Model for chemotherapy/cytotoxic dispensing has been applied to the current workload in the unit. This has identified a staffing deficit of 3.6wte pharmacists. A meeting to discuss staffing capacity took place on 28th April 2014 at which the HSCB requested additional information. This has now been submitted. In the interim, HSCB has funded one additional Pharmacist for 6 months – now in post.<br>• The first replacement isolator was installed at the beginning of March 2014 and then developed various faults. These were finally rectified in July 2014 and it is now fully operational. The second isolator arrived at the end of March 2014, but could | Director of Acute Services | **HIGH** |

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| | | | not be installed as the wrong ducting had been supplied despite a site visit. A new installation date is awaited – BSO PaLs are in contact with the supplier. | | |
| | **Risk Area and Principal Risks** | **Key Controls** | **Action Planned/Progress update (August 2014)** | **Lead Director** | **Status** |
| 13 | HCAI<br>• Risk to achievement of Priorities for Action target identified<br>• Risk to patient safety<br>• Lack of automated HCAI surveillance system linked to Trust laboratory system<br>• Lack of appropriate isolation facilities (including negative pressure facilities) within the Trust hospital network<br>• Emerging infections (CPE & VHF) | • Comprehensive isolation policy in place and strictly adhered to<br>• On-going mandatory and tailored IPC training<br>• Manual surveillance systems in place<br>• Comprehensive governance structure in place, including bi-monthly Strategic Forum and monthly Clinical Forum meetings<br>• New negative pressure room opened in Medical Admissions Unit, CAH<br>• Patient Flow Managers are prioritising single room with ensuite facilities accommodation for patients with infection/suspected infection<br>• Daily Infection Prevention Control (IPC) HCAI report of inpatients with C.difficile and MRSA histories to bed managers and patient flow staff<br>• Outbreak /incident management plan in place<br>• Independent and self-audit programme in place<br>• Extensive action plans in place for trends/prevalent HAIs<br>• Antibiotic stewardship including antibiotic ward rounds | • On-going measurement of compliance against DHSSPS Communiqués<br>• Ongoing self-auditing using the RQIA Audit tools.<br>• Learning outcomes from RCAs being shared with senior and junior medical staff. Shared learning calendar for 2014 now agreed.<br>• Engagement meeting with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases. Communication has been issued to GPs and will be supported by a Newsletter to be circulated in May 2014<br>• Further development of Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters. A snap shot audit undertaken at the outset of the project and has been supported via a staff awareness audit questionnaire which was completed in January 2014 in Acute/Non Acute sites across the Trust. Community staff will also receive a questionnaire to complete in the near future<br>• Engagement with PHA on Regional Surveillance system funding and procurement to recommence | Medical Director | MODERATE |

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| | | • Establishment of antimicrobial management team to oversee antimicrobial stewardship<br>• HCAI Root Cause Analysis process in place<br>• Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI<br>• Following step down of Ramone Ward (November 2013), further enhancement of Risk Management Plan<br>• Daily meetings between IPCT/Bed Management/Senior Acute staff to discuss current IPC situation including IPC issues and bed/side room availability<br>• Weekly meeting between Medical Director and Acute Services Senior Management/IPC nursing staff/Lead IPC Doctors to review weekly IPC activity/infection prevention and control trends<br>• Revised and updating of Trust Outbreak Plan in line with most recent Regional Outbreak Guidance published December 2013 | • IPCT continue ongoing monitoring and report against the 'time to isolation' standard of 2 hours for patients diagnosed with C.difficile infection<br>• Director of Acute Services and ICT Clinical Lead have undertaken a series of engagements with Ward Managers to reinforce the need for effective IPC and identify any further training/support needed<br>• Director of Performance and Reform and Medical Director have explored options on how to enhance isolation capacity through modular build and this has been included within SOC for CAH redevelopment<br>• New weekly E-Alert issued to staff to provide a digest of current IPC threats and issues locally, nationally and internationally. E-Alert is mailed directly to Doctors, GP Out of Hours, Clinical Forum members and Operational Directors<br>• New negative pressure room for 2 North, Craigavon Area Hospital, at planning stage. Completion targeted for early 2015<br>• Management Plans for emerging infections CPE and VHF in progress | | |

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
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| 14 | Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas) | • Water Safety Group in place<br>• Water Safety Plan<br>• Revised Legionella policy and procedures in place<br>• Compliance with PHA and HEIG guidance: HSS(MD)6/12 - Water sources and potential for pseudomonas aeruginosa infection from taps and water systems<br>• Legionella risk assessments, sampling and monitoring regime in place (as per L8, PHA & HEIG), results analysed, appropriate action taken as required<br>• Pseudomonas sampling and monitoring regime in place in Neonatal Unit and Special Care Baby Unit; in progress in augmented care<br>• IPC guidance on environmental cleaning developed and rolled out (sinks, equipment, etc.)<br>• Infection prevention and control guidance and procedures are continuously reviewed, modified and issued to address emerging risks<br>• Infection prevention and control audit programme and implementation of appropriate actions based on findings<br>• On-going staff education programme highlighting risks of water borne pathogens<br>• Design of water systems within care facility/environment; attention is given to designing system that will reduce the likelihood of propagation of water borne pathogens | • A water dosing system for copper sliver ionisation of Ramone Building is currently under trial<br>• Consideration of opportunities to increase automated water temperature and flow monitoring<br>• Review of resources needed to manage water quality systems (Microbiology, IPC and Estate Services) completed and identified to Health and Social Care Board/Public Health Agency as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines (July 2013)<br>• Independent review of water safety plans completed and draft report received – assurance and recommendations agreed at Water Safety Group (July 2013)<br>• £200k MES General Capital funding secured for priority works identified through risk assessments<br>• New sampling regime approved by Trust Board and new monitoring regime now in place with bi-monthly monitoring. This will continue until September 2014 at which point testing will go to quarterly (subject to satisfactory reduction in legionella positives.<br>• Second Independent Review of Water Management arrangements to be undertaken during Autumn 2014.<br>• New Trust wide contract for the control of water systems to be tendered by PALs (estimated start date of contract – March 2015) | Director of Performance & Reform/ Medical Director | MODERATE |

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
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| 15 | Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status | • Action Plan in place to address non-conformances<br>• External Quality Assurance and Internal Quality controls | • Action plan updated as progress is made.<br>• Application for re-accreditation under the new ISO15189 standards submitted end April 2014. | | **HIGH** |

**CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE**

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
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| 16 | Fully embedded appraisal system – lack of evidence of compliance | There are a variety of mechanisms in place to ensure appraisal takes place:-<br>• Consultant Appraisal<br>• Professional Supervision<br>• Knowledge and Skills Framework (KSF) policy and monitoring system in place<br>• KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings<br>• Action Plan in place<br>• Staff Attitude Survey results provide staff view<br>• Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation. | **Consultant Appraisal**<br><br>The 2012 appraisal round is 100% complete. The 2013 appraisal round commenced in March 2014 and the current status as at 22.8.2014 is as follows:- | Director of Human Resources | **MODERATE** |

| Division/ Directorate | No. of Eligible Doctors | % of 2013 Appraisals Completed/ In Progress |
|---|---|---|
| Children & Young People's Services Directorate | 46 eligible doctors | 52% complete |
| Mental Health & Learning Disability Directorate | 28 eligible doctors | 21% complete |
| Anaesthetics, Theatre & ICU Division | 24 eligible doctors | 55% complete |
| Surgery & Elective Care | 47 eligible doctors | 38% complete |

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| Cancer & Clinical Services | 47 eligible doctors | 51% complete |
| Medicine & Unscheduled Care | 64 eligible doctors | 34% complete |
| Integrated Maternity & Women's Health | 27 eligible doctors | 41%complete |
| Emergency Medicine | 21 eligible doctors | 38% complete |
| **TOTAL** | **304** | **42% complete** |

It is anticipated that all 2013 appraisals will be completed by November 2014. In the meantime, the Medical Director and Revalidation Support Team have issued reminders to those whose appraisals are outstanding.

**Knowledge and Skills Framework**

KSF / Personal Development Plans (PDPs) are operational in the Trust. It is recognised that the majority of professional staff groups avail of the Supervision process, therefore the current focus is to ensure the unregulated workforce has the opportunity to have a Personal Development Review meeting with their Line Manager and develop a Personal Development Plan.

During 2013/14, 1,800 staff have attended KSF update sessions which have been delivered in different locations throughout the Trust.

June 2014 saw the re-launch of KSF and the new streamlined documentation. Roadshows took place at various locations across the Trust. Following these sessions, there has been a

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| | | | significant increase in completed PDP being returned to the HR Department. In July 2014, the returned PDPs increased to 45.7%.<br><br>In order to further increase uptake levels, targeted work will be undertaken within Directorates and various methods of communication will be deployed such as desktops, e-brief, global e-mails, etc.<br><br>**Staff Attitude Survey**<br><br>2012 HSC Staff Survey results for the Trust provided evidence that 60% of respondents to the survey had a Development Review/Appraisal in the last 12 months. This had increased from 48% in 2009. | | |

| CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES | | | | | |
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| **No.** | **Risk Area and Principal Risks** | **Key Controls** | **Action Planned/Progress update (August 2014)** | **Lead Director** | **Status** |
| 17 | • Achievement of financial balance in 2014/145 | • Contingency Plan for 2014/15 in place<br>• Best Care Best Value (BCBV) Project structure<br>• Financial monitoring systems in place<br>• Monthly report to SMT and Trust Board | The Trust has indicated that it will be unable to achieve a balance in 2014/15 and is currently working with Health and Social Care Board and Departmental colleagues to quantify what constitutes a 'doable ask' and secure solutions for any shortfall<br><br>Financial Resource Budget approved by Trust Board on 29th May 2014. Further to this the Permanent Secretary issued a letter to all Trust Chief Executives on 1st August 2014 reminding Trusts of their responsibility to live within available resources and to focus more on the delivery of recurrent savings. It also reinforced the statutory duty to break-even. As a direct result, the Trust was required to submit a contingency plan to the Department by 18th August 2014. This plan was required to address the complete financial gap for 2014/15 and secure break-even in year. The Trust submitted its plan for in year contingency of £29m. | Finance and Procurement/ All | **HIGH** |

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
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| 18 | Management and monitoring of procurement and contracts – not compliant with best practice guidance | • Clarification required with respect to Centre of Procurement Excellence coverage and capacity. Issue raised with A McCormick July 2011 seeking regional way forward<br>• Interim approach for social care procurement agreed by Senior Management Team in absence of Centre of Procurement Excellence support including awareness training for Community Contracts Team and 'light touch' support/advice to ongoing procurements by Centre of Procurement Excellence<br>• Contracts management improvement group established and key actions formed<br>• New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided in March 2013.<br>• Training on Contract Management with focus on responsibilities of Contract Owners rolled-out in November with follow up sessions delivered in January 2013 | • Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee<br>• Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing (Central monitoring ceased in October 2013)<br>• Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity.<br>• Additional capacity for procurement sourced via third party provider contracted by BSO/PaLS. Further small amount of in-house capacity has been established to support low risk procurements in Estates<br>• Capacity sought via IPT for social care procurement of key projects including(Domiciliary Care and Meals) under influence of CoPE Bid approved and recruitment underway.<br>• Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited<br>• Proposals brought forward by Trusts on regional basis to address procurement deficit for Estates services not agreed regionally. Regional Social Care Procurement Group developing | Director of Performance and Reform/ Director of Finance and Procurement/ All Directors | MODERATE |

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| | | | strategy for social care procurements. No agreed regional way forward for procurement capacity gaps. Issues continue to be raised with DHSSPS and Regional Procurement Board<br>• New Structures for contract & procurement management being developed as part of Management Review<br>• New Regional Task and Finish Group established to determine impact of new EU Directives for Social Care Procurement and provide guidance for social care. Work is ongoing on this process with input from Trust.<br>• Measured Term Contract (MTC) in place for 2014/15 which mitigates risks to procurement for schemes <£30k<br>• Internal Audit Report on Estates Procurement and Contract Management 2013/14 provided an unacceptable level of assurance. Improvement action plan in place and discussed at Audit Committee in June 2014. Improvement Plan in part contingent on increase in Estates team resources within current funded levels. The risks associated with not proceeding with this recruitment were noted/accepted by the Senior Management Team on 13th August 2014. Further consideration will be given to the need to escalate these risks to the Corporate Risk Register | | |

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
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| 19 | Implementation of Business Systems Transformation Programme (BSTP)<br><br>HRPTS:<br>• Payroll & Travel Payments - potential for inaccurate and/or late payments. Negative medic publicity and impact on Trust's reputation as a good employer.<br>• Licensing Issues - (new issue March 2014) – limited number of SAP GUI licences available across HSC. Impact on number of users within SHSCT, and risk of increased workload for HROD Directorate in relation to non-HR led training. Risk also of limited roll out of new Team Support Role (when available) and of Professional Registration Roles.<br>• Go-live and stabilisation - resource requirements for training and support for MSS&ESS deployment<br>• Staff Engagement - potential lack of 'buy in' from managers and staff (critical as system operates on self-service)<br>• Staff preparedness required within | • The Trust has established an implementation structure, including a BSTP Project Board, BSTP Change Network and HRPTS Directorate LITs.<br>• Engagement in regional process<br>• Risks documented and shared with BSO HRPTS Central Team<br>• Staff internally redeployed<br>• SHSCT HRPTS E-Roster Work Group established<br>• HRPTS ICT Lead identified and involved in project work, and participates in regional ICT work.<br>• HRPTS Systems Team monitoring user/licensing levels and working with BSO HRTPS Central Team.<br>• Trust Functional Specialists draw on knowledge from regional HSC colleagues, including BSO HRPTS Central Team and BSO ITS.<br>• BSTP Change Network and HRPTS Directorate LITs<br>• HRPTS Go-live & Stabilisation group | • Planned roll out of Manager Self Service (MSS) and Employee Self Service (ESS) for Older People and Primary Care Directorate early September 2014, and Acute Services Directorate in November 2014. Deployment plan continues to be kept under review<br>• Payroll & Travel Department continue to experience system issues and work to resolve these to enable successful payroll closedowns. Where appropriate INFRAs are raised for the suppliers consideration.. Pension/tax code system problems experienced in April 2014 payroll (HSC wide issues). A revised/improved regional timesheet was implemented in July 2014<br>• Urgent review of SHSCT users and reduction in number of users/licences. BSO HRPTS Central Team is leading work on reviewing licensing options.<br>• Awareness Sessions and MSS/ESS training continues to be provided for staff & Directorate HRPTS Local Advisors being identified<br>• ICT infrastructure resources being progressed by BSO HRPTS Central Team. Initial focus on staff with PC access.<br>• HRPTS System Team established with responsibility for systems management.<br>• INFRAs for resolution by BSO ITS and/or HCL Axon continue to raised where appropriate. There | Human Resources/ Finance | HIGH |

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| | challenging timescales for MSS/ESS roll out across the Trust<br>• Lack of HRPTS Team Support Role and impact on service managers workloads<br>• E-roster interfaces - non-availability of update functionality for Commcare and Allocate - 4 uploads were to be available (Master Data, Time & Enhancements, Absences etc) Only– Time & Enhancements one is available.<br>• ICT Infrastructure – to roll out MSS/ESS<br>• Solution functionality - full functionality of the solution is still not available - e-recruitment functionality is only like as a pilot in BSO<br>• Reporting functionality – number of reporting concerns eg Sickness Absence reporting problems/inaccuracies<br>• Benefits realisation - all anticipated benefits may not be achievable eg reduction in data inputting, non-availability of Team Support Role and reporting functionality).<br>• New/ additional unforeseen work will impact benefits realisation, eg new OM work and increased | | are a number of issues in relation to the HRPTS/FPL interface/mapping rules<br><br>. | | |

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| | systems management work.<br>• Data Security - risks in terms of access to staff data, at local and regional level.<br>• Regional 'Business as Usual' Structures – not yet in place. SAP Knowledge – staff have limited knowledge and training, and risks therefore increase as supplier personnel (HCL Axon) move off the project<br>• Unresolved HRPTS INFRAs affecting system functionality and resource implications for 'workarounds' | | | | |
| | • Transfer to Shared Services and maintenance of service delivery | • Human Resources Strategy<br>• Progress updates to Audit Committee | • Regular contract meetings continue to be held with the Trust's Head of Resourcing and the BSO Head of R&S.<br>• The Accounts Payable function is in the process of transferring to BSO with an estimated completion date of 31st October. The date for transfer of the payroll service is now due to be January 2015. Agreement has been secured with payroll staff to continue until then but the risk of losing temporary staff as this date approaches increases, impacting the stability of the service. | | |

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
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| 20 | GP Out of Hours Service – Reduced ability to maintain adequate service provision and patient safety due to vacant GP shifts | • Recruitment process for vacant posts<br>• Business Continuity Plan<br>• Medical Managers with medical responsibility for the service<br>• Call Centre Co-ordinator<br>• Call Manager system<br>• Late availability payment<br>• Flexibility re shift patterns offered<br>• Daily monitoring of rotas | • Advertisement on HSC recruit for sessional GPs has now closed with 9 applicants. 6 have been interviewed and 3 pending interviews.<br>• Regular updates to HSCB/Integrated Care Department regarding vacant shifts.<br>• Daily text messages and phone calls to GPs in attempts to cover shifts.<br>• Small team of nurses in GP Out of Hours Service working extra hours, where possible to assist in covering gaps<br>• IPT submitted to appoint 50 Nurse Triage staff. Trust proceeded at risk to commence the recruitment process.<br>• Rolling advertisement for as and when bank Advanced Nurse Practitioner<br>• Review of workload of clinicians ongoing by Clinical Lead<br>• KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB<br>• Working with Integrated Care Dept to address capacity issues and use of locum GPs. Locum agencies had been contacted and no doctors available.<br>• Working with other OoH providers to secure additional capacity<br>• Working ongoing with HSCB to progress Pharmacy Pilot and enable Pharmacist to undertake triage at weekends for medication related calls | Older People and Primary Care | |

| No. | Risk Area and Principal Risks | Key Controls | Action Planned/Progress update (August 2014) | Lead Director | Status |
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| 21 | Health Visiting Service – Impact on children/families due to reduced ability to deliver services as a result of decreased staffing levels in the service | • Control measures in place for when staffing levels reach certain levels within teams<br>• Direction to Team Managers and teams regarding expected service delivery during periods of extended reduced service<br>• Team Manager access to current caseload weighting information<br>• Utilisation of bank and additional hours of existing health visiting staff<br>• Health Visitors from fully staffed teams providing clinic cover in depleted teams<br>• Drop in clinics available to ensure rapid access to health visitor if parent worried or concerned about an infant / child<br>• Rota system in place for allocation of new births and for clinic cover<br>• Child protection cases are allocated equitably across the team<br>• Team managers to notify Head of Service and Named Nurse for Safeguarding Children is they are unable to allocate a child protection case.<br>• Letter has been sent to GP Practices in Lurgan / Brownlow and Armagh to keep them appraised of current situation. | • In August 2014 the Health Visiting Service is 12.46 WTE down which equates to 16% of the service. 2 Teams are in 30% step-down – Portadown and Armagh. 2 teams are in 20% step-down – Lurgan and Newry & Mourne Team 2. 7 permanent posts have been offered with staff starting in September 2014. These posts equate to 5.9 WTE. The Trust will then have no permanent vacancies.<br>The estimated shortfall will be 7.50 WTE – 9% of the workforce (some additional Maternity leaves starting in September). Tthis shortfall is made up from long term sick leave and maternity leave.<br>• Bank health visitors in place where available.<br>• Ongoing monitoring of situation between Assistant Director, Head/Deputy Head of Service, Health Visitor Team Managers and Health Visitors<br>• Regional recruitment for Health Visitor training has commenced and numbers being trained in 2014/15 will be increased subject to funding being made available from DHSSPS . In August 2014, the Trust is still awaiting confirmation of this funding . Successful candidates were advised on 7th August 2014 not to resign from their permanent posts.<br>• Confirmation from PHA of recurrent funding to support Public Health Nursing posts. These posts to have a focused remit for | Executive Director of Nursing/ Director of Children & Young People | |

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| | | | BME, homelessness, sexual health and travellers. Allocation for SH&SCT is Travellers: 1.0 WTE Band 6; BME: 0.8WTE Band 6 and 0.4 WTE Band 3 | | |

## Changes to Corporate Risk Register by SMT since April 2014 to date

| Date | Decision taken at | Changes to Corporate Risk Register |
|---|---|---|
| **30th April 2014** | **SMT** | Agreed 'Outpatient Review Backlog' now of such significant risk to separate out as a high risk – to be completed by next monthly review by SMT. Further escalation to HSCB to be progressed.<br><br>Agreed to merge Risk No. 5 Compliance with Standards and Guidelines with Risk No. 4 'Systems of assessment and assurance in relation to quality of Trust services'.<br><br>Agreed removal of Risk No. 9 Asbestos and maintain on Estates Risk Register<br><br>Escalation of Medicines Management compliance to be considered at next monthly review by SMT |
| **28th May 2014** | **SMT** | Risk No. 9 High Pressure Hot Water System, Craigavon Area Hospital now completely replaced with a new Low Temperature Hot Water System - Agreed removal from Corporate Risk Register and maintain on Estates Risk Register |
| **9th July 2014** | **SMT** | Agreed additional risks:-<br><br>Risk No. 6 – Medicines Management compliance<br>Risk No. 7 - Medical Workforce – inability to recruit/retain Consultant medical staff for specific specialties<br>Risk No. 8 – Long Term Placements for clients with challenging behaviour resulting in delayed discharge from hospital |
| **27th August 2014** | **SMT** | Consideration given to removal of Risk No. 19 ' Implementation of BSTP' and manage at Directorate Risk Register level (HR and Finance) on the following basis:-<br><br>1. HROD Directorate will escalate as appropriate to the Corporate Risk Register any future change in the HR HRPTS risks<br>2. If Finance colleagues feel any payroll/travel risks need to remain on the Corporate Risk Register, or at any stage in the future need to be escalated to the Corporate Risk Register, they can progress that through Finance & Procurement Directorate risk management structures.<br>3. The Trust's BSTP Project Board continues to review HRPTS risks and can decide at any stage to escalate risks to SMT/Corporate Risk Register. |

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| | | 4. HR HRPTS risks can move to be fully managed at HROD Directorate Risk Register and HR Departmental Risk Register levels, with payroll/travel/ finance HRPTS risks being managed via Finance Directorate and/or Departmental risk registers.<br><br>Agreed to remain on Corporate Risk Register at present and review in detail at next monthly review (end September 2014). |

- The leaving date for Jennifer Holmes - **Seconded to NHSCT from 1 September 2009 to 31 August 2010. Returned to the Trust on 1 September 2010 and her last day of employment was 31 March 2011.**
- The appointment date for Sandra Judt – **16th May 2012**
- A summary of duties for each of the above – **job descriptions attached**

# Trust Chronology of Events

## Final Draft

## Updated 28th February 2012

**CONTEXT:**

In December 2008, there was a C Diff outbreak in the Southern Trust. The organisational learning from this event resulted in a range of sustainable measures being implemented to improve the Trust's monitoring and response to infection control prevention and management. These measures included:

- Strengthening the resources for infection control
- Clarifying the role and responsibility of the Medical Director as lead for Infection Control within the Trust
- Establishing a structure for full engagement and oversight of infection Control issues, including a Strategic HCAI Forum chaired by the Chief Executive, supported by and reported to by two key Groups: 1) a Clinical Forum chaired by the Medical Director and 2) an Operational Forum chaired by Senior Manager – Medical Directorate. (See ORG 3 – Reference 3.1)
- A '10 Point Action Plan' for controlling C Difficile was implemented, with wider application to HCAI, which included education of staff, same day diagnosis, prompt management and treatment, prompt isolation, best practice in hand washing, antibiotic stewardship, environmental cleaning, continuous surveillance and auditing with reports to Senior Management Team, Root Cause Analysis process for all positive cases, and revision of hospital visiting policy.
- Significant capital investment was made at and since that time in assessed infrastructure risks within the Trust's hospitals, including the provision of an Isolation Ward, upgrading of sluices, etc.

During the early part of 2010, the Trust undertook a Review of Clinical and Social Care Governance to strengthen the structures and integration of this critical function and to learn from the lessons of the events in Mid Staffordshire. As a consequence of this review, the system of

accountability was revised, most notably that the lead responsibility for Clinical and Social Care Governance moved from the Medical Director to the Chief Executive, and the Executive Director role of the Medical Director in relation to Responsible Officer, Infection Control and Patient Safety was further clarified (See ORG 3 Reference 3.2).

As a consequence of this review, the line management of the Clinical Director for Infection Control and the Infection Prevention and Control Team moved to the Medical Director in April 2011.

As lead Director for Infection Prevention and Control, the Medical Director provides regular updates to the Senior Management Team, Governance Committee and Trust Board on this issue.

The current procedure for the control of legionella is being carried out in accordance with the guidance in HTM 04/01. These control measures have been in place since the 1980's and have been constantly updated as and when new guidance is issued. The Trust Estates Department and the Infection Control Team have always worked together to provide a co-ordinated approach to the control of legionella. The control measures include the following:

- A bi-annual risk assessment of the water systems to identify and document the state of the water systems
- To develop a Trust wide action plan and implement any remedial works identified from the risk assessment
- On-going monitoring of the water systems in accordance with the requirements of HTM04/01
- Bacterial analysis of the water systems

The control of legionella actions does minimise the risk of pseudomonas infection. Based on the surveillance information the Trust does not have endemic infection of pseudomonas.

The Trust Microbiology Department report alert mico-organism to PHA via CoSURV. In addition to this the Trust Infection Prevention and Control Team undertake on-going surveillance for C-difficile, MRSA and MSSA. The Trust Infection Control Team visit wards and clinical areas and carry out laboratory based ward liaison surveillance. All infection control issues are discussed at 12:00 MDT meeting attended by Microbiologist/s, Senior Biomedical Scientist & Infection Control Nurses.

| Date | | Comments | References |
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| **September 2010** | | HSS [MD] 34/2010 – Water Sources and Potential Cross Infection Risks from Taps & Basins – Interim Advice received in Trust<br><br>Advice was considered by Infection Prevention and Control team, Estates and Facilities Department. Circular was discussed at Senior Management Team Governance Committee – 29th September 2010.<br><br>The Trust has undertaken legionella bi-annual risk assessments since 2003. Legionella monitoring and implementation of control measures in late 1980's since legionella was identified as a risk. | 2909-01 HSS [MD] 24/2010 – Water Sources and Potential Cross Infection Risks from Taps & Basins<br><br>2909-02 SMT Governance Meeting Minutes– 29Sept |
| **20th October 2010** | | A draft response was brought forward to Senior Management Team Governance 20th October 2010. The Medical Director advised that the Trust would respond to the CMO advising of compliance in all areas except in relation to the Hand hygiene guidance as the Trust was currently following the WHO hand hygiene and would not be implementing the use of hand gels after hand washing and drying. He also advised that there was currently no evidence within our high risk areas of cross infection from taps and basins and therefore the use of point of use filters would not indicated at this time. He advised that the IPC and Estates Teams would continue to monitor this very closely | 2010-01 SMT Governance Meeting Agenda and Minutes – 20oct |
| **27th October 2010** | | A letter of response to the circular was issued on October 27th from the Trust Medical Director in consultation with Estates, Facilities and Infection Prevention and Control | 2710-01 SHSCT Letter of Response |

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| | | Teams.<br><br>Assurances were provided in relation to Hand Hygiene stations [Action 1-4] *Pseudomonas aeruginosa* bacteraemia analysis for that time [2009 – no cases <1 year old and 2010 – no cases <1 year old] indicated low incidence based on the clinical sample submitted to the laboratory. No outbreak was recorded in the Trust. Trust maintained hand hygiene guidance as per WHO Hand Hygiene guidance [2009]. The Trust's Consultant Microbiologist discussed the requirement for sampling of water and/or taps with a Consultant colleague from the Public Health Laboratory in the Belfast Trust [circa. 08th October 2010] and it was agreed that water would be tested if there were clinical cases in the unit but routine testing would not be undertaken. Hand hygiene and environmental cleanliness auditing continued during this period. | 2701-07 CoSURV Report |
| **October 2010 – January 2011** | | On-going monitoring and control measures for legionella in place.<br>On-going surveillance of alert organisms via CoSERV and daily review and discussion at IPCT meeting.<br>On-going auditing of hand hygiene and environmental cleanliness and reporting to Senior Management Team and via IPC e-dashboard. | |
| **January 2011** | | A Trust wide Legionella Working Group was formally constituted with Representation from Infection Prevention and Control Team, Estates Department. This was to replace existing Estates groups which had been in place since late 1980's. The Working Group commenced a review and update of existing Legionella Policies and procedures – this work was completed and endorsed by the HCAI Strategic Forum on 07th September 2011.<br>The draft procedures document identified the following high risk areas: Ramone; Intensive Care Unit; Neo-Natal unit - CAH, Haematology Ward (2 North); Mandeville Unit; Renal Unit – DHH and 3 North Paediatrics. | |

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| **February 2011** | | Revised Legionella Policy drafted and enacted to replace existing 2009 Legionella policy. | 0102-01 Revised Legionella Policy |
| **January – April 2011** | | Trust completed its latest bi-annual Legionella risk assessment in all facilities. An action plan to address high level risks was developed. In-house works commenced at that time.<br><br>- Immediate dead leg removal in high risk areas.<br>- Maintenance of control measures (primarily temperature based) to reduce the likelihood of legionella growth in water systems<br>- Completion of schematic drawings for water systems within all Trust sites *[completed November 2011]*<br>- Establishment of a programme of Risk Assessments undertaken by competent persons across all Trust facilities to inform an Annual Action plan *[draft report completed October 2011]*<br>- Programme of remedial works to address infrastructure issues (prioritised by risk) as highlighted through the Risk Assessment Programme *[£200k secured through MES planned for completion by April 2012]* | 0101—01 Legionella Risk Management Plan<br><br>0101-02 - Implementation of Legionella Control System |
| **01st July 2011** | | PEL [11] 13 Water Systems and Potential Infection Risks received in Trust. This letter followed a workshop with Belfast Health and Social Care Trust & Health Estates Investment Group.<br><br>Process to develop response was engagement between Estates and IPC team. Action was on-going already as above plus the action listed below and included in the 4/9 response was underway | 0107-01 - PEL [11] 13 Water Systems and Potential Infection Risks received in Trust |

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| **04th September 2011** | | The Trust responded to Mr J Cole on 04th September 2011. The letter outlined the development of the revised Trust Operational Procedures for Legionella Control, the identification of high risk areas by the Estates and IPC Team and the establishment of legionella testing. It also confirms the completion of on-going risk assessments by a specialist water contractor and the development of a works programme for remedial actions. | 0409-01 - Trust Response to Mr J Cole – 04th Sept |
| **07th September 2011** | | Trust Operational Procedures – The Control of Legionella, Hygiene, Safe Hot Water, Cold Water & Drinking Water Systems – was developed by the Infection Prevention and Control Team and Estates Department was approved at the Trust HCAI Strategic Forum on the 07th September 2011. | 0709-01 HCAI Strategic Forum Agenda and Minutes – 07th Sept.<br><br>0709-02 Trust Operational Procedures – The Control of Legionella, Hygiene, Safe Hot Water, Cold Water & Drinking Water Systems |
| **September 2011** | | Infection Prevention and Control and Estates Department had identified high risk areas for Legionella Trust wide in January 2011. While no cases of legionella had been found the Trust commenced a first phase of legionella testing in the identified high risk areas.<br><br>The following areas, deemed high risk, were agreed for water sampling to be undertaken on a regular basis in accordance with Trust procedures:<br>- Isolation ward (Ramone) CAH (Sept - Oct 2011)<br>- Intensive Care Unit CAH (Sept 2011) | |

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| | | - Neo-Natal unit CAH (commenced Oct 2011)<br>- Haematology Ward (2 North) CAH (Sept - Oct 2011)<br>- Mandeville Unit CAH (commenced Oct 2011)<br>- Renal Unit DHH (commenced Nov 2011)<br><br>Initial testing indicated the presence of Legionella in some samples taken from ICU, NNU, 2N Haematology and the Mandeville Unit. All of the positive samples were found to L. pneumophila serogroup 2-16 and none were Pneumophila serogroup 1, which is most commonly associated with cases of legionnaire's disease.<br><br>Whilst no suspected or confirmed cases of Legionella were seen its presence was regarded as serious and appropriate control measures were immediately put in place which included isolating hand washing facilities etc. where the bacteria was found and then subjecting the areas to a regime of Chlorination, hot flushing and removal / replacement of key water system components (pipework, shower heads, taps etc).<br><br>Sampling remained on-going with further remedial measures being implemented as required. Whilst the approach appears to be reducing the colony count it remains to be seen if this will be a satisfactory long term approach and so additional forms of treatment, such as copper-silver ionisation are being researched. | |
| **13th & 29th September 2011** | | Two Infection Prevention and Control Interactive training sessions were held for neonatal/SCBU staff on the 13th and 29th September 2011. In total 70 nursing staff attended from CAH & DHH. The aim here was to standardise clinical practices between the two units and each session was for 2.30 hours. This was part of an on-going programme of work where policies and procedures were standardised across the two units and training needs identified. This was followed by additional medical staff training Tuesday 24th January 2012 [it was intended that this training would involve all MDT staff who had interaction with babies in the unit and was supplementary to | 1309-01 IPC Neo-natal Training Presentation |

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| | | medical staff IPC induction training]. | |
| **27th October 2011** | | Legionella Control Group held an urgent meeting with Chief Executive, Medical Director and Director of Performance and Reform to brief them on the results of first set of legionella water testing results and the following was agreed:<br><br>- Control measures to continue to be implemented as described above and results to be carefully monitored by Infection Prevention and Control – Chief Executive to be advised immediately if escalation is required.<br>- Staff to be informed of recent findings and reassured in light of actions being taken and absence of any confirmed or suspected cases.<br>- Research to be undertaken into longer –term control measures (Copper-silver Ionisation) and trialled in the Ramone building (which includes the Isolation Ward).<br>- Awareness training to be provided to IPC Link Nurses.<br>- Consideration to be given to utilising FM staff in the flushing of water outlets (i.e. running taps, showers etc.) on a routine basis.<br><br>In addition, the following measures were implemented:<br>- Filtered shower heads fitted in 2 north and also installed in Mandeville unit and isolation ward<br>- Automatic flush valves fitted to sensor taps in the isolation ward and installed on all sensor taps in High risk areas<br>- New steri -showers are to be installed in all patient showers in High risk areas. These new showers, already in use in the Belfast Trust, have an integral ultra violet light source which kills all bacteria that passes through the shower, therefore protecting the patient. | 2710-02 Legionella Emergency Team Meeting mins 27oct<br><br>2710-01 minutes of Legionella Control Group |

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| **07th November 2011** | | Terms of Reference for Legionella Control Group approved by the HCAI Strategic Forum Group. | 0711-01 Legionella Group Terms of Reference |
| **November 2011** | | Completion of schematic drawings for water systems within all Trust sites. The schematics are a requirement under Legionella legislation (L8) – they are part of the information required to be able to (practically) understand, analyse and manage your system (identify dead legs; key valves, sample points etc) – in themselves they don't reduce risk but assist the process of risk management .<br><br>Establishment of a programme of risk assessment to be undertaken by competent persons across all Trust facilities to information an annual action plan. The Risk assessments were completed Oct 2011 and formed the basis for the prioritised works being funded from MES.<br><br>Programme of remedial works to address infrastructure issues [prioritised by risk] as highlighted through the risk assessment programme [£200k secured through MEC – planned completion April 2012] – See Estates Matrix Evidence. | |
| **14th November 2011** | | The Trust Estates staff and several of Trust plumbing contractors completed awareness training delivered by a specialist contractor on the risks associated with legionella and the good practices associated with legionella control. This assures that staff working on water systems understand the risk from legionella both to themselves and to others through the work that they are undertaking (not introducing dead legs etc). | 1411-01 Estates Legionella Presentation |
| **14th November 2011** | | Trust wide Legionella Awareness Training also been provided via IPC Masterclass to all Trust Infection Prevention Control link staff and Trust Medical staff. This training was developed and delivered by Trust Infection Prevention and Estates staff. 69 Link person attendees. | 1411-02 Legionella Training Presentation |
| **23rd - 25th** | | Development of Management of Legionella in Water Systems Briefing paper – for | 2511-01 Management of |

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| **November 2011** | | December Governance Committee. Reviewed and approved by Senior Management Team Governance Meeting. | Legionella Briefing Paper<br><br>2411-02 Extract SMT Governance Mins |
| **November 2011 – on-going** | | Capital works to address legionella works on-going. | |
| **06th December 2011** | | Briefing provided to Trust Governance Committee on legionella testing and action plan by Director of Performance and Reform. Minutes of Legionella Control Group of 27/10 also shared | 0612-01 Extract from Governance Committee minutes |
| **14th December 2011** | | Email from Clinical Director IPC to Planning Department in relation to use of sensor taps in Theatres and a recommendation for use of lever action taps in all other areas.<br><br>IPC are actively involved in all capital development projects and as part of this involvement give advice on the type of taps to be used. | 1412-01 Email – Theatres – Sensor Taps 14dec |
| **16th December 2011** | | Email relating to Article of the *American Journal of Infection Control* – Hand Hygiene in Paediatric and Neonatal Intensive Care unit - Circulated by C Clarke, IPC Lead Nurse to IPC Team for information. | 1612-01 Email C Clarke to IPC Team 16dec |
| **Late December 2011** | | Informal telephone call between Dr M Hogan, Consultant Paediatrician and Dr M Ledwidge- WHSCT. In passing Dr Ledwidge mentioned that a baby had died from pseudomonas in the Altnagelvin NNU. Dr M Hogan presumes this to be an isolated occurrence. | |

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| **22nd December 2011** | | CMO letter HSS [MD] 31/2011 Water Sources & Potential Risk to Patients received in Trust<br><br>The Trust received correspondence to reinforce important messages contained in two earlier communications [September 2010 & July 2011] – see summary notes above to evidence actions taken to date and the team work involved therein.<br><br>Letter distributed by Chief Executive on 22 December to Director of Performance & Reform; Assistant Director of Estates, Director of Acute Services; Clinical Director Infection Prevention and Control; Medical Director for action as required.<br>Clinical Director Infection Prevention and Control circulated to Lead Infection Prevention and Control Nurse 23rd December 2011.<br>Lead Infection Prevention and Control Nurse circulated to IPC Nurses 23rd December<br>Circulated to all Clinical Staff 28th December 2011 by Medical Director<br><br>Circular distributed to and considered by January 2011 HCAI Strategic Forum [20th January 2011]**.** The membership of the HCAI Strategic Forum includes representation from PHA. Forum considered Trust to be compliant. | 2212-01 HSS [MD] 31/2011 Water Sources & Potential Risk to Patients<br><br>2212-02 Strategic Forum Agenda & Minutes Jan 2012 |
| **January 2012** | | The Health and Safety Executive carried out a high level inspection of Trust procedures document and the management of legionella within the Trust. Some minor adjustments to the procedure were suggested and are currently being implemented [due to be tabled at March 2012 Strategic Forum]. | |
| **11th January2012** | | Email request from Dr M Hogan [Consultant Paediatrician] & U Toland [NNU Ward Manager] to meet with Infection Prevention and Control Team regarding general infection prevention and control issues with particular reference to MRSA. | 1101-01 - Email Request for meeting from the neonatal team – 11jan |

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| **14th January 2012** | | As routine practice BHSCT Neonatal Unit advised CAH NNU Nursing staff of death of Baby [redacted]. Cause of death advised as 'sudden collapse'. No further clinical details were provided. | |
| **Monday 16th January [PM]** | | 18:30 Dr Rajendran [Consultant Microbiologist – SHSCT] received a telephone call from Dr Wesam Elbaz [Consultant Microbiologist RVH] regarding 2 babies from CAH who had been transferred to the RVH. Dr Elbaz queried if we had any problems with pseudomonas bacteraemia or colonisation within the last year. Dr Rajendran contacted Dr Damani [as Clinical Director of Infection Prevention and Control] immediately after the phone call from Dr Elbaz and advised him of developments. | |
| **Tuesday 17th January** | | 08.30 C Clarke [Lead IPCN] telephoned Mary Hanrahan [Senior IPCN – Belfast Health Social Care Trust ] following discussion with Dr Damani. M Hanrahan advised C Clarke of the current pseudomonas status in BHSCT although BHSCT were still trying to get information together. She advised that SHSCT were 'not implicated'. C Clarke informally briefed the ICPN Team. | |
| | | 13:23 C Clarke emailed Dr Damani and IPC Team with a brief summary of the conversation. | 1701-01 Pseudomonas Neonatal 17jan212 |
| | | Dr Damani informed the Medical Director. | |
| | | Consultant Microbiologist requested detail on all previous Pseudomonas results from NNU in the last 12 months from John Porter [Head BMS – Microbiology] | |

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| | | Email from Dr Clifford Mayes [BHSCT] to lead neonatologists to inform of infection outbreak and request from the other to unit to assist with taking infants. | 1701-02 Email C Mays |
| **Wednesday 18th January** | | 12:00 IPCT Multidisciplinary Meeting. Dr Damani requested that John Porter [Lead Biomedical Scientist in Microbiology Lab at CAH] alert Consultant Microbiologists directly if Pseudomonas is isolated in NNU from any site. | |
| | | 14.00 Dr Damani updated the NNU Clinical and Management staff about the pseudomonas issue. Enhanced monitoring and IPC precautions were reinforced and the unit was visited by the IPC Clinical Director and Senior IPCN after the meeting. It was agreed that:<br>• staff should be more vigilant<br>• pseudomonas to be included in the routine swabs of babies admitted from other units outside of the Trust.<br>• these babies are also to be isolated on admission until results are available with dedicated nursing staff [standard practice].<br>• should bed pressure increase, it has been agreed amongst the group that these babies would be cohorted. | |
| | | Medical Director updated Senior Management Team on current information on Pseudomonas. | 1801-04 - SMT Minutes 18th January |
| **Thursday 19th January** | | Meeting with Chief Executive, Medical Director and Clinical Director Infection Prevention and Control on RVH outbreak. The group discussed the need to screen all babies for pseudomonas in the Neonatal Unit This was completed Friday 20th January. | |

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| **Friday 20th January** | | 08:55 Email from Dr L Geoghegan re HP/IPC Guidance – Transfers from Belfast NNU. NNU staff to join teleconference later in the day to discuss capacity and offer assistance to the Regional network. | 2001-01 - HP/IPC Guidance – Transfers from Belfast NNU – 20jan email |
| | | 09:30 IPC meeting with Senior Managers and Clinicians in NNU. Following discussion with Medical Director and Chief Executive on 19th Jan it was agreed to screen all babies for pseudomonas. All babies in NNU and SCBU had swabs taken from axilla, groin, nasal plus rectal and stools. All swabs were taken with parental consent. | 2001-02 - Notes of Meeting 20jan – |
| | | All parents in the units were informed by a Consultant and Nurse regarding the situation and the precautionary measures the Trust were taking. | |
| | | 10.45 Dr N Damani received phone call from Dr Lorraine Doherty, PHA regarding transfers to and from RMJH and SHSCT Units who were subsequently found to be colonised/infected. Dr Damani said that he will send all the information by e mail | |
| | | 11.01 Email from C Clarke as requested by Dr Damani to Dr Lorraine Doherty, PHA transfers between CAH NNU and RMJH [as above]. | 2001-03 Confirmation of information given from CAH at PHA teleconference – 20jan |

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| | | 11:30 Meeting of Chief Executive, Clinical Director IPC, Lead IPCN, Director of Nursing and Medical Director . Group discussed information to date on RMJH status and details of babies transferred to and from SHSCT units and RMJH. It was agreed to advise PHA of screening and to remain vigilant and act accordingly as new information emerges. | 2001-06 Minutes of Meeting with CEO re pseudomonas & neonates - 20jan |
| | | 14:09 Follow up email from C Clarke to Dr L Doherty PHA re transfers between CAH NNU and RMJH | 2001-04 follow up email |
| | | 12:00 HCAI Strategic Forum. The Chief Executive advised group that there had been meeting earlier that morning on recent events, which a number of Strategic Forum members [Chief Executive, Medical Director, Director of Infection, Prevention and Control & Lead Infection Control Nurse] had been present at in relation to the current pseudomonas situation. She advised that a number of actions were agreed and that there was agreement that SHSCT would assist if there were neo-natal bed pressures in BHSCT.<br><br>The meeting was attended by Dr Neil Irvine, PHA.<br><br>CMO Letter of 22nd December was referenced. | 2001 -07 Strategic Forum 20jan – Agenda & Minutes |
| | | 14:18 Email from C Clarke to Chief Executive re: Cot Capacity in CAH Neonatal Unit. | 2001-08 Cot Capacity in CAH Neonatal Unit |
| | | 12:00 Daily Infection Prevention and Control Multidisciplinary Meeting noting NNU MRSA, Enterobacter and Pseudomonas screen. | 2001 -09 Meeting Summary 20jan – |

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| | | NNU accepted ex-utero transfer from RJMH [Baby [redacted]] who had 2 previous clear pseudomonas screens from RJMH. Screened on admission to NNU – presumptive positive on Sat 21st and discharged home on Saturday. Results confirmed on Sunday 22nd. Subsequently confirmed as having BHSCT strain. | |
| | | CAH NNU Cleaning schedules remained at twice daily by domestic services and six hourly by nursing staff. | |
| | | 14:00 Participation in Regional Teleconference – [Dr Bell, Dr Hogan, U Toland participated] to discuss bed capacity and offer assistance to the Regional network.<br><br>Actions following the meeting:<br>• Increased staffing<br>• Guidance from RJMH re transfers<br>• Maintaining existing isolation procedures and if necessary cohort infected babies | 2001-10 Update from Regional Teleconference |
| **Saturday 21st January** | | Provisional results of swabs (at 24 hours) received noting 2 babies presumptive in NNU and 1 in SCBU [which was a transfer from Paul Ward – BHSCT, subsequently found to have BHSCT strain].<br><br>Additional nurse staffing rota established to ensure 1:1 cohort nursing and isolation for all colonised infants. Paediatric staff with neonatal experience from within acute and community paediatric settings utilised to ensure cohort nursing provided | |

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| | | C Clarke telephoned M Hanrahan IPCN BHSCT. They had an informal conversation regarding use of sterile water for washing of babies. This issue raised on Teleconference later in the day. | |
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| | | Email from P Moore PHA re pseudomonas press release | 2101-01 Pseudomonas press release 21jan |
| | | 2:00pm Participation in Regional PHA Teleconference – Internal Notes of discussion/action [Dr N Damani, Paul Morgan; G Maguire; Dr B Bell; C Clarke]<br><br>The teleconference discussed swabbing results, regional neonatal capacity and issues relating to transfers. | 2101-02 Internal Notes of discussion21jan |
| | | 16.30hr Dr Bell spoke to both parents who infants had presumptive colonisation | 2101-05 communication with parents |
| | | Visible presence of IPC and CYP Senior Management on the Unit over the weekend. | |
| | | Staffing levels increased with Consultants on duty all weekend with back up provided in both Units | |

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| | | Nursing staffing levels increased to maximum:<br>• Children's Community Nurses relocated to DHH<br>• Ward Sisters in DHH Children's ward located to SCBU<br>• Experienced SCBU Nurses located to CAH<br>• Bank Nurses to 3 North | 2101-04 Email contingency arrangements |
| | | Sterile water for washing of babies practice implemented in NNU and SBCU following C Clarke conversation with BHSCT colleague [above] | 2101-03 Email use of sterile water |
| **Sunday 22nd January** | | 14:30 Participation in Regional PHA Teleconference<br>[Dr N Damani, Paul Morgan; G Maguire; Dr B Bell; C Clarke] | 2201-01 Internal Notes of Action Points arising from Teleconference |
| | | Results confirmed on Sunday on two colonised babies NNU and 1 in SCBU [which was a transfer from Paul Ward – BHSCT, subsequently found to have BHSCT strain]. | |
| | | 19.30 Dr Damani and Dr Bell spoke to one set of NNU parents [Irrelev] and Dr Bell rang the parents of the 2nd baby [Irrelev] to confirm the colonisation. Dr McWilliams spoke to the parents of the SCBU baby [Irrelevant inform | |
| | | Antibiotic policy for NNU and SCBU was revised to include anti-pseudomonas cover was agreed between Dr Bell and Dr Damani and subsequently with Dr Quinn on Monday 23rd. | |
| **Monday 23rd January** | | 9:00 Control Team meeting (Chief Executive, Medical Director, Director CYP, Clinical Director IPCT, IPC Lead Nurse, Estates Lead, Head of Communications)Visit to unit by ICT – number of further actions which were discussed at the 09:00 Incident Control Team meeting were agreed for immediate implementation<br>• Babies moved away from sink | 2301-01 Internal Notes of discussion23jan |

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| | | • Breast pumps single use only<br>• Removal of staff water cooler<br>• Reminder re disposal of waste in hand-washing sinks<br>• Isolation Unit Horne Tap not to be used<br>• Under-sink drainage pipes to be changed [23rd] Regular chlorination of sinks by estates staff to continue - Scheduled for 5pm 25/1 but cancelled at staff request and rescheduled for 27/1 - Subsequently cancelled following conference call on Friday 27/1<br>• Fit signage at sinks in NNU & SCBU for hand-washing only<br>• Enhanced cleaning three times per day [*Antichlor ™*cleaning 3 per day]<br>• Increased domestic services supervision<br>• Eight times daily horizontal cleaning | |
| | | Participation in Regional Teleconference | 2301-04 Regional Health Response Group Decision Log |
| | | 10:00 Chief Executive and Senior Management from Children's & Young People's Services visit NNU to discuss with Lead Nurse the pressures on the Unit, whether all support required was in place and to offer assurance on rapid response to any issues requiring action.<br><br>Staff given clear messages verbally about hygiene and infection control measures | |

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| | | 12:00 Daily Infection Prevention and Control Team Meeting – Actions for monitoring and compliance in NNU discussed. | |
| | | Development of Confidential Briefing for Non-Executive Directors<br>Trust received first media inquiry and holding line was developed as regional media handling plan under development at this stage. | 2301-02 Email – Confidential Briefing for NEDs 23jan |
| | | Dr Quinn spoke to parents of baby [Irrelevant] [previously discharged] when they returned for follow up outpatient appointment. | |
| | | 18:38 Receipt and circulation of email from Dr L Doherty – re Pseudomonas Outbreaks Neonatal Units - Case Definitions, Reporting Requirements and Screening Advice<br><br>There was a discussion as to whether we met the case definition for outbreak. Based on the epidemiology at that point it was decided that we did not meet the definition of an outbreak. | 2301-03 Email Pseudomonas Outbreaks Neonatal Units 23jan |
| **Tuesday 24th January** | | Participation in Regional PHA Teleconference<br><br>Discussion on case definitions, reporting definitions and screening advice. | 2401 -01 Email Action points, notes and new developments from teleconference – 24jan |
| | | 14:17 Email from G. Maguire to Informal Incident Control Team re Update from Infection Control telelink today - pseudomonas<br><br>Update on screening advice, use of sterile water for baby bathing and guidance on communication with the PHA re swabbing results. SHSCT compliant with all. | 2401-02 - Email Update from Infection Control telelink today – pseudomonas 24jan |

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| | | 2.15 Dr Damani briefed Chief Executive | |
| | | 48 hour screen of babies in NNU and SCBU. No change - 2 colonised [Irrelevant information re] babies in NNU & 1 SCBU [Irrelevant informa] | |
| | | Incident Control Team Meeting where the following decisions are taken:<br>• Dr Damani seeking advice from PHA on how often we should test the water<br>• Clarity consultant's role regarding direct communication with parents of patients<br>• Dr Damani provided feedback on regional protocol and leaflet from PHA<br>• Geraldine Maguire has secured one further member of staff from 3 North<br>• More SCUBU staff to NNU with backfill | |
| | | IPC/Neonatal Presentation to lunch time training session (nursing and new doctors) 30 min slot. The IPCT took the opportunity to reinforce messages about the current pseudomonas situation to the doctors during this pre-arranged session. | 2401-03 IPC Training Presentation |
| | | Replacement of sink waste and traps completed in NNU. | |
| | | Minsters Oral Statement to the Assembly | 2401-04 Ministers Oral Statement to the Assembly. |
| | | Memo from Medical Director & Director of Children & Young People's Services regarding hygiene and infection control guidance in NNU and SCBU. This was a strong reminder to all staff visiting the unit to observe good infection control practices. | 2401-08 memo re Pseudomonas |

Commented [BA1]: **was this result of actions agreed at Incident control team meeting previous day?**

Commented [BA2]: **What did this say? We need to get this?**

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| | | In response to media coverage a number of calls were received from concerned parents of babies recently discharged from the NNU and SCBU.<br><br>All calls from parents responded to by paediatrician/lead Nurse offering immediate advice and referral to PHA website.<br><br>Head of Health Visiting to ensure that parents of premature babies now in the community know where to get information. A home visit was offered to concerned parents. Completed 24th January. | |
| | | NNU initiated Staff Briefing document and formal briefing at every handover. This document was amended and updated in response to every development and advice (daily or more frequently) | 2401-06 Sample NNU Briefing |
| | | Dr Quinn informed the parents of a 3rd infant in NNU who was confirmed colonised on 24th January [irrelev] from the swabbing which took place on 20thJanuary.<br><br>Thereafter all parents were updated on a regular basis with regard to swab results and condition of their baby | |
| | | Email from P McKeown [Communications] to Chief Executive re BBC Website extract on WHSCT.<br><br>Press release issued to Portadown Times and Banbridge Chronicle in response to media queries. | 2401-07 Email BBC Website – WHSCT had 3 baby infection cases last year |

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| **Wednesday 25th January** | | Participation in Regional Teleconference<br><br>Group discussed update on current cases, communications issues and considered how each Trust were communicating with parents. The PHA also advised that they were working with each unit on environmental sampling risk assessment. | 2501-01 Regional Teleconference Notes<br><br>2501-08 update from pseudomonas teleconference |
| | | Email from C Clarke to Incident Control Team – Pseudomonas Update re screening. He advised that 13 babies had been screened in SCBU and NNU with one new presumptive positive [redacted]. | 2501-02 Email Pseudomonas Update 25jan |
| | | 2:30 IPCN Visit to Delivery Suite – meeting with W Clarke – Delivery Suite Co-ordinator<br><br>Nursing Staff Briefing document amended and circulated to NNU/SCBU for briefing at every handover | 2501-03 IPC Diary Extract 25jan |
| | | Press release to Portadown Times | |
| | | 12:00 Dr Rajendran contacted Dr Elbaz [Consultant Microbiologist BHSCT] regarding the outcomes of the typing results of the pseudomonas isolates sent to Colindale. Dr Elbaz was unable to provide information and advised Dr Rajendran that information would be shared on the Regional Teleconference. Subsequently no information on typing was provided on the Regional Teleconference. | |
| | | Estates Department replaced all sink waste and traps in SCBU DHH as part of previously agreed actions. | |

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| | | Email from R Rogers to members of Control Team re pseudomonas questions to develop regional position. | 2501-04 Email pseudomonas questions 25jan |
| | | Email from G Maguire to Control Team re: Update from Today's Pseudomonas Meeting.<br><br>Discussion on treatment regimens being used in each Trust. | 2501-05 Email Update from Today's Pseudomonas Meeting. – 25jan |
| | | Circulation by Chief Executive to Control Team from Dr L Doherty Re further Updated Pseudomonas Outbreaks Neonatal Unites Case Definitions Reporting Requirements Screenings Advice for review. SHSCT still did not consider that we met the definition of outbreak. | 2501-06 Email Re Updated Pseudomonas Outbreaks Neonatal Unites Case Definitions Reporting Requirements Screenings Advice – 25jan |
| **Thursday 26th January** | | Email Dr N Damani to Control Team re pseudomonas update on screening and plans for environmental swabbing on Monday 30th. Pending advice from PHA. | 2601-01 Email pseudomonas update 26jan |
| | | Email Dr N Damani to Control Team re – Transfers from RJMH November 2011 – 25 Jan 2012 | 2601-02 Email and attachment Transfers from RJMH November 2011 – 25 Jan 2012 – 26jan |
| | | Telephone call to Chief Executive from John Cole, Health Estates advising that taps should be sourced and provision made for urgent order if required, and that tap | |

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| | | numbers should be provided.<br><br>Chief Executive subsequently telephoned Colin Spiers [SHSCT Estates] to confirm that information on tap requirement completed and supplier sourced, the supplier willing to provide on 'use or return' basis, Chief Executive instructed C Spiers to proceed with order. | |
| | | 11.30 Dr Damani met with Chief Executive, Medical Director and Director Children & Young People to brief on latest position to allow Medical Director to update Trust Board that day (12.30) under confidential section of Trust Board.<br><br>It was agreed that environmental testing and water testing should be organised for Monday 30 January.<br><br>There was still no epidemiology information to suggest outbreak/further cases linked with CAH NNU. | |
| | | Email Update from C Spiers [Estates] to Chief Executive for circulation to Control Team re Tap Numbers following earlier telephone conversation. The email confirmed tap numbers and numbers fitted with in line filter. | 2601-09 Email C Spiers and M McAlinden re taps |

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| | | 16:26 Email from Dr N Damani re Control Team re Pseudomonas Update regarding babies screening positive on 20/01/2012 | 2601-03 Email Pseudomonas – 26jan |
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| | | 18:05 Email Dr N Damani to Control Team re pseudomonas update outlining actions taken to date:<br><br>• Enhanced IPC measures and contact<br>• Hand hygiene practice reinforced<br>• Clinical teams are reminded to strictly adhere to hand hygiene and follow aseptic non touch technique in insertion and maintenance of all in dwelling devices<br>• Enhanced cleaning in the unit - 3 times daily with actichlor+, this is complemented by 8 times per day cleaning of horizontal surfaces<br>• Work identified to deal with the environmental issues has been addressed which includes water pipes under the sink is now completed.<br>• All overflow outlets are sealed.<br>• Estates have completed out chlorination of water as part of legionella control. Other issues relating to Estates are currently being addressed.<br>• Existing water cooler in staff room NNU CAH has been removed<br>• Sterile water is being used for all nappy changing and bathing<br>• All infants are being nursed as far away from wash hand basins as possible<br>• All breast pumps are now single use disposal<br>• Reminded that no clinical waste including bathing water and water left over from nappy change should be disposed of in hand washing sinks<br>• Training and support provided to all clinical staff in NNU with respect to Hand | 2601-05 NNU Actions to date Email 26jan |

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| | | hygiene, environmental cleaning, and ANTT<br>• Additional hand rubs to be placed outside NNU<br>• USS observations discussed for action with relevant staff<br>• Routine screening of all new born babies and transfers to NNU for MRSA, Enterobactor and Pseudomonas<br>• Consideration of environmental sampling on Monday | |
| | | IPC Action Plan for Pseudomonas in NNU updated 26 Jan 2012 | 2601-06 IPC Action Plan |
| | | Email from M McAlinden to Control Team re Pseudomonas re point of use attachments guidance<br><br>In line filters fitted to all taps in interim and adaptors researched/sourced – CAH DHH completed + any rubber flexes identified removed | 2601-07 Email re Pseudomonas -26jan |
| | | Confirmation of revised cleaning schedule and standards of cleaning<br>Reinforcement of principles of ANTT in clinical practices | |
| | | Lead IPCN discussions with domestic staff re assurance and clarity on cleaning practice. | |
| | | 19:30 Dr Damani was informed by telephone by Dr A Loughrey ( Consultant Microbiologist) about baby ( [redacted]) who was transferred from CAH to RVH in early January and who subsequently died had a strain Pseudomonas which was *not* the Belfast strain and was possibly a Craigavon strain.<br><br>This was the first alert to SHSCT of an infection and baby death possibly linked to CAH | |

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| | | NNU. | |
| | | 20:01 Email from Dr N Damani to Control Team re Typing of Pseudomonas advising of telephone call from Dr A Loughrey BHSCT re strains | 2601-08 Email re Typing of Pseudomonas – 26jan |
| **Friday 27th January** | | 09:00 Consultant Microbiologist [Dr Rajendran], IPCN, SPR Microbiology, Risk assessments and investigations were carried out to establish possible link between the cases.. This included a review of patient records, the environment, and equipment. | |
| | | 10:50 Email received by Dr Rajendran from Dr Grace Ong in BHSCT which provided information on typing results of isolates sent to Collindale. This information did not identify specific stains related to location. | 2701-02 Email G Ong to Dr Rajendran – 27jan |
| | | 10:42 Email from Dr L Geoghegan re URGENT Pseudomonas Guidance to Chief Executive on guidance for environmental sampling. This was circulated to Control Team [Environmental Sampling] | 2701-03 Email URGENT Pseudomonas Guidance – 27jan |

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| | | 11:00 Regional Microbiologist Teleconference – Dr Rajendran and Dr Farren [SPR Microbiology] participated. Discussion took place on Health Protection and Infection prevention and control aspects of outbreak. | |
| | | The third set of screening swabs were taken on all the babies | |
| | | Small stock of adaptors received and fitted with POU filters installed in sinks in CAH nursery 1 and 3 | |
| | | 12:30: Dr Rajendran, Dr Farren; Chief Executive, Medical Director teleconferenced re actions to date. | |
| | | Nurse in charge SCBU requested Domestic Services Manager to implement a third daily clean by domestic services in SCBU every day<br><br>Third daily clean commenced in SCBU. | |
| | | 14:00 Estates Regional Teleconference – Microbiology, Medical Director, Estates Management staff participated in teleconference with HEIG re estates issues. Advice from this meeting was not to undertake environmental or water testing pending further advice. | |
| | | 14:45 Regional Teleconference | 2701-04 Email Regional Teleconference Agenda and papers – 27jan |

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| | | 17:00 Regional Medical Directors Teleconference with Chief Medical Officer.<br><br>CMO contacted all Medical Directors to request written submissions by Monday 30th lunch time regarding Trust responses to CMO letters - Water Sources and Risk of Cross Infection. This information was required to brief the Health Minister prior to his Assembly Statement. | |
| | | 18:00 Dr Rajendran contacted by Dr N Irvine PHA. He advised him of discussions on going in the PHA regarding the possible closure of the CAH NNU to new admissions in light of the emerging epidemiology and possible link of a baby death to NNU. Dr Rajendran advised that he would need to discuss with the Medical Director and Trust Chief Executive before implementation. | |
| | | 18:20 Dr Rajendran contacted Medical Director and Clinical Director Infection Prevention and Control. | |
| | | 19:00 Chief Executive and Dr Harper discussed emerging evidence of colonisation and potential infected baby linked to CAH NNU. It was agreed that not enough information to declare outbreak, however Dr Harper would be issuing PHA guidance to Trust to implement. Chief Executive agreed to call Incident Control Team meeting the next morning to review the guidance and implement any actions necessary and that she would Chair this meeting.<br><br>Chief Executive contacted Medical Director, CD IPC and Director CYP to trigger Incident Control Meeting at 10am Saturday 28 January and contacted Head of Communications to act as loggist.<br><br>Medical Director telephoned Clinical Director Infection Prevention and Control – CD IPC advised that the team would undertake the environmental swabbing that evening. | |

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| | | 20:00 Email from M McCartney to Chief Executive re Interim Advice for Craigavon Area Hospital in light of Pseudomonas typing results received today from M McCartney. | 2701-05 Email PHA Advice – 27jan |
| | | 20:30 Dr Damani advised that environmental swabbing was going to take place that evening. ICPN and laboratory staffs were mobilised. | |
| | | Decant options already being considered by ST incident control group and contingency plan to be drafted in the event that a decant is required | |
| | | 21:00 – 21.30 : Dr Damani and Kate Kelly carried out extensive environmental sampling.<br><br>Environmental swabbing (130 swabs) completed evening of 27 January. | 2701-06 Swabbing Information |
| **Saturday 28th January** | | 10:00 SHSCT Pseudomonas Formal Incident Team Meeting attended by PHA representatives Dr Philip Donaghy and Mary McIlroy.<br><br>Chief Executive discussed status of incident with Dr Philip Donaghy PHA who attended the Incident Team Meeting. It was agreed that on the balance of evidence this was an incident not an outbreak. | 2801-01 Notes of Incident Team Meeting 28.1.12 |

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| | | Trust reviewed M McCartney guidance and were satisfied that much of the advice had already been implemented. Two queries were raised and were subsequently resolved via Regional Teleconference<br><br>1. Screening of babies – Complete<br>2. Environmental risk assessment and water sampling – underway<br>3. Deep clean – enhanced practices in place – deep clean to commence following transfers of babies<br>4. Cohort babies by strain – standard practice<br>5. Consider clean cohort area for new admissions –see action 3 and 4<br>6. Dedicated staff to cohort area – in place since 21 Jan<br>7. Do not transfer babies – transfer to DHH agreed with PHA to allow for deep clean<br>8. Alert clinicians – complete since 21st Jan. Dr Damani available to all clinicians. Antibiotic policy altered<br>9. Excellent line management –assured an on-going<br>10. Sterile water for contact with babies – in place since 21st Jan<br>11. Flush taps - in place – query over length of flush<br>12. Stringent hand hygiene with gel – in place with rub<br>13. Only use dedicated hand washing sinks – standard practice<br>14. Do not dispose anything in HW sinks except HW water – guidance in place with signage as extra reminder<br>15. Do not locate HH gel at HW sinks – none at sinks<br>16. Don't refill dispensers – in place | 2801-02 SHSCT Update Against PHA Advice for CAH NNU 27.01.2012 |
| | | Dr P Donaghy and M McElroy visited the NNU and viewed hand-washing practice discussed and reviewed all infection control practices | |

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| | | Sensor taps replaced and sufficient adaptors received to allow POU filters to be fitted to all remaining taps CAH WHB X,Y,V,U,Z &AC<br>Above was planned for DHH but postponed based on guidance issued 28/1 pm i.e not to proceed to replace taps until water testing completed | 2801-12 Progress report on remedial tap and pipe work 28.1.12 |
| | | Plan to commence Water testing in line with guidance by independent expert contractor both sites on Monday 30th. | |
| | | Neonatal Staff update – Updated and re-circulated by U Toland advising staff of current guidance and practices to be followed. It also provides a swabbing update. | 2801-03 Neonatal Staff Update |
| | | 12:54 Email from Chief Executive to Dr C Harper re SHSCT Status Update of progress against Actions in Interim advice. | 2801-04 Email SHSCT Status Update & Updated Action Plan– 28jan |
| | | Afternoon - an early draft of guidance was issued by Dr P Quinn and a paper copy was circulated amongst NICU and paediatric staff pertaining to the enhanced hand washing guidance.<br><br>Dr Quinn issued a number of clinical emails to staff pertaining to 2nd line antibiotic choices for the period. | |
| | | 14:00 Chief Executive verbally updated Dr Harper on status against PHA guidance, status of NNU/SCBU, status of test results, etc. | |

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| | | 14:00 Participation in Regional Teleconference – Chaired by Dr McBride<br>[Dr J Simpson; M McAlinden, C Spiers, Dr N Damani, P Morgan]<br><br>The following was discussed/reviewed:<br>• Overview of swabbing results from Regional units<br>• Use of sterile water and sampling procedures was reinforced.<br>• Guidance on temporary use of point of use filters. | |
| | | 17:28 Email from Chief Executive to Incident Control Team - re SHSCT Status Update of progress against Actions in Interim advice. | 2801-05 Email SHSCT Status Update & Updated Action Plan– 28jan |
| | | 17:40 Email from K Kelly [IPCN] to Dr N Irvine re SHSCT [clarity on babies that moved between 2 Trusts] | 2801-06 Email SHSCT – 28jan |
| | | 18:01 Email from Chief Executive to Ronan Henry [PHA] re development of local briefing for local elected reps and staff. | 2801-07 Email Pseudomonas 29012 – 28jan & briefing |
| | | 18:12 Email from Dr M McBride to Chief Executive & return email approving local risk management. | 2801-08 Email SHSCT Status update – 28jan |
| | | 18:40 Email to Ronan Henry PHA from Chief Executive re DHSSPS News Release – Pseudomonas Update & further clarification email at 19:04 | 2801-09 Email re DHSSPS News Release – Pseudomonas Update – 28jan |

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| | | 19:49 Email Interim guidance on Pseudomonas and neonatal units HSS [MD] TEMP from CMO & internal circulation. This was considered at ICT meeting the next day | 2801-10 Email Interim Guidance on Pseudomonas and Neonatal Units – 28jan |
| | | 21:15 Email from Chief Executive to R Rogers [Communications] re development of local briefing. Return email confirming that this could be completed and presented at Sunday meeting. | 2801-11 Email Incident Control Team – tomorrow at 3pm – 28jan |
| **Sunday 29th January** | | 15:00 SHSCT Pseudomonas Incident Team Meeting<br><br>Meeting reviewed the following:<br>• Current capacity and babies<br>• Update on environmental swabbing & estates remedial actions<br>• CMO Interim Guidance on Pseudomonas and Neonatal Units<br>• Update on deep cleaning<br><br>Decisions made on the:<br>• Implementation of enhanced Hand washing guidance to NNU and SCBU<br>• Removal diffusers from taps at DHH as interim step before replacement and until water testing completed (in accordance with regional guidance)<br>• Development of a staff briefing | 2901-01 Notes of Meeting & 2901-02 Updated SHSCT Interim Advice for NNU Action Plan<br><br>2901-09 Estates Action Plan following Incident Control Meeting 29.01.2012 |
| | | 14:40 Internal Circulation by Chief Executive of Guidance on Central Collation of Water Sample Results email from Dr Anne Wilson [PHA] | 2901-03 Pseudomonas Outbreak – Guidance on Central Collation of Water Sample Results – 29jan |
| | | Medical Director, IPCN, Domestic Services, CD IPC to observe practice of cleaning regime. | |

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| | | 18:26 Email to Internal Incident Team by Chief Executive re use of internal Cleaning of Sinks Protocol and roll out to high risk areas | 2901-05 Email Cleaning of hand-washing basins – 29jan |
| | | 18:33 Email to Internal Incident Team by Chief Executive re approval of SHSCT briefing - advice to be shared with parents if appropriate | 2901-06 Email Pseudomonas Update & Briefing 29jan |
| | | 18:44 Circulation of SHSCT Briefing regarding the precautionary measures being undertaken in relation to Pseudomonas via Global Email to all SHSCT staff and MLA's in Southern Area | 2901-07 Email Pseudomonas update circulation – 29jan<br>2901-08 Email Pseudomonas update circulation – 29jan |
| | | 19:37 SHSCT Wash-hand basin cleaning protocol developed and implemented and forwarded for information to PHA [as requested] | 2901-04 Email Guideline re Cleaning of Wash-hand basins – 29jan |
| **Monday 30th January** | | 09:00 SHSCT Incident Control Team<br><br>Children & Young People's Services senior nursing and medical staff met to continue to risk assess and update decant arrangements using previous decant plans from 2009 and 2010 for unit refurbishments | 3001-10 Notes of Meeting & 3001-01 SHSCT Update on Interim Actions for CAH NNU |
| | | Locality Support Services Manager advised by Assistant Director CYP Services to carry out deep clean of SCBU in DHH<br><br>Deep clean of all clinical areas completed | |

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| | | 10:32 Emailed confirmation of Confirm tap replacement in levels 1,2 and 3 to include all taps including those with clear result to HEIG | |
| | | Press release to Newry Democrat and Banbridge Leader | |
| | | Completion and submission of Form 1 to PHA for NNU and SCBU | |
| | | 13:00 Submission of Trust responses to CMO letters of Water Sources and Potential for Cross Infection Risks – as requested on Regional Medical Directors teleconference with CMO on Friday 28th at 17:00. | 3001-07 SHSCT Response to CMO letter |
| | | 2:45 Regional Health Response Group Teleconference | 3001-03 Agenda and notes of meeting |
| | | Children & Young People's Services Meeting re nursing and medical issues associated with possible decant. The previous decant plan was reviewed and any actions would be needed to decant again from NNU to 3 North were considered. | 3001-09 - Meeting to look at medical and nursing issues regarding decant |
| | | Receipt and circulation of letter Dr C Harper re pseudomonas in neonatal units | 3001-08 – PHA Letter |
| | | NNU Screening on both sites | |
| | | 17:33 SHSCT Hand Hygiene Guidance forwarded to PHA for information | 3001-06 Hand hygiene Guidance |
| | | 19:37 SHSCT Wash-hand basin cleaning protocol developed and implemented and forwarded for information to PHA [as requested] | 3001-05 Email Guideline re Cleaning of Wash-hand basins – 29jan |

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| **Tuesday 31th January** | | 10:30 Health Ministers Statement to the Assembly | 3101-12 Health Ministers Statement |
| | | 11:05 Email to Incident Control Team of Interim Results of swabbing | 3101-15 Interim Results of swabbing |
| | | Response to Daily Mirror queries | |
| | | 12:00 SHSCT Incident Team Meeting<br><br>Actions discussed include:<br>• Completion of dead-leg removal in DHH and Clinical Areas NNU<br>• Deep clean of all non-clinical areas completed SCBU DHH | 3101-10 SHSCT Update on PHA Interim Actions for CAH NNU |
| | | 2:45 Participation in Regional Teleconference | 3101-01 Agenda and Notes of teleconference |
| | | Email queries to Dr Geoghegan re guidance on pseudomonas management | 3101-14 Dr Geoghegan re guidance on pseudomonas management |
| | | Procedure agreed with ICT to carry out disinfection of waste pipes in both units | |
| | | 3.00pm IPCN Training in SCBU /NNU on enhanced Hand Hygiene Guidance and use of PPE | 3101-04 IPC Training Session |

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| | | 17:38 Revised Hand hygiene guidance circulated to Director of Acute Services for roll out to defined augmented care settings<br><br>Circulation to all junior doctors via email | 3101-13 Email Hand Hygiene Guidance<br><br>3101-15 Email Circulation to Junior doctors |
| | | 17:42 email from Dr Damani to PHA regarding process for environmental sampling used in CAH | 3101-16 environmental sampling |
| | | 18.30 Telephone call from Dr Harper PHA to Trust Chief Executive. Dr Harper advised that Dr Doherty had been in contact with Health Protection Agency (HPA) that day and had sought advice from the HPA as to whether the emerging epidemiological information would require consideration of a status change of the Trust's response from Incident to Outbreak. Confirmed via email at 18:48 | 3101-07 Email Strictly Confidential – 31jan |
| | | SHSCT Chief Executive contacted RHSCB Chief Executive to brief John Compton re Incident Status and discussions with Dr Harper, Mr Compton not available, so spoke with Mr Paul Cummings who was deputising and she agreed to keep him appraised.<br><br>Chief Executive attempted contact with Dr Andrew McCormick, Permanent Secretary, and briefing completed following morning (see 8.30 am 1 February) | |
| | | 20:53 Email from Chief Executive to confirm internal arrangements re twice weekly swabbing referencing Dr L Doherty – update on Interim Guidance issued on 21/01/2012 'Pseudomonas Case Definitions, Reporting' | 3101-08 Email update on Interim Guidance issued on 21/01/2012 'Pseudomonas Case Definitions, Reporting' – 31jan |

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| | | 20:46 Email from Chief Executive to Incident Control Team re planned PHA visits to NNU – including terms of reference | 3101-09 Email Visit to Neonatal Units – 31jan |
| | | 20:59 Email from B Godrey HEIG - Confirming 1st stage works to replace like for like with filter and stage 2 works to replace with lever action and NO tmv<br><br>This correspondence confirmed that water tank sampling not required until post samples returned (further confirmed at HPA teleconference at 14.45) | |
| **Wednesday 01st February** | | 8.30 SHSCT CX briefed Andrew McCormick re Incident Status and discussions with Dr Harper, she agreed to keep him appraised for briefing of Minister. | |
| | | 11.45 SHSCT Chief Executive contacted BHSCT Chief Executive to discuss potential response to Incident Status and joined up communication with parents of Baby [redacted] who died in RJM but appeared to have CAH strain. Agreed that Dr Hogan would continue to liaise with Dr Mays and general point of when and how to share typing information with families to be raised for discussion at regional teleconference that day. | |
| | | 12:00 SHSCT Incident Control Team Meeting – followed by PHA Representatives – Dr P Donaghy; Mary McElroy; Denise Boulter & Dr Neil Irvine.<br><br>Group reviewed/discussed the following:<br>• Information received from Dr Doherty 31st Jan and resultant actions to be undertaken by the Trust.<br>• Current swabbing results and capacity – 3 babies colonised<br>• Confirmation that Trust was following Dr Doherty's screening advice<br>• Progress against the PHA Interim Advice Action plan – including estates remedial actions. | 0102-01 Agenda and Notes of Meeting & 0102-02 SHSCT Update on Interim PHA Actions for CAH NNU<br><br>0102-05 Estates Action Plan/Timeline |

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| | | • The regional update on possible decanting of neonatal units<br><br>Group agreed the following actions:<br>• Domestic staff in DHH SCBU trained in Wash Hand Basis protocol.<br>• Wash Hand Basin protocol implemented in DHH SCBU<br>• Roll out to other high risk areas commenced - Domestic staff in Delivery Suite, Renal Unit and HDU trained in WHB protocol [Feb 1st – 3rd]<br><br>The PHA attendees outlined the purpose of their visit in terms of building an epidemiological picture. They confirmed that they were satisfied with actions taken to date by the Trust. The meeting was followed by a walk-about of the visiting team in the CAH NNU. | |
| | | Receipt and distribution of PHA Information Leaflet on Pseudomonas | 0102-04 PHA Pseudomonas Leaflet |
| | | Receipt and distribution of PHA Information on Water sampling | 0102-09 PHA Information on Water sampling |
| | | HEIG Teleconference<br><br>Group discussed the following:<br>• the submission of proforma for tap replacements.<br>• the regional tap replacement programme and frequency of water testing after 7 days was to be confirmed | 0102-10 Update from Regional Estates Teleconference |
| | | 16.30 Trust remained unclear how the CAH situation met the definition of an outbreak, particularly given the assurances provided in relation to the interim control measures in place. Chief Executive asked Medical Director to contact Dr Carolyn Harper to clarify. | 0102-03 Email M. Magee – 01feb |

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| | | Head of Communications also double checked position with PHA counterparts. Response from Margery Magee re definition attached. | |
| | | 17:02 Receipt and distribution of M McGeary guidance on cleaning guidance for care environment | 0102-07 Cleaning guidance for care environment |
| | | 17:32 Initiation of screening for admissions to Paediatric Ward from RVH ward | 0102-08 3 North Screening |
| | | 17:55 Circulation of Dr Damani guidance on environmental sampling to regional IPC leads by Dr Geoghean, PHA. | 0102-05 Circulation environmental swabbing guidance |
| | | 18.30 Dr Harper contacted Medical Director and also spoke with Chief Executive. She advised that the CMO had conducted a teleconference with HPA and HPA colleagues which had included a discussion on the Trust's status. She advised that, on the basis of 3 criteria of science/incidence, that there was no further action required from the trust and our response had been deemed effective, and potential for negative impact on parents/public, it had been decided to maintain the status at 'Incident'.<br><br>This was subsequently confirmed in email of 2 February | |
| | | 19:00 Roll out of Hand hygiene guidance to maternity/delivery wards | 0102-06 - Roll out of HH to Maternity and delivery Wards |

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| **Thursday 02nd February** | | HEIG Teleconference<br><br>The group discussed the following:<br>• Requested to test water supply at mains and tanks<br>• Request for information on results from water tests | |
| | | Notification from Health Estates to commence water testing. Testing of Water Tanks in NNU and SCBU commenced | 0202-10 C Spiers to CX re tank testing 2.2.12 |
| | | 11:00 Meeting with Consultant Microbiologist to review environmental sampling and action. Actions required to address interim water results were also discussed. | |
| | | Letter from Chief executive letter given to all parents by nursing and medical staff with accompanying verbal explanation. Enlarged copy of this pseudomonas update for parents was laminated and publically displayed in the neonatal environment | 0202-01 P McKeown to ICT update for parents 3.2.12 |
| | | Domestic Services Manager informed relevant Domestic staff in SCBU, Renal, Delivery | |

Commented [BA3]: **any key issues discussed/decisions/action required?**

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| | | suite and HDU re revised hand hygiene protocol and placed posters above hand sinks in cleaners stores in aforementioned areas<br><br>Terminal clean carried out in Isolation Room in SCBU | |
| | | 12:00 Pseudomonas Incident Team Meeting<br><br>The group reviewed/discussed the following:<br>• Further update on change of status and definition of incident as a cluster rather than an outbreak<br>• Positive feedback from PHA following yesterday's visit<br>• Current swabbing results and capacity -2 babies positive<br>• Early indications of environmental swabbing results<br>• Communication with parents were being developed for sharing immediately<br><br>Actions included:<br>• Change of swabbing days to Sunday and Wednesday<br>• Seeking clarification from Joint Reponses re the use of sterile water for equipment cleaning<br><br>• Contact with Lead IPCN and Joint Response re standardising cleaning practices and terminology<br><br>• Development of Joint response with PHA on release of water testing information | 0202-02 Incident Team meeting Agenda & minutes<br><br>0202-03 SHSCT Update on Interim PHA Actions for CAH NNU<br><br>0202-07 E-mail C Clarke to J Response re use of sterile water 2.2.12<br><br>0202-08 C Clarke to PHA re cleaning guidance 2.2.12<br><br>0202-09 R Rogers to CX re joint approach on release of info PHA & SHSCT 2.2.12<br><br>0202-11 Dr Damani to C Clarke re cleaning incubators 2.2.12 |

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| | | • Use of MTO staff to support enhanced incubator cleaning | |
| | | 12:29 Email confirmation from Dr C Harper to Chief Executive re Pseudomonas in Neonatal Units regarding definition of Craigavon situation to be described as a cluster not an outbreak. | 0202-04 Email re: Pseudomonas in Neonatal – 02feb |
| | | Early update to Incident Control Team on water testing results | 0202-12 Dr Damani to CX re water results 2.2.12 |
| | | Receipt and distribution to Incident Control Team of responses to queries raised via JRR | 0202-13 E-mail JRNN to Trust response to queries 2.2.12 |
| | | Receipt and distribution of PHA news release to Incident Control Team | 0202-06 PHA News Release 2.2.12 |
| | | Interim Water testing results circulated to Incident Control Team | |
| | | Notification of RQIA Independent Review of the Incidents of Psuedomonas Aeruginosa Infection and Colonisation in Neonatal Augmented Care Settings in Northern Ireland received by CX and circulated to Chair, Directors and Incident Control Team on 02nd February | 0202-05 RQIA Letter to Chief Executive |
| **Friday 03rd February** | | 12:00 Pseudomonas Incident Team Meeting<br><br>Group discussed/reviewed the following:<br>• Seeking of regional advice on alert on babies charts<br>• Current capacity and swabbing results – no further cases of colonisation since 24th January - 1 baby positive<br>• Staff capacity | 0302-01 Incident Team meeting Agenda & Minutes<br><br>0302-02 SHSCT Update on Interim PHA Actions for CAH NNU |

Commented [BA4]: **what were they??**

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| | | • Update on estates remedial actions<br>• Early indications of water testing results<br><br>Email from Chief Executive to Dr Harper PHA and Incident Control Team that all 16 actions in PHA Interim Advice are now completed.<br><br>• Actions from meeting included:<br><br>• Confirmation of change of NNU/SCBU screening to Sunday and Wednesday<br><br>• Make Contact with CONNECT re regional transport incubator cleaning | 0302-02 Confirmation of completed SHSCT Status Update 3.2.12<br><br>0302-05 J Porter to Dr Damani re NNU Screening 3.2.12<br><br>0302-07 E-mail C Clarke to JRNN 3.2.12 |
| | | Regional IPC Leads Teleconference. C Clarke, Lead IPCN participated. | 0302-04 C. Clarke -Email- Notes of IPC Leads 16.02.2012 |
| | | WHB protocol implemented in Delivery suite , HDU and Renal as part of roll out to high risk areas | |
| **Saturday 04th – February** | | C Clarke contacted Chief Executive on Saturday for verbal briefing on status of units etc. | |
| **Sunday 05th February** | | Chief Executive visited the NNU Craigavon Area Hospital and met with staff and patients families. | |

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| **Monday 06th February** | | 12 noon Pseudomonas Incident Team Meeting<br><br>Group discussed/reviewed the following:<br>• Capacity and swabbing results – 2 babies colonised<br>• Dates for receipt of water testing results<br>• Completion of deep cleaning<br>• Update on estates remedial works<br>• Update on contingency planning<br>• Update on communications with parents<br><br>Actions included:<br>• Flagging of notes of babies tested positive by ICT<br>• Response to AQ re use of sterile water [since 21st Jan] | 0602-01 Incident Team minutes<br><br>0602-05 Flagging of notes<br>0602-06 Response to AQ |
| | | 11:00am Estates meeting with G Maguire [CYP] re proposed decant areas | |
| | | Email re attendance at Regional Teleconference [07th Feb] to discuss Adult and Paediatric ICU – This teleconference was subsequently cancelled. | 0602-07 Regional Teleconference ICU |
| | | Email from Dr Damani to Incident Control Team with swabbing results – no new babies positive. | 0602-08 Dr Damani to M McAlinden update on babies 6.2.12 |
| | | Email to Dr Harper, PHA from Medical Director re information to accompany public release of water testing results | 0602-09J Simpson to C Harper re water testing 6.2.12 |

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| | | Email Invitation from Chief Executive to Ms M Gildernew and Mr J Wells (Chair and Deputy Chair of Health Committee) to visit NNU and to observe practice/speak with staff and parents, etc | 0602-02 Email Invitation to visit Craigavon NNU |
| | | Receipt and circulation to Incident Control team of PHA SITREP Update | 0602-03 SITREP 06th Feb Notes |
| | | Completion of revision of Decant Options for SBCU Daisy Hill Hospital | 0602-10 Decant Options for SCBU Daisy Hill Hospital Feb 2012 version 2 |
| | | Confirmation to Dr Damani that all drains and waste outlets cleaned | |
| | | Estates email PHA Health Estates re requirement for filter change every time a sample is taken or every 3 days. | |
| | | Receipt, distribution and review to Incident Control Team of B Godfrey Health Estates letter re tap replacement programme in neonatal units | 0602-04 – Tap replacement letter – Health Estates |
| **Tuesday 07th February** | | 9.30 Governance Committee meeting<br><br>Chief Executive and Medical Director updated Governance Committee on pseudomonas and also brought members through the CMO documentation of 22 December, the two previous circulars referenced and the Trust's response at that time (on agenda and included in papers). Governance Committee members indicated they felt the Trust's response to these circulars to be satisfactory.<br><br>Chief Executive advised Governance Committee that she had agreed with Chair to instigate Internal Review Team to assess Trust's response and identify any learning for | 0702-01 Extract from Governance Committee minutes |

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| | | the organisation. Membership of Internal Review Team to be Mrs Angela McVeigh, Director of Older People and Primary Care (not involved in Incident Control Team and not responsible for any of the operational areas affected nor support functions involved in the response), Non Executive Director (Mr Edwin Graham) and Mrs Debbie Burns, Assistant Director for Clinical and Social Care Governance. Terms of Reference being finalised and would be circulated | |
| | | 12:00 Pseudomonas Incident Team Meeting<br><br>Group discussed the following<br>• Roll out of hand hygiene guidance to other augmented care settings<br>• Capacity and swabbing results – 2 colonised babies<br>• Water testing results – confirmation that taps which were positive were out of use<br>• Communications with parents | 0702-02 Incident Team meeting Agenda<br>& Incident Team minutes [e |
| | | Planned Regional Teleconference to discuss Adult and Paediatric ICU – This teleconference was subsequently cancelled. | |
| | | Domestic staff informed to use only 'mains' water in parents room and milk kitchen to make up Actichlor Plus solution. | |
| | | Second letter from Chief Executive to parents for an update on the pseudomonas colonisation.<br><br>Enlarged copy of this pseudomonas update for parents was laminated and publically displayed in the neonatal environment | |

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| | | Participation in Regional HEIG Teleconference<br><br>Group discussed the following;<br><br>• Clarification of tap replacement programme<br>• Confirmation of HEIG interface with PHA during the incident | |
| | | Email from A Metcalfe to Incident Control Team re: Pseudomonas Important re HEIG contact regarding numbers of taps in ICU and paediatric ICU. He advised numbers of taps were being collated | 0702-03 Pseudomonas Important email |
| | | Receipt and circulation to Incident Control team of PHA SITREP Update | 0702-04 SITREP 07th Feb Notes |
| | | Email from C Clarke to Patricia McDermott re CONNECT – and cleaning of incubators between use | 0702-05 Email CONNECT – and cleaning of incubators between use 07feb2012 |
| | | Receipt and circulation RQIA – Independent Review of the Incidents of Pseudomonas infection and Colonisation in Neonatal Augmented Care Settings in Northern Ireland – Terms of Reference to Incident Control Team | 0702-06 RQIA Review letter 07feb2012 |
| **Wednesday 08th February** | | Email from C Spiers re Pseudomonas Water Test Results to Dr N Damani | 0802-02 Pseudomonas Test Results |
| | | 10am G Maguire chaired meeting to progress plans for possible decant and discuss impact on all and associated services | |

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| | | Email from P McKeown to Incident Control Team re PHA Draft press release for information. | 0802-03 Draft press release email |
| | | Chief Executive visited the SCBU in Daisy Hill Hospital and met with staff and patients families. | |
| **Thursday 09th February** | | 12:00 Pseudomonas Incident Team Meeting.<br><br>Group discussed/reviewed the following:<br>• Capacity and swabbing results – no new cases – 1 baby colonised<br>• Transfer of babies/neonatal network<br>• Update from Chief Executive on recent discussions with parents<br>• Update on remedial estates actions | 0902-01 Incident Team meeting Agenda & Minutes |
| | | Email to Joint Response from Colin Spiers re Water Sampling at mains and tanks at CAH and DHH.<br>Confirmed water samples of the mains water supply and the tank water supply feeding the NNU CAH and SCBU DHH have zero pseudomonas count. | 0902-02 Water Sampling at Mains and tanks at CAH and DHH [hc] |
| | | Circulation of email re: Swabbing for Pseudomonas in Neonates from Joint Response. Providing clarification of advice issued on January 26th. Tabled and discussed at SHSCT Incident Team meeting | 0902-03 Swabbing for Pseudomonas in Neo-nates |
| | | Circulation of email re: Message to all neonatal Units from Joint Response for information. Tabled at SHSCT Incident Control Team for information. | 0902-04 Message to all neonatal Units |

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| | | Receipt and distribution of SITREP report followed by e mail update from Chief Executive to Chair for information/update. | 0902-05 SITREP 09th Feb update |
| | | Response to Dr A Wilson at Joint Response re HPA Colindale for typing with map | 0902-06 K Kelly email to Joint Response |
| | | Receipt and circulation of HSS [MD] 6/2012 Circular – Water Sources and Potential for Cross Infection for Pseudomonas aerguinosa infection from Taps and Water systems – Further Interim Advice<br><br>Infection Control and Estates team considering advice reporting compliance and action required to Medical Director | 0902-07 HSS MD 6/2012 |
| | | Receipt and circulation to Incident Control Team of email from Dr Geoghean, PHA regarding approach to transfers. Tabled and considered at SHSCT Incident Control team meeting. | 0902-08 0902-08 L Geoghegan to C Harper Transfers between NNUs |
| **Friday 10th February** | | Participation in Regional HEIG Teleconference<br><br>Group discussed the following<br>• Confirmation of advice on removal of point of use filter [after 1st clear test]<br>• Still awaiting guidance on type of tap for clinical whb<br>• New proforma for tap replacement to be reissued | |
| | | Chief Executive visited the SCBU in Daisy Hill Hospital and met with staff and patients families. | |

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| | | Email from C Spiers to Incident Control Team regarding the removal of filters and the commencement of work to check water flows into plug holes throughout the Trust | 1002-05 C Spires re tap filters 10.2.12 |
| | | Email circulation of HSS [MD] 6/2012 Circular to relevant staff for review and action | 1002-01 Circulation CMO letter<br><br>1002-02 Actions on CMO Circular |
| | | Circulation for information to Incident Control Team Dr Geoghean email on movement of neonates | 1002-04 E-mail L Geoghegan re movement of neonates 10.2.12 |
| | | Circulation of clarification on CMO letter by Dr J Simpson to Incident Control Team for information | 1002-03Email E Reaney to M McBride |
| **11th – 12th February** | | | |
| **Monday 13th February** | | Pseudomonas Incident Team Meeting<br><br>Group discussed/reviewed the following<br>• Guidance and progress on definition of augmented care settings<br>• Update on regional teleconference regarding transfer advice<br>• No new colonised babies<br>• Review of Trust against the CMO letters relating to Water Sources and the Risk of Cross Infection | 1302-01 Incident Team meeting Agenda & Minutes |
| **Wednesday15th February** | | Participation in Regional Teleconference | 1502-01 Agenda and Notes of Meeting |
| | | IPCT briefing to Chief Executive regarding further roll out of actions to augmented care settings. | 1502-02 Notes of CX briefing meeting |

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| | | Circulation by Dr Rajendran of Information on environmental swabbing results noting some matching of environmental sampling with that of the babies. | 1502-03 Email Scanned ref lab reports -15feb |
| | | Terminal Clean carried out in Isolation Room in SCBU | |
| | | Email from Dr Damani to Incident Control Team & Joint Response Re isolates sent for typing to HPA Colindale | 1502-04 Email from Dr Damani re typing -15feb |
| | | Participation in Regional HEIG Teleconference<br><br>Group discussed the following:<br>• Advising that group to be established to look at good engineering practice for clinical whb<br>• Incident to be stood down but all results from water tests to forwarded to PHA | |
| | | Circulation of further details Estates visits as part of the of RQIA Review for information to Incident Control Team | 1502-05 Email – RQIA Pseudomonas Review – 15feb |
| **Thursday 16th February** | | Circulation of email from Dr McBride re Pseudomonas deaths to SHCT Incident Team for information | 1602-01 Email Pseudomonas deaths – 16feb |
| | | 12:00 Pseudomonas Incident Team meeting<br><br>Group discussed/reviewed the following:<br>• Update from Regional Teleconference re standing down of regional response group | 1602-02 Incident Team meeting agenda & Incident Team minutes |

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| | | • Update on typing results received to date<br>• Identification of priority 1 areas from list of SHSCT defined augmented care settings<br>• Update on water testing results | |
| | | Circulation of email from Dr Harper re stand-down of the Regional Health Response Group to SHSCT Incident Team for information | 1602-03 Email Letter re standing down regional response – Pseudomonas – 16feb |
| | | Circulation of email – Cleaning Guidance for Care Environments to SHSCT Incident Team for information. | 1603-04 Email – Cleaning guidance – 15feb |
| **Friday 17th February** | | Internal circulation and agreement of attendees at planned Regional Health Response Group – Epidemiology Briefing 28th February | 1702-01 Email Regional Health Response Group – Epidemiology Briefing – 17feb |
| | | Email from Dr Rajendran to SHSCT Incident Control Team confirming Tuesday screening results | 1702-02 Email Dr Rajendran – 17feb |
| | | Email from C Spiers to Incident Control Team outlining Interim Water Results – CAH and DHH – advising that 2 taps in DHH still high – filters to remain & taps not to be used and 2 taps in CAH with high pre-flush results – a filter will be fitted. | 1702-03 Email – Interim Pseudomonas results – 17feb |
| **18th – 19th February** | | | |
| **Monday 20th** | | Clinical Forum Meeting – Pseudomonas Incident discussion on augmented care | 2002-01 Clinical Forum |

Commented [BA5]: **Was this to advise of meeting to be held OR Was this for factual accuracy check by us, and if so when and how did we respond?**

Commented [BA6]: **which were??**

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| **February 2012** | | settings<br><br>It was decided to commence water testing in the priority 1 areas of Renal Unit, ICU, HDU, Haematology Ward and Mandeville Chemotherapy Unit. Project Teams would be established to take forward this work in each clinical area. It was agreed to roll out all enhanced good practice in relation to hand hygiene and wash hand basin cleaning and use to all defined augmented care settings.<br><br>Dr Hogan contacted parents of the 3 infants who were colonised to inform them that RQIA will be contacting them | Agenda & Minutes<br><br>2002-02 Augmented Care Settings – Action Plan |
| **Monday 27th February 2012** | | SHSCT Incident Control Meeting & Internal Review of Pseudomonas Meeting | |

Pseudomonas RECURRENT Funding 2013/2014

# Investment Proposal Template (IPT2)
# Evaluation Proforma - Revenue funding > £100,000 < £500,000
***(Unless in exceptional circumstances and approved by Commissioner for >£500,000)***

## Commissioner's Statement

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| **Reference Number** | **BC/SHSCT/314** |
| **Commissioner Representative** | **Dean Sullivan** |
| **Contact Tel. No. & Email** | Personal Information redacted by USI Personal Information redacted by the USI **Tel:** Personal Information redacted by USI |
| **Scheme Title** | **Southern HSC Trust : Pseudomonas Service Pressures: Recurrent Investments to commence 2013 / 2014** |
| **Date** | **3 June 2013** |

**1. Strategic Context – (if provider requires to add any further information for strategic context this should be added to box 8 in the main proposal attached)**

On 20 January 2013, the Minister for Health Social Services and Public safety announced an independent review of incidents of *Pseudomonas aeruginosa* (*Pseudomonas*) infection in Neonatal Units in Northern Ireland. An interim report was submitted to the Minister on 30 March 2012 which made 15 recommendations. A final report *"Independent Review of Incidents of Pseudomonas aeruginosa Infection in Neonatal Units in Northern Ireland: Final Report 31 May 2012",* made a further 17 recommendations.

**The SHSCT is required to implement all the recommendations arising from the Independent Review, as detailed in both the Interim and Final reports**.

In addition, during and subsequent to the outbreak of *Pseudomonas* specific correspondence was issued by DHSSPS and the PHA in relation to the management of *Pseudomonas* i.e.

1. HSS(MD) 31/2011 – Water sources and potential infection risk to patients; 22nd Dec 2011.
2. HSS(MD) 4/2012 – Interim guidance on Pseudomonas and neonatal units; 28th Jan 2012.
3. HSS(MD) 6/2012 – Water sources and potential for *Pseudomonas aeruginosa* infection from taps and water systems; 9th Feb 2012.
4. HSS(MD) 15/2012 – Pseudomonas update: interim report of the independent review of incidents of *Pseudomonas aeruginosa* infection in neonatal units in Northern Ireland *and* Water sources and potential *Pseudomonas aeruginosa* contamination of taps and water systems – advice for augmented care units; 6th Apr 2012.
5. HSS(MD) 16/2012 - Water sources and potential *Pseudomonas aeruginosa* contamination of taps and water systems - advice for augmented care units (including neonatal units caring for babies at levels 1, 2 & 3); 30th Apr 2012.
6. HSS(MD) 17/2012 - Guiding principles for the development of decontamination procedures for infant incubators and other specialist equipment for neonatal care; 15th May 2012.
7. HSS(MD) 23/2012 - Final report of the independent review of Incidents of *Pseudomonas*

*aeruginosa* infection in neonatal units in Northern Ireland; 14th June 2012

8. 23rd January 2012 – Letter to Trusts re Case Definitions, Reporting Requirements & Screening Advice
9. 30th January 2012- Letter to Trust Chief Executives for Action
10. 31st January 2012 – Letter To Trust Directors/IPC Leads/ CMO re Update on Interim Guidance issued on 25.1.12
11. 15th February 2012 – Letter for Action to DHSSPS/TRUSTS/PHA re Standing Down Regional Response Mechanisms
12. 31st May 2012-Letter to Trusts re Regional Protocols in respect of Pseudomonas
13. 19th October 2012 – Letter to Lead IPC Directors re IPTs for Pseudomonas-related work
14. 4th January 2013 - Letter to Trust Chief Executives re RQIA Report Pseudomonas Recommendation 10.

**The SHSCT is required to comply with all this guidance**

**2. <u>Description of Services - (if provider requires to add any further information for strategic context this should be added to section 8 in the main proposal attached)</u>**

The SHSCT in both its Craigavon Area and Daisy Hill Hospital sites is required to ensure that all the recommendations of the Interim and Final reports of the *Pseudomonas* independent review and the guidance issued by DHSSPS and PHA are fully responded to in the services and other measures put in place as a consequence of the investment signaled in this IPT. In demonstrating that the Trust is achieving this, it is required to provide a baseline position (2011 / 2012 ) for the following current services:

- The number of augmented care beds at both CAH and DHH sites
- The number and level of Neonatal beds on both sites
- Neonatal Unit nursing staffing numbers and grades at both sites (including ENNP and ANNP staff)
- Dedicated consultant, middle grade and junior medical staffing input to neonatal care and arrangements for on call relating to neonatal care at both sites (including ENNP / ANNP staff included on the medical Rota)
- Infection Control Team – Nurse staffing numbers and grades
- Laboratory staffing levels
- Patient and Client Support Services (PCSS) cleaning staff and grades
- Estate Staff

and identify and provide a rationale for any increase in these levels resulting from the

investment made through this IPT. This will provide a baseline for 2013 / 2014.

The commissioner expects that any additional staff recruited as a consequence of investment, post full service implementation, should generate additional outputs and outcomes which should be detailed in Section 4 of the Provider section of this IPT.

Whilst the Trust is expected to fully comply with all the recommendations and guidance issued as a result of the Pseudomonas outbreak in Northern Ireland in 2011/2012, services required to address specific recommendations of the Independent Review are detailed below:

1. **Estates Recommendations** including water testing (Final Report recommendations Numbers 2,3,4,5,6,7 and 8).

   The Trust is to put in place measures to ensure full compliance with the recommendations above in particular:-

   - All appropriate policies and procedures must be kept fully up to date, evidence of which should be available to the commissioner. In particular, reports developed on an annual basis following independent validations of self management processes should be made available on request
   - A programme of training and as appropriate, accreditation, for staff with prescribed functions in water management must be in place and updated annually
   - All water testing outlined in the recommendations above must be in place with required flushing regimes implemented. Evidence of this through appropriate laboratory testing and reporting should be available to the commissioner on request.

2. **Environmental Cleanliness** (Interim Report recommendation Numbers 5 and 6)

   The Trust is to ensure compliance with these recommendations outlining in their response the additional staffing numbers and grades (additional to the baseline identified as requested above) and supporting consumables e.g. cloths and protective equipment to achieve these standards.

3. **Infection Prevention and Control** (Interim Report recommendations Numbers 1,2 ,7 and 11. Final report recommendations numbers 9, 10, 14 and 17).

   It is important to re-affirm that infection prevention and control must be central to all Trust activity, with a culture of infection control supported by Chief Executive, Senior Management, clinicians and supporting staff. This should be evident to all who come into Trust premises, particularly into clinical areas and those areas where the most vulnerable patients are receiving treatment. In particular:

   - SHSCT must comply with guidance on the use of sterile water and defrosting of stored breast milk
   - Additional resources should be invested in augmented care areas, particularly but not exclusively, in neo natal areas with a programme of audit using appropriate tools completed to an agreed schedule

NB. Refer to PHA letters Nos. 8 and 10 in section 1 above, which specifically refer to recommendations Nos 9 and 10 in the Interim Report

4. **Laboratory Services** (Interim Report recommendations numbers 3,4,9,10 and12)

It is acknowledged that as a consequence of implementing the above recommendations, additional laboratory testing including screening and surveillance resources will be required. The Trust is asked to outline in their response the additional staffing numbers and grades (additional to the baseline identified as requested above) and the outcomes these additional staff will achieve.

5. **Neonatal Services** (Interim Report recommendation numbers 13,14)

A formal regional neonatal network is being established by PHA / HSCB and the Trust is expected to contribute to this. In addition the neonatal transport system is also being extended and will cover the hours between 9am and 9pm, seven days a week. This system will continue to be available to the Trust to transfer acutely ill neonates to receive appropriate care.

It is recognized that Neonatal Units have some of the most vulnerable patients in the health and social care system and the Trust must fully comply with all estate and service requirements signaled in the Interim and Final reports' recommendations for the units at Craigavon Area and Daisy Hill hospitals. In addition to requirements to adhere to health protection guidance on transfer of neonates between units, the Trust should also outline the intended impact of plans as outlined in the IPT in relation to any planned increased/ change in profile of medical cover, nursing profile, approaches to risk reduction, training (medical and/or nursing) and communication / links with families etc.

The Trust is therefore asked to outline in their response the additional staffing numbers and grade, intended impact of investment (additional to the baseline identified as requested above) and requirements for any supporting consumables e.g. sterile water

6. **Communications (Final Report recommendation numbers 1,11,12,13,15 and 16)**

The management of the Pseudomonas outbreak in 2011 / 2012 highlighted the importance of effective and timely communication processes, both within and between Trusts and also between the Trust and PHA /HSCB, including the Duty Room.

The Trust must ensure that communication protocols are in place and implemented for families, professional and clinical staff and management and also with the media.

**Service Implementation Requirements**

- In costing additional staff required to respond to the above commissioning intent, a template for staff costs is attached and this should be used by the Trust in their summary

costing schedule
- For PCSS cleaning staff, no higher than a Band 2 grade will be supported
- SHSCT is expected to implement these services within 3 months of funds having been approved by the Commissioner. Failure to do so may result in the funding being withdrawn.

**3**. **Funding**

The HSCB is making available regionally an indicative recurrent allocation of £3.5million to support the implementation of the recommendations of the Independent Review of Incidents of *Pseudomonas aeruginosa* infection in Neonatal Units in Northern Ireland.

£451,227 is being made recurrently to the Southern HSC Trust to implement the requirements identified in this IPT.

**4**. **Timescale and process for submitting**

This IPT is to be completed and returned to Mrs Lyn Donnelly Irrelevant information redacted by the I Personal Information redacted by the USI on or before **Friday 28 June 2013.**

## Provider Sections

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| **Provider** | Southern Health & Social care Trust | **Submission date** | 24th July 13 |
| **Scheme Title** | SHSCT – Pseudomonas Cost Pressures | | |
| **Responsible Officer -including title** | Dr John Simpson, Medical Director, SHSCT | | |
| **Contact Details – Tel. No. & Email** | Personal Information redacted by USI Personal Information redacted by the USI Personal Information redacted by USI | | |

- This business case should be prepared in line with the Green Book and NIGEAE Guidance.
- Please complete this template with proportional effort, i.e. detail provided should be commensurate with the size of the bid.

**1 a) Explain how this proposal specifically meets the need for this investment**
*(Must link directly to the Commissioner statement)*

The guidance referenced in the Commissioner Statement provides direction and a wide range of recommendations to ensure that the risk to vulnerable patient groups associated with water borne pathogens is minimised and that on-going audit of compliance is carried out. The scope of the guidance is wider than just pseudomonas. The Trust is also incurring significant cost resulting from the on-going management of legionella. This has been set out in a separate short paper to enable discussion with the Commissioner. This IPT only relates to Pseudomonas associated costs.

The impact of the recommendations highlighted in the Commissioner Statement on the main service areas relating to Pseudomonas only is described in the paragraphs that follow.

- *Estates Services* – Water sampling and testing of wash hand basins, showers and baths for pseudomonas in patient/client areas.

  Pseudomonas sampling must be carried out 6 monthly with 2 separate tests for each wash hand basin. More frequent sampling, along with chlorination and the fitting of filters on outlets follows if a positive result is returned. Samples are sent to a laboratory accredited by the UK Accreditation Service.

  In order to ensure a turnover of water at all outlets and assist in keeping the level of any opportunistic pathogen at an acceptable level, flushing of water outlets is required. All outlets in high risk areas are being flushed daily for a minimum of 1 minute. For all other areas, flushing is being carried out for a minimum of 3 minutes at each outlet at least twice per week.

- *Environmental Cleanliness* – Since the introduction of the Guidance on Cleaning Sinks and Taps in Clinical Settings the Trust now cleans all sinks in high risk areas using a more rigorous 4 cloth methodology and the sinks in all other clinical areas using a 2 cloth method. The time to clean each sink has now increased by 2 minutes and the frequency of cleans in augmented care areas has increased from 2 to 3 times daily. In addition to the increase in time taken to clean a sink the Trust has increased expenditure on PPE and cloths, and also the disposing of extra waste.
- *Infection Prevention and Control* – Enhanced audit function including the implementation of

full independent audit in augmented care areas.

- *Laboratory Services* – Additional screening and typing. The additional tests are estimated at 40 routine screens each from CAH and DHH per week (minimum of 80 swabs). Further testing will also be generated from water, environmental and extended screening.

- *Neonatal Services* – Adherence to the guidance on decontamination of incubators and specialist equipment. The decontamination process is very specific and time consuming and staff need to be trained to such a standard that the equipment is completely decontaminated and safe for each baby.

In addition there is a requirement to manage neonates with infection in isolation and provide 1:1 care where previously one member of staff may have looked after 3 or more babies.

Current Staffing

The 2011/12 baseline funded staffing [as defined in discussion with commissioner] is as follows:

| | | | **WTE** |
|---|---|---|---|
| **Estates** | | | |
| Supervisors Band 5 | | | 3.00 |
| Electrical Band 4 | | | 8.00 |
| Mechanical fitters & plumbers Band 4 | | | 11.00 |
| Maintenance Assistants Band 2 | | | 7.00 |
| | **DHH** | **CAH** | |
| **Neo Natal Units (Nursing)** | | | |
| Band 7 | 1.00 | 1.00 | 2.00 |
| Band 6 | 3.00 | 8.13 | 11.13 |
| Band 5 | 5.50 | 24.86 | 30.36 |
| Band 3 | 5.50 | 3.59 | 9.09 |
| Band 2 | 0.00 | 2.76 | 2.76 |
| Advanced Neo Natal Nurse Practitioner Band 7 [1] | 1.00 | 3.64 | 4.64 |
| **Laboratories** | | | |
| Lead Biomedical Scientist Band 8B | | | 1.00 |
| BMS Team Leader Band 7 | | | 3.00 |
| Biomedical Scientist Band 5/6 | | | 11.17 |
| Medical Laboratory Assistant Band 3 | | | 3.61 |
| **Support Services** | | | |
| Band 2 | | | 232.36 |

| **Infection Control** | |
|---|---|
| Lead IPC Nurse Band 8A | 1.00 |
| Senior IPC Nurse Band 7 | 3.90 |
| IPC Nurse Band 6 | 1.55 |
| Audit Assistant Band 3 | 2.00 |
| Team Secretary Band 3 | 1.00 |

[1] ANNPs are not included in the nursing rota.

Neonatal Unit Medical Cover:

Medical cover is provided as follows:

**CAH**

*Monday to Friday 9am – 5pm* – dedicated Consultant cover for Neonatology

*Monday to Friday 5pm – 9am & weekends* – Middle tier doctor ST3 and above / staff grade, First tier rota resident ST1, ST2, FY1, GP trainees. Consultant on call. The medical cover is not dedicated to NNU but is shared across Neonatal and general paediatrics.

ANNP staff also participate in the medical rota but there are insufficient numbers to provide 24/7 cover to have a dedicated member of staff for neonates.

**DHH**

The medical cover at all times is shared across SCBU/Children's ward/ED/Delivery suite/ Maternity/OP. There is no dedicated medical cover for SCBU. Current Medical cover for these areas is as follows:

Junior/middle grade cover/Consultant of the Week *Monday to Friday 9am – 5pm*

Middle grade (resident) & consultant on call: *17:00-0900, 24/7*

Junior doctor(resident) & consultant on call: *1700-2100 Mon-Fri*

Junior doctor & consultant (on site): *0900-1300 : Weekends and Bank Holidays*

Junior doctor/Middle grade(resident)& consultant on call *1300-2100 Weekends and Bank Holidays*

**Augmented Care Definition/Risk Assessment**

HSCB has indicated that funding will be provided for additional cleaning, flushing and water sampling/testing of wash hand basins in the regionally defined augmented care areas only.

Following risk assessment and taking into account the regional specification of augmented care areas as being those to which the recommendations apply, the Trust has reduced the additional locally defined high risk/augmented care areas from 4 to 3 including Recovery ward & Delivery Suite, CAH and Delivery Suite, DHH.

The risks to these patient cohorts associated with water borne contaminants are such that that the Trust believes it is essential to continue with the enhanced procedures in these additional Trust

defined Augmented care areas. In taking this position the Trust accepts it will require to prioritise resources towards continuing to mitigate the risks in these high risk areas which will require both impact on other areas of worked deemed to be of lesser priority and increased productivity.

The table below provides a comparison of Trust high risk areas and the HSCB augmented care areas.

| | **Trust High Risk Areas** | **HSCB/Regional View of Augmented Care Areas** |
|---|---|---|
| Craigavon | Neonatology<br>ICU<br>Haematology Ward<br>Delivery Suite<br>Recovery | Neonatology<br>ICU<br>Haematology Ward |
| Daisy Hill | Renal Unit<br>Special Care Baby Unit<br>High Dependency Unit<br>Delivery Suite | Renal Unit<br>Special Care Baby Unit<br>High Dependency Unit |

**1b) Describe how this proposal will reduce inequalities in Health and Wellbeing**

Pseudomonas aeruginosa is a type of bacterium which is widely found in the natural environment. It is commonly found in soil and water and is particularly associated with wet and humid environments. It can survive in conditions that other bacteria are unable to. P. aeruginosa rarely infects healthy people but can cause severe infection in patients who have underlying health problems. Pseudomonas can cause infections in different body systems including the skin, urinary tract, gut, respiratory system and blood. P. aeruginosa can be found on the skin without necessarily causing infection, a situation known as colonisation.

Premature babies are very susceptible to infection with P. aeruginosa. They have not yet developed their full immune system and have much less protection than full term babies from antibodies passed across the placenta from their mother. Very premature babies have delicate skin which can be damaged and infected very easily. Consequently, pseudomonas infection can have a devastating effect on the baby. These babies are also particularly at risk from colonisation of their respiratory system which can lead to severe infection. A premature baby is also frequently cared for in a humidified incubator, and P aeruginosa thrives in a humid environment.

Funding of the preferred option will enable implementation of DHSSPS and RQIA guidelines and will minimise the risk of pseudomonas infection amongst this vulnerable group of babies.

**2a) Options Considered and Benefits**

**Option 1** Status Quo involves no change to the current funded service.

**Disadvantages**

- DHSSPS and RQIA guidelines would not be adhered to in relation to minimisation of risk associated with pseudomonas:
    - Cleaning of wash hand basins and taps throughout the Trust
    - Water sampling at water outlets and testing for pseudomonas at recommended intervals in patient/client areas
    - Flushing regimes at wash hand basins in patient/client areas
    - Development and implementation of independent audits
    - One to one care in isolation of neonates with infection
    - Bathing with sterile water of all babies in neonatal care
- This would increase the risk of infection to all patients in the care of the Trust, especially vulnerable neonates;
- Systems and procedures that have been put in place using temporary staff and funding would have to be discontinued.

**Option 2** involves using the available recurrent funding of £451,227 and redirecting resources from other areas of important work deemed to be of lesser priority/absorbing through productivity to enable compliance with the Department and RQIA guidelines in relation to minimisation of risk associated with pseudomonas in augmented care areas:

- *Cleaning of wash hand basins and taps* - in [Trust defined] augmented care areas using a more rigorous 4 cloth methodology.
- *Water sampling and testing* at water outlets in [Trust defined] augmented care areas for pseudomonas. Pseudomonas sampling will be carried out 6 monthly with 2 separate tests for each wash hand basin. More frequent sampling, along with chlorination and the fitting of filters on outlets will follow if a positive result is returned. Samples will be sent to a laboratory accredited by the UK Accreditation Service.
- *One to one care in isolation of neonates with infection*. Previously one member of staff may have looked after 3 or more babies.
- *Bathing with sterile water* of all babies in neonatal care.
- *Additional screening and typing of lab samples*. The additional tests are estimated at 40 routine screens each from CAH and DHH (minimum of 80 swabs) per week. Further testing will also be generated from water, environmental and extended screening.

**Advantages**

- DHSSPS and RQIA guidelines in relation to pseudomonas risk in [Trust defined] augmented care areas, as specified above, would be adhered to;
- The risk of infection to patients being treated in [Trust defined] augmented care areas, especially vulnerable neonates, would be managed in accordance with the recommendations;
- Systems and procedures that have been put in place in [Trust defined] augmented care

areas using temporary staff and funding would be maintained and consolidated. Permanent staff would be appointed and trained to a high standard;

- Regional IPC Audit Tools for Augmented Care Settings will be implemented.

**Disadvantages**

This option maximally stretches existing services to meet with recommendations highlighted in the commissioner's statement. To fufil these the Trust will be required to reconfigure certain services to ensure is demand is met within existing resources.

**2b) Reasons for rejection of options described and identification of preferred option from box 2a**

**The base case** has been rejected as it would enable very limited compliance with guidance relating to management & control of water services and cleaning of sinks, as no additional funding would be available to increase cleaning or water testing regimes etc. The nursing rotas in the Neonatal Unit/Sick Baby Unit would not be enhanced and therefore one to one nursing care for babies with infection could only be facilitated when staffing levels (and patient numbers) permit. Additional audit could not be facilitated within the existing staff complement.

**Option 2** is the Trust's preferred option. It will enable the Trust to comply with DHSSPS directives and RQIA recommendations in relation to minimisation of risk associated with pseudomonas, within the HSCB and Trust definitions of augmented care areas. Water sampling and testing for pseudomonas will continue in these areas. Cleaning of wash hand basins and taps in these care areas will continue in accordance with the guidance. The enhanced 2 cloth method will continue in all other clinical areas. One to one care in isolation of neonates with infection will be facilitated. Independent auditing will be achieved. The Trust will follow up with the commissioner to seek acknowledgement of the monetary value of the absorbed work into the Trust CSR productivity plan.

**3) Financial Quantification of chosen option**

| Option Type | Option Name | Total £ (Rec) | Total £ (Non-Rec) | Overall Total £ |
|---|---|---|---|---|
| Base Case | Option 1 – Status Quo | 0 | | 0 |
| Preferred | Option 2 –Comply with the Guidance in Augmented Care Areas | 451,226 | **Productivity equivalent to follow** | 451,226 |
| **Additional Cost** (Marginal Increase: Preferred Option less Base Case) | | 451,226 | | 451,226 |

*Express costing in total rather than incremental terms to expose full resource consequences*
*Note: Detail to be contained in costing appendix and where cost savings or efficiency improvements are projected these will be further detailed in the VFM Section 6.*

**4) What are the Specific Outcomes of the preferred option**

Quality, Timescales, Quantity – (detailed in box 11 below)

- Compliance with DHSSPS directives and RQIA recommendations in relation to minimisation

of risk associated with pseudomonas in augmented care areas, as set out in the Commissioner Statement.

- Water sampling and testing for pseudomonas in augmented care areas will be implemented.
- Cleaning of wash hand basins and taps in augmented care areas will be undertaken.
- One to one care in isolation of neonates with infection will be facilitated.
- The audit function will be enhanced including the implementation of independent audit of augmented care areas, hand hygiene and commode use.

**5) Activity Outcomes**

*Contacts, placements, procedures etc, please identify*

**SBA Activity**

| **Original Baseline Activity** | **New Baseline Activity** | **Currency (FCE/IP/OP/DC/ Contacts/Caseload etc.)** |
|---|---|---|
| **Additional Baseline Activity** | | |
| **New Baseline Activity** | | |

**NOT APPLICABLE**

*If approved, activity will be added to Indicative volumes in the Service and Budget Agreement (if applicable), further sub analysis may be required by LCG/LGD please refer to Commissioner Statement.*

*The above table must be completed for each discreet element of the service in question and by hospital site if appropriate, please replicate if necessary. If activity is for more than one LCG, please also replicate this table.*

**6) Value for Money**

A) Efficiency Savings (Where applicable)

*- Provide an accurate costing of any savings. Are these savings to be cash released or redeployed? If redeployed please provide full details of redeployment (cost, activity, outcomes etc).*

B) Further demonstrate overall Value for Money by including benchmarking evidence

*B1) Breakdown the elements of the option and compare cost and activity to Status Quo option and benchmarking statistics eg Community Statistical Indicators, Reference Costs, Specialty Costs, HRGs etc.*

B2 Please explain the reason for any positive or negative variances that exist when the preferred option is compared

to B1 above.
*Positive Variances: eg Better working practices, more efficient use of resources etc. These will indicate VFM.*
*Negative Variances: eg Increased complexity of services etc. These will not initially indicate VFM – More information required below in B3.*

B3) *If there are negative variances shown in B2 above explain how are these offset by, for example Qualitative benefits and the context of the project.*

**7) Assess Risks and Uncertainties of achieving the Objectives and Outcomes**
*Identify main risks associated with the proposal and how can these be mitigated – these should be scored using the Providers scoring tool*

Risk has been assessed using the Trust's scoring methodology:

| Consequence | | Likelihood | |
|---|---|---|---|
| **1** | Insignificant | **1** | Rare |
| **2** | Minor | **2** | Unlikely |
| **3** | Moderate | **3** | Possible |
| **4** | Major | **4** | Likely |
| **5** | Catastrophic | **5** | Almost certain |

The consequence and likelihood are combined to provide a risk rating

**Risk Rating**

| | |
|---|---|
| **H** | Red Risk - High = 20 - 25 |
| **M** | Amber Risk - Moderate = 12 -19 |
| **L** | Yellow Risk - Low = 6 - 11 |
| **VL** | Green Risk - Very Low = 1 - 5 |

| Description of Risk | Consequence | Likelihood | Risk Rating |
|---|---|---|---|
| *Loss of life or harm to patient due to insufficient funding to implement control measures* | 4 | 5 | **H** |
| *Inability to appoint permanent staff* | 3 | 2 | **L** |

*Loss of life or harm to patient due to insufficient funding to implement control measures*

The constraint on funding is the most significant risk for the project. The Trust will seek to mitigate this risk by diverting funding from other areas. However this may in turn increase risk in other areas.

As indicated in section 1A (page 6) the risk to patients from water borne pathogens is such that the Trust intends to continue with the regime of additional sink cleaning, water sampling and flushing of water outlets in all clinical areas throughout the Trust which was established following risk assessment. This will incur costs in excess of the available funding allocation and the balance will require to be funded from other service reductions to be agreed with commissioner.

*Inability to appoint permanent staff*

The risk is assessed as a low risk for option 2. The Trust has recruited for similar posts in the recent past and has had a good response to recruitment initiatives.

**8) Monitoring and Post Implementation Evaluation Process – please also refer to detail contained within the Commissioner's Statement**

*Who will manage the implementation of this scheme? When will the development be fully implemented, when will benefits and outcomes be realised?*
*What post evaluation arrangements are in place, these evaluations are also subject to test drilling and should be available 12 months after full implementation of the scheme if approved.*

The Senior Manager, Medical Directorate will manage the implementation of this scheme.

The development will be fully implemented within 3 months of approval of funding.

Monitoring/post project evaluation will be undertaken by one of the Project Managers, Medical Directorate.

**9) Other relevant information**

*Please make note of appendices or attachments*

Costing Schedule

| **10) Signature of individuals responsible for this bid ( section)** | | |
|---|---|---|
| **Trust Authorising Officer** | | **Date** |
| **Title** | | |
| **Trust Director of Finance Signature** | | **Date** |
| **Trust Chief Executive Signature** | | **Date** |

| **11) Approval or rejection ((Local/Regional Commissioning Use only-HSCB and PHA )** | | | |
|---|---|---|---|
| | **Approved** | **Rejected (if yes detail reasons)** | **Approved in Principle (if yes detail reasons)** |
| **Yes/No** | | | |
| **Responsible Officer**<br>Signature Date Position | | | |
| **Authorising Officer**<br>Signature Date Position | | | |
| **Director of Finance Authorisation or delegated officer**<br>Signature Date Position | | | |
| **Chief Executive Authorisation or delegated officer**<br>Signature Date Position | | | |

| **SUMMARY OF FUNDS APPROVED – IF THIS DIFFERS FROM PREFERRED OPTION PLEASE DETAIL SHOULD BE PROVIDED** | | | |
|---|---|---|---|
| **TO BE UPDATED BY THE RESPONSIBLE OFFICER FOR TRAFFACS** | **FYE of project (£)** | **CYE of project (£)** | **Non Recurrent (£)** |
| | | | |
| **SOURCE OF FUNDS** | | | |

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

# GOVERNANCE COMMITTEE

**Minutes of a meeting of the Governance Committee held on Tuesday, 7th February 2012 at 9.30 a.m. in the Boardroom, Trust Headquarters**

**PRESENT**:

Dr R Mullan, Non Executive Director (Chairman)
Mr R Alexander, Non Executive Director
Mrs D Blakely, Non Executive Director,
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs S Rooney, Non Executive Director

**IN ATTENDANCE**:

Mrs M McAlinden, Chief Executive
Mrs P Clarke, Director of Performance and Reform
Mrs A McVeigh, Director of Older People and Primary Care Services
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Dr G Rankin, Director of Acute Services
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr J Simpson, Medical Director
Mr K Donaghy, Director of Human Resources and Organisational Development
Mr S McNally, Director of Finance and Procurement.
Mrs S Judt, Committee Secretary (Minutes)

**APOLOGIES**

Mrs D Burns, Assistant Director, Clinical and Social Care Governance
Dr Boyce, Head of Pharmaceutical Services

1. **DECLARATION OF INTERESTS**

Dr Mullan requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

2. **MINUTES OF MEETING HELD ON 6th DECEMBER 2011**

The Minutes of the meeting held on 6th December 2011 were agreed as an accurate record and duly signed by the Chairman.

3. **MATTERS ARISING FROM PREVIOUS MINUTES**

Members noted the progress updates from Directors to address those matters arising from the previous meeting. In relation to the interim audit of omitted and delayed doses of medicines, Dr Rankin addressed this under agenda item no.6 on Medicines Governance.

4. **INFECTION CONTROL – PSEUDOMONAS UPDATE**

The Chief Executive referred members to communications in their papers from the Chief Medical Officer in relation to water sources and the potential risk to patients issued since 15th September 2010. She drew members' attention to the Trust's written responses to these circulars and advices and noted that these evidence that the content of these were fully considered and appropriately responded to.

Mrs McAlinden provided members with a timeline of recent events:

27.1.2012 - Telephone call from Dr Harper and receipt of PHA interim advice
28.1.2012 – Incident Control Team established
- Further CMO guidance received
3.2.2012 – All actions on PHA interim advice completed

The Trust continues to work with the Public Health Agency and the Chief Medical Officer's office and proactive measures are in place.

Mrs McAlinden confirmed that whilst no babies in the neonatal unit at Craigavon Area Hospital are infected with pseudomonas, three babies have been colonized.

Dr Simpson stated that the speed and flexibility with which the Trust responded to Pseudomonas is to be commended. He advised that RQIA will be undertaking an independent review of the incidents of Pseudomonas.

Mrs McAlinden paid tribute to the commitment and hard work by all staff involved across both sites. She advised that the final water testing results are expected that day and a progress update will be given at Trust Board meeting on 1st March 2012.

Mrs Rooney welcomed the comprehensive updates in the papers and acknowledged the efforts of all staff involved.

In response to a question from Mrs Blakely, Mrs McAlinden advised that the Trust did not test for pseudomonas. Mrs Blakely also asked about the current situation regarding the use of water filters and Dr Simpson advised that these are a temporary solution.

5. **CORPORATE RISK REGISTER**

Mrs McAlinden reported that the Corporate Risk Register was last reviewed and updated at the SMT Governance meeting on 25th January 2012. She gave a brief summary of the discussion at that meeting when updates were received for a number of risks and decisions taken in respect of risks to be included and those to be removed from the Register. Mrs McAlinden advised that issues for further consideration at the next SMT will include:-

- Pseudomonas – potential infection risk from water sources
- HSC Review 'Transforming your Care'
- 2012/2013 Financial Plan

Mrs McAlinden stated that whilst the Corporate Risk Register had been shared with the Department and Regional Board recently, there had not been the opportunity for discussion as the Accountability Review meeting scheduled for 1st February 2012 had been cancelled.

Of the 16 current risks on the Corporate Risk Register, 6 are high risk and a brief discussion took place on the high risk area of high voltage capacity at Craigavon Area Hospital. Mrs Clarke referred to the interim measures underway to provide assurance that the risk is being managed. She stated that the Trust continues to work with Northern Ireland Electricity to find sustainable solutions.

6. **MEDICINES GOVERNANCE REPORT**

In the absence of Dr Boyce, Dr Rankin presented the Medicines Governance Report for the third quarter of 2011/12.

Mrs Blakely referred to the risk associated with the number of Pharmacy staff being on maternity contracts and asked about the current position. Dr Rankin stated that at the highest level, 30% of Pharmacists in Craigavon Area Hospital had been on maternity leave for a short period of time. This risk has now reduced and steps have been taken to look at skill mix in the department with the use of technicians.

**Interim Audit of omitted and delayed doses of medicines in Surgery and Elective Care and Medicine and Unscheduled Care**

Dr Rankin reminded members that a Trust wide audit across all Directorates had been conducted in 2011 indicating areas for improvement and an associated action plan was put in place. In order to assess progress, an interim audit was undertaken during January 2012 with a sample of patients from Surgery and Elective Care (SEC) and Medicine and Unscheduled Care (MUSC). This demonstrated an improvement for both SEC and MUSC in reducing omitted and delayed doses of critical medicines since 2011.

Dr Rankin noted that the national audit data tool used in 2011 did not explore that some omissions or delays are appropriate for the patient's care at that point in time and stated it would be useful to incorporate the determination of the appropriateness of omitted and delayed doses into future audits.

The improvement since the previous audit on the Kardex omission codes was noted. Dr Rankin stated that a detailed action plan is being taken forward to include a range of actions and the implementation of electronic ordering will be a key action. Mrs Blakely sought clarity on the omitted doses with no code recorded against them and Dr Rankin agreed to provide this for the next meeting.

Dr Rankin informed members that a Root Cause Analysis is undertaken when an incident of omitted critical medicines occurs. She reported that 7 RCAs had been undertaken since November 2011 and Mrs McAlinden asked if there were any common themes emerging. Dr Rankin advised that there were no themes or trends emerging and all investigations had been completed in a timely manner.

Mr Graham asked about a benchmark as to what might be appropriate. Dr Rankin stated that there was no national benchmark, but suggested it would be useful to benchmark across the 5 Trusts. Dr Simpson agreed to raise this matter at the next meeting of the Patient Safety Forum.

Mrs Mahood welcomed the progress made since the previous audit, but stated that more work remains to be done. Dr Rankin acknowledged this and spoke of the 'Organisation of Care' project. One of its key workstreams is uninterrupted medicines rounds on the wards.

7. **INCIDENTS AND COMPLAINTS MANAGEMENT REPORT AND UPDATE ON OMBUDSMAN CASES**

Mrs McAlinden presented the above-named report for the period September - November 2011. A total of 3,256 incidents were reported during this period. Mrs Rooney pointed out that the figures in the tables on pages 2 and 3 of the report did not reconcile and Mrs McAlinden agreed to raise this with Mrs Burns.

Complaints were discussed. Mrs McAlinden noted an upward trend in the number of complaints responded to within the 20 working days timeframe. It was agreed that it would be helpful if future reports

included the number of complaints letters responded to as well as the percentage figures. Mrs Burns to take forward.

Mrs Mahood made reference to the dip in performance during October 2011 in relation to complaint acknowledgements issued within 2 working days of complaint being received.

Mrs McAlinden highlighted the significant amount of work undertaken to close off cases with the Ombudsman with seven cases closed by the Ombudsman during the period.

8. **SERIOUS ADVERSE INCIDENTS REPORT FOR THE PERIOD 1.4.2011 – 31.12.2011**

Mrs McAlinden presented a summary of the Serious Adverse Incidents reported during the period 1st April – 31 December 2011 and those that remain open from 1st April 2007 – 31st December 2011. She reported a total of 32 SAIs during 1st April – 31st December 2011.

9. **PROFESSIONAL GOVERNANCE REPORTS**

**i) Medical Director**

Dr Simpson highlighted the key aspects of this report as follows:-

Medical Appraisals 2010: Dr Simpson reported a high performance for the appraisal round 2010. He confirmed that those doctors who have not completed their 2010 appraisal are being contacted directly by himself.

Junior Doctors Mandatory Training Competencies: Dr Simpson advised that the Trust continues to monitor the training competencies of Junior Doctors. He stated that attaining full compliance among the Junior Doctor cohort remains challenging. Members welcomed the fact that Dr Simpson has written to the new intake to remind them of their responsibilities to fully complete the Trust mandatory training competencies and that a process has been put in place for escalation of non-

compliance. A short discussion ensued in which Committee members raised concern at the potential risk to patient safety if some junior doctors do not achieve the necessary competencies for working on wards. Mrs McAlinden and Dr Simpson both acknowledged the concerns of the Committee in this regard and agreed to look at further possible measures to address non-compliance.

HCAI: Dr Simpson advised that there have been 27 C.difficile infections year to date which exceed the target of 22 and referred to the Health and Social Care Board's letter to indicate performance remains satisfactory at SH&SCT target lowest in Northern Ireland . The Trust remains on course to achieve the MRSA target as the total number to date has been 7.

Patient Safety Interventions: Members noted the performance against each of the 13 Patient Safety Interventions. Dr Simpson advised that there have been no exceptions or trends of a worrying nature since the November 2011 report in respect of these targets. Mrs McAlinden highlighted the variance in overall bundle compliance between Craigavon Area Hospital and Daisy Hill Hospital in relation to surgical site infection (SSI) Caesarean Section. Dr Simpson agreed to provide an explanation for this variance in his next report.

**ii) Social Work and Social Care**

Mr Morgan presented his report which summarizes progress against six key areas of activity. Within these six areas, are 22 sub-sections and Mr Morgan highlighted the significant progress made towards compliance in that 15 are green, 7 are amber and there are no red areas.

Mr Morgan noted the Trust's strong performance in relation to the achievement of the Post Qualifying Award in Social Work for specific staff groups. Of the 650 Trust social workers currently registered with the Northern Ireland Social Care Council, 377 of these hold full post-qualifying awards with 154 staff enrolled with the N.I. Post Qualifying framework. Mrs Blakely raised the issue of ongoing support to social

workers to avail of training and asked if there were any problems in terms of inequity of training opportunities across Directorates. She also raised the issue of young, in experienced social work staff and the training opportunities open to them. Mr Morgan advised that as well as formal professional induction, the Training Unit produces an action plan each year which is consulted on across Programmes to ensure that the training is relevant and prioritized.

10. **RQIA REVIEWS STATUS UPDATE**

Members discussed the update in their papers on RQIA Reviews. It was noted that the draft report has been received for accuracy checking in relation to the Review of Mixed Gender accommodation in Acute Wards and the report on the Review of Care for Under 18s in Adult Acute Wards is awaited.

11. **ACCOUNTABILITY REPORT FOR STANDARDS AND GUIDELINES**

Mrs McAlinden stated that this is the second report to the Governance Committee and covers the period 1st July 2011 to 31st December 2011. During this period the Trust received 44 new standards and guidelines from the DHSSPS or other external agencies. Of these, 6 have been issued with a requirement to provide an assurance response to the Health and Social Care Board within a specified timescale. Mrs McAlinden stated that this report demonstrates the breadth and complexity of the standards/guidelines the Trust receives and the ongoing and significant work to ensure that full compliance is received.

Mr Graham queried why compliance with standards and guidelines remains on the Corporate Risk Register given the progress made which includes the development of an algorithm on the Trust's processes to effectively disseminate, implement and assure itself against all newly issued standards. Mrs McAlinden responded by advising that there remains an issue in terms of capacity to undertake a complete look back exercise in relation to those standards that have been issued prior to January 2009. For that reason, this item remains on the Corporate Risk Register. In response to a question

from Mrs Kelly on the requirement to replace the current ambulatory syringe drivers, Dr Rankin advised that the replacement programme is dependent on a regional procurement process and there has been no progress regarding this work. Mrs McVeigh provided assurance that there is considerable focus on training of staff in the community on the use of ambulatory syringe drivers. Mrs Rooney referred to the partial compliance in relation to the RQIA follow up Review of Reducing the Risk of Hyponatraemia when administering intravenous fluids to children and the NPSA Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants and asked when work will be completed. Mrs McAlinden agreed to ask Mrs D Burns to provide this information to the Committee for the next meeting.

12. **FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REQUESTS – SUMMARY REPORT FOR THE PERIOD SEPTEMBER - DECEMBER 2011**

Mrs Clarke presented the summary report for the period 1st July – 30th September 2011. A total of 56 requests were responded to in this period and of these, 35 were processed within the 20 day deadline and 21 processed outside of the 20 day deadline. Mrs McAlinden noted that the majority of requests were received from members of the public, businesses and the media. Details of the individual requests for information are included in the report.

13. **GMC TRAINEE AND TRAINER SURVEY 2011 RESULTS**

Dr Simpson spoke to a report which details the responses from Junior Doctors National Training Responses Survey as carried out by the General Medical Council in 2011. Members discussed the Trust results and the associated action plans to address outlying areas/issues. Mrs McAlinden stated that the survey results are a very valuable source of information and this work is critically important in the context of NIMDTA's role in quality assuring the Trust's plans in response to Transforming Your Care. She stated that it would be useful for the SMT to have further discussion on the issues raised in the survey. Dr Mullan asked if the Trust could take steps to improve the availability of internet access in the workplace. Mrs Clarke

advised that the Trust is looking to providing wi-fi hotspots in the hospital.

14. **TRUST ARRANGEMENTS FOR HANDLING CLINICAL AND SOCIAL CARE NEGLIGENCE AND PERSONAL INJURY CLAIMS**

Members noted receipt of an updated action plan. Procedures for the management of claims have been issued to Directors for comments and once finalised, will be brought to the Governance Committee. Dr Simpson advised that the Litigation Manager and himself now attend Directorate Governance meetings.

15. **BREAST SCREENING ANNUAL REPORT**

Members received, for information, the Trust's Breast Screening Unit's Annual Report for 2011. Dr Rankin stated that this report demonstrates that both minimum and target standards were met for all criteria and no issues emerged. There was a brief discussion on uptake rate and Dr Rankin advised that the Breast Screening Committee has been looking at various health promotion strategies and linking with Community Development and Health Promotion teams to increase awareness in an attempt to increase screening uptake.

16. **UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE**

Mr Graham updated members on the meeting held on 1st December 2011. At that meeting, the Committee revised its membership to include all of the Non Executive Directors. At its next meeting, the Committee will determine what complaints information it requires in order to avoid duplication of this information with the Governance Committee.

***Action: Mr Graham***

17. **REVIEW OF GOVERNANCE COMMITTEE**

An assessment tool is being finalised and will be issued to members thereafter. The Committee will review and revise its terms of reference at the next meeting.

***The next meeting of the Governance Committee will take place on Tuesday, 15th May 2012 at 9.30 a.m. in the Boardroom, Trust Headquarters, Craigavon***

**SIGNED: _____**

**DATED: _____**

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

# Minutes of a Trust Board meeting held in Public on Thursday, 1st March 2012 at 9.30 a.m. in the Boardroom, Daisy Hill Hospital, Newry

## PRESENT:

Mrs R Brownlee, Chairman
Mrs M McAlinden, Chief Executive
Mr R Alexander, Non Executive Director
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr S McNally, Director of Finance and Procurement
Dr J Simpson, Medical Director

## IN ATTENDANCE:

Mrs P Clarke Director of Performance and Reform
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs A McVeigh, Director of Older People and Primary Care Services
Dr G Rankin, Director of Acute Services
Mr M Crilly, Assistant Director of Disability Services (for Mr F Rice)
Mrs S Cunningham, Patient and Client Council
Mrs R Rogers, Head of Communications
Mrs S Judt, Committee Secretary (Minutes)

## 1. CHAIRMAN'S WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting, in particular members of the public.

Apologies were recorded from Mrs E Mahood, Non Executive Director and Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing.

The Chairman sought and received confirmation from members that they had read their papers in advance of the meeting.

2. **DECLARATIONS OF INTEREST**

There were no declarations of interest in relation to any items on the agenda.

3. **CHAIRMAN'S BUSINESS**

The Chairman briefed members on a number of events held since the previous meeting.

- **LEAN Healthcare Academy Awards on 8 February 2012**

  The Trust won a national award for its implementation of remote telemonitoring of patients with long term chronic conditions, beating competition from across the UK. In addition, the Trust's 'Releasing Time to Care' initiative which looks at ways of improving patient experiences on busy hospital wards, received runner up in the Productive Series – International category at the Awards.

- The Mayor of Craigavon, Councillor Alan Carson has paid tribute to the work of local foster carers by treating them to a reception in his parlour. Around 30 carers from the Craigavon area, some foster children and their social workers attended the event.

- The Mayor of Dungannon South Tyrone Borough Council, Cllr Kenneth Reid hosted a reception to give recognition for the Trust's 16 + Service User Group for their recent achievements. They came highly commended in the 2011 Children's Commissioner's Participation Awards for the production of a DVD, 'The Low Down'

## 4. CHIEF EXECUTIVE'S BUSINESS

i) Pseudomonas: Mrs McAlinden updated members on the current position. She advised that there have been no new colonisations since those swabbed on 20th January 2012. The Trust's Incident Control Team has now been formally stood down and any outstanding actions will be taken forward within the Trust's HCAI structures. The work of the Internal Review Team is ongoing and recently attended a round table discussion to finalise the documentation required for the RQIA Review. Mrs McAlinden acknowledged the efforts of those involved in compiling the documentation and particularly thanked Mrs McVeigh and Mr Graham for their input.

Mrs McAlinden advised of Professor Troop's visit to the Trust the previous day which included a visit to the Neonatal Unit in Craigavon Area Hospital. Part of the discussion had focused on the HCAI culture within the Trust and how staff raise concerns on infection control issues. Mr Graham stated that Professor Troop was impressed with the Trust's HCAI culture and the Chairman paid tribute to the Chief Executive and Directors for their leadership in this regard.

ii) **Community Meals**: Mrs McAlinden informed members that the Health Committee had held an evidence session with DHSSPS officials on the issue of community meals on 15th February 2012. The issues discussed included the level of provision and Trust representatives have been invited to present evidence to the Health Committee on 7th March 2012. Mrs McVeigh will be representing the Trust. A briefing is to be submitted to the Committee by 2nd March 2012 and this will be shared with Trust Board members. Mrs McVeigh stated that the Trust has a range of approaches to supporting individuals within the community to meet their nutritional needs. These include meals in statutory or independent sector day care; attendance at luncheon clubs and social centres and domiciliary care and subsidised meals on wheels. The Trust employs community dietetic staff as well as a range of other professional staff who are also involved in reinforcing good nutrition and dietary advice.

Mrs Blakely asked how the Trust ensures that individuals in the community are receiving quality and nutritional meals. Mrs McVeigh outlined some of the initiatives the Trust is engaged in to promote good nutrition within the community.

## 5. MINUTES OF MEETING HELD ON 26TH JANUARY 2012

The Minutes of the meeting held on 26th January 2012 were taken as read and agreed as an accurate record. The Minutes were duly signed by the Chairman.

## 6. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the responses to issues raised at the previous meeting.

## 7. RESEARCH AND DEVELOPMENT ANNUAL REPORT 2010/11 (ST 370/12)

The Chairman welcomed Dr P Sharpe, Consultant Chemical Pathologist/Associate Medical Director, Research and Development to the meeting to present the Research and Development Annual Report 2010/11. Dr Sharpe began by reporting a further increase in research and development activity in the Trust during 2010/11 with 84 research applications and 48 enquiries received. He stated that applications were received from various professions within the Trust and included clinical trials and research studies for academic purposes. He then outlined some of the studies which made specific achievements. Dr Sharpe referred to the tangible commitment to Research and Development within the Trust with the Southern Trust second in the league of Trusts in the Province as regards Research and Development.

Dr Sharpe advised that the Trust received £50,000 in 2010/11 for the Director's Discretionary Fund for the third successive year to support small research projects and £100,000 in 2011/12. He stated that the availability of this funding has been invaluable and enabled many research projects to commence with some developing into large Clinical Trials.

Dr Sharpe stated that he welcomed the appointment of Dr Patricia Gillen as Head of Nursing and Allied Health Professions Research and Development/Honorary Research Fellow. Dr Gillen commenced on 1st February 2012 and her main aim is to promote research and development amongst nurses and allied health professionals within the Trust.

Dr Sharpe concluded his presentation by advising that a key challenge going forward is to embed research and development as a core function within the Trust and to encourage staff to bring forward innovative ideas.

Mrs Kelly stated that she would like to see the public made more aware of the results of successful research studies. Dr Sharpe endorsed this and stated that the challenge is translating the research into practice.

The Chief Executive stated that it was evident from Dr Sharpe's presentation that to be a high performing, progressive organisation, requires investment in Research and Development and this is an area the Trust Board is very committed to. She paid tribute to the continued commitment of Dr Sharpe and his team in driving forward this area of work within the Trust.

There was a short discussion on funding and the need to move away from the dependency of a central funding stream and use Endowments and Gifts money in a more proactive way. Mr Alexander asked about links with the private sector to attract funding to which Dr Sharpe outlined some of the links which are ongoing.

The Chairman thanked Dr Sharpe for his excellent presentation and apologised for the technology difficulties he encountered. She invited Dr Sharpe and Dr Gillen to attend a future Board Workshop to present some successful research studies.

**The Board approved the Research and Development Annual Report 2010/11(ST 370/12)**

## 8. STRATEGIC ISSUES

### i) Consultation on the Model of Shared Services for Implementation in Health and Social Care within Northern Ireland – SH&SCT response (ST 371/12)

Mr Donaghy presented the Trust's response to the above consultation document for approval. Mr Donaghy advised that the response reflected a range of issues raised during the consultation process. Dr Mullan highlighted the strong criticisms contained within the Trust's response to the initial Equality Impact Assessment (EQIA) contained in the consultation paper. Mr Donaghy confirmed that the Trust's response pointed out a number of limitations concerning the original EQIA. Members indicated that the response reflected a balanced position.

**The Board approved the Trust response to the consultation on the model of shared services implementation (ST 371/12)**

### ii) Update on 'Transforming Your Care'

In terms of local planning, Mrs McAlinden advised that a Trust/Local Commissioning Group meeting is scheduled for 7th March 2012 to finalise the project structure and workstreams content. A draft communications plan is being drawn up with PPI focus. A regional business case is being developed by Mr J Compton. Mrs McAlinden stated that she is the Chief Executive representative on the Department's Quality Assurance Group.

Mrs McAlinden highlighted the NICON Conference held on 23rd February 2012 to discuss the proposals and implementation arrangements for the 'Transforming Your Care' programme. Mrs Blakely commented on the lack of representation from the Local Commissioning Groups and staff side at the Conference and stated that in her view this was a missed opportunity.

iii) **Summary of Internal Capital Business Cases in excess of £300,000 (ST 372/12)**

Mrs Clarke presented, for approval, a summary of business cases with a capital/revenue value greater than £300,000 which had been developed since the previous report approved by Trust Board on 25th August 2011. She stated that full business cases for each of the projects are available for review by Board members.

Mrs Clarke advised that the Trust has now received approval for the community information system business case. The Chief Executive welcomed this development and congratulated Mrs Clarke and those staff involved in bringing this to fruition.

The Chairman noted the £450,000 ring-fenced CRL allocation for the replacement of vehicles acquired prior to 2003 and asked if the vehicles would be procured by 31st March 2012. Mrs Clarke confirmed that this would be the case. Mr Alexander referred to the rising fuel costs and asked if the Trust considered other options such as electric vehicles. Mr Crilly responded by advising that the Trust has explored electric vehicles, but these are high cost.

The Chairman expressed the view that the service development proposed for Urology should be expedited as quickly as possible, given the current waiting lists. Mrs Clarke explained that this service expansion will also enable patients from outside the Southern Trust's catchment area to be treated. Mr Alexander asked about the lead time from approval to installation for the second MRI scanner . Mrs Clarke stated that this proposal is part of a draft programme which has not yet received business case approval from the DHSSPS. She went on to advise that the Trust does highlight priorities in advance and there is a willingness from the DHSSPS to work with the Trust as a business case develops.

**The Board approved the Internal Business Cases in excess of £300,000 (ST 372/12)**

iv) **Proposed future service model for mainstream residential care (ST 373/12)**

The Chairman welcomed Mr Michael Hoy, Head of Short-term Residential Team Services, who joined the meeting for this item. Mr Morgan presented, for approval, a proposal for the future service model for mainstream residential care. He referred members to the detail in the proposal document which sets out the strategic context, research and literature review, consultation with staff and service users and details the results of a needs assessment and non-financial option appraisal.

Mr Morgan highlighted the six options identified to be considered in relation to the future service provision. He advised that the preferred option is a re-configuration to one assessment unit (to include 3 frontline fostering assessment service beds), 5 long-term therapeutic care units (non-age or non-gender specific). He outlined the benefits of this option which include a 'step up' – 'step down' alternative to secure accommodation, fewer emergency admissions to residential care, faster assessment of new admissions and improved capacity to manage complex/high risk situations. This would be a phased introduction over a period of time with the aim of reducing from 36 beds to 30.

Mrs Blakely welcomed this model, in particular the 'family link' service in the community. Mr Alexander spoke of his recent visit to Bocombra Children's Centre and asked about the level of continual assessment to ensure that capacity is optimised. Mr Hoy stated that the Children's Resource Panel will be key in that it will co-ordinate the allocation of places within units to meet the ever changing needs and complexity of young people requiring residential care. Mrs Kelly commended this proposal and acknowledged the dedication and commitment of staff in the residential settings. In response to a question from Dr Mullan regarding timescales, Mr Morgan advised that the reconfiguration would take place over the next few years and an evaluation undertaken, the results of which will be brought to a future Trust Board meeting.

**The Board approved the proposed future service model for mainstream residential care (ST 373/12)**

9. **PATIENT/CLIENT SAFETY AND QUALITY OF CARE**

**i) Unallocated Child Care Cases**

Members discussed the unallocated child care cases performance management report for January 2012. Mr Morgan, in presenting this report, provided assurance on the allocation of child protection referrals and the throughput of child care referrals generally. He reported a reduction in unallocated cases from 125 in December 2011 to 55 in January 2012 with no unallocated referrals in Gateway. Of the 55 unallocated cases, 30 were within the Family Intervention Teams and 25 were within Children with Disability Teams. Mr Morgan stated that the Trust remains on target to fully deliver on the Health & Social Care Board's reduction plan. The Chairman welcomed this and stated that she looked forward to the Trust having no unallocated cases as at 30th April 2012.

In terms of challenges, Mr Morgan spoke of the three Family Support Hubs to be established by end of April 2012. He advised that one of the hubs has been operational since December 2011 and that once all three have been embedded, this will have a significant impact on referral rates into the service. The Chief Executive stated that the Family Support Hubs are an exciting and innovative way of engaging with the community/voluntary sector to manage low level Family Support referrals.

There was a short discussion on staffing. In response to a question from the Chairman, Mr Morgan advised that discussions are taking place with Human Resources to build up the Bank of qualified social work staff. Mrs Blakely asked Mr Morgan how the new Gateway Duty system was operating. Mr Morgan advised that it was early days, but the system has brought consistency in terms of decision-making and thresholds. Mrs Blakely raised an issue whereby some families may have several different social workers over the course of a

year and asked if the Trust collated this information. Mr Morgan advised that the Trust does not collate this data, but if Mrs Blakely provided him with further details, he would look into this. Mrs Rooney commented on the challenge of sick leave on the service and asked if the sick leave was short term or long term and what measures the Trust was putting in place. Mr Morgan responded by saying that sick leave is monitored very closely, but there is no evidence to suggest a particularly high sick leave rate within teams. It was agreed to provide a comparison of the sick leave rate against the Trust average in future reports.

**ii) Infection Control update**

**Pseudomonas**

This item was addressed under Chief Executive's business (agenda item no.4).

**10 Elements of Board to Ward Assurance on Healthcare Associated Infections**

Dr Simpson presented a compliance paper and explained that the '10 Elements' are statements describing infection prevention and control (IPC) in a high performing Trust and are intended as an aide-memoire to help Non Executive Directors focus on key aspects of IPC in order to strengthen board to ward assurance. He drew members' attention to the two 'amber' areas. In relation to No. 10, Dr Simpson undertook to provide a confidential report to Trust Board regarding HCAI related deaths for the next meeting.

10. **OPERATIONAL PERFORMANCE**

i) **Performance Report (ST 374/12)**

Mrs Clarke presented the Performance Management Report and Corporate Dashboard Report for January 2012. She explained that the Healthcare Associated Infections and Patient Safety Quality Improvement Targets are now reported in the

Medical Director's report to Trust Board. Mrs Clarke referred to the detailed update in the Dashboard Report, highlighting key areas of risk as follows:-

Access times for 1st Outpatient appointment: Whilst the Independent Sector contracts placed for Orthopaedics, Ophthalmology and Oral Surgery are on-going, the impact of these remains to be evidenced on recording systems. It is expected that this will reflect improvement in the February report.

Access times for Diagnostic test: There has been an improvement particularly in imaging with a slight increase in the total volumes waiting within non-imaging. Dr Rankin stated that the high level of cancer and urgent work in Urology have taken clinical precedence with associated impact on routine waiting times.

Inpatient and Day Cases: There has been a significant improvement since December 2011 with a decrease in the total number of patients waiting in excess of 36 weeks to 650 and with an increase to 57% of patients treated within 13 weeks.

Accident and Emergency: The position remains challenging regionally and locally over recent weeks with local performance remaining relatively strong.

Allied Health Professions: A significantly improved position from December 2011 with a decrease in the total number of patients waiting in excess of 9 weeks to 1102.

Outpatient Review Backlog: Significant progress has been made with only 17% now waiting prior to 2011/12.

Cancer: Internal breaches are reducing due to new service models in Urology whilst there is an increase in external breaches due to pressures in other Trusts.

The Chairman expressed her concern at a number of areas of risk to the achievement of the 9-week access target by March

2012. A short discussion ensued on access times for a range of services across Acute, Allied Health Professions and Mental Health provision in which Board members expressed concern at the lack of recurrent solutions to address capacity gaps. The Chief Executive agreed to write to the HSCB expressing the Board's views and concerns.

Mrs Kelly commented on the Did Not Attend performance and stated that it was disappointing to note that there had not been a significant improvement despite the recent publicity. Dr Rankin spoke of the 'Don't Waste Your Space' campaign which has been publicised in the local papers and posters and advised that the use of text messages in outpatients across four specialties is currently being piloted and will be evaluated.

Mr Graham expressed his concern at the A&E position in Craigavon Area Hospital. The Chief Executive stated that there is enormous pressure on the Emergency Department (ED) system across Northern Ireland at present. The Trust continues to monitor the impact of increased demand associated with flow to the ED of residents from outside the Trust area in response to service changes regionally. Dr Rankin stated that it is an area of identified pressure and a range of actions are being taken which include the commencement of two new ED Consultants with two further new Consultants due to commence by end of March 2012.

Mrs Cunningham stated that over the past few weeks, there have been an increased number of contacts from the public on the waiting times at the ED Department in Craigavon Area Hospital. She asked about the sustainability of the use of the Independent Sector for elective access in the longer term. Mrs Clarke responded by advising that the use of the Independent Sector is only in a limited number of specialties and is not intended to be an ongoing solution. Discussions remain ongoing in relation to demand and capacity issues. In some other areas, for example, ophthalmology services, the lack of success in recruiting consultant staff is an issue, but the Trust is looking at alternative ways of addressing this.

The Chief Executive stated that the Trust is continuing discussions with the Health and Social Care Board to reach a longer term solution to address agreed capacity gaps.

**The Board approved the Performance Report (ST 374/12)**

ii) **Finance Report (ST 375/12)**

Mr McNally presented the Finance Report for the 10 month period to 31st January 2012 for approval. He advised members that the Trust has generated a surplus of £1,838k, an increase of £334k on the December position. This position includes slippage of £82k on SureStart Schemes. He stated that the Trust continues to forecast a year end break-even position.

In relation to expenditure on payroll, Mr McNally highlighted a downward trend, except for agency. This is mainly attributable to providing back-fill for staff in Finance and Human Resources who are involved in the shared services and the Business ServicesTransformation Programme. The Trust has been funded for this back-fill.

Dr Mullan expressed his concern that the Trust has only spent 24% of its total general capital allocations at this point in the year.

The Chairman asked about the current position regarding financial assessments. Mr McNally advised of an improvement from the position in January 2012 due to use of agency staff.

**The Board approved the Finance Report (ST 375/12)**

iii) **Human Resources Report (ST 376/12)**

Mr Donaghy presented the Human Resources Report and noted that this month's report focuses on two of the NHS HR High Impact Changes 'Support and Lead Effective Change Management' and 'Promote Job and Service Design'.
The report also provides workforce data and an update on general Human Resources activities/issues.

Mr Donaghy highlighted a few issues including:-

- Involvement in a regional recruitment exercise for the creation of a Band 5 Physiotherapist waiting list. This will be concluded by the first week in March 2012 and evaluated with a view to rolling this model out for other basic grade professional posts.

- Nurse Bank IT system and telephone system are continuing to progress.

- Turnover rate at 3.5% as at December 2011 was the lowest in the Province.

- Sickness absence for December 2011 was 5.29%. Members noted the additional information provided in the report on sickness absence as requested at the previous meeting.

**The Board approved the Human Resources Report (ST 376/12)**

11. **BOARD REPORTS**

**i) Security Management Annual Report 2010/2011 (ST 377/12)**

Dr Rankin presented the Security Management Annual Report 2010/11 for approval and highlighted the following key areas:-

- The Trust's 2010/11 self –assessment score against the Security Management Controls Assurance Standard was substantive;

- A Trust Security Strategy has been agreed and will be implemented and communicated by March 2012;

- The Trust's current lockdown arrangements for Craigavon and Daisy Hill Hospitals will be documented by February 2012;

- There were 3 prosecutions for assault against Trust staff during 2010/11 and 1 case is pending.

The Chief Executive commented on the increasing number of violent/abusive behavior incidents by patients reported in the daily ward reports for both Craigavon and Daisy Hill Hospitals and asked about the Trust's response in these circumstances. Dr Rankin advised that the Security Porters are the first point of call and all have received the appropriate Management of Actual or Potential Aggression (MAPA) training as have all front line staff. There are joint protocols between the Trust and the Police Service N.I. (PSNI) in place for responding to such incidents and the PSNI is very responsive in providing assistance to the Trust. The Chief Executive stated that staff are to be commended for how they deal with these challenging situations. The Chairman concurred with this comment and referred to the Trust's zero tolerance approach and its commitment to protect staff without the fear of abuse.

Mrs Blakely referred to the 1458 violent/threatening behaviour incidents reported in the Mental Health and Disability Directorate during the year, of which 523 were physical abuse of staff by patients. She asked if this was an expected level of incidents and what actions the Trust were taking to manage these situations. A short discussion ensued in which Mr Donaghy outlined the various interventions and training the Trust has in place. Mr Alexander asked if the actions being taken this year to provide effective security management were having an impact. It was agreed to provide a breakdown of reported security incidents, absconders/missing patients and violent/threatening behaviour incidents as referenced in the Security Management Annual Report at the next meeting.

**The Board approved the Security Management Annual Report for 2010/11 (ST 377/12)**

**ii) Food Hygiene Annual Report 2010/2011 (ST 378/12)**

Dr Rankin presented the Food Hygiene Annual Report 2010/11 for approval. The Chairman welcomed the fact that 47 Trust facilities scored a maximum of 5 under the National Food Hygiene Rating Scheme. She asked that Dr Rankin convey the Board's congratulations on this achievement to Mrs A Carroll and all staff involved in the provision of catering services.

Dr Rankin advised that the Trust achieved substantive compliance (87%) in its self-assessment against the Food Hygiene Controls Assurance Standard in 2010/11. She informed members that revenue funding has been made available for ward refrigeration equipment and also capital funding of £450k has been made available from the Department for the purchase of new equipment. This will contribute significantly to minimising the risk of listeriosis in all hospitals.

Dr Rankin drew members' attention to the various initiatives which have greatly enhanced the food service and nutritional care delivered to patients. These include protected meal times and the introduction of red trays/mats to identify patients needing assistance with feeding.

The Chairman acknowledged the fact that the Catering Department at Craigavon Area Hospital won the award category 'Behind the Scenes' at the Trust Excellence Awards 2010 and, on behalf of Board members, congratulated all those involved.

**The Board approved the Food Hygiene Annual Report 2010/11 (ST 378/12)**

12. **REPORT TO THOSE CHARGED WITH GOVERNANCE – CHARITABLE TRUST FUND ACCOUNTS – YEAR ENDED 31ST MARCH 2011**

Mr McNally presented the above-named report for information. Members noted that the C&AG issued an unqualified audit opinion on the Charitable Trust Fund accounts. Mr McNally advised that the issue of Gift Aid had been discussed at the recent Audit Committee meeting when assurance was provided in terms of the action the Trust is taking to promote Gift Aid.

13. **BOARD COMMITTEES**

**i) Governance Committee**

**Minutes of meeting held on 6th December 2011 (ST 379/12)**

Dr Mullan presented the Minutes for approval. He advised that at that meeting members had received a presentation on Datix Web implementation and received assurance on the Trust's management of Legionella in water systems. Dr Mullan also provided verbal feedback on the recent Governance Committee meeting held on 7th February 2012. He advised that the key issues discussed included Pseudomonas and the potential infection risk from water sources and Junior Doctors Mandatory Training Competencies.

**The Board approved the Governance Committee Minutes held on 6th December 2011 (ST 379/12)**

14. **CHAIRMAN'S AND NON-EXECUTIVE DIRECTORS' BUSINESS AND VISITS**

A list of business and visits undertaken since the previous Board meeting was noted for information.

15. **CHIEF EXECUTIVE'S BUSINESS AND VISITS**

A list of business and visits undertaken by the Chief Executive during January and February 2012 was noted.

**SIGNED: _____**

**DATED: _____**

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

# GOVERNANCE COMMITTEE

**Minutes of a meeting of the Governance Committee held on Tuesday, 15th May 2012 , at 9.30 a.m. in the Boardroom, Trust Headquarters**

**PRESENT**:

Dr R Mullan, Non Executive Director (Chairman)
Mrs D Blakely, Non Executive Director,
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs S Rooney, Non Executive Director

**IN ATTENDANCE**:

Mrs M McAlinden, Chief Executive
Mrs P Clarke, Director of Performance and Reform
Mrs A McVeigh, Director of Older People and Primary Care Services
Dr G Rankin, Director of Acute Services
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr J Simpson, Medical Director
Mr K Donaghy, Director of Human Resources and Organisational Development
Mr S McNally, Director of Finance and Procurement
Mrs D Burns, Assistant Director, Clinical and Social Care Governance
Dr Boyce, Head of Pharmaceutical Services
Mrs S Judt, Committee Services Manager
Mrs S McCormick, Administrative Assistant

## APOLOGIES

Apologies were recorded from Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work, Mrs C Rooney, Assistant Director of Corporate Parenting and Mr R Alexander, Non Executive Director

## DECLARATION OF INTERESTS

Dr Mullan requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

## 1. MINUTES OF MEETING HELD ON 7th February 2012

The Minutes of the meeting held on 7th February 2012 were agreed as an accurate record and duly signed by the Chairman.

## 2. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates from Directors to address those matters arising from the previous meeting. In relation to the query over variance in overall bundle compliance between Craigavon Area Hospital and Daisy Hill Hospital in relation to surgical site infection (SSI) Caesarean Section, Dr Simpson explained that the variation is in respect of the Management of Elective C/section mothers who are diabetic. The SSI Bundle states that mothers who are diabetic should have their glucose monitored Day 1 & Day 2 post c/section. Mrs McAlinden asked if this was a new standard. Dr Simpson replied by saying that he was not in a position to confirm but was happy to discuss this outside the meeting. With regard to the issue under GMC Trainee and Trainer Survey 2011 Results, Dr Simpson advised members that an Action Plan has been formulated by the Associate Medical Director for Medical Education. Mr Weir had met with Clinical Leads and an update will be provided at a future Governance Committee meeting.

*Mrs Burns and Mrs McVeigh joined the meeting at 9.40 am*

3. **CORPORATE RISK REGISTER**

Mrs McAlinden advised that the Corporate Risk Register was last reviewed and updated at the Senior Management Team meeting on 2nd May 2012. She gave a brief summary of the discussion at that meeting when updates were received for a number of risks and a decision taken to separate out the risk of harm to patients from water borne pathogens from the HCAI general risk and include as a separate moderate risk.

Mrs McAlinden advised that the Corporate Risk Register had been discussed at the Trust's Accountability Review meeting the previous day.

Of the 18 current risks on the Corporate Risk Register, 6 are high level and 12 are moderate level. Mrs Mahood referred to the moderate status of the risk associated with water borne pathogens and sought assurance that sufficient actions were being taken to mitigate this risk. Mrs Clarke advised that following a rigorous risk assessment, a range of actions have been identified, some of which will be ongoing. Mrs Kelly asked about input from the Water Service, to which she was advised that the source of the water is not an issue. In relation to risk no. 15 on the appraisal system, Dr Mullan referred to the fact that Personal Development Plans have been received from over 40% of staff and asked what the target was. Mr Donaghy advised that the target was 55% and that regular reports are presented to the SMT. Mrs Mahood asked about the risks associated with re-letting of contracts and Mrs Clarke explained the framework in place.

**4. 2011/12 END YEAR STRATEGIC REVIEW AND ACCOUNTABILITY MEETING**

Mrs McAlinden briefed members on the Trust's year end strategic review and accountability meeting held the previous day as follows:-

i) The Trust had provided a revised Statement of Internal Control (SIC) which addressed the issues raised by the Department in the draft SIC. There was discussion at the meeting on the internal control issues highlighted, particularly around procurement.

ii) The Trust's Report on Standards and Guidelines was discussed. This report is provided to the Governance Committee on a six-monthly basis.

iii) In relation to Corporate Manslaughter, the Trust had sent an assurance statement to Mr Jim Livingstone. This will be shared with Governance Committee members.

The formal minutes, once available, will be shared with Governance Committee members.

5. **MEDICINES GOVERNANCE REPORT**

Dr Boyce presented the Medicines Governance Report for the third quarter of 2011/12 and highlighted the key aspects as follows:-

i) 236 medication incidents were reported during this period. The average number of reported medication incidents each month was 79, representing a slight decrease from 80 per month in the previous quarter. This remains less than the highest average of 114 reports per month achieved during 2008/09. There were no trends of specific concern amongst the reports.

ii) Work on the Medicines Management procedures and guidelines continues. A small scale pilot of a Medication Administration Record sheet was well received. The pilot will be extended to include all patients of the paediatric respite facility in Armagh and their GPs and Community pharmacists.

iii) The Trust's Medicines Code will be ready for distribution shortly.

Members discussed the updates in relation to the National Patient Safety Agency Patient Safety Alerts. It was agreed that an update on actions taken to reduce harm from omitted and delayed medicines in hospital would be provided for the next meeting.

Members noted the information on C.difficile related antibiotic usage and the good management of broad spectrum antibiotics.

## 6. C&SC GOVERNANCE – KEY THEMES

Mrs Burns provided a verbal update on the progress of the patient safety / quality groups set up to look at and propose and implement action on 4 key areas across the Trust as follows:

1. Immediate post falls intervention
2. Early warning systems for the deteriorating patient
3. Child protection -
4. Managing category 1 offenders

It has been agreed that a Non Executive Director will join each of the groups.

## 7. INCIDENTS AND COMPLAINTS MANAGEMENT REPORT AND UPDATE ON OMBUDSMAN CASES

Mrs Burns presented the above-named report for the period December – March 2012. A total of 3,446 incidents were reported during this period.

Incidents were discussed. Members noted that on page 7, CYPS recorded 7 catastrophic incidents and asked for clarity on the procedure for recording. Mr Rice advised that MHDS followed the same procedure as CYPS in recording both natural causes or suspected suicide incidents as Catastrophic. Dr Mullan drew member's attention to page 3 and asked was the number of major incidents reported raising. In responding, Mrs Burns advised that incident numbers were not substantially changing and that the Trust had good reporting procedures in place. Mrs Mahood asked in relation to page 13, figure 1.5, if the Trust was placed at risk due to the lack of suitably trained/skilled staff. Mrs Burns undertook to look at this again. Complaints were then discussed. Mrs Rooney pointed out that some of the figures on page 18 did not reconcile. Mrs Burns agreed to check this.

In response to a query from Mrs Mahood, Mrs Burns explained the process whereby complaints are feed back into the medical appraisal process and other professional appraisal processes.

Mrs Burns highlighted the significant amount of work undertaken to close off cases with the Ombudsman with eight cases closed by the Ombudsman during the period.

8. **SERIOUS ADVERSE INCIDENTS REPORT FOR THE PERIOD 1.4.2011 – 31.3.2012**

Mrs Burns presented a summary of the Serious Adverse Incidents reported during the period 1st April 2011 – 31st March 2012 and those that remain open from 1st April 2007 – 31st March 2011. She reported a total of 44 SAIs during 1st April 2011 – 31st March 2012. Mrs Burns drew member's attention to Table 1 of the report and advised that she would be meeting with the Regional Health & Social Care Board with regard to closing down long standing cases. Members considered Table 2, Overview of notified SAIs for period 1st April 2011 – 31st March 2012 and were reminded that a new high level SAI report was included in the Confidential Section.

9. **ACCOUNTABILITY REPORT FOR STANDARDS & GUIDELINES**

Mrs Burns presented the above report and informed members that from 1st January 2012 – 30th April 2012 the SH&SCT has received 57 new standards and guidelines from the DHSSPS or other external agencies. Mrs Burns advised that the Trust is working towards securing resources to undertake a 'Look Back' exercise on standards and guidelines issued prior to 2010. Mrs Mahood referred to the fact that the information comes through from a variety of sources and she sought assurance that all of this information was being captured. Mrs McAlinden stated that at present there are a multitude of entry points into the Trust and that it was envisaged that the Trust Standards & Guidelines Prioritisation and Risk Review Group would provide some assurance to ensure a more robust process and single point of entry to the system.

Dr Mullan highlighted the red risk associated with syringe drivers. Dr Rankin responded by saying this requires regional action. Mrs Rooney acknowledged the work to date and the enormous task involved.

10. **PROFESSIONAL GOVERNANCE REPORTS**

**i) Medical Director**

Dr Simpson highlighted the key aspects of this report as follows:-

Appraisals Round 2011: Dr Simpson reported that progress has been slow, however the overall system is good and there has been an improvement in terms of quality. He acknowledged that more work needs to be done in terms of appraisal training and training new appraisers. Dr Simpson reported that the Beeches have developed a useful mechanism called the 360 degree appraisal tool. In terms of training competencies there still remains work to do.

There was a short discussion on medical revalidation and Dr Simpson advised that preparation for commencement of revalidation in December 2012 continues. Doctors who have been identified by the GMC as requiring revalidated in the first year have been informed. In the first 3 months 20% of our Doctors are required to be revalidated.

Junior Doctors Mandatory Training Competencies: Dr Simpson reported an improved position this year and he anticipated that the 100% target would be reached at the end of the 6 months. Mrs Mahood queried the European Working Team Directive (EWTD) Compliance and asked why the Trust is not compliant in this area. Mr Donaghy provided assurance that this area is closely monitored and managed. Action is taken to fill gaps in rotas and there is no risk to patient safety.

HCAI: Dr Simpson advised that Priorities for Action (PfA) targets for 2011-12 were set at: MRSA Infections 11 and C.difficile infections 22. The Trust End of year figures were 33 C.difficile infections and 10 MRSA. 38 cases of MSSA bacteraemias were recorded. Dr Simpson stated more work remains to be done on Peripheral Lines and that a change in approach is required. Mrs Mahood asked about how such a

change would be embedded within the organisation, to which Dr Rankin advised that this is one of the elements of the Organisation of Care Initiatives.

Antibiotic useage was also discussed.

Mrs McAlinden highlighted the Reduction of Pressure Ulcers with the Implementation of SKIN Care Bundle on page 30 of the report. Dr Rankin spoke of the 24/7 care required in this area and praised the huge team effort to date. She said it was hoped to undertake a Baseline Audit of the SKIN Care Bundle in June 2012 but early indication showed good achievements had been reached through excellent commitment by staff providing a high quality of care.

*Mrs Kelly left the meeting at 9.45 am and returned at 11.45 am*

**ii) Social Work and Social Care**

In Mr Morgan's absence, Mrs McAlinden asked members to consider this report, which summarizes progress against 7 key areas of activity. Within these 7 areas, are 24 sub-sections of activity, she asked members to note the significant progress made towards compliance in that 15 are green, 9 are amber and there are no red areas. Mrs Blakely expressed concern at the high number of amber against progress made. In responding Mrs McAlinden stated that some of these actions were of a complex nature and would take time to address. It was agreed that Mr Morgan would provide clarification at the next meeting.

11. **RQIA REVIEWS STATUS UPDATE**

Members discussed the update in their papers on RQIA Reviews. The SH&SCT Review of Pseudomonas Action Plan (Appendix 1) recorded a position at 5th April 2012 as green flag against 9 recommendations. Members noted the Joint Review by RQIA and CJI of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (Appendix 2) and the associated Action Plan (Appendix 3). Mrs McAlinden updated

members on the RQIA Radiology Phase 2 item and advised that at the request of Trust Board she had written to the Regional Board seeking advice on the regional recommendations.

12. **WATER SAFETY UPDATE**

Mrs Clarke spoke to the report and informed members that in meeting its statutory obligations the Trust established a Legionella Control Group in 2011. This group developed a set of operational procedures which were approved by the Strategic Health Care Acquired Infection Forum in September 2011. Subsequent to the emergence of Pseudomonas as a significant risk this group evolved to become the Trust Water Safety Group. The group plan to develop a comprehensive Water Safety Management Plan, reflecting lessons learned in the past year from Pseudomonas/Legionella and moving forward. This will be a live document kept under review and regularly updated. Mrs McAlinden informed members that since the outbreak of Pseudomonas the Trust had received ten sets of guidelines and she commended the Water Safety Group as an extremely important committee lead by Mrs Clarke and Dr Simpson. Dr Simpson commented that members of the Water Safety Group have a good appreciation of patient safety and a good understanding of the issues that affect infection prevention and control.

13. **DRAFT STATEMENT OF INTERNAL CONTROL**

Mr McNally distributed a revised copy of the above named report. He reported that 66% of the 287 priority one and two previous Internal Audit recommendations examined at year end, were fully implemented, a further 30% of the recommendations examined were partially implemented and 4% have not yet been implemented. Client Monies – Adult Supported Living and Private Patient Income both received a Limited level of assurance. In reference to Controls Assurance Standards Mr McNally stated that for 2011/12, the Department had determined that the minimum score to achieve substantive compliance had been raised from 70 to 75. The statement demonstrates that the Trust achieved substantive compliance in all 22 standards.

14. **FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REQUESTS – SUMMARY REPORT FOR THE PERIOD JANUARY – MARCH 2012**

Mrs Clarke presented the summary report for the period 1st January – 31st March 2012. A total of 68 requests were received and responded to in this period and of these, 54 were processed within the 20 day deadline and 14 processed outside of the 20 day deadline. Members noted that the majority of requests were received from members of the public, businesses and the media. Details of the individual requests for information are included in the report.

15. **SH&SCT TRANSFUSION TEAM ANNUAL REPORT**

Dr Rankin presented the Report and highlighted for members the role and membership of the SH&SCT Transfusion Team. Dr Rankin stated that the report provides an overview of the major projects undertaken by the SH&SCT Transfusion Team to ensure safe blood transfusion practice and compliance, across all Acute and Non Acute Hospitals. Dr Rankin advised that with regard to Better Blood Transfusion, a working group chaired by Mr Ronan Carroll, met regularly throughout the year to access compliance and develop action plans to ensure compliance with the recommendations.

16. **MANAGEMENT OF PODIATRY REVIEW APPOINTMENTS**

Mrs McVeigh presented the above named report and highlighted how the Trust has been working to address the waiting times targets:-

- Setting referral access criteria, to support staff in identifying referred patients who are at greatest clinical risk and require Podiatry assessment and treatment
- Increasing overall Podiatry capacity by assessing and treating percentage of patients in clinic rather than in domiciliary settings and
- Migrating the admin management of patient registration and booking of appointments, to the AHP Central Booking Unit.

Mrs McVeigh advised that it is recognised that there is an increased level of demand on the Podiatry Service. There are challenges in regard to identifying sufficient appointment slots for 'new' patients

versus slots for 'routine' review patients. It is important to note that the length of time between review appointments is decided following a clinical risk assessment, with those patients assessed as being at higher risk seen most frequently. Mrs McVeigh stated that the Trust is currently engaged with the Southern Local Commissioning Group and the Public Health Agency in carrying out a review of AHP Service Capacity and Demand and that it is envisaged that this work will identify a need for additional investment in a range of specialist and core Podiatry services. Mrs McAlinden informed members that she had received correspondence from a number of MLAs on this issue. She stated that the information provided in this report would provide a robust response to these.

17. **BSI ASSESSMENT REPORTS FOR STERILE SERVICES DEPARTMENTS, CAH AND DHH**

Dr Rankin asked members to note the above named BSI Assessment Reports. She informed members that these excellent reports had followed a rigorous external assessment of the Sterile Services at both Acute Hospitals. One minor non-compliance issue had been reported in Craigavon Area Hospital and two minor non-compliance issues reported in Daisy Hill Hospital. Dr Rankin advised that this assessment is carried out on an annual basis.

18. **UK BORDER AGENCY SPONSORSHIP**

Mr Donaghy asked members to note for information that the Trust had received confirmation that the UK Border Agency will be maintaining the Southern Health & Social Care Trust as an A-rated sponsor. Mr Donaghy stated that this provided reassure that robust processes are in place.

19. **IN DEFENCE OF DIGNITY**

Mrs McVeigh spoke to a recently published report by the Northern Ireland Human Rights Commission. The purpose of the report is to share the findings of a strategic investigation during 2009-2010 into the rights of older people in nursing and residential homes with reference to social inclusion/activity, personal care, nutrition, restraint, access to medical care and the administration of medicines.

The Southern Trust contracts with 44 homes in the Southern Health and Social Care area for older people, people with physical and learning disability and people with dementia, with approximately 1700 beds. In addition, contracts are in place with homes in other Trust areas. Mrs McVeigh informed members that the Trust had carried out investigations into 5 cases and she was pleased to report that the findings had shown no fault. The Trust has an active Care Home Manager's forum led by the Nurse Consultant for Older People. The purpose of the forum is to support the quality agenda and share learning and best practice. Mrs McVeigh advised that Trust staff have a contract compliance process and a protection of vulnerable adults procedure allowing them to formally raise care issues/concerns with Home/Trust managers and that progress is being achieved in regard to compliance issues and that the Care Home Support Team is working to move this process forward. Mrs McAlinden stated that the key issue for the Trust is how to access the individual care of clients, she reminded members that a Review of Care Plans is currently on the Trust Corporate Risk Register. Mrs McVeigh responded by stating that over 80% of annual care reviews had been completed at the end of March. Mrs Mahood asked in regard to the legal requirements that the Trust has in supporting nursing homes. Mrs McVeigh responded by stating that a change of thinking was required in relation to the role of nursing homes and the duty of care towards clients. She informed members that due to the high turnover of staff, nursing homes are facing more challenges than ever before in regard to competency and it is our responsibility to make sure all staff are kept up-to-date with appropriate training which is closely monitored by RQIA.

20. **DHSSPS REVALIDATION DASHBOARD**

Dr Simpson due member's attention to the DHSSPS Revalidation Dashboard.

21. **UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE**

Mr Graham updated members on the meeting held on 8th March 2012. At that meeting, the Committee discussed complaints

information and the duplication of this information particularly to the Governance Committee. Mr Graham informed members that a workshop would take place on Thursday, 7th June 2012 at which Mrs Irene Hewitt would act as facilitator and that links with the Governance Committee would be discussed.

22. **REVIEW OF TERMS OF REFERENCE**

Members noted the revised Terms of Reference highlighted in red. Mrs Mahood stated that the Terms of Reference may require further updating following the proposed Patient Client Experience Workshop in regard to the duplication of complaints information. Mrs Rooney drew member's attention to point 6 Remit and asked if Health and Safety could be included. It was agreed to include Health & Safety in the Terms of Reference.

23. **REVIEW OF GOVERNANCE COMMITTEE**

An assessment tool is being finalised and will be issued to members thereafter, for completion following the next Governance Committee Meeting.

24. **ANY OTHER BUSINESS**

At the request of Mrs Mahood an update was provided on the outbreak in Loan House.

Dr Rankin advised that a regional meeting will take place on 16th May 2012 with regard to the Listeria outbreak.

***The next meeting of the Governance Committee will take place on Tuesday, 11th September 2012 at 9.30 a.m. in the Boardroom, Trust Headquarters, Craigavon***

**SIGNED: _____**

**DATE: _____**

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

**Minutes of a confidential meeting of the Trust Board held on Tuesday, 15th May 2012 at 2.00 p.m. in the Boardroom, Trust Headquarters, Craigavon**

**PRESENT**:

Mrs R Brownlee, Chairman
Mrs M McAlinden, Chief Executive
Mr E Graham, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs H Kelly, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director.
Mr S McNally, Director of Finance and Procurement
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr J Simpson, Medical Director

**IN ATTENDANCE**:

Mrs P Clarke, Director of Performance and Reform
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs A McVeigh, Director of Older People and Primary Care Services
Dr G Rankin, Director of Acute Services
Mrs G Maguire, Assistant Director (for Mr P Morgan)
Mrs J McKimm, Acting Head of Communications
Mrs S Judt, Committee Secretary (Minutes)

**APOLOGIES**:

Apologies were recorded from Mrs D Blakely, Non Executive Director, Mr R Alexander, Non Executive Director and Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work.

1. **SH&SCT REVIEW OF REGIONAL PSEUDOMONAS COLONISATION AND INFECTION INCIDENT**

An internal review team comprising Mrs A McVeigh, Director of Older People and Primary Care, Mr E Graham, Non Executive Director and Mrs D Burns, Assistant Director, Clinical and Social Care Governance, had been established to assess the Trust's response to the regional issue and identify any learning. Mr Graham presented the review team's report and drew members' attention to section 6.2 which outlined the Trust's response to the regional outbreak. He stated that the review team concluded that the Trust's response was timely and effective and the proactive approach adopted by senior management, clinical teams and support services was to be commended. The learning for the Trust from the review centres on the need to risk assess all standards and guidelines issued to the Trust.

Mrs McAlinden endorsed Mr Graham's comments and thanked the review team for their work. She stated that the report provides the Board with a good level of independent assurance on the Trust's actions during this incident. The Trust has now set up a Standards and Guidelines Prioritisation and Risk Review Group to ensure a systematic and integrated approach to the implementation, monitoring and assurance of standards and guidelines. She stated that constraints that may limit the Trust's ability to achieve implementation will be highlighted and fed back.

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

# Minutes of a Trust Board meeting held in Public on Thursday, 14th June 2012 at 9.30 a.m. in the Navan Room, Hill Building, St Luke's Hospital site, Armagh

## PRESENT:

Mrs R Brownlee, Chairman
Mrs M McAlinden, Chief Executive
Mr R Alexander, Non Executive Director
Mr E Graham, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs H Kelly, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director.
Mr S McNally, Director of Finance and Procurement
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr J Simpson, Medical Director

## IN ATTENDANCE:

Mrs P Clarke, Director of Performance and Reform
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs A McVeigh, Director of Older People and Primary Care Services
Dr G Rankin, Director of Acute Services
Mrs G Maguire, Assistant Director, Specialist Child Health and Disabilities (for Mr P Morgan)
Mrs J McKimm, Acting Head of Communications
Mrs S Cunningham, Patient and Client Council
Mrs S Judt, Board Assurance Manager (Minutes)

## APOLOGIES:

Apologies were recorded from Mrs D Blakely, Non Executive Director and Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work.

1. **CHAIRMAN'S WELCOME AND APOLOGIES**

The Chairman welcomed everyone to the meeting, in particular members of the public.

The Chairman sought and received confirmation from members that they had read their papers in advance of the meeting.

2. **DECLARATION OF INTERESTS**

There were no declarations of interest in relation to any items on the agenda.

3. **CHAIRMAN'S BUSINESS**

The Chairman advised of the following developments:-

- The Trust has been recognised as one of the top 40 acute hospital Trusts in the UK at the prestigious CHKS awards in London. Recognising excellence and rewarding 40 of the best performing acute Trusts across the UK, the CHKS 40 Top Awards are based on the evaluation of 23 indicators of clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

- **2012 Craigavon Business Awards**

  The Trust Communications team won a Special Recognition Award at the Craigavon Business Awards held at the Craigavon Civic Centre on 24 May 2012. The award was given for the 'Don't Waste Your Space' communications campaign launched in December 2011 to reduce the number of wasted appointments across the Trust area.

- Eight System Managers from the Systems Team in Informatics and two Managers from Learning & Development in Human Resources received the internationally recognised Institute of Leadership Management Level 4 Award in Management. The course included business improvement, contingency planning, governance, data quality and software testing.

- **Regional Social Work Awards on 8th June 2012**

  The Trust won the Partnership Team Award for Supporting Carers for Looked After Children (Child and Adolescent Mental Health Service).

- **Health Service Journal Efficiency Awards 2012**

  Estates Rationalisation has been shortlisted for the Health Service Journal Efficiency Awards 2012. The winners will be announced at an awards ceremony in London on 25th September 2012.

On behalf of Board members, the Chairman congratulated all staff involved in the above achievements on their successes.

4. **CHIEF EXECUTIVE'S BUSINESS**

The Chief Executive briefed members on a number of issues since the previous meeting.

i) **Banbridge Community Treatment and Care Centre**

Work on this project has been slightly delayed as remains were found on the former Banbridge Hospital site. A memorial service for those reinterred at Banbridge Cemetery, following recent exhumation from the grounds of the former Banbridge Hospital site is being held that afternoon and will be attended by the Chief Executive, Mrs Clarke and other staff.

ii) **Newry Community Treatment and Care Centre**

The proposed new-build Community Treatment and Care Centre in Newry has attracted some local publicity. The Health and Social Care Board and the Local Commissioning Group are leading discussions with GPs in the wider Newry area to ascertain the potential for GPs to either relocate or utilise space within a new health and care centre to support the delivery of the proposed model. The Trust is seeking involvement in these discussions to represent the accommodation needs for Trust staff. If agreement

is reached on the service model, the Trust will take forward the development of the business case.

5. **MINUTES OF MEETINGS HELD ON 26th APRIL AND 15TH MAY 2012**

The Minutes of the meeting held on 26th April 2012 were taken as read and agreed as an accurate record subject to one amendment on page 16 to read Mrs Harney and not Mrs Rooney.

The minutes of the meeting held on 15th May 2012 were taken as read and agreed as an accurate record.

The Minutes were duly signed by the Chairman.

6. **MATTERS ARISING FROM PREVIOUS MINUTES**

Members noted the progress updates from the relevant Directors to issues raised at the previous meeting.

- **RQIA Review of Radiology – Phases I and II**

As requested at the previous meeting, the Chief Executive had written to the Chief Medical Officer and the Health and Social Care Board to seek advice on the arrangements for progressing the regional recommendations, including the approach for the reporting of plain film x-rays. A response is awaited.

- **Corporate Mandatory Training**

As requested at the previous meeting, Mr Donaghy provided a briefing paper summarising the various Corporate Mandatory Training elements and the number of staff trained in these elements by Directorate. He advised of the potential provision of elements by e.learning.

## 7. STRATEGIC ISSUES

### i) Update on Transforming Your Care

Mrs Clarke advised that a first draft of the Southern Area Local Economy Population Plan was submitted on 13th June 2012 with the final draft required to be submitted by 22nd June 2012. The final draft will be considered at the Directors' Workshop on 20th June 2012 prior to submission.

The Trust and the Southern Local Commissioning Group have undertaken a significant public engagement process with key stakeholder groups. Mrs McAlinden thanked Directors for their work and to Mrs Clarke, in particular, for leading the process. She also thanked the Chairman and the Non Executive Directors for their input into the process. The next stage will be wider engagement with staff which Mrs McKimm and the communications team will take forward.

### ii) Summary of Internal Capital Business Cases in excess of £300,000 (ST394/12)

Mrs Clarke presented, for approval, a summary of proposals with a capital/revenue value greater than £300,000 that were developed since the previous report which was approved by Trust Board on 1st March 2012. Mrs Kelly referred to the remedial works to the main block at South Tyrone Hospital and asked if there were plans to replace the glass windows at the front which she felt had a high energy loss. Mrs Clarke stated that if a window replacement was required as part of the remedial works, this would go ahead. Mr Graham referred to the fact that the outline business case for Low Voltage Works at Craigavon Area Hospital is an interim solution and he asked about the timescale for this and if it will be sufficient to mitigate the risks identified. He also queried if this will this be nugatory work. Mrs Clarke clarified that this would not be the case as this is a three-phased approach with the low voltage element involving the purchase and installation of diesel generators which can then be used elsewhere. It is anticipated that approval of the business case will be granted very soon.

Mr Alexander asked if the business case for revenue funding for biologic therapies for treatment of patients with severe arthritis was not approved, would this impact on waiting lists. Mrs Clarke clarified that this case is for new patients with severe arthritis and the funding is available.

**The Board approved the Internal Business Cases in excess of £300,000 (ST 394/12)**

iii) **Community Information System**

Mr Rice presented a paper which provides an update on the progress of the project to date and advised of business case approval for costs of £6.01m to implement this new system. A Project Manager has now been appointed and the Trust has now entered the Procurement and Planning stage.

The paper also outlined a risk assessment of the project and the measures in place to mitigate the risks which are reviewed regularly by the Project Board. Mrs Rooney asked about the red risk in relation to staff moving to use of electronic record instead of paper record. Mr Rice stated that further progress has now been made with transformational leads appointed to support adoption by professional staff. Mrs Kelly asked if patient held records would still be maintained in patients' own homes and Mr Rice confirmed that this would be the case.

8. **OPERATIONAL PERFORMANCE**

i) **Performance**

The Chairman welcomed Mr Dean Sullivan, Director of Commissioning, Health and Social Care Board, to the meeting for a discussion on capacity gap issues.

Mr Sullivan welcomed the opportunity to address the Board and spoke of the effective working relationship between the HSCB and the Trust. He began by providing an overview of the position across a range of services experiencing access waiting times and indicated that as a Commissioner, he was bound to

take a view on capacity across the region and not just within one Trust area. He stated that he felt progress was being made on the issue of recurrent investment across the region and once Investment Proposal Templates (IPTs) are submitted by the Trust, decisions would be made soon thereafter.

Mr Sullivan referred to those Specialties being managed as regional specialties which include ENT, Urology, Ophthalmology, Orthopaedics and Dematology and stated that four of the five Local Commissioning Groups have identified gynaecology as a priority for investment. He advised that the Commissioner is supportive of the proposed solution for gynaecology in the Southern Trust.

Following a question from the Chief Executive on the timescales for decisions on closing capacity gaps that result in long waiting times for the local population, Mr Sullivan clarified that the HSCB will consider a number of key factors in making decisions on investment. These include delivery against core contracted activity; ability to implement the proposed solution in a timely way and avoiding destabilising provision across the system. If these issues are resolved through impending discussions for specialties where there is clear agreement that capacity gaps exist, then HSCB would intend to make decisions in the next 4-6 weeks.

Members asked a number of questions around specific specialties as follows:-

**General Surgery** - Mrs Rooney asked what consideration has been given to the impact of the removal of complex vascular surgery (AAA) procedures from the Southern Trust and the ability to continue to attract and retain consultants to sustain a general vascular service. Dr Rankin referred to the HSCB review of the delivery of complex vascular surgery in a regional setting and highlighted the difficulties for the Southern Trust in retaining consultants with a general vascular interest should the current vascular service be disaggregated. The Chief Executive stated that the removal of complex vascular capacity from the Southern Trust will present significant patient safety

issues. Mr Sullivan stated that there is an absolute standard on AAA procedures, however, the issues raised by the Trust regarding the impact on related procedures will be taken into account through the agreed review process.

**Gynaecology and Colposcopy –** Mrs Kelly asked about the timescale for decision-making on these locally agreed specialties to which Mr Sullivan advised that he did not envisage any difficulties in approving these proposals.

**Cardiology -** Mr Graham asked when the commissioning intentions for regional interventional cardiology services would be available to which Mr Sullivan responded by advising that a paper was being considered by the HSCB on 28th June 2012 and would be shared with the Southern Trust thereafter.

**Rheumatology** – Dr Mullan asked when the decision on funding the additional Consultant post would be made and the timescale for the demand management project. Mr Sullivan advised that the decision has been made in principle, but the detail needs to be worked through.

**Urology –** Mrs Mahood asked why all centralisation appears to be focused in the Belfast Hospitals when it is clear that other Trusts could be centres of excellence and utilise a wide range of professional networking arrangements. Mr Sullivan stated that the direction of travel is based on safety, accessibility, reliability etc. and to deliver services that are locally accessible. The Chief Executive raised the importance of explanations for any centralisation of services being communicated to clinicians in a clear and straightforward way as well as to the public. Mr Sullivan responded by stating that there is either an evidence base or there is not.

**Pain management and Psychological Therapies** - Mrs Mahood asked if the HSCB would consider supporting this capacity gap from elective services funding. Mr Sullivan advised that there is not sufficient elective care funding to cover the capacity gap and acknowledged that a source of funding needs to be found to address the pressures. He stated that it

would be his expectation that the LCG would work closely with GPs on these issues. He spoke of a recent Pain Management Summit and work undertaken by the Western H&SCT in relation to pain management.

**Primary Mental Health Care** – The Trust has identified this area as a priority for recurrent investment and Mr Graham enquired how this is being taken forward. Mr Rice highlighted the lack of availability of year 3 funding for the development of the new stepped care model of mental health care and stated that the Trust can no longer sustain this service. The Trust is keen to see a resolution to this issue and Mr Sullivan undertook to discuss this with the Southern Local Commissioning Group.

**Allied Health Professions** – Mrs Rooney asked if the Trust would receive non recurrent funding until final decisions on the regional demand and capacity exercise were made. Mr Sullivan acknowledged that this exercise was taking longer to complete than originally envisaged. He went on to say that non-recurrent funding has been secured for Quarter 1 and will be made available for Quarter 2. The Chairman stated that the issue of employing staff on a temporary basis is a risk as they leave for permanent positions and this is an issue that needs to be addressed urgently.

**Radiology** - Mrs Kelly asked about plans for managing capacity gaps in radiology reporting. Mr Sullivan advised that a letter was about to be issued to the Trust on this matter.

The Chairman thanked Mr Sullivan for taking the time to attend the meeting.

ii) **Financial Resource Budget 2012/13 (ST395/12)**

Mr McNally presented a summary report which outlines i) the issues surrounding the Trust's financial resource budget for the 2012/13 financial year and ii) the financial framework within which resource budgets must be managed. In terms of financial management, he stated that time has been spent with budgetholders on increasing awareness of cost drivers and the

accuracy of financial forecasting. Further involvement and refinement is required and will be pursued during 2012/13 particularly in relation to updating and refining cost apportionments for all costing returns.

Mr McNally advised that the Trust's total anticipated RRL for 2012/13 is £470.4m, non RRL income is £33m, therefore the total maximum income available to the Trust to prepare an expenditure budget is £503.4m. He drew members' attention to table 5 in the report which details the final resources available to each Directorate for expenditure in 2012/13 and reminded Directors of the need to ensure that their expenditure does not exceed this limit.

**The Board approved the Trust's financial resource budget for 2012/13 (ST395/12)**

iii) **Capital Resource Limit Performance Report**

Mr McNally presented a report summarising the final capital expenditure position as at 31st March 2012. He stated that the Trust's Capital Resource Limit is split between ring-fenced and general capital. The ring-fenced allocation for 2011/12 was £12,938,109 and £7,711,415 was available for general capital expenditure. He reported an underspend of £125k against total CRL which represents 0.6% of the total CRL made available to the Trust.

Dr Mullan referred to the profile of allocation for capital spend and acknowledged the efforts of staff to ensure that capital spend was not back loaded into the final quarter of the financial year.

**iv) Human Resources Report (ST 396/12)**

Mr Donaghy presented the Human Resources Report and highlighted the key aspects as follows:-

Sickness absence rate at 4.67% for April 2012 is the lowest in the Province.

The centralisation of the Nurse Bank system continues to progress.

Mr Donaghy referred members to a briefing on the British Medical Association (BMA) Planned Day of Strike Action on 21st June 2012. In terms of contingency planning, he stated that the Trust continues to work with the BMA to put in place an operational framework for the planned day of action. This will be underpinned by an agreed set of principles which will form the basis of regional guidance for implementation across all Trusts. The Trust has written to its medical staff asking about their intention to take strike action and this information will be considered as part of contingency planning.

The impact of Transforming Your Care and the financial targets on workforce numbers was raised and Mr Donaghy agreed to reflect workforce numbers in future reports.

**The Board approved the Human Resources Report (ST 396/12)**

9. **PATIENT/CLIENT SAFETY AND QUALITY OF CARE**

**i) Unallocated Child Care Cases**

In the absence of Mr Morgan, Mrs Maguire presented the performance management briefing report for April 2012. She reported a total of 38 unallocated cases as at 30th April 2012 with no unallocated cases as at 31st May 2012, thus meeting the target set in the Health & Social Care Board's reduction plan. Mrs McAlinden stated that this was an excellent position and congratulated Mr Morgan and his team on this significant achievement. She referred to the Family Support Hubs and their positive impact on referral rates and asked that Mr Morgan provide an update on progress in his next report to Trust Board.

**Medical Director Report**

Dr Simpson presented his report and highlighted the key aspects as follows:

HCAI – There have been 9 C.difficile, 0 MRSA and 9 MSSA cases to date (29th May 2012). Throughout May, there has been an increasing incidence of V&D among inpatients on the Craigavon Area Hospital site. The bug is still active in the community and the incidence has highlighted the need for a cohort ward. The HCAI Clinical Forum is overseeing the implementation of the Trust's V&D escalation plan. The Chairman reiterated the Trust's zero tolerance approach to infection control and Dr Simpson stated that enhanced monitoring continues and there is no evidence of an emerging trend as regards the c.difficile cases.

Dr Simpson updated members on the process for managing Gideon Bibles on hospital wards in line with the Trust's Infection Prevention and Control Policy. It has been agreed that bibles should be supplied individually wrapped in a plastic cover and placed in bedside lockers. If the seal is broken, each patient will be advised that they may take the Gideon Bible with them on transfer or discharge. Bibles with a broken seal left behind will be removed from the locker and returned to the Gideon Society for disposal.

Dr Simpson advised that Trust representatives had met with the RQIA Pseudomonas Review Team on 16th May 2012 to discuss items under the second phase of the review. The Trust has confirmed compliance with all relevant recommendations from the first phase of the review and issued a range of best practice guidelines to call clinical staff bases on the learning.

With regard to the Environmental Cleanliness Report, Mr Alexander asked about the reasons for the low audit score in emergency resus at Craigavon Area Hospital and Dr Rankin agreed to provide an explanation for this. In relation to emergency planning, Mr Alexander asked about progress on the multi-agency desktop exercise undertaken in the Older

People and Primary Care Directorate to test emergency response and business continuity issues in relation to a fire in a nursing home. Mrs McVeigh advised that whilst the desk top exercise has been completed, the report is not yet available.

*Mrs Kelly left the meeting at this point (12.00 noon)*

**ii) Director of Nursing Report**

Mr Rice presented an update report on the implementation of the Nursing Quality Indicators (NQIs) within the Acute and Older People and Primary Care Directorates and plans for the proposed roll out across all Directorates. He reminded members that an initial progress report had been presented to the Trust Board in November 2011. Mr Rice stated that significant activity has been undertaken to date, both ward based and Trust wide, to support the implementation of the NQIs. This work is being taken forward in two phases. Phase 1 requires that selected nursing processes are in place and Phase 2 assesses if the nursing standards applied impacted positively on the health and wellbeing of patients/clients. He referred members to the results from Phase 1 in the report where audits were undertaken on eight wards in acute and non-acute adult inpatient wards. Mr Rice stated that these results evidence that processes fundamental to nursing care are in place. Quality Improvement Plans are in place to address gaps and a regional record initiative is supporting improvement to nurse record keeping.

Mr Rice stated that it is important to recognise that complementary projects are also ongoing in the Trust which include the Regional Nurse Record Keeping Initiative and the Organisation of Care project (Acute Directorate) and which will support the embedding NQIs.

The Chairman highlighted the poor results for adult safeguarding training and was advised that the training schedule is being revised to target those areas of greatest need. Mrs McAlinden commended the report and paid tribute to Mr Rice and staff involved.

10. **APPROVAL OF WRITE-OFF OF LOSSES (ST397/12)**

Mr McNally presented a schedule of losses and sought approval for total losses of £6,567,082. Mrs Mahood confirmed that the Audit Committee had considered all of the losses in detail at its recent meeting.

**The Board approved the write-off of losses (ST397/12)**

11. **CONTROLS ASSURANCE STANDARDS – REPORT ON COMPLIANCE 2011-12**

Mrs McAlinden presented the Controls Assurance Standards Report on Compliance for 2011-12 and stated that she was pleased to report that the Trust had achieved substantive compliance in all 22 standards. She referred members to the self-assessment scores and advised that action plans have been developed for all standards. Mrs Mahood stated that the achievement of substantive compliance in all 22 standards was particularly significant given that the score for substantive compliance had been increased from 70 to 75 this year.

12. **DRAFT ANNUAL REPORT**

Mrs McAlinden presented the Trust's Annual Report for 2011/12 for information. She stated that this sets out how the Trust is meeting its priorities, the achievements of staff, service developments and the personal experiences of some people who use its services. She thanked Mrs J McKimm and the communications team for compiling the report and the Directorates for providing the content.

13. **BOARD REPORTS**

**i) Emergency Preparedness Annual Report (ST398/12)**

Dr Simpson, in presenting this report for approval, advised that it is in a standard template developed by the Health and Social Care Board and Public Health Agency to capture the key emergency planning/response activities of the Trust on an

annual basis. The report demonstrates that the Trust has undertaken emergency planning and business continuity activities that will prepare it to deal with any major emergency incident or situation which arises and maintain essential services in line with the requirements of the 2005 Civil Contingencies Framework.

An appendix to the document included a report and associated action plan on a multi-agency debrief exercise into the fire in Greenpark Nursing Home. It was highlighted that participating organisations are responsible for pursuing any actions relevant to them.

**The Board approved the Emergency Preparedness Annual Report (ST 398/12)**

*Mr Alexander left the meeting at this point (12.30 p.m.)*

14. **BOARD COMMITTEES**

**i) Governance Committee**

**Minutes of meeting held on 7th February 2012 (ST 399/12)**

Dr Mullan presented the Minutes for approval and members noted the key discussion points. Dr Mullan also provided feedback on the subsequent meeting held on 15th May 2012 when assurance was provided on the arrangements for the prevention of infection from water borne sources.

**The Board approved the Governance Committee Minutes held on 7th February 2012 (ST 399/12)**

**ii) Audit Committee**

**Minutes of meeting held on 16th February 2012 (ST 400/12)**

Mrs Mahood presented the minutes for approval.

Mrs Mahood then provided an overview of the key issues discussed at the meeting on 24th May 2012.

**The Board approved the Audit Committee Minutes held on 16th February 2012 (ST 400/12)**

15. **CHAIRMAN'S AND NON-EXECUTIVE DIRECTORS' BUSINESS AND VISITS**

A list of business and visits undertaken since the previous Board meeting was noted for information.

16. **CHIEF EXECUTIVE'S BUSINESS AND VISITS**

A list of business and visits undertaken by the Chief Executive since the previous Board meeting was noted.

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

**Minutes of a meeting of the Governance Committee held on Tuesday, 4th December 2012, at 9.30 a.m. in the Boardroom, Trust Headquarters**

**PRESENT**:

Dr R Mullan, Non Executive Director (Chairman)
Mr R Alexander, Non Executive Director
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs S Rooney, Non Executive Director

**IN ATTENDANCE**:

Mrs M McAlinden, Chief Executive
Mrs P Clarke, Director of Performance and Reform
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Mr S McNally, Director of Finance and Procurement
Mrs A McVeigh, Director of Older People and Primary Care Services
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr J Simpson, Medical Director
Dr G Rankin, Director of Acute Services
Mrs D Burns, Assistant Director, Clinical and Social Care Governance
Dr T Boyce, Head of Pharmaceutical Services
Mrs S Judt, Board Assurance Manager
Mrs J Comac, PA to Chair (Minutes)

**APOLOGIES**:

Apologies were recorded from Mr K Donaghy, Director of Human Resources and Organisational Development.

The Chairman welcomed everyone to the meeting.

## DECLARATION OF INTERESTS

Dr Mullan asked members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

## 1. MINUTES OF MEETING ON 11TH SEPTEMBER 2012

The Minutes of the meeting held on 11th September 2012 were taken as read and agreed as an accurate record. The Minutes were duly signed by the Chairman.

## 2. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates from Directors to address those matters arising from the previous meeting.

Dr Mullan discussed the recent Panorama programme on 'How Safe is Your Hospital' with members. Mrs McAlinden asked Mrs Judt to send the link to the Panorama programme if available on iPlayer to members and also forward the Dr Foster report.

**Action: Mrs Judt**

Mrs Clarke left the meeting at 10.30 am

## 3. CORPORATE RISK REGISTER

Mrs McAlinden presented the Corporate Risk Register and stated that this was recently reviewed and updated by SMT on 28th November 2012. The Register was shared with the DHSSPS at the Mid Year Accountability Review meeting on 12th November 2012 and no issues were raised.

Mrs McAlinden advised that of the 18 Corporate Risks, 6 are high level and 12 are moderate. The Register indicates in red font where controls have been strengthened or actions progressed since last Governance Committee meeting in September 2012. Mrs McAlinden advised of the new risk added under risk no. 2 'achievement of statutory duties/functions' in relation to the comprehensiveness of

care management processes and stated that members have been briefed on the context for the identification of this risk. Actions include a review of care management processes which will include roles and responsibilities (internally and externally). In relation to fire safety, members noted that an update on the Fire Safety Action Plan had been presented to Trust Board on 29th November 2012 as part of Estates Annual Report. At that meeting, the action plan was remitted to Governance Committee to monitor progress on outstanding actions. Mrs Clarke confirmed that an updated action plan will be brought to Governance Committee in February 2013. At this point, Mrs Mahood stated that in the context of a discussion at Audit Committee on previous Internal Audit recommendations from 2010/11, concern was raised at the inconsistency of wording used regarding evacuation plans. In response, Mrs Clarke stated that the audit report reflected the position at the time of the audit in 2010 and referred members to the update in the action plan which reflects progress to improve the position. Dr Rankin provided assurance that all acute wards have now completed simulated fire evacuation drills and have evacuation plans in place. Dr Rankin agreed to provide a short briefing to Governance Committees to demonstrate the progress made.

**Action: Dr Rankin**

Mrs McAlinden stated that in relation to BSTP/FPL, a presentation on the key challenges/risks to implementation was provided to the Audit Committee on 18th October 2012. Updates on progress will be provided to Trust Board.

Mrs Blakely commented on the fact that risk no. 5 'lack of compliance with RQIA recommendations in relation to the supervision and administration of medication' remains a high risk. Mr Rice spoke of the measures taken by the Trust to mitigate this risk and regional action required which is outside the governance of the Trust. An update will be provided to a future Governance Committee meeting on this matter.

**Action: Mr Rice**

4. **MEDICINES GOVERNANCE REPORT**

Dr Boyce presented the Medicines Governance Report for the first quarter of 2012/13 and highlighted the key aspects as follows:-

i) 214 medication incidents were reported during this quarter. The average number of reported medication incidents each month was 71, representing a slight decrease from 75 in the previous quarter. There was one major incident during this quarter. There were no trends of specific concern amongst the reports.

ii) A framework to determine the complexity of medication regime and guide the involvement of domiciliary care staff in medicines management has been developed.

iii) A HypoBox (a ward based box containing all the products required to treat hypoglycaemia) has been developed and will hopefully be launched in the next couple of weeks.

iv) The consultation on the final draft of the revised SHSCT Medicines Code has now been completed and the aim is to launch the new version in the Trust during January 2013.

Dr Mullan asked if the Medicines Code was regional. Dr Boyce explained that other Trusts do have a Medicines Code but that the Southern Trust's arrangements for transport etc are very specific. Dr Rankin added that the principles are generic.

Mrs McAlinden asked Dr Boyce to brief members on the incident referred to in the analysis as 'major'. Dr Boyce gave members a brief synopsis of an issue within the Mental Health Directorate and advised that as part of the investigation the Trust looked at ways in which the treatment could have been done differently.

Mrs Kelly informed members that the issue of medication at point of hospital discharge was raised at a recent Patient Client Experience Committee meeting. Dr Boyce advised that the Pharmacists

encourage patients to return all medication at point of discharge so they are only leaving with the required medication and that this seems to work well. Mrs Kelly emphasized the importance of patients and their relatives/carers having a clear understanding of the medication they need. Dr Rankin advised that this is an issue which could be appropriately addressed through the Organisation of Care project and she agreed to take this forward.

**Action: Dr Rankin**

Mrs Kelly mentioned an article in the papers regarding research into tamiflu and an allegation that the findings of clinical trials were not always fully disclosed. Mrs McAlinden advised that the R&D Annual Report discloses all of the clinical trials underway within the Trust.

Dr Mullan commented on the visit to the Pharmacy Robot and stated that the Non Executive Directors were very impressed.

5. **CLINICAL AND SOCIAL CARE GOVERNANCE UPDATE**

i) Post Falls Pathway

Mrs McVeigh and Dr Rankin gave a presentation to members on the Post Falls Pathway. Members asked a number of questions to which Mrs McVeigh and Dr Rankin responded.

Mrs McAlinden advised members that herself and Mrs McVeigh would be visiting a falls service as part of the promotion of how the Trust is already implementing **'**Transforming Your Care' and to raise awareness of the service.

Mrs Blakely highlighted the 750,000 young carers in the UK and asked if this matter was included in the schools curriculum. Mrs McVeigh advised that there is a significant physical activity programme. Mrs Blakely asked if young carers are getting support regarding falls i.e. for themselves and in a carers role. Mrs McVeigh and Mr Morgan to follow-up on this matter. Mr Morgan said it is important that young carers have the information that they need.

**Action: Mrs McVeigh/Mr Morgan**

Mrs Burns informed members that a Datix web project group has been set up to look at how to improve recording of the incidents of inpatient falls and that hopefully in the New Year the information and analysis should improve. Mrs Mahood asked if we would be able to pick up trends. Mrs Burns said that looking forward the Trust should be able to, but that the new data collection would not be able to be compared with historic data.

Mrs Rooney queried point 3 of the Post-Falls Pathway where it states 'Inform relatives/next of kin, urgently if serious injury suspected'. Mrs Rooney asked even if the injury isn't serious should a relative/next of kind not be informed. Mrs Burns explained that if a fall happens, for example, during the night, unless there was definitely a serious injury then the relatives/next of kin wouldn't be contacted until the morning. If the injury was serious then the relatives/next of kin would be contacted straight away. Mrs Rooney advised members that this could be misinterpreted that there isn't a need to ring a relative/next of kin at all. Mrs McAlinden said that Mrs Rooney's point would be taken on board and Mrs Burns to amend protocol.

**Action: Mrs Burns**

Dr Rankin highlighted the Bed Rails Policy and advised that there is now evidence which would suggest that there is an increasing risk of injury by using bed rails. She added that a risk assessment is now carried out for each individual patient to guide staff on whether or not to use bed rails. Mrs Burns added that potentially we could have more falls out of bed after implementing the bed rails policy but that the emphasis is on preventing real harm caused by a 'high' fall.

Mrs McAlinden commended Mrs McVeigh, Dr Rankin and Mrs Burns on the work undertaken to date in this area.

6. **INCIDENTS AND COMPLAINTS MANAGEMENT REPORT AND UPDATE ON OMBUDSMAN CASES**

Mrs Burns presented the above report in which a total of 2,661 incidents were reported during July-September 2012. Mrs Burns advised that falls are included in the report and that although the figures have gone up, this is more to do with raised awareness and more staff reporting incidents of falls.

Mrs Blakely asked about the grading of complaints and how these compared to this time last year. Mrs Burns advised that there have been no significant changes.

Mrs McAlinden asked about the feedback loop to the person who reports the IR1. Mrs Burns advised that there isn't an automatic email but that IR1s should be reviewed weekly/fortnightly at incident review team meetings and then feedback to the clinical review team. She added that this is working well in some areas and that emphasis is being put on staff to feedback through review team meetings.

Dr Mullan highlighted the catastrophic incidents and the concerning number of suicides. Mr Rice advised that there has been a significant increase in suicides in Northern Ireland.

Mrs Mahood queried the figures on Page 9 under the Mental Health Directorate for Self-harm and asked why there was such a significant rise in figures from July 2011 to July 2012. Mr Rice advised that he would look into this and advise Mrs Burns for the next meeting.

**Action: Mr Rice/Mrs Burns**

Mrs Burns briefed members on the cases with the N.I. Commissioner for Complaints as at 30 September 2012. She advised that there has been one new case for Acute and one for Children and Young People's Services. Mrs Burns concluded by saying that there has been an overall reduction in the number of cases with the Ombudsman.

7. **SERIOUS ADVERSE INCIDENTS REPORT FOR THE PERIOD 1.4.2012 – 30.9.2012**

Mrs Burns presented a summary of the SAIs reported during the period 1st April 2012 – 30th September 2012. She reported a total of 8 new notified SAIs during 1st July 2012 – 30th September 2012. Mrs Burns advised members that the Trust had held a very challenging meeting with the Health and Social Care Board (HSCB) to try and close the longest outstanding cases. The Trust succeeded in closing three from 2006. Mr Morgan asked if there was ongoing discussion with HSCB and DRO. Mrs Burns advised that they are trying to work on a case by case basis.

8. **PROFESSIONAL GOVERNANCE REPORTS**

**i) Medical Director**

Dr Simpson highlighted the key aspects of this report as follows:-

**Medical Appraisal and Revalidation:**

Dr Simpson updated members on medical appraisal and revalidation. Mr Morgan asked how many appraisals have been completed. Dr Simpson said that the figures would be approximately 96% in the next week or so. Mrs Kelly asked what the consequences would be if a Doctor fails to comply with revalidation. Dr Simpson informed members if the Trust identifies Doctors who haven't been engaging in the appraisal system at all then the General Medical Council (GMC) would be notified. He added that the GMC haven't made clear what the consequences will be. Dr Mullan asked about the Junior Doctors Mandatory Training. Dr Simpson said he could give an assurance that the majority of Junior Doctors are engaged in Mandatory Training and that the Trust is aware of those who have not completed the mandatory training.

**HCAI Update:**

Dr Simpson advised members of 4 cases of C'Diff the previous week and confirmed that RCAs for each have commenced.

Dr Simpson informed members that MRSA is very low in the Trust which is good news. Mrs McAlinden highlighted the Stroke Collaborative report which has been discussed regionally and specifically the figures for August of 62% for CT Scans. Mrs McAlinden asked if the next Medical Director report could include more detail on this. Mrs McAlinden added that it would be good to focus specifically on this area for a future meeting similar to the Falls presentation given at today's meeting.

**Action: Dr Simpson/Dr Rankin**

**Litigation:**

Dr Simpson advised that a reporting system to ensure that lessons have been shared and embedded within the organisation is being developed as part of the relationship between himself, Governance Leads and Service Directors.

9. **DELEGATION OF STATUTORY FUNCTIONS ACTION PLAN FOR THE PERIOD 1/4/2012-31/3/2012**

Mr Paul Morgan referred members to the above report and presented the action plan.

Mr Morgan advised that the key issues were carers assessments and vulnerable adults. He added that the Trust is waiting for a regional steer regarding the threshold for vulnerable adults. Mr Morgan said that Mrs P Trainor had undertaken research on vulnerable adults and the results are expected in December.

Mrs McAlinden asked Mr Morgan if it would be helpful to bring back the report after 31 March giving a red/amber/green update. Mr

Morgan said he would be confident that most would be green but that he would bring back after 31 March for assurance to the Committee.

**Action: Mr Morgan**

10. **RQIA REVIEWS STATUS UPDATE**

Mrs McAlinden spoke to the above paper and advised that all areas are being actively worked on. She also advised that the report now included an update on Failure to Comply Notices. In relation to announced/unannounced hygiene inspections, Dr Mullan highlighted that there are quite a few recommendations not completed. Mrs McAlinden advised that a lot of these recommendations are related to the quality of the Estate and reflect the Trust's Minor Works rolling programme of improvement. She confirmed that all minor works were prioritized by Directors to ensure that the limited funding for such work is effectively targeted and Mrs Clarke would take these forward through the minor works programme.

11. **HSCB HOSPITAL STANDARDISED MORTALITY RATIOS**

Dr Simpson spoke to members on the above report and highlighted the analysis of diagnostic coding which demonstrates the high level of performance in the Southern Trust, reflecting the considerable efforts made over the past years. Mrs McAlinden mentioned the Dr Foster report which came out the previous day which focused specifically on mortality and has detailed the best and worst mortality by UK hospital.

Mrs Blakely asked about the areas which are excluded, specifically in relation to Maternity. Dr Simpson advised that the CHKS select these areas, not the Trust.

Dr Rankin advised that there is a Perinatal Mortality Report. Mrs McAlinden stated that it was important that the Trust is reporting mortality in all areas and not just those specified in the report.

12. **THE SAFETY OF SERVICES PROVIDED BY NI HEALTH AND SOCIAL CARE TRUSTS**

Mrs McAlinden informed members that this paper was for information and had been referenced at the recent Trust Board meeting. Correspondence from Dr McCormick is also included in members' packs and the Trust response for information. Dr Mullan asked if the updated Mandatory Training Policy has been finalised. Mrs McAlinden agreed to follow this up with Mr Donaghy.

**Action: Mrs McAlinden**

13. **ACCOUNTABILITY REPORT FOR STANDARDS AND GUIDELINES**

Mrs Burns briefed members on the above report compiled by Mrs Caroline Beattie and advised that formed part of the information submitted by the Trust to the recent Accountability Review Meeting with DHSSPS. Mrs Burns referred members to the risk register which reflects the lack of evidence/assurance on compliance with standards and guidelines prior to the current process being implemented in April 2010, and informed members that a look back exercise extending back to April 2007 is currently being undertaken which should be finished before Christmas. A list of standards and guidelines with no/incomplete evidence of compliance will then be issued to Directors to prioritise and take forward to assure compliance or identify any issues requiring escalation within or external to the Trust.

Mrs McAlinden advised members that the Trust is carrying out the look back exercise for our own assurances and that a huge amount of work is involved.

14. **FEEDBACK ON MID-YEAR ACCOUNTABILITY REVIEW MEETING**

Mrs McAlinden informed members that the Chair had given an update to Trust Board and to date the Trust has not received the formal minutes from the meeting. These will be circulated to members, once available.

15. **MANAGEMENT OF WATER SYSTEMS**

Mrs Clarke advised members that the above is a brief assurance paper summarizing actions and progress underway. She added that a comprehensive water sampling process is in place. Mrs McAlinden queried if there is a systemic approach agreed at regional level regarding water sampling. Mrs Clarke advised that the Trust had arranged to meet with the Health and Safety Executive to discuss a shared position on the water sampling regime that would be deemed acceptable for both Legionella and Pseudomonas. The Trust would then share the outcome of this discussion with DHSSPS to seek to secure regional agreement to same.

Mrs McAlinden advised when the sampling requirements have been agreed the Trust will need to cost this as recurrent funds for this work are not in place.

**Action: Mrs Clarke**

16. **BSI ASSESSMENT REPORT FOR STERILE SERVICES**

Dr Rankin spoke to the above report and advised members that all previous nonconformities are now compliant. She added that the report for Daisy Hill Hospital will be available soon. Mrs McAlinden said that it was important to note where we have requirements to achieve that we have done so.

17. **FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REQUESTS – SUMMARY REPORT FOR THE PERIOD JULY-SEPTEMBER 2012**

Mrs Clarke advised members this is the standard report and highlighted that there was an improved position on responses in the 20 day timeframe.

18. **UPDATE FROM AUDIT COMMITTEE**

Mrs Mahood updated members on the meeting which had taken place on 18th October 2012 and highlighted an area of concern in relation to Claims Management/Litigation Payments. Mrs Mahood

advised members that the Audit Committee required further clarification on the inconsistencies in wording in reports regarding lessons learnt. In response, Mrs McAlinden asked Dr Simpson to provide a briefing to both Audit and Governance Committees.

**Action: Dr Simpson**

19. **UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE**

Mr Graham advised members that an update had been provided at Trust Board and there was nothing further to add. He informed members that a service user will be attending the meeting on 6th December 2012 to discuss a complaint regarding their mother.

20. **ANY OTHER BUSINESS**

Mrs Mahood reminded members that the Trust Excellence Awards Ceremony will be held on Wednesday 5th December 2012.

***The next meeting of the Governance Committee will take place on Tuesday, 5th February 2013 at 9.30 a.m. and will be held in the Boardroom, Trust Headquarters.***

Southern Health and Social Care Trust

# Minutes of a meeting of the Board of Directors held on Thursday, 25th March 2010 at 10.00 a.m. in the Boardroom, Craigavon Area Hospital

## PRESENT:

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

## IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources and Organisational Development
Dr G Rankin, Interim Director of Acute Services
Mrs A McVeigh, Acting Director of Older People and Primary Care Services
Mrs P Clarke, Acting Director of Performance and Reform
Mrs R Rogers, Head of Communications
Mrs S Cunningham, Southern Area Manager, Patient and Client Council
Mrs S Judt, Committee Secretary (Minutes)

## 1. CHAIRMAN'S WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting. Apologies were recorded from Dr R Mullan, Non Executive Director

## 2. ROLE OF THE PUBLIC HEALTH AGENCY – PRESENTATION

The Chairman welcomed Dr Eddie Rooney, Chief Executive, Public Health Agency (PHA) to the meeting. Dr Rooney welcomed the opportunity to address the Board and provided members with a brief overview of the Agency and the challenges and priorities for 2010-11.

The Acting Chief Executive assured Mr Rooney of the Trust's willingness to work with the PHA on emerging initiatives to deliver improved health and wellbeing and reduced health inequalities. The Chairman stated that it would be useful to have Board to Board meetings between the Trust and the PHA in future and she undertook to write to the Chair of the PHA to take this forward.

## 3. MINUTES OF BOARD MEETING HELD ON 25TH FEBRUARY 2010

The minutes of the meeting held on 25th February 2010 were agreed as an accurate record and duly signed by the Chairman.

## 4. MATTERS ARISING

### i) Access to Central Booking Lists

As agreed at the previous meeting, Dr Rankin provided a response to the query raised by Mrs Kelly. Dr Rankin advised that every effort was being made to maximise the numbers seen on Outpatient lists across the Trust. A new procedure is in development to ensure that a patient who cancels at short notice is rebooked locally by staff in South Tyrone Hospital, while the freed up outpatient slot is reused by the Central Booking Unit.

## 5. STRATEGIC ISSUES

### i) Changing for Children Consultation (ST 221/10)

Mrs Geraldine Maguire, Assistant Director of Specialist Child Health and Disability and Dr Bassam Aljarad, Associate Medical Director, Children and Young People's Services, were welcomed to the meeting for a presentation on Phase 1 of the Changing for Children strategy in relation to Acute Paediatric Services. Trust Board approval is sought for the proposal to locate planned paediatric surgical services (General Surgery; ENT and Paediatric Dentistry) to a centralised service based at Daisy Hill Hospital, Newry. This centralisation would establish a centre of

excellence for the delivery of surgical and dental services for children. Mrs Maguire outlined the current service models and the challenges for the service. She then explained the key drivers for the proposal, the project methodology, the proposed new service models and the next steps. Mrs Cunningham welcomed the engagement of parents as part of the process and suggested that the consultation document should seek views on whether the proposed location would present any particular difficulties for people. Members approved the proposal for public consultation, subject to amendments to the consultation questionnaire proposed by Mr Joynes and agreed by the Board.

Mrs Maguire explained that the Trust will now consult over a 10-week period commencing 1st April 2010 and ending on 10th June 2010. Following this consultation, the proposal will be presented to Trust Board in June 2010 for approval and a full business case will be developed for elective surgical and unscheduled paediatric medicine pathways.

Mr Dornan paid tribute to the immense work undertaken by staff, particularly Mrs Maguire, Mrs Burns and Dr Aljarad. He stated that the priorities had been identified by staff working in Paediatrics and that the direction of travel has Commissioner approval.

**The Board of Directors approved the proposal for public consultation (ST 221/10)**

ii) **Daisy Hill Hospital Strategic Outline Case (ST 222/10)**

Mrs Clarke presented the Strategic Outline Case for the redevelopment of the Daisy Hill Hospital site in order to maximise it as part of the Trust's network of hospital services. She explained that the Trust is currently undertaking an extensive review of the existing services at Daisy Hill Hospital and from this will develop new models of care/service. Redevelopment of the site is therefore necessary to support the implementation of the new models of care and improve on existing accommodation. Following the option appraisal, the Trust is recommending implementation of the preferred option which proposes the reconfiguration and refurbishment of the existing ward/theatre block, A&E, OPD and Radiology. Total capital costs are estimated at £49.8m. In response to a question from Mrs Mahood on funding and timescales, Mrs Clarke advised that it is

estimated that the work could be completed within 5 years at the maximum and to ensure stability of services during this time, will be carried out in 6 phases. Capital funding is being sought from the DHSSPS. Revenue funding for Phase 1 is linked to the Changing for Children strategy and Commissioner approval will be sought on that basis.

**The Board of Directors approved the Strategic Outline Case for Daisy Hill Hospital site redevelopment (ST 222/10)**

iii) **Strategic Action Plan for the Promotion of Health & Wellbeing (ST 223/10)**

Mrs McVeigh presented the Trust's response to its requirement to develop a Promoting Wellbeing Strategic Action Plan. She explained that following a consultation process which highlighted the need to evidence a more partnership approach and a workshop in January 2010, the strategy has been amended and is being presented for approval for launch in April 2010. Mrs McVeigh stated that the promotion of health and wellbeing is a key strand in the work of all Directorates. Mr Joynes stated that it would be helpful if the action plan included named individuals to take forward required actions together with timescales for completion and asked about an annual action plan to Trust Board. The Acting Chief Executive agreed that Mrs McVeigh and herself would consider how best to provide this information to Trust Board. Mrs Blakely referred to funding and resources and asked how this information would be shared with community groups. The Acting Chief Executive agreed that Mrs McVeigh and herself would discuss this further and respond to Mrs Blakely.

**The Board of Directors approved the Strategic Action Plan for the promotion of Health & Wellbeing (ST 223/10)**

iv) **Strategic Outline Case for Refurbishment/Replacement of Theatres 1-4 at Craigavon Area Hospital (ST 224/10)**

Dr Rankin presented the Strategic Outline Case for the refurbishment/replacement of the existing main theatres 1 – 4 at Craigavon Area Hospital for approval. She stated that these theatres have been in use since the hospital was opened in 1972 and the accommodation is no longer fit for purpose.

A full business case will be brought to a future Trust Board meeting.

**The Board of Directors approved the Strategic Outline Case (ST 224/10)**

v) **User and Carer Involvement in Mental Health Services Proposals (ST 225/10)**

Mr Rice presented for approval, the Trust response to the consultation paper on proposals for Regional Service Improvement in the delivery of Adult Mental Health Services; Users and Carers as Stakeholders. He stated that this consultation paper was developed by the Bamford Implementation Taskforce Project Board to move forward on delivering a partnership approach with service users and carers in planning and delivering care. Members noted the comprehensive response and the Trust's agreement to the proposals set out in the consultation paper.

**The Board of Directors approved the Trust's response to the consultation for submission to the Health and Social Care Board (ST 225/10)**

vi) **Consultation on Autism Bill (NI) – Trust response (ST 226/10)**

Mr Dornan presented the Trust response to the consultation on the Autism Bill (NI) 2010. In discussion, it was agreed that Mr Dornan would make some amendments to the response, referencing the significant work undertaken in the Southern Trust area on Autism.

**The Board of Directors approved the Trust's response to the Consultation on Autism Bill (NI) pending the proposed amendments (ST 226/10)**

6. **PATIENT/CLIENT SAFETY AND QUALITY OF CARE**

i) **Infection Control update**

Dr Loughran outlined progress against the PfA targets for MRSA, MSSA and C-difficile.

Dr Loughran stated that the Trust is succeeding in its efforts to minimise C-difficile. Referring to MSSA, Dr Loughran advised that considerable work has and continues to be progressed to achieve the MSSA target. This work includes a comprehensive package of infection control measures, one of which is the maintenance of peripheral venous cannulas which has been identified as the main cause of MSSA. He advised that £10k of the £25k funding received from the Public Health Agency for HCAI will be spent on acquiring IV Cannulation trolleys and packs for use in the pilot aimed at reducing MSSA infections.

Dr Loughran informed members that the Trust's poster presentation on 'E-Dashboards and Reporting' received first prize at the regional HCAI symposium on 4th March 2010.

ii) **H1N1 Flu Vaccination Programme update**

Dr Loughran provided a summary of the Trust's progress in relation to the delivery of the H1N1 flu vaccination programme. This includes a number of streams and Dr Loughran advised that the Trust has been asked to continue to offer the vaccination to all pregnant women for the remainder of the calendar year. Members were advised that this will become part of the antenatal booking clinic appointments across the Trust. Dr Loughran concluded by advising of a forthcoming de-briefing meeting regarding the Trust's internal response to H1N1 flu vaccination programme.

iii) **Scheme for the Delegation of Statutory Functions by the Health and Social Care Board to the Southern Health and Social Care Trust (ST 227/10)**

Mr Dornan presented the Scheme for the Delegation of Statutory Functions for approval prior to its formal submission to the HSCB for approval. He advised that the Scheme has been updated following the establishment of the regional HSCB and to take account of new legislative requirements.

The Acting Chief Executive expressed the view that the document does not specify the responsibility of the Regional Board to adequately fund the Trust to enable it to fully discharge the delegated functions. Trust Board members asked that there be consideration of the inclusion of this responsibility in relation to

both the Regional Board and the Department. The Chairman agreed to convey this request in writing to the Regional Board.

**The Board of Directors approved the Scheme for the Delegation of Statutory Functions (ST 227/10)**

## 7. OPERATIONAL PERFORMANCE

### i) Performance Report (ST 228/10)

Mrs Clarke presented the report summarising the Trust's performance in February 2010 against Priority for Action (PfA) 2009/10 standards and targets and key performance indicators of corporate performance. She drew members' attention to a number of risk areas. Referring to the Inpatient/Daycase, Outpatient and Diagnostic Access target, Mrs Clarke stated that delays in securing investment have presented risk as non-recurrent solutions have had to be sustained for longer than anticipated. The Commissioner has acknowledged that particular speciality areas will not meet the agreed targets, but will not exceed 17 weeks and these are Urology, Endoscopy, T&O and MRI services. The majority of breeches in February (77%) were in these specialties.

Mr Dornan provided members with an update on unallocated child care cases. He stated that the number of cases has fluctuated over the past weeks, with the significant rise being in the number of cases across the Gateway Service due to staff vacancies. This is compounded by the difficulty in recruiting social work staff on temporary contracts. Mr Dornan stated that it is a difficult situation which is being closely monitored and assured members that there are no unallocated child protection cases. He outlined proposed actions to address the situation including redeployment of staff and the re-deployment of some staff to direct client involvement. He stated that the system will be strengthened in June/July with newly qualified social workers and spoke of the trainee social worker scheme whereby the Trust had agreed to offer contracts to some social work trainees within the Trust. In response to a query from Mr Joynes, Mr Dornan outlined some initiatives to attract social workers to child care and advised of the work within the Trust and regionally, looking at the retention of social work staff.

Mr Dornan agreed to keep the Board updated on the situation as regards unallocated child care cases.

Mr Dornan referred to the statutory requirement that each Looked After Child should have a permanently allocated social worker and advised of the current difficulty in meeting this requirement in the Newry/Mourne and Armagh/Dungannon areas. He stated that this is a short-term difficulty as 3 social workers are due to take up post in May 2010 and this should address the situation.

**The Board of Directors approved the Performance Report (ST 228/10)**

ii) **Finance Report (ST 229/10)**

Mr McNally presented the Financial Performance Report for the period ending 28th February 2010. He reported that the month 11 outturn shows an encouraging decrease in the deficit of £1,270k with the accumulated deficit now standing at £2.2 million. He stated that the best estimate of year-end outturn is a deficit of around £1.3 million.

The Chairman advised of a Financial Planning Workshop on 14th April 2010.

**The Board of Directors approved the Finance Report (ST 229/10)**

iii) **Human Resources Report (ST 230/10)**

Mr K Donaghy presented the Human Resources report and highlighted four key aspects as follows:-

- Midwifery recruitment activity has resulted in success in recruiting midwives in acute services;
- Staff turnover rate is 3.5%;
- Sick leave rate at end January 2010 was 5.06%;
- Skills mix. Members were advised that the Nursing & Midwifery and AHP staff skills mix issues are being considered by the Directorate specific Workforce Planning and Modernisation Groups.

Mrs Kelly asked about the Midwifery Trainee Scheme (direct entry) and Mr Rice advised that the Trust would have 11 practising midwives in May 2010.

**The Board of Directors approved the Human Resources Report (ST 230/10)**

8. **PROPOSED AMENDMENT TO SCHEME OF RESERVATION AND DELEGATION OF POWERS (ST 231/10)**

This item was deferred to the next meeting.

9. **CHAIRMAN'S AND NON-EXECUTIVE DIRECTORS' BUSINESS**

A list of the Chairman's and Non Executive Directors' business was noted.

10. **ANY OTHER BUSINESS**

10.1 **Board to Board meetings with the HSCB, PHA and PCC**

Members agreed to proceed with the Chairman's suggestion to meet with the Board members of the above.

10.2 The Board of Directors congratulated Emma Grimley, one of the fourth year students in the Trust due to graduate in May this year with an Adv Diploma in Mental Health nursing and registration, who will also receive the prestigious Sir John Daniel award. This prize is given to a graduate who has achieved their award in spite of adversity and difficulty during their time of study with the Open University.

10.3 Mr Rice reported that the total of registered suicide cases within the Southern area for 2009 was 47 cases, a decrease from the 2008 total figure of 69.

10.4 Mr Rice advised that the Regional Uniform and Work Wear Steering Group has awarded the contract for HSCNI uniforms to Hunters Apparel Solutions (HAS) NI.

***The next Board of Directors meeting will be held on Thursday, 29th April 2010 at 10.00 a.m. in the Boardroom, Craigavon Area Hospital***

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

# Minutes of a meeting of Trust Board held in public on Thursday, 29th May 2014 at 1.45 p.m. in the Boardroom, Trust Headquarters, Craigavon

## PRESENT:

Mrs R Brownlee, Chair
Mrs M McAlinden, Chief Executive
Mr R Alexander, Non Executive Director
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs H Kelly, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/ Executive Director of Nursing
Dr J Simpson, Medical Director

## IN ATTENDANCE:

Mrs D Burns, Interim Director of Acute Services
Mrs P Clarke, Director of Performance and Reform
Mr Miceal Crilly, Acting Director of Mental Health and Disability Services
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs J McKimm, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

## APOLOGIES:

Mrs A McVeigh, Director of Older People and Primary Care Services

## 1. CHAIR'S WELCOME AND BUSINESS

The Chair welcomed everyone to the meeting. She reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops 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. There were no conflicts of interest declared.

## 3. CHIEF EXECUTIVE'S BUSINESS

Mrs McAlinden presented her written report which included a number of items of business both internal and external to the Trust. She highlighted the following developments:-

- **Regional Payroll issues**

  Trust staff were affected by regional payroll issues which included the overpayment of National Insurance Contributions and incorrect assignment of tax codes. Arrangements were put in place to pay staff their outstanding salaries as soon as corrections were put in place. Referring to May payroll, Mr McNally advised of one issue in relation to payment of travel expenses which affected 121 staff and arrangements have been made to pay these expenses to those staff affected.

  Mrs McAlinden commended payroll staff for their work in ensuring that payroll system issues have had minimal impact on Trust staff.

- **Public Facing Accountability Review**

  A Public Facing Accountability meeting will be held with the Southern Trust on 2nd July 2014 at 7.00 p.m. on the Craigavon Area Hospital site. The meeting will be facilitated by the Patient Client Council.

- **RCN Northern Ireland Nurse of the Year Awards 2014**

  Mrs McAlinden advised that the Awards were held on 22nd May 2014 and she commended the Trust finalists.

## 4. SH&SCT FINANCIAL RESOURCE BUDGET 2014/15 (ST 507/14)

Mr McNally presented the Trust's 2014/15 Financial Resource Budget for approval. He advised that following Trust Board agreement in principle to the proposed resource budget, a detailed resource budget will be confirmed to all budget holders, together with a paper on the financial framework within which Resource Budgets must be managed.

Mr McNally set the financial context within which the Budget has been established. He stated that the Trust has not yet received confirmation from the Commissioners of the exact level of funding for 2014/15. The Minister continues to explore additional funding options and, at this stage, it has been indicated that the Trust should develop an operational plan for the current year with an assumption that additional income of up to £18m may be available during the course of the year. Mr McNally summarized the budget for 2014/15 advising that total anticipated income is £522.3m, total estimated spend is £559.7m, resulting in a total opening gap of £37.4m. Mr McNally stated that the first task in addressing the gap is to ensure that TYC plans introduced during 2013/14 deliver their full year potential in 2014/15 and vacancy control and other contingency measures continue. These measures provide a total offset of £9.7m thereby reducing the gap to £27.7m for 2014/15. Mr McNally outlined potential additional off-sets and advised, if implemented, this would reduce the deficit to around £21m. This is, however, £3m in excess of the additional income which may be secured by the Minister during the course of the year. Members discussed the potential deficit position arising in 2014/15. Mrs McAlinden spoke of the options being explored for further savings, in particular, the potential to fast track TYC schemes in order to increase the in-year yield. She stated that initial feedback from Ernst & Young would not indicate that there is a high degree of savings to be achieved from TYC schemes. Mrs McAlinden noted that discussions with HSCB colleagues continue on normative staffing levels with an anticipated further allocation of

around £3m.Mrs Mahood raised the performance issue against the 9 week access standard for AHP services and asked had the risk of non recurrent support been escalated. The Chair confirmed that she had written to Mrs F McAndrew, Interim Chief Executive, HSCB, and a response was awaited.

The Chair concluded by seeking Trust Board approval of the budget allocations outlined in the Financial Resource Budget paper, acknowledging the potential deficit position arising in 2014/15. She spoke of her intention to raise the Trust Board's concerns about the lack of confirmation of the exact level of funding for 2014/15 at the Trust's End Year Accountability meeting on 2nd June 2014. Mrs McAlinden acknowledged the fluidity of the situation and stated that Mr McNally and herself would keep Trust Board informed of funding decisions and income streams, as they become known.

**The Board approved the Financial Resource Budget (ST 507/14)**

**SIGNED: _____**

**DATED: _____**

Southern Health and Social Care Trust

# Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

## 16 September 2010

# 1.0 Introduction

**1.1** **Maintaining High Professional Standards in the Modern HPSS** ***A framework for the handling of concerns about doctors and dentists in the HPSS*** (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.

**1.2** The MHPS framework is in six sections and covers:

I. Action when a concern first arises
II. Restriction of practice and exclusion from work
III. Conduct hearings and disciplinary procedures
IV. Procedures for dealing with issues of clinical performance
V. Handling concerns about a practitioner's health
VI. Formal procedures – general principles

**1.3** MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

**1.4** This guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

a) Ascertain quickly what has happened and why.
b) Determine whether there is a continuing risk.
c) Decide whether immediate action is needed to remove the source of the risk.
d) Establish actions to address any underlying problem.

**1.5** This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.

**1.6** This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

**1.7** This guidance should be read in conjunction with the following documents:

Annex A
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005

Annex B
"How to conduct a local performance investigation" NCAS, 2010

Annex C
SHSCT Disciplinary Procedure

Annex D
SHSCT Clinical Manager's MHPS Toolkit

## 2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

2.1 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) indicates that regardless of how a is concern in identified, it should go through a screening process to identify whether an investigation in needed. The Guide also

indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

2.2 Concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.

2.3 Concerns which may require management under the MHPS framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.

2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.

2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expediously as possible and the Oversight Group will monitor progress.

2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.

2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.

2.10 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager

and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.
Reference Section 1 paragraph 8 – MHPS 2005

## 3.0 MANAGING PERFORMANCE ISSUES

3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1
An informal process. This can lead to resolution or move to:

Appendix 2
A formal process. This can also lead to resolution or to:

Appendix 3
A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4
An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5
Exclusion can be used at any stage of the process.

Appendix 6
Role definitions

3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or

recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).

3.4 All formal cases will be presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review when the case is closed.

3.5 During all stages of the formal process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but not acting in a legal capacity. Refer MHPS Section 1 Point 30.

**Appendix 1**

## Step 1 Screening Process

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→ Clinical Manager/Operational Director informs:

- Chief Executive
- Medical Director
- Human Resources Department
- Practitioner

↓

Clinical Manager and HR Case Manager undertake preliminary enquires to identify the nature of the concerns and assesses the seriousness of the issue on the available information.

↓

Chief Executive appoints an Oversight Group – usually comprising of:

- Medical Director / Responsible Officer
- Director of Human Resources and Organisational Development
- Appropriate Operational Director

↓

Clinical Manager and HR Case Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and HR Case Manager notify the Oversight Group of their assessment and decision. The decision may be:

- No Action Necessary
- Informal remedial action with assistance and input from NCAS
- Exclusion / Restriction

** If co ndertaken by the appropriate Associate Medical Director (AMD). If concern arises l Director

**Appendix 1**

## Step 2 Informal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the informal process.

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

The Clinical Manager should seek advice from NCAS. This may involve a performance assessment by NCAS if appropriate.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors and provides regular feedback to the Oversight Group regarding compliance.

**Appendix 2**

## Formal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the formal process.

Chief Executive, following discussions with the MD and HROD, appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific allegations raised.

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and decisions taken.

Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

**Appendix 3**

# Conduct Hearings / Disciplinary Procedures

Case Manager makes the decision that there is a case of misconduct that must be referred to a conduct panel. This may include both personal and professional misconduct.

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

↓

Case referred under the Trust's Disciplinary Procedures. Refer to these procedures for organising a hearing.

↓

If a case identifies issues of professional misconduct:
- The Case Investigator must obtain appropriate independent professional advice
- The conduct panel at hearing must include a member who is medically qualified and who is not employed by the Trust.
- The Trust should seek advice from NCAS
- The Trust should ensure jointly agreed procedures are in place with universities for dealing with concerns about Practitioners with joint appointment contracts

↓

If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member.

In all cases following a conduct panel (Disciplinary Hearing), where an allegation of misconduct has been upheld consideration must be given to a referral to the GMC/GDC by the Medical Director/Responsible Officer.

If an investigation establishes suspected criminal action, the Trust must report the matter to the police. In cases of Fraud the Counter Fraud and Security Management Service must be considered. This can be considered at any stage of the investigation.

Consideration must also been given to referrals to the Independent Safeguarding Authority or to an alert being issued by the Chief Professional Officer at the DHSSPS or other external bodies.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

**Appendix 3a**

# Clinical Performance Hearings

Case Manager makes the decision that there is a clear failure by the Practitioner to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance i.e. a clinical performance issue.

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Case MUST be referred to the NCAS before consideration by a performance panel (unless the Practitioner refuses to have their case referred).

Following assessment by NCAS, if the Case Manager considers a Practitioners practice so fundamentally flawed that no educational / organisational action plan is likely to be successful, the case should be referred to a clinical performance panel and the Oversight Group should be informed.

Prior to the hearing the Case Manager must:
- Notify the Practitioner in writing of the decision to refer to a clinical performance panel at least 20 working days before the hearing.
- Notify the Practitioner of the allegations and the arrangements for proceeding
- Notify the Practitioner of the right to be accompanied
- Provide a copy of all relevant documentation/evidence

Prior to the hearing:
- All parties must exchange documentation no later than 10 working days before the hearing.
- In the event of late evidence presented, consideration should be given to a new hearing date.
- Reasonably consider any request for postponement (refer to MHPS for time limits)
- Panel Chair must hear representations regarding any contested witness statement.
- A final list of witnesses agreed and shared between the parties not less than 2 working days in advance of the hearing.

Composition of the panel – 3 people:
- **Chair -** Executive Director of the Trust (usually the Medical Director)
- **Panel 1 -** Member of Trust Board (usually the Operational Director)
- **Panel 2 -** Experienced medically / dentally qualified member not employed by the Trust

** for clinical academics including joint appointments a further panel member may be required.

Advisors to the Panel:
- a senior HR staff member
- an appropriately experienced clinician from the same or similar specialty but not employed by the Trust.

** a representative from a university if agreed in any protocol for joint appointments

**Appendix 3a**

# Clinical Performance Hearings

During the hearing:

- The panel, panel advisors, the Practitioner, their representative and the Case Manager must be present at all times
- Witnesses will only be present to give their evidence.
- The Chair is responsible for the proper conduct of the hearing and should introduce all persons present.

During the hearing - witnesses:

- shall confirm any written statement and give supplementary evidence.
- Be questioned by the side calling them
- Be questioned by the other side
- Be questioned by the panel
- Clarify any point to the side who has called them but not raise any new evidence.

During the hearing – order of presentation:

- Case Manager presents the management case calling any witnesses
- Case Manager clarifies any points for the panel on the request of the Chair.
- The Practitioner (or their Rep) presents the Practitioner's case calling any witnesses.
- Practitioner (or Rep) clarifies any points for the panel on the request of the Chair.
- Case Manager presents summary points
- Practitioner (or Rep) presents summary points and may introduce any mitigation
- Panel retires to consider its decision.

Decision of the panel may be:

1. Unfounded Allegations – Practitioner exonerated
2. A finding of unsatisfactory clinical performance (Refer to MHPS Section IV point 16 for management of such cases).

If a finding of unsatisfactory clinical performance - consideration must be given to a referral to GMC/GDC.

A record of all findings, decisions and warnings should be kept on the Practitioners HR file. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. The decision must be confirmed in writing to the Practitioner within 10 working days including reasons for the decision, clarification of the right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external body.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

**Appendix 4**

# Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision. The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

**Appendix 5**

# Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

**Immediate Exclusion**

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

**Appendix 5**

# Restriction of Practice / Exclusion from Work

**Formal Exclusion**

Decision of the Trust is to formally investigate the issues of concern and appropriate individuals appointed to the relevant roles.

Case Investigator, if appointed, produces a preliminary report for the case conference to enable the Case Manager to decide on the appropriate next steps.

The report should include sufficient information for the Case Manager to determine:

- If the allegation appears unfounded
- There is a misconduct issue
- There is a concern about the Practitioner's Clinical Performance
- The case requires further detailed investigation

Case Manager, HR Case Manager, Medical Director and HR Director convene a case conference to determine if it is reasonable and proper to formally exclude the Practitioner. (To include the Chief Executive when the Practitioner is at Consultant level). This should usually be where:

- There is a need to protect the safety of patients/staff pending the outcome of a full investigation
- The presence of the Practitioner in the workplace is likely to hinder the investigation.

Consideration should be given to whether the Practitioner could continue in or (where there has been an immediate exclusion) could return to work in a limited or alternative capacity.

**If the decision is to exclude the Practitioner:**

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

The Case Manager along with the HR Case Manager must inform the Practitioner of the exclusion, the reasons for the exclusion and given an opportunity to state their case and propose alternatives to exclusion. A record should be kept of all discussions.

The Case Manager must confirm the exclusion decision in writing immediately. Refer to MPHS Section II point 15 to 21 for details.

All exclusions should be reviewed every 4 weeks by the Case Manager and a report provided to the Chief Executive and Oversight Group. (Refer to MHPS Section II point 28 for review process.

**Appendix 6**

# Role definitions and responsibilities

## Screening Process / Informal Process

### Clinical Manager

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

### Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

### Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

## Formal Process

### Chief Executive

The Chief Executive in conjunction with the Oversight Group appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of formal the investigation and requests that a Non-Executive Director is appointed as "designated Board Member".

**Case Manager**

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

**Case Investigator**

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

**Note:** Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

**Non Executive Board Member**

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

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

**Minutes of a Trust Board meeting held in Public on Thursday 23rd October 2014 at 11.00 am in the Board Room, Craigavon Area Hospital.**

**PRESENT**:

Mrs R Brownlee, Chair
Mrs M McAlinden, Chief Executive
Mr R Alexander, Non Executive Director
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr J Simpson, Medical Director

**IN ATTENDANCE**:

Mrs D Burns, Interim Director of Acute Services
Mrs P Clarke, Director of Performance and Reform
Mr M Crilly, Acting Director of Mental Health and Disability Services
Mr K Donaghy, Director of Human Resources and Organizational Development
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)
Mrs S McLoughlin, Acting Committee Secretary (Minutes)

**APOLOGIES**:

Mrs H Kelly, Non Executive Director

## 1. CHAIR'S WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and before commencing with the business of the meeting, she reminded members of the principles of Board meeting etiquette and asked that phones are turned to silent and laptops are to be used for accessing Trust Board papers only.

The Chair sought and received confirmation from members that they had read and fully understood their papers in advance of 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. There were no declarations of interest noted.

## 3. CHAIR'S BUSINESS

The Chair referred members to her written report detailing events she had attended since the previous meeting, together with details of some good news stories across the Trust. The Chair drew members' attention to the posters displayed within the room from the very successful Acute Audit Conference held on 21st October 2014. The Chair also drew members' attention to the 3 awards on display which the Trust received at the recent Regional E-Health Conference. On behalf of Board members, the Chair extended congratulations to all of the award winners.

## 4. CHIEF EXECUTIVE'S BUSINESS

Mrs McAlinden referred members to her written report which included a number of items of business both internal and external to the Trust. Mrs McAlinden highlighted the "Hello, my name is …" campaign which has been launched throughout the Trust. This campaign emphasises to staff the importance of introducing themselves to their patients and clients and members were shown a short video in which a number of Trust staff took part explaining who they are and what they do.

## 5. SERVICE IMPROVEMENT/LEARNING FROM USER EXPERIENCE

Mrs Mary Burke, Head of Medicine and Unscheduled Care, gave a presentation on the new Medical Model/Emergency Department Medical Workforce changes. She began her presentation by explaining the background to the changes before outlining the new medical staffing model within the Medical Admissions Unit (MAU) in Craigavon Area Hospital. Mrs Burke then explained how Base Wards were linked to Buddy Wards and spoke of weekend and public holiday cover by Consultants. Mrs Burke drew her presentation to a close when she spoke of the outcomes of the new model drawing everyone's attention to the Quality Improvement Plan which is now in place.

Mrs Burns paid tribute to Mrs Burke and Chief Executive for their hard work in putting this new model in place. The Chair concurred with Mrs Burns' comments and thanked Mrs Burke for an excellent presentation.

## 6. MINUTES OF BOARD MEETING HELD ON 25th SEPTEMBER 2014 (ST538/14)

The Minutes of the meeting held on 25th September 2014 were agreed as an accurate record. The Minutes were duly signed by the Chair.

**The Board approved the Minutes of the Meeting held on 25th September 2014 (ST538/14)**

## 7. MATTERS ARISING FROM PREVIOUS MINUTES

There were no matters arising that were not addressed elsewhere on the agenda.

## 8. STRATEGIC ISSUES

i) Update on Transforming Your Care

Mrs Clarke spoke to a short paper, for information, which provides an overview of the regional reform programme position.

ii) SHSCT Departmental Business Objectives 2014-15 (ST539/14)

Mrs Clarke explained that the Trust is required by Department of Health and Social Services and Public Safety (DHSSPS) to identify annually how it will meet service and organisational objectives set for it as an Arm's Length Body (ALB). Members discussed the update which evidences progress against each objective as at end September 2014 and approved same for submission to the DHSSPS.

**The Board approved the SHSCT Departmental Business Objectives 2014-15 (ST539/14)**

iii) Memorandum of Understanding between Craigavon Borough Council and Southern HSC Trust (ST540/14)

Dr Simpson stated that from 2012, Craigavon Borough Council has been liaising with the Trust to develop Life Sciences in the area which culminated in the successful Cardiology, Commerce and Collaboration Conference on 8 February 2013. Liaison between Council and Trust staff has continued since then and a further Joint Conference is arranged for 28 November 2014.

Dr Simpson presented, for approval, a Memorandum of Understanding to formalize the liaison between the Council and the Trust. Following Trust Board approval, it is proposed that the Memorandum of Understanding will be signed-off by the Chief Executives of the Trust and the Council at the Joint Conference on 28 November 2014.

Mr Graham asked if this formal link with Craigavon Borough Council would continue after the creation of the ABC Super-Council in April 2015. Mrs McAlinden replied that at that stage there would be a need to renegotiate the Memorandum of Understanding.

**The Board approved the Memorandum of Understanding between Craigavon Borough Council and Southern HSC Trust (ST540/14)**

## 9. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Director of Social Work Report

Unallocated Child Care Cases

Mr Morgan reported a total of 100 unallocated cases as at 30 September 2014. He stated that unallocated cases have increased due to 200 additional referrals, as well as sick leave, noting that Portadown and Lurgan Family Intervention Teams continue to have a high level of cases transferred from Gateway. Staff have been identified to fill current vacancies in both these teams and should be in post by the beginning of November 2014.

Mr Morgan advised of the new boundaries which will be implemented during November resulting in part of Craigavon and Banbridge moving into Armagh & Dungannon or Newry & Mourne localities. This will create additional capacity for Craigavon & Banbridge Family Intervention Teams to reduce unallocated cases. Alongside boundary changes, a full complement of staff is required.

Mrs Blakely referred to the current sick leave and asked if there were any underlying concerns. Mr Morgan stated that the Directorate has one of the lowest levels of sick leave, but acknowledged the current increase. Mrs Blakely asked about the 200 additional referrals to which Mr Morgan stated that he

felt a recent regional awareness raising campaign had had an impact on referrals.

- Care Management Reviews

Mrs A McVeigh reported that Older People and Primary Care (OPPC) is not in compliance with the Delegated Statutory Functions Target relating to Annual Review of Community Care Package, stating that the decrease in compliance compared to August position was due to increased sickness absence.

The Chair sought clarity that RQIA had no concerns with any Residential Home currently outside of the 12 month Annual Review Target. Mrs McVeigh provided this assurance.

ii) Medical Director Report

- C.Difficile Action Plan

Dr J Simpson began his report by informing members that regionally c-difficile trends are increasing. As regards the Southern Trust, 23 c-difficile cases have been confirmed year to date (13 October 2014) which is an increasing trend in comparison to the previous two years. Dr Simpson referred to the action plan which outlines a range of interventions proposed.

iii) Director of Nursing Report

Mr Rice spoke to his report which focuses on how Ward Sisters/Charge Nurses and Team Leaders are pivotal to the delivery of a high quality, person centred care and the delivery of Trust objectives. He stated that over the past five years there has been a range of work streams undertaken regionally to provide support to the Ward Sister/Charge Nurse/Team Leader role, the principal objective of which was to support and strengthen these roles across all Trusts.

The Chair asked for further assurance in future reports on how the Sister/Charge Nurse is held to account; staffing complement in

place and how often do Sister/Charge Nurse undertake ward rounds.

Mr Rice also gave an update on the Trust's Health Visiting service drawing attention to 8 health visiting students who have now completed the regional programme and are awaiting registration with the Nursing and Midwifery Council. Although highlighting staffing deficits of 20% in places, Mr Rice drew member's attention to an improved position from May 2014 when parts of the Trust had a reduction of 40% to core services. Mr Rice concluded his report by drawing attention to the increasing child population within the Southern Trust which is expected to grow by 13.5% by 2020 compared to the NI average of 6.5% as well as the significant migration of new BME families into the Trust area and an increase in safeguarding issues and cases resulting in the complexity and number of caseloads for the Health Visiting Workforce. In response to a question from Mrs Blakely, Mr Rice provided assurance that there efforts would be concentrated on families where there are concerns. Mrs McAlinden re-iterated that the Health Visiting workforce is on the Corporate Risk Register and is regularly monitored and reviewed.

**iv) Trust Annual Quality Report 2013/14 (ST541/14)**

Mrs Clarke presented the Trust's Annual Quality Report for approval. Mrs Blakely commented on the fact that the report is more acute than community focused and made a number of suggestions for considerations.

The limitations of the regionally prescribed format was discussed and that the format would be reviewed by the Regional group and Trust Board comments would be fed into this process.

Mrs McAlinden welcomed the comments and stated that comparative information would also be useful and the Trust will continue to lobby for this. The Chair commended all those staff involved in compiling this report.

**The Board approved the Annual Quality Report 2013/14 (ST541/14)**

## 10. OPERATIONAL PERFORMANCE

### i) Finance Report (ST542/14)

Mr McNally advised that as at 30th September 2014, the Trust has exceeded its expenditure budget by £11.5m. Non-rrl income is more than anticipated, thereby decreasing the overspend to £10.2m. Mr McNally spoke of the Trust's projected deficit for the current year of c£27.5m and advised that the Health and Social Care Board has indicated its intention to make additional allocations totalling £3.5m thereby reducing the Trust's contingency requirements from £9.5m to £6m.

There was a short discussion on capital expenditure in which Dr Mullan expressed his concern that the expenditure of £8.1m incurred to date is significantly below target. Mrs McAlinden stated that this is a direct consequence of contingency measures as recruitment of key posts within Estates has not proceeded. Mrs Clarke spoke of improved processes in place with regular review and reporting to the DHSSPS.

Mrs Mahood welcomed the downturn on payroll expenditure and asked about the number of posts currently in the recruitment process. Mrs McAlinden responded by providing assurance on the weekly scrutiny applied by the Senior Management Team. The Chair sought assurance that staff are engaged and encouraged to come forward with suggestions for efficiency savings. Mrs Clarke outlined the range of initiatives in place.

**The Board approved the Finance Report (ST542/14)**

### ii) Performance Report (ST543/14)

Mrs Clarke presented, for approval, the performance report as at the end of September 2014 against the Commissioning Plan standards and targets, together with an assessment of current performance. Mrs Clarke drew members' attention to the key areas of risk predominantly with respect to elective access standards. She noted that performance against this target has become increasingly

challenging, particularly in the Acute Services Directorate. Mrs Burns referred to the deteriorating position in access times and stated that priority continues to be directed to the most clinically urgent work as a first call, however there are a number of areas where the potential risks have escalated. Members considered a short briefing paper which outlines four risk areas: Symptomatic Breast Clinics; CT; Endoscopy and T&O and discussed the proposed options/actions.

After a detailed discussion, members agreed to create additional capacity for routine patients in CT, Endoscopy and Symptomatic Breast Clinics, at financial risk, for one month in the first instance. Mrs McAlinden undertook to the write to the Chief Executive, Health and Social Care Board, to advise of this decision.

The Chair asked about the Speciality risks of Urology and Dermatology to which Mrs Burns advised that Urology remains a risk related to access times. She spoke of a new service model developed by the clinical and service team proposed to be implemented on 1 December 2014. In relation to Dermatology, Mrs Burns advised that workforce constraints are the significant impacting factor.

**The Board approved the Performance Report (ST545/14)**

iii) **Human Resources Report (ST544/14)**

Mr Donaghy spoke to this report and explained it covered three areas – High Impact Change, Consultant Contract and key workforce productivity information. Mr Donaghy referred to the Industrial Action on 13th October 2014 by UNITE and GMB and advised that its impact was negligible.

Mrs Mahood asked for an update on the transfer of Shared Services to Business Service Organisation (BSO) to which Mr Donaghy replied there had been some initial problems with e-recruit and also with payroll. He envisaged these would be eliminated in the near future before other Trusts also move to the new system. Mrs Mahood expressed her concern about these issues.

The Chair asked Mr Donaghy for assurance that all payroll issues had been resolved to which Mr Donaghy advised that this was the case. Ms O'Neill stated that there were incidences where some staff had not been paid for travel but this was because they had not submitted the most up to date Duty of Care documents which must be on the system to allow payment to be made.

Mr Donaghy stated that the Trust continues to monitor workforce staffing levels, paid WTE and flexible workforce spend using HR and financial information. This is also being considered in terms of Trust financial contingency plans. Recruitment scrutiny arrangements continue to operate.

There was a short discussion on the difficulties in recruiting nurses in which the Chair raised the impact of recruiting from within and outside other Trusts. Mr Rice advised that this issue has been discussed at Director of Nursing level and stated that a graduated approach is required.

Mrs McAlinden concluded the discussion by advising that medical workforce planning is a matter of concern which the Trust will continue to raise at Departmental level and referenced the specific specialiteis on the corporate Risk Register.

**The Board approved the Human Resources Report (ST544/14)**

## 11. BOARD REPORTS

### i) Research and Development Annual Report 2013/14 (ST545/14)

The Chair welcomed Dr P Sharpe and Dr P Gillen to the meeting. Dr Sharpe gave a presentation on the Research and Development Report for 2013/14. He drew attention to the increase in research studies completed (80 during 2013/14) compared to 56 in the previous year, stating that the Southern Trust had the second highest research studies in Northern Ireland.

Dr Sharpe spoke of the collaboration with Craigavon Borough Council who are particularly interested in Life Science as part of Cardiology

Research. Dr Sharpe informed members of a delegation from Massachusetts who visited the Trust in June 2013 and of another delegation from Asia Pacific who visited the Trust in December 2013.

Dr Sharpe stated that across all disciplines, there was an impressive list of research achievements as outlined in the Annual Report, as well as cardiology publications by Dr David McEneaney and also publications in the area of Renal Denervation by Dr Ian Menown. Dr Sharpe acknowledged the fact that Craigavon Area Hospital is the largest Cardiovascular Research Centre in Ireland

Dr Sharpe concluded his presentation by highlighting the forthcoming conference on 28 November 2014 entitled “At The Heart of It” which will be held in Craigavon Civic Centre.

Mrs Patricia Gillen then gave a presentation on the topic of Building Capacity and Capability for Research and Development among Nurses, Midwives and AHP’s in the Southern Trust. She gave examples of Research and Development Engagement Activity as well as research funding and discretionary funding. Mrs Gillen’s presentation was concluded by drawing member’s attention to ongoing and future plans for research and development.

Dr Mullan noted the impressive outcomes of research and asked how these are disseminated into practice. Dr Sharpe advised that whilst this is done within the Trust, there is further work to be done.

The Chair thanked both Dr Sharpe and Dr Gillen for excellent presentations and reports. She commended the Research and Development Department and their work to date and assured them of the Trust Board’s continued support.

**The Board approved the Research and Development Annual Report 2013/14 (ST545/14)**

**ii) Food Hygiene Annual Report (ST546/14)**

Mrs D Burns presented this report for approval.

**The Board approved the Food Hygiene Report. (ST546/14)**

**iii) Decontamination of Medical Devices (ST547/14)**

Mrs D Burns presented this report for approval.

**The Board approved the Decontamination of Medical Devices Annual Report (ST547/14)**

## 12. DRAFT MID-YEAR ASSURANCE STATEMENT (ST548/14)

Mrs Mahood advised that the draft Mid-Year Assurance Statement had been considered in detail by the Audit Committee and some minor amendments had been made.

**The Board approved the Mid Year Assurance Statement (ST548/14)**

## 13. BOARD ASSURANCE FRAMEWORK (ST549/14)

Mrs McAlinden presented the Board Assurance Framework for approval. She stated that this document reflects on how the Trust is currently balancing risks and reflects the discussions at previous Trust Board meetings.

Mrs McAlinden thanked Directors for their active risk management despite current pressure and the Board Assurance Manager for her work.

**The Board approved the Board Assurance Framework (ST549/14)**

## 14. REPORT TO THOSE CHARGED WITH GOVERNANCE

Mr McNally presented the final report for information.

## 15. REGISTER OF INTERESTS 2014/15

The Chair advised that the Register of Interests for 2014/15 had now been updated and was available on request from the Chair/Chief Executive's office.

## 16. BOARD COMMITTEES

### i) Minutes of Audit Committee Meeting held on 7th May 2014 (ST550/14)

Mrs Mahood presented the minutes of the meeting held on 7th May 2014 for approval.

**The Board approved the Minutes of the Audit Committee Meeting held on 7th May meeting (ST550/14)**

### Minutes of Audit Committee Meeting held on 10th June 2014 (ST551/14)

Mrs Mahood presented the minutes of the meeting held on 10th June 2014.

**The Board approved the Minutes of the Audit Committee Meeting held on 10th June 2014 (ST551/14)**

### ii) Audit Committee Annual Report (ST552/14)

Mrs Mahood presented the Audit Committee Annual Report 2013/14 for approval and acknowledged the amount of work carried out by Non-Executive Directors and Executive Directors during the past

year, having met on six occasions. She also thanked Mrs Judt, Board Assurance Manager, for her work in compiling this report.

**The Board approved the Audit Committee Annual Report for 2013/14 (ST552/14)**

**iii) Audit Committee Terms of Reference (ST553/14)**

Mrs Mahood presented the revised Terms of Reference for approval. She stated these has been recently reviewed by the Committee.

**The Board approved the Revised Terms of Reference (ST553/14)**

**iv) Feedback from Audit Committee Meeting held on 16th October 2014**

Mrs Mahood informed members that a presentation had been given by Mr Mark Harvey from Counter Fraud and Probity Unit, BSO.

## 17. CHAIRMAN AND NON EXECUTIVE DIRECTIORS' BUSINESS

A list of business and visits undertaken since the previous Board meeting was noted for information.

## 18. CHIEF EXECUTIVES BUSINESS AND VISITS

A list of business and visits undertaken by the Chief Executive since the previous Board meeting was noted for information.

## 19. PROPOSED MEETING DATES 2015 (ST554/14)

The list of proposed dates for meetings during 2015 was circulated to members with their papers prior to the meeting. Members approved proposed dates for meetings during 2015.

**The Board approved the Proposed Meeting Dates for 2015 (ST554/14)**

## 20. ANY OTHER BUSINESS

i) The Chair reminded everyone of the forthcoming Board Development Day scheduled for Thursday 13th November 2014.

ii) Dr Mullan asked for an update on Ebola. Dr Simpson outlined the Trust's preparedness with a significant number of staff trained.

The Chair asked each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles as professional advisors to the Board. No further issues were reported other than those detailed in the Board reports.

The Chair asked members if they felt they had sufficient time to ask questions during the meeting and members confirmed that they had.

***The meeting concluded at 3.45 p.m.***

Signed: _____

Date: _____

**SOUTHERN HEALTH AND SOCIAL SERVICES BOARD**

# INDIVIDUAL PERFORMANCE REVIEW

# *IPR*

## 2010/11
## Mairead McAlinden
## Chief Executive

# SOUTHERN HEALTH AND SOCIAL SERVICES BOARD - INDIVIDUAL PERFORMANCE REVIEW

## PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

| 1. Key objectives for the coming period | 2. Rank order (Importance to overall success) | 3. Action required (Who needs to do what, by when for each key objective) | 4. Development Need? Yes/No? (If yes, detail in PDP) | 5. Notes on attainment (for completion by manager prior to major review) | 6. Rating 1-5 (if applicable - see guide notes) |
|---|---|---|---|---|---|
| **CORPORATE OBJECTIVE 1** | 1 | Key service changes for 2010/11 | | | |
| **Providing Safe, High Quality Care** | | Ongoing implementation of 'Change in Mind' Strategy | | 'Support & Recovery' phase implemented | |
| - **Ongoing implementation of Trust 5 Year Plan 'Changing for the Better'** | | Changing for Children Strategy to be finalized and consulted upon | | Consultation completed and NNU changes delivered | |
| | | Improved efficiency of Hospital network | | Improved ACOS, Pre-Op Assessment, Day Case Rates, Phase 1 enhanced recovery plan implemented | |
| | | Older People's Strategy 'Living your Life to the Full' to be completed and consulted upon | | Completed | |
| | | First phase of 'Re-ablement' Strategy to be delivered | | Completed | |
| | | New Children's Respite Unit to be completed | | Newry Unit opened | |

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|---|---|---|---|---|---|
| **Delivery of Ministerial/PfA Standards & Targets** | 1 | Develop Services with robust review and performance management arrangements, to maximize as far as possible delivery of PfA<br><br>Secure investment for key areas of under capacity/under funding | | See 2010/11 Performance Report<br>High delivery compared to NI Trust average<br><br>Key recurring funding secured, for example:<br>- Opthalmogy local service<br>- Autism and family support<br>- Demography funding for care of Older People utlised for rapid assessment, securing Domiciliary Care Provision<br>- Capital funding secured for CAH Maternity, CT Scanner DHH, Upgrading of Diagnostic Rooms, Fire Safety and other Infrastructure Projects, Refurbishment of Lurgan Hospital, IT Investment (£26.2m) | |

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|---|---|---|---|---|---|
| **Improved Clinical & Social Care Governance Arrangements to ensure Patient & Client Safety** | | Review of C&SC Governance Systems & Structures to be undertaken | | C&SC Governance Review completed and implementation plan agreed for 2011/12 | |
| **CORPORATE OBJECTIVE 2** | | | | | |
| **Maximise Independence & Choice for our Patients & Clients** | 1 | Ongoing Implementation of PPI | | PPI Panel established and action plan developed with implementation structures in place | |
| | | Increase levels of Direct Payments | | 556 people began using Direct Payments to access their care against target of 339 | |

# PERFORMANCE PLAN

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|---|---|---|---|---|---|
| | | Achieve Resettlement Targets | | 24 people with learning disability resettled against target of 23 | |
| | | Use of technology to improve independence of people with Long Term Conditions | | 251 people with COPD, Chronic Heart Failure, Diabetes and Stroke received telehealth monitoring support in their own home | |
| | | Increase Services for Children Leaving Care | | Employability scheme for 16+ Care Leavers established | |

# PERFORMANCE PLAN

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|---|---|---|---|---|---|
| **CORPORATE OBJECTIVE 3**<br><br>**Supporting People and Communities to live Healthy Lives and improve their health and wellbeing** | | Implement 'Card Before you Leave' Scheme in ED's<br><br>Family Support Services to be extended<br><br>Ongoing implementation of Trust's promoting wellbeing strategic action plan<br><br>Progress against Trust's 'Protect Life' Action Plan | | Completed<br><br>Bi Lingual HV Assistants providing targeted service in family intervention teams<br><br>Range of initiatives developed including<br>- Reach<br>- Smoking Cessation (1184 people supported with 63% quit rate)<br>- Nutrition/Obesity Action Plans<br><br>Key developments by PLIG include development of Protect Life Resource Centres, provision of Counselling and provision of comprehensive training programme | |

# PERFORMANCE PLAN

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| **1. Key objectives for the coming period** | **2. Rank order** (Importance to overall success) | **3. Action required** (Who needs to do what, by when for each key objective) | **4. Development Need? Yes/No?** (If yes, detail in PDP) | **5. Notes on attainment** (for completion by manager prior to major review) | **6. Rating 1-5** (if applicable - see guide notes) |
|---|---|---|---|---|---|
| **CORPORATE OBJECTIVE 4**<br><br>**Being a Great Place to Work, Valuing our People** | | Ensure a well skilled and safe workforce<br><br>Progress the Trust's Health & Well-being plan for Staff<br><br>Be creative in terms of valuing staff<br><br>Ensure effective staff engagement | | - Recruitment Process in place to vet staff and provide effective induction<br>- Post Graduate training opportunities increased<br>- Increased number of staff trained to NVQ 3<br>- 'Lean' Training offered to all staff and Lean Academy Awards secured<br><br>Range of initiatives delivered and reported to Trust Board<br><br>Celebration Event delivered Dare to be Different imitative launched<br><br>- Ongoing Staff Side engagement at all levels of Trust<br>- Range of workshops with Staff<br>- BCBV structures in place | |

# PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

| **1. Key objectives for the coming period** | **2. Rank order** (Importance to overall success) | **3. Action required** (Who needs to do what, by when for each key objective) | **4. Development Need? Yes/No?** (If yes, detail in PDP) | **5. Notes on attainment** (for completion by manager prior to major review) | **6. Rating 1-5** (if applicable - see guide notes) |
|---|---|---|---|---|---|
| **CORPORATE OBJECTIVE 6**<br><br>**Being a Good Social partner within our local community** | **2** | Delivery of Environmental Strategy<br><br>Trust in the Community Strategy to be progressed | | 2% reduction in consumption of oil, water and electricity achieved and improved waste management implemented<br><br>£8m invested in range of community and voluntary sector partners and more robust and appropriate service delivery agreements put in place | |

# PERFORMANCE PLAN

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|---|---|---|---|---|---|
| **CORPORATE OBJECTIVE 5**<br><br>**Make Best Use of Resources** | **1** | Ongoing delivery of BCBV Plans to secure CSR Savings<br><br>Achievement of Financial Balance in 2010/11<br><br>Improving Efficiency of Workforce<br><br>Reduce cost of estate and G&S | | 95% of CSR efficiency target achieved<br><br>Small surplus achieved<br><br>Management overheads reduced<br><br>Consultant job planning progressing to increase capacity<br><br>Technology improvements to support efficiency implemented including NIPACS<br><br>Reductions achieved in cost of leases and procurement of G&S | |

# PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

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|---|---|---|---|---|---|
| **1. Delivery of agreed Population Plan by June 2012** | **1** | | **N** | | |
| **2. Delivery of £11m funding release for financial breakeven in 2012/13** | **1** | | **N** | | |
| **3. Ongoing improvements in patient safety and clinical and social care governance** | **1** | | **Y** | | |

We agree that the above objectives are a fair basis on which this work will be planned and reviewed

| 7. Individual's signature | 8. Manager's signature | Date | 9. Grandparent's signature | Date |
|---|---|---|---|---|
| | | | | |

| Date(s) agreed For interim review |
|---|
| |

| 10. Manager's overall rating | 11. 'Grandparent's comments & signature |
|---|---|
| | |

Southern Health and Social Care Trust

**Minutes of a meeting of the Board of Directors held on Thursday, 28th January 2010 at 10.00 a.m. in the Boardroom, HSCB, Armagh**

## PRESENT:

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

## IN ATTENDANCE:

Dr G Rankin, Interim Director of Acute Services
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs P Clarke, Acting Director of Planning and Reform
Mrs A McVeigh, Acting Director of Older People and Primary Care
Mr P Morgan, Acting Director of Children and Young People's Services
Mrs S Cunningham, Area Manager, Patient Client Council
Mrs R Rogers, Head of Communications
Mr P Toal, Communications Manager
Mrs S Judt, Committee Secretary (Minutes)

## 1. CHAIRMAN'S WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting, in particular members of the public. Apologies were recorded from Mrs R Brownlee, Non Executive Director Dr R Mullan, Non Executive Director.

2. **PRESENTATION: 'ROLE OF THE PATIENT AND CLIENT COUNCIL'**

The Chairman welcomed Ms Maeve Hully, Chief Executive, Patient Client Council. Ms Hully welcomed the opportunity to address the Board and began by outlining the role and structure of the Patient and Client Council. She advised that a Local Advisory Committee has been established in the Southern Area and this will be the reporting mechanism to the Patient & Client Council Board. Over 3,600 people have made contact with the Patient & Client Council to date and Ms Hully outlined the work planned for the next 12 months. In discussion, Ms Hully acknowledged the need to raise the profile of the organisation and to develop innovative processes for engagement with patients, clients, carers and communities. The Acting Chief Executive stated that the Trust wished to build on the good working relationship that has existed in the Southern Area between the Trust and the Local Advisory Body. Ms Hully advised that the Patient & Client Council would welcome working closely with the Trust on issues of concern.

The Chairman thanked Ms Hully for her presentation.

3. **MINUTES OF MEETING HELD ON 26th NOVEMBER 2009**

The minutes of the meeting held on 26th November 2009 were agreed as an accurate record, subject to one amendment on page 3, item 4ii), last sentence to read Mrs Clarke rather than the Acting Chief Executive.

The Minutes were duly signed by the Chairman.

4. **MATTERS ARISING**

i) **Patient/Client Experience Standards**

The monitoring compliance report for the quarter ended December 2009 is addressed under agenda item no. 6i).

ii) **Corporate Risk Register**

The Chairman confirmed that a full discussion on the Corporate Risk Register had taken place at the Governance Committee meeting on 15th December 2009.

5. **STRATEGIC ISSUES**

i) **Business Case to replace CT Scanner at Daisy Hill Hospital (ST 200/10)**

Dr Rankin presented the Business Case to replace the CT Scanner in the Radiology Department at Daisy Hill Hospital for approval. She advised that the current scanner was installed during 2000, is now outdated and does not meet the required standards. She referred members to the limitations of the current CT Scanner as outlined in the Business Case and stated that the quality of care to patients, appropriate pathways and patient throughput are all affected by the constraints of the current CT scanner. The preferred option identified in the Business Case is the replacement of the existing Single-Slice CT Scanner with the purchase of a Multi-Slice (64) CT Scanner. The associated capital costs are £559,500 and the revenue costs £74,500.

Mr Joynes queried the decision to purchase as opposed to the leasing of this equipment and asked if leasing would not be more beneficial given the speed at which technology develops. The Acting Chief Executive agreed to provide further reassurance on this issue and respond outside of the meeting.

At this point, the Chairman asked what the financial limit was for presenting a Business Case to Trust Board for approval. She emphasised the importance of ensuring that there is consistency of application across the Trust and that the agreed limit is in line with other Trusts. Mr McNally advised that other Trusts had set the limit at £0.5 million and it was agreed that the Southern Trust

should also operate within this limit. Mr McNally agreed to bring the necessary amendment to the SFIs to the Board for approval.

**The Board of Directors approved the Business Case to replace the CT Scanner at Daisy Hill Hospital (ST 200/10)**

ii) **Business Case for replacement Fluoroscopy Room 1 at Craigavon Area Hospital (ST 201/10)**

Dr Rankin presented the Business Case for the replacement of the Fluoroscopy Room (Screening Room 1) in the Radiology Department at Craigavon Area Hospital. She explained that the current facility was installed during June 1994 and referred members' to the limitations of the existing Fluoroscopy Room as detailed in the Business Case. The preferred option is the purchase of a new screening room at a capital cost of £443,500 and revenue costs of £95,625.

**The Board of Directors approved the Business Case for replacement Fluoroscopy Room 1 at Craigavon Area Hospital (ST 201/10)**

iii) **GP Out of Hours Service – Service Review (ST 202/10)**

Mrs McVeigh presented the recommendations of the GP Out of Hours Service Review for approval. She explained the background to the review, the main objective of which is to improve the responsiveness of the overall service to patients across the Southern Trust area by designing a rota that would better match the demand profile of the service. A demand and capacity analysis was undertaken and the results used to form the basis of the service review document. A staff consultation process was held from 10th – 31st December 2009 and some amendments were made to the original proposal to reflect feedback. She emphasised that the GP Out of Hours Service will continue to be provided to patients in the same way as it

is currently provided and over the existing hours and from existing centres and therefore public consultation was not required.

In response to a query from Mrs Blakely on the consultation process, Mrs McVeigh advised that a meeting was held with staff prior to the consultation period and during the three-week consultation period a further two meetings were held on 21st and 22nd December 2009. Staff comments are included in Appendix 1 of the Service Review paper. She went on to explain that a phased approach to the implementation of the service reform proposals will be undertaken and monitored through the performance management framework. Mr Graham asked about the introduction of nurse triage into the service and asked if this had the potential for frustration from patients, particularly at busy periods due to the patient having to go through a series of staff. Mrs McVeigh stated that the introduction of nurses into the service would not reduce quality and she explained the role of nurse triage. Mr Joynes asked if there were any job losses associated with the proposals. Mrs McVeigh stated that HR processes will be applied so that every possible effort can be made to avoid compulsory redundancies.

Mrs McVeigh concluded by advising that the changes will lead to a better service which better meets patient demand and is best use of resources. Board members stressed the importance of communicating this review in a positive way. Mrs Rogers advised that following the Board's approval of the recommendations, a Press Release will be issued.

**The Board of Directors approved the recommendations of the GP Out of Hours Service Review (ST 202/10)**

iv) **Strategic Outline Case for Phase 1 Capital Works to Lurgan Hospital (ST 203/10)**

Mrs McVeigh presented the Strategic Outline Case for Phase 1 Capital Works to Lurgan Hospital for approval. This sets out proposals for refurbishment works to be carried out to the ward accommodation at Lurgan Hospital as well as the need to upgrade the infrastructure and, in particular, the existing lift. She stated that the preferred option is refurbishment of Ward 5 and Stroke Unit accommodation and the installation of a new lift within Lurgan Hospital.

**The Board of Directors approved the Strategic Outline Case for Phase 1 Capital Works to Lurgan Hospital (ST203/10)**

v) **Recurrent Investment for Elective Care**

At this point, Mrs Clarke circulated and spoke to a briefing note which provided members with an update on current progress in relation to negotiations with the Commissioner on recurrent investment for elective care. To date, the Trust has secured recurrent investment of £1.3m into ENT services (£590k); Pain management services (£185k) and AHP services (£555k). In addition, the Trust expects to secure a further £0.75m into Gynaecology and Neurology services. Negotiations continue as regards investment into other services, namely Endoscopy; Ophthalmology and Orthopaedics. With the degree of funding sought for these services being approximately £2.6m, negotiations are considering the potential options to make best use of the available funding against this requirement.

## 6. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

### i) Standards for improving the Patient and Client Experience – Monitoring report for quarter ending December 2009

Mrs McVeigh referred members to the results obtained from the satisfaction survey undertaken in Ward 2 Medical, Craigavon Area Hospital during the quarter ending December 2009. She explained that this pilot was intended to test a regional survey template and comments and findings were being fed back to the Regional Steering Group. 80 questionnaires were given out to patients on discharge, 39 of which were returned (a 49% response rate). Overall the comments were very positive and Mrs McVeigh presented some of the key findings. Members were advised that the Ward Manager will develop an action plan to address areas of improvement. The use of a questionnaire with amendments to reflect the views of the patient groups will now be rolled out to Ward 6 in Lurgan Hospital and wards in the Bluestone Unit. Mr Graham asked if the experiences of families are captured in cases where a patient dies. Mrs McVeigh stated that the questionnaire in its current form would not provide that level of detail and she agreed to feed this comment back to the Trust representative on the Regional Steering Group. Mr Joynes expressed reservation about the covering letter accompanying the questionnaire and queried whether this should be issued by the Ward Sister. Mrs McVeigh agreed to feed these comments back to the Trust representative on the Regional Steering Group.

### ii) Hospital Hygiene and Cleanliness

The Chairman referred members to correspondence from the Minister dated 11th December 2009 emphasising the need for Trust Boards to afford highest priority to hygiene and cleanliness standards across its hospitals. A new regional review team has been set up and will report directly to the Minister on progress on hygiene and