departmental plans so that these can inform discussions with the doctor (e.g: job plan review, training needs).

Appraisers should also be aware of:

- Any complaints pertaining to appraisee within the period [this will be provided by the MD office to both the appraiser/appraisee early in the calendar year]
- Any clinical incidents pertaining to appraisee within the period [this will be provided by the MD office to both the appraiser/appraisee early in the calendar year]

The appraisee should bring forward information on:

- Any NCAS/GMC referrals or performance concerns handled under 'Maintaining High Professional Standards'
- Any issues being handled under the Trust Disciplinary Policy

10.6 Appraisal Meeting:

The Appraisal meeting should be a two-way dialogue focussing upon joint problem solving and development.

The Agenda should consist of:

- Review of workload
- Reflection
- Identification of achievements
- Identification of challenges
- Problem solving
- Factors that have inhibited practice and development.
- Long term career plans
- Progress towards revalidation
- Training needs

10.7 Personal Development Plans

Each appraisal should identify individual needs to be addressed through a Personal Development Plan. This should include key development objectives for the following and subsequent years. These objectives may cover any aspect of the appraisal such as personal development needs, training goals, organisational issues, CME and CPD.

Information derived from Personal Development Plans (PDPs) will also provide the basis for a review with specialty teams of their working practices, resource needs and clinical governance issues.

Development needs should be prioritised on the Personal Development Plan in line with the appraisal recommendations and the needs of the Trust for safe high quality care.

Personal Development Plans will be shared with the Appraisee's Clinical Director and Associate Medical Director for the purpose of making the correct linkage between the PDP, Trusts objectives and the granting of study/professional leave. It is recommended that appraisee's refer to the GMC Guidance on CPD and Trust CPD guidance via the Southerndocs website.

11 Guidance on Completion of Appraisal Documentation Secondary Care

Appraisal documentation has been revised to reflect the GMC's *Framework for Appraisal and Revalidation*[3]. This framework is intended to encourage you to:

- Reflect on your practice and your approach to medicine
- Reflect on the supporting information you have gathered and what that information demonstrates about your practice
- Identify areas of practice where you could make improvements or undertake further development
- Demonstrate that you are up to date and fit to practise.

The GMC do not require every type of supporting information to be extensively mapped to each domain and attribute of the Framework. The revised appraisal documentation is, however, based on the four domains to provide structure to the appraisal discussion and collation of supporting information. [See Section 14]

The documentation comprises 7 Forms (refer to Appendix 2 of this document):

- **Form 1** - Background Details
- **Form 2** - Current Medical Activities
- **Form 3** - Supporting Information & Summary of Appraisal Discussion

[3] http://www.gmc-uk.org/GMP_framework_for_appraisal_and_revalidation.pdf_41326960.pdf

- **Form 4** - Personal Development Plan
- **Form 5** – Health & Probity
- **Form 6** - Sign Off
- **Form 7** – Revalidation Progress

Guidance on completion of each section is detailed below.

11.1.1 Form 1 – Background Details

The aim of this section is to provide basic background information and brief details of the appraisee's employment in the previous year. The appraisee can supplement this with any additional information they think helpful for example medical and specialist societies they belong to.

11.1.2 Form 2 – Current Medical Activities

The aim of this section is to provide the appraisee with an opportunity to describe their current posts in the HSC, other organisations or the independent healthcare sector. They should explain what their responsibilities are, where they work/practise and ensure they include all of their practice and work at all locations since their last appraisal.

The appraisal should encompass **all** areas of practice. If the appraisee undertakes any other work outside the HSC, they will need to bring supporting information to the appraisal that evidences they are up to date and fit to practice this work, as well as their work for the HSC. This may include, but is not limited to, work undertaken in the independent sector, medical work for business (e.g. insurance companies) and charities (e.g. hospices work), work undertaken as a sports doctor and work for panels, tribunals and government.

11.1.3 Form 3 – Supporting Information and Summary of Appraisal Discussion

The aim of this section is to allow the appraisee to list the supporting information they are bringing to appraisal and to document the discussion between the appraiser and appraisee that the information prompts. This discussion should include consideration of the information source and what it tells the appraiser about the appraisee's medical practice. Any actions arising from the appraisal discussion should be documented here.

Section 14 outlines suggested sources of supporting information and the appropriate Domain they may be tabled under. Due to the varied nature of medical practice, these are not prescriptive. A key component of the appraisal discussion will be consideration of the supporting information and which Domain it should be tabled under.

One type of supporting information may be applicable to one or more Domains of the GMP Framework. Reflection on supporting information may be included within a second Domain. For example, updating knowledge via CPD may lead to reflection on improving patient safety. Therefore CPD may be listed under Domain 1 (Knowledge, Skills and Performance) and reflection leading to improved safety and quality listed under Domain 2 (Safety and Quality).

Section 13 outlines the supporting information that Southern Health and Social Care Trust can provide to support appraisal. Further details on how to access this information is also available on www.southerndocs.hscni.net – Appraisal and Revalidation.

11.1.4 Form 4 – Personal Development Plan

In this section, the appraiser and appraisee should review progress against the previous years' personal development plan (PDP) and identify key development objectives for the year ahead. This will include actions identified during completion of Form 3 but may also include other development activity where this arises during the appraisal discussion. Any PDP outputs should be practical and achievable, ideally with defined outputs targeted against development needs.

The anticipated timescale within which the objectives will be met should be indicated. The appraiser should countersign the agreed PDP.

The anticipated timescale within which the objectives will be met should be indicated. In general, the same doctor who undertook the appraisal should countersign the agreed PDP.

11.1.5 Form 5 – Health and Probity

The appraisee should read the statements that apply to health and probity and sign and date them. Any supplementary proformas for health and probity should form part of the supporting documentation.

The following are examples of areas which could form part of the discussion on probity; research conduct, conflicts of interest, contacts with pharmaceutical industry, and financial probity. This list is not exhaustive.

Any health issues which may affect the appraisee's work as a doctor should be discussed during the appraisal discussion and any action arising from this noted in Form 4. Due to potential confidentiality issues, specific details of a health complaint or probity issue should not be entered directly into Appraisal Forms but recorded in the additional Forms contained in Appendix 6 of this Guidance and retained by the appraisee in their portfolio of supporting information.

11.1.6 Form 6 - Sign Off

This section requires both the appraiser and appraisee to confirm that the documentation is an accurate record of the appraisal discussion, the supporting information presented and the agreed personal development plan.

If the appraisee has been unable to provide all the required elements of supporting information, or demonstrate their practice is meeting the requirements of the *GMP Framework*, the reason/s why should be recorded in this section.

This may be due to a period of absence from employment or other mitigating circumstances. The organisation's Responsible Officer may wish to reference this information to inform the revalidation recommendation process.

This Form also includes a checklist to ensure the required sections of the appraisal documentation have been completed.

11.1.7 Form 7- Revalidation Progress

This section provides an overview of progress towards meeting revalidation requirements. It should demonstrate annual participation in appraisal and that the appraiser has evidenced they have met the GMC and employer required supporting information elements.

It is envisaged that this summary will be a valuable source of information for the Responsible Officer to reference when required to make a revalidation recommendation to the GMC.

It is the responsibility of the appraisee to send the completed Forms 1-7 to the Medical Directors Office. Receipt of forms will be acknowledged in writing.

The Southern Trust also requires appraisees to complete the following

- **Appendix 1 Education and Training Competencies for Medical Staff (Appendix 3 of this document)**

  There are several core modules of training that all doctors must undertake for their appraisal and revalidation. In addition, there are a series of optional modules that the individual doctor should agree with their Appraiser which of these necessary for them to undertake their role within the Trust.

- **Appendix 2 and 3 Evaluation Proforma – Appraisee and Appraiser Feedback Questionnaire (Appendices 4 and 5 of this document)**

The completion of these questionnaires are optional but encouraged as it may inform the organisation's quality assurance processes and highlight areas where further training may be required.

- **Appendix 4 Aide Memoire and Quality Assurance Audit Tool (Appendix 6 of this document)**

The use of this form is encouraged as an aide memoire to assist in the identification of areas of development.

- **Structured Reflective Templates**

The use of Structured Reflective templates are encouraged and where appropriate should be used to demonstrate reflection on supporting information (templates available here). These are as follows:-

- Complaints
- Declaration of Absence of Complaints
- Declaration of Absence of Significant Events/Incidents
- Significant Events/Incidents
- 360/Multisource Feedback
- Patient Feedback
- Personal Development Plan
- Appraiser Role
- Data Collection/Audit
- CLIP Report
- Case review
- Other roles

12 Minimum Requirements for Revalidation

GMC Minimum Requirements:	
The doctor must be participating in an annual appraisal process which has Good Medical Practice as its focus and which covers all of their medical practice.	The Trust appraisal Scheme is based on the principles of Good Medical Practice. The scheme and forms can be accessed at: Scheme: Medical Staff Appraisal Scheme Forms: Appraisal Forms
The doctor must have completed at least one appraisal, with Good Medical Practice as its focus, which has been signed off by the doctor and their appraiser.	You must ensure you have at minimum completed 2011 calendar year appraisal, which references the GMC supporting information requirements. The scheme and forms can be accessed at: Scheme: Medical Staff Appraisal Scheme Forms: Appraisal Forms
The doctor must have demonstrated, through appraisal, that they have collected and reflected on the following information as outlined in the GMC's guidance Supporting information for appraisal and revalidation: [see below]	Team-based information may also meet the requirements where no individualised information is available for quality improvement activities, significant events or complaints and compliments - as long as the doctor has reflected on what this information means for their individual practice.

13 Supporting Information Trust Support

Supporting Information	GMC Guidance	How the SHSCT Revalidation Support Team can help?
Continuing professional development	Evidence of continuing professional development must relate to the twelve month period prior to the appraisal that precedes any revalidation recommendation.	A summary report of your approved study leave is available from medical.revalidation@southerntrust.hscni.net In addition, guidance on CPD has been developed and is available to download. CPD Guidance A Structured Reflective template is available to assist you in demonstrating reflection/learning from your Personal Development Plan (PDP) Structured Reflective Template for PDP
Quality improvement activity	Evidence of regular participation in quality improvement activities that demonstrates the doctor reviews and evaluates the quality of their work must be considered at each appraisal. The activity should be relevant to the doctor's current scope of practice. Evidence may include: Clinical audit; review of clinical outcomes; case reviews; teaching activities; improvement projects Evaluate and reflect on results; take action; what is the outcome – improvement or maintenance of practice	Consultant Level Indicator Programme [CLIP] reports are available annually to doctors who have recorded activity on the hospital PAS system. If you have not received your CLIP Report please contact: medical.revalidation@southerntrust.hscni.net A guide for CLIP reports is available to download. CLIP Guidance For those doctors who participate in Surgical or Medical Morbidity/Mortality meetings as report of meetings attendance is available. If you have not received your CLIP Report please contact: medical.revalidation@southerntrust.hscni.net There are also Structured Reflective Templates on Data Collection and Case Review You can also request a 'Training Passport' which will summarise logged details of training you have participated in. Please contact: medical.revalidation@southerntrust.hscni.net
Significant events	Evidence of review of significant events and review of complaints and compliments must relate to the twelve month period prior to the appraisal that precedes any revalidation recommendation.	A report extracted from the Trust Datix incident management system has been forwarded to you. If you have not received please contact medical.revalidation@southerntrust.hscni.net A Structured reflective template is available to assist you in demonstrating reflection/learning from incidents. Significant event audit SEA structured reflective template
Feedback from colleagues	Evidence of feedback from colleagues must have been undertaken no earlier than five years prior to the first revalidation recommendation and be relevant to the doctor's current scope of practice. Feedback from colleagues that does not fully meet the criteria set by the GMC may also be included but must have been: Focused on the doctor, their practice and the quality of care delivered to	Colleague Feedback is available through the HSC Leadership Centre. To participate in this on-line tool please identify your appraiser and email medical.revalidation@southerntrust.hscni.net If you have already completed a non HSC Leadership Centre colleague feedback please email details to medical.revalidation@southerntrust.hscni.net so it can be assessed under the GMC criteria to ascertain acceptability for

Supporting Information	GMC Guidance	How the SHSCT Revalidation Support Team can help?
	patients Gathered in a way that promotes objectivity and maintains confidentiality	revalidation. A Structured Reflective template is available to assist you in demonstrating reflection on Colleague Feedback. Structured Reflective Template Colleague Feedback
Feedback from patients	Evidence of feedback from patients must have been undertaken no earlier than five years prior to the first revalidation recommendation and be relevant to the doctor's current scope of practice. Feedback from patients and colleagues that does not fully meet the criteria set by the GMC may also be included but must have been: Focused on the doctor, their practice and the quality of care delivered to patients Gathered in a way that promotes objectivity and maintains confidentiality	Patient Feedback is available through the HSC Leadership Centre. To participate please email medical.revalidation@southerntrust.hscni.net for a nomination form. If you have already completed patient feedback please email details to medical.revalidation@southerntrust.hscni.net so it can be assessed under the GMC criteria to ascertain acceptability for revalidation. A Structured Reflective template is available to assist you in demonstrating reflection on Patient Feedback. Structured Reflective Template Patient Feedback
Review of complaints and compliments		A report extracted from the Trust Datix complaints management system has been forwarded to you. If you have not received this report please contact medical.revalidation@southerntrust.hscni.net A Structured reflective template is available to assist you in demonstrating reflection/learning from complaints. Complaint report structured reflective template There is also a template regarding absence of complaints.
Mandatory Training		The Southern Docs website has been launched which holds all necessary information regarding mandatory training and can be accessed at www.southerndocs.hscni.net Password is 2012

14 Mapping Supporting Information to Good Medical Practice Domains

The table below provides examples of supporting information which may be appropriate to evidence each domain/attribute and is based on information cited by participants of the NI Medical Revalidation Pilot (2009).[4] **Information is required in relation to all areas of practice.**

Domain	Suggested Evidence/Supporting Information
1 - Knowledge, Skills and Performance: Attribute: 1.1 Maintain your professional performance Attribute: 1.2 Apply knowledge and experience to practice Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.	• Job plan, workload records • Evidence of how educational activity may have affected service delivery outcomes • Information about teaching and training activities. Include any information in relation to delivering workshops and lectures, mentoring activities and tutorials undertaken. • Evidence of reflective practice • Evidence of CPD and audit activity • Research activity • Relevant process and outcome data • Previous Form 4 and Personal Development Plan
2 - Safety and Quality: Attribute: 2.1 Contribute to and comply with systems to protect patients Attribute: 2.2 Respond to risks to safety Attribute: 2.3 Protect patients and colleagues from any risk posed by your health	• Evidence of any resource shortfalls which may have compromised outcomes • Up to date audit data including information on audit methodology and a record of how results of audit have resulted in changes to practice (if applicable) • Reflection on significant events/critical incidents/near misses • Records of how relevant medical guidelines have been reviewed by you and your team and how these have changed practice • Evidence of attendance at, and participation in, governance activity relevant to practice. • Evidence of risk management to include near misses and action taken to addresses/reduce risks • Evidence of registration with a GP, Statement of Health, vaccination records • Statement of satisfactory research practice • Records of training related to enhancing safety and quality of patient care • Analysis of, and reflection on, current practice

[4] http://www.dhsspsni.gov.uk/cic-revalidation-report.pdf

3 - Communication, Partnership and Teamwork Attribute: 3.1 Communicate effectively Attribute: 3.2 Work constructively with colleagues and delegate effectively Attribute: 3.3 Establish and maintain partnerships with patients	Evidence of any team development activity Description of the team you work within (medical and/or multidisciplinary) Description of all activities in which you interact with other healthcare workers e.g multidisciplinary meetings, working groups and committee work. Analysis of trainee/medical student survey (where appropriate) Patient and colleague feedback Evidence of participation in multi-professional team meetings
4 - Maintaining Trust: Attribute:4.1 Show respect for patients Attribute:4.2 Treat patients and colleagues fairly and without discrimination Attribute:4.3 Act with honesty and integrity	Statement of Probity and Health Complaints Compliments Patient and colleague feedback.

15 Allocation of an Appraiser

It is expected that a doctor will be appraised by one of the trained appraisers within their specialty/division or directorate albeit they can choose an appraiser from a different specialty.

It is recommended that you should have at least 2 appraisers within the 5 year revalidation cycle.

All new permanent appointments should have selected and contacted an appraiser from the Trust's Directory of Appraisers by Week 4 following their appointment

All temporary/locum doctors with contracts greater than six months but less than 1 year should also have selected and contacted an appraiser from the Trust's Directory of Appraisers by Week 4 following their appointment

The Medical Director will be appraised for his/her clinical work by a suitable consultant nominated by the Chief Executive (excluding any consultant appraised by the Medical Director in that year).

If a consultant is unhappy about his/her appraiser, he/she should discuss this in the first instance with their Clinical Director/ Lead Appraiser or if appropriate Associate Medical Director. If the situation cannot be resolved at this level, the Medical Director will be ultimately responsible for confirming the appraiser or nominating a suitable alternative. The decision of the Medical Director will be final.

16 Internal/External Peer Review

If during the appraisal, it becomes apparent that more detailed discussion and examination of any aspect is needed, either the appraiser or the consultant can request internal or external peer review. The Medical Director will organise this. This should normally be completed within one month and a further meeting scheduled as soon as possible thereafter (but no longer than one month) to complete the appraisal process.

In exceptional circumstances, it may be necessary to assess more specialist aspects of a consultant's clinical performance. This is best carried out by peers who are fully acquainted with the relevant areas of expertise and knowledge. Where it is apparent in advance that peer review is an essential component of appraisal, the appraiser and the consultant should plan for this into the timetable for the appraisal meeting.

As a matter of routine, the results of any other peer review or external review carried out involving the consultant or the consultant's team (e.g. by an educational body, a professional body, or similar bodies) must be considered at the next appraisal meeting. This will not prevent the Trust from following its normal processes in dealing with external reviews.

17 Serious Concerns About a Doctor's Fitness to Practise, Identified by the Appraisal Process

If an Appraiser identifies aspects of a doctor's conduct or health which may potentially be a serious cause for concern, the Appraiser will inform the doctor that the Appraiser's professional obligations require these concerns be shared with the Clinical Director/Lead Appraiser and Associate Medical Director as soon as possible and in writing within 5 days.

Such decisions will be based on the guidance in the GMC document 'Good Medical Practice'.

The responsibility for assessment and investigation lies with the Medical Director/Associate Medical Director and will be dealt with under the guidance of 'Maintaining High Professional Standards'. Appraisers may refer to Trust Guidelines on Handling Concerns about Doctors and Dentists.

The Associate Medical Director will notify the Clinical Director/Lead Appraiser when the doctor is to continue in the appraisal scheme or is to be reinstated in the appraisal process. The Clinical Director/Lead Appraiser will ensure the necessary arrangements are

made to re-register the doctor in the appraisal scheme. The doctor will be formally notified of their position and advised of the next steps by the Clinical Director/Lead Appraisal

18 The Role of the Responsible Officer in Revalidation

The Trust Responsible Officer is responsible for making recommendations to GMC on the revalidation of doctors within their designated body. The Responsible Officer will make a revalidation recommendation to GMC in one of the following categories:

- A positive recommendation that the doctor is up to date and fit to practice
- A request to defer the date of recommendation
- A notification of the doctor's non-engagement in revalidation.

The GMC will invite doctors to confirm their revalidation details [including the identity of the Responsible Officer and designated body six months before the submission date.

Four months before the submission date, the GMC will issue notice to the doctor, informing them of the date by which they expect to receive a recommendation.

Following receipt of the RO's recommendation the GMC will consider the recommendation and make a decision on the doctor's revalidation

The GMC will then notify the doctor and the RO when a decision has been made and the content of that decision.

Full details can be accessed in Appendix 7, Making Revalidation Recommendations: the GMC responsible Officer Protocol - Guide for Responsible Officers [December 2012] (click here).

19 Non Engagement in the Appraisal Process

Southern Trust Medical Staff contracts require all doctors to undergo an appraisal annually. Participation is a statutory requirement for successful revalidation and re-licencing.

Refusal by a doctor to participate in the appraisal process will be a disciplinary matter to be dealt with, where necessary, under the Trust's Disciplinary Procedures.

Failure to participate in appraisal will result in the inability of the Responsible Officer to make a recommendation to the GMC and will put a doctors licence to practice in jeopardy.

Additionally, failure or refusal to participate will debar the doctor from applying for Clinical Excellence Awards/Higher Awards/Performance Supplements Scheme until the doctor\demonstrates full participation in the appraisal process.

19.1 Non-Engagement Due to Extenuating Circumstances

On occasion a doctor may have extenuating circumstances and request postponement of their appraisal for the current year, [see Section 20 – Deferment of Appraisal]. It is the responsibility of the doctor to advise their Associate Medical Director and Medical Director of their intention to request deferment. The request form can be requested via medical.revalidation@southerntrust.hscni.net.

19.2 Non-Engagement

Either before or during the appraisal discussion the Associate Medical Director and/or Appraiser may identify that a doctor is not engaging satisfactorily in the appraisal process.

There is an expectation that the doctor will arrange and attend the Appraisal meeting without presenting any resistance, the doctor will provide a folder [at least 10 days before the planned appraisal meeting] which gives enough information to allow engagement in a meaningful appraisal discussion, and demonstrate a willingness to participate in the process recognising it as formative and developmental.

If, however, the Appraiser/Associate Medical Director finds this is not the case the Appraiser should advise the Medical Revalidation Support Team. Advice can be sought from the Corporate Lead for Revalidation or the Trust Lead Appraisers.

19.2.1 Non-engagement - Failure to Schedule an Appraisal Meeting

It is the responsibility of the Appraisee to instigate their appraisal meeting by selecting and contacting an Appraiser.

If the Appraisee has difficulty contacting an Appraiser s/he can refer that appraisal back to the Trust Revalidation Support Team [medical.revalidation@southerntrust.hscni.net] for re-scheduling.

Appraisees who fail to arrange a meeting will be referred to the Trust Medical Director for appropriate action recognising the contractual and statutory obligation to participate.

Under these circumstances a recommendation will not be made for revalidation to the GMC by the Trust Responsible Officer.

19.2.2 Non-engagement - Evidence

It is the responsibility of the doctor to provide their Appraiser with access to their appraisal folder at least 10 working days before the date of the appraisal discussion. This is to ensure the Appraiser has sufficient time to prepare for the discussion. If this access is not provided the Appraiser has a right to postpone the appraisal, which will be rescheduled at a time that will suit the Appraiser.

On gaining access to a doctor's folder the Appraiser may decide that it does not the meet the minimum standards as required by the GMC to allow a meaningful discussion to take place. In such cases the Appraiser may feel it is necessary to postpone the discussion pending receipt of adequate materials. The appraisal will be rescheduled at a time that will suit the Appraiser.

If this is the case the Appraiser will provide guidance to the doctor on what is necessary. Support and guidance is also available from the Medical Revalidation Support Team.

If, however, following facilitation from the Appraiser/Medical Revalidation Support Team, the Appraisee fails to produce evidence sufficient for discussion, despite reasonable time frames, reminders and offers of support, the matter will be referred to the Medical Director.

Under these circumstances a recommendation will not be made for revalidation to the GMC by the

19.2.3 Non-engagement Identified by the Appraiser During the Appraisal Discussion

During the appraisal the Appraiser may feel that the doctor is not participating fully in the discussion and this is preventing a meaningful appraisal from taking place or the Appraisee behaves – at any point in the process – in an aggressive or threatening manner such as the Appraiser feels unable to continue with the Appraisal meeting. The Appraiser should advise the doctor of these reservations either during or immediately after the discussion.

Guidance and support for Appraisers can be sought from the Trust Lead Appraiser/s.

If they agree that a meaningful appraisal has not taken place the appraisal will not be recorded as complete

The appraisal should be rescheduled within 3 months or before the end of the current appraisal year, whichever is the shorter period of time, on the understanding that the Trust can facilitate this appraisal at short notice. If the subsequent Appraiser decides the doctor has still not engaged in the process in a meaningful way the Medical Director will be notified.

Under these circumstances a recommendation will not be made for revalidation to the GMC by the Trust Responsible Officer.

20 Deferment of Appraisal

Southern Trust Medical Staff contracts require all doctors to undergo an appraisal annually. It is expected that this will also be a requirement for successful revalidation and re-certification.

There are however exceptional circumstances when an doctor may request that an appraisal is deferred such that no appraisal takes places during one appraisal year

Instances when doctors may request a deferment:

- breaks in practice due to sickness or maternity leave
- breaks in practice due to absence abroad or sabbaticals

Doctors who have a break from practice may find it harder to collect evidence to support their appraisal, particularly if being appraised soon after their return to clinical practice. However often an appraisal can be useful when timed to coincide with a doctor's re-induction to clinical work. Appraisers will use their discretion when guiding appraisees as to the best timing for their appraisal, and when deciding the minimum evidence acceptable for these exceptional appraisals.

As a general rule it is advised that doctors having a career breaks:

1) in excess of 6 months you should try to be appraised within 6 months of returning to work

2) less than 6 months should try to be appraised no more than 18 months after the previous appraisal and wherever possible so that an appraisal year is not missed altogether.

Each case can be dealt with on its merits and the Trust is mindful that no doctor must be disadvantaged or unfairly penalised as a result of pregnancy sickness or disability.

Doctors who think they may need to defer their appraisal should complete the deferment application form [Appendix 8] or available from medical.revalidation@southerntrust.hscni.net and submit it to the Associate Medical Director who will make a decision where necessary in consultation with the Medical Director. The decision can be appealed and appeals will be dealt with by the Medical Revalidation Support Team.

Deferment application should be submitted at the earliest possible opportunity and no later than 3 months before the doctor's appraisal date would be due. The decision to allow a deferment will depend on a number of factors:

- how many appraisals have or will have been missed in a 5 year period
- whether there is anticipated to be further breaks from practice in the near future
- if there have been problems with evidence in previous appraisals
- if the doctor is undergoing any investigation about his/her performance(this list is not exhaustive)

Informal advice on the likelihood of a deferment being agreed can be obtained from the Clinical Director/ Appraisal Lead. A formal response to the application will be either a letter advising against an appraisal or a deferment certificate.

21 Responding to Concerns and Complaints about Appraisal

21.1 Introduction

Southern Health and Social Care Trust is committed to providing its services in a professional, fair and courteous manner. The following section outlines a protocol for dealing with concerns/complains relating to the appraisal process.

The key aims of the complaints protocol are to;

- Be an open process
- Be simple to understand and use
- Allow speedy handling and resolution, keeping people informed of progress
- Address all the points at issue
- Satisfy the complaint, where ever possible
- Be fair to complainant and staff alike
- Provide information, which will help improve the appraisal process and so ensure that the problem does not arise again.

21.2 What does the protocol cover?

The protocol covers complaints about

- The standard or quality of services provided by Medical Directorate – Southern Trust
- Divergence from appraisal procedures
- The behavior of appraisers
- Any action or inaction by the Appraisal Team affecting an individual
- Administration of the scheme
- Confidentiality
- Dissatisfaction with decisions reached and or matters relating to professional or clinical judgment in individual cases

This protocol does **not** cover:

- Dissatisfaction with Southern Trust Appraisal Scheme
- Anonymous complaints

Any concerns or complaints regarding a doctor's fitness to perform should be taken forward through the Associate Medical Director & Medical Director

21.3 Duties and Accountability

This complaints protocol provides for complaints to initially be dealt with through **Local Resolution.** This is where the members of the appraisal team concerned have a direct involvement in attempting to resolve the issue at the earliest opportunity. It is essential that all appraisers are fully conversant with this protocol. Effective documentation of all concerns and complaints received will ensure the Medical Directorate, Southern Trust can consider any lessons learnt from the feedback received

21.4 Defining a Complaint

Whenever there is a specific statement on the part of the appraisee that they wish their concern to be dealt with as a complaint they will be treated as such. The Department of Health has suggested that one definition of a complaint is *"An expression of dissatisfaction that requires a response"* However it would not be appropriate to label all expressions of dissatisfaction as a complaint.

From the individual's point of view they may just want their concern documented and appropriate action taken. Clearly this means that this protocol encompasses an extremely wide definition of the term 'complaint'.

21.5 Informal Resolution of Concerns and Complaints

It is not intended that every minor concern should warrant a full-scale complaints investigation. Rather, the spirit of the protocol is that front line Appraisers are empowered to resolve minor comments and problems immediately and informally.

Appraisee should in the first instance take their concern or complaints to the appraiser who should aim to respond and resolve the issue within 2 weeks of receiving the concern or complaint (holidays not withstanding).

Where the above step has not settled the complaints, or where they feel it would inappropriate to raise the issue with the appraiser, the appraisee should be offered the opportunity to talk to the relevant Associate Medical Director who will respond within 2 weeks of receiving the concern or complaint attempting to resolve the matter informally.

In both of the above, where resolution is achieved an anonymised note should be made by the appraiser or manager of the action taken and passed to the Associate Medical Director, so the concern can be noted as having been received and settled. There is no need for the incident to be centrally logged unless the incident arose as a consequence of procedure not being followed or being inadequate or misleading.

If the complaint is still not resolved following the above steps and the individual wishes to take the matter further or the Appraiser concerned has to take action to ensure resolution of the issue a formal written submission of the complaint is to be made and forwarded as soon as possible to the Associate Medical Director.

21.6 Procedure When Responding to a Formal Written Complaint

- The Medical Director ascertains that the complaint is about the appraisal Service (if not then referral to the appropriate department)
    - If it is about the appraisal service acknowledge written complaint within 4 working days
- Medical Director coordinates fact finding about the complaint in liaison with Associate Medical Director
    - Response to complainant within 25 days by on the Medical Directors Office behalf of Associate Medical Director
- If complainant still not happy referral to Chief Executive.

In all cases:

- Lessons learnt should be logged to be reviewed as part of the appraisal QA Process
- Appraisee is informed that support is available from the Medical HR Department

21.7 Things to Cover When Responding to a Complaint

All concerns and complaints, whether oral or written should receive a positive and full response, with the aims of satisfying the individual that his/her concerns have been heeded. The written response will normally include:

- A summary of the complaint
- An explanation of the departments or teams view of events
- An apology where appropriate
- A summary of the outcome of the meeting
- Details of any changes made as a result of the complaint

- Information on what action the complainant can take if still dissatisfied

21.8 Confidentiality

Any information provided by a complainant must be treated in the strictest confidence and in accordance with the provision of the Data Protection Act 1998

21.9 Support for Complainants

Advice, support or representation is available for appraisees from the Medical HR Department

22 Confidentiality

Appraisal should be in the main a confidential process between the appraiser and the apppraisee.

A summary of the purposes for which appraisal documentation are used and who has used and who has access to them, is set out in the table below.

Task	Individuals Involved	Comments
Clinical governance	Medical Director	Has access to all appraisal forms.
Filing of completed appraisal	Administrator to check all sections complete	Held in personal secure electronic folder
Preparation for Revalidation	Medical Revalidation Support Team	Review of appraisal folder/record of appraisal to ensure it meets minimum requirement for revalidation.
Personal Development Plans	Associate Medical Directors Clinical Directors Medical Revalidation Support Team	Completed PDPs should be available to Clinical Director and Associate Medical Director to facilitate approval of study/professional leave.
Personal Development Plans	Associate Medical Directors Clinical Directors	Completed PDPs should be available to Clinical Director and Associate Medical Director to facilitate approval of study/professional leave.
Appraiser has concerns about performance and wishes to discuss this to register a “concern”	Associate Medical Director Medical Director	May include: Medical director, Associate Medical Director & Clinical Director/Lead Appraiser Medical HR Manager
Appraisee wants to make complaint about appraisal process	Medical Revalidation Support Team Medical HR Department	To follow due process
To follow through Appraisal actions.	Appraiser	Previous years Form 2 1- 7 & Personal Development Plan supplied to next years appraiser.

23 Appraiser Performance Review, Development and Support[5]

The quality and consistency of appraisal relies on the skills and the professionalism of the appraiser. The appraiser needs to understand the purpose of appraisal and revalidation and to appreciate his or her responsibilities within those structures. Whilst robust appointment processes are needed, the on-going performance review, development and support of appraisers is vital in assuring the quality of appraisal

Individual appraisers will be provided with the following support/development:

- Access to leadership and advice on all aspects of the appraisal process from the Trust Lead Appraisers and Corporate Lead for Revalidation. The Trust Medical Revalidation Team should also offer peer support and discussion of challenging appraisals.
- Structured reflective template for the appraiser should be completed once annually when they are being appraised. These will be reviewed by the Trust Lead Appraisers and will help identify development needs for appraisers.
- An annual review of development as an appraiser with the identification of a developmental needs which should be included in the Appraisers personal development plan.
- Access to training and professional development resources to continually develop appraiser skills including in-house and regional events.

For further details see 'Assuring the Quality of Medical Appraisers' click here

24 Appraisal Scheme Quality Assurance

24.1 Scheme Quality Assurance

On-going quality assurance will be maintained through the yearly undertaking of the following audits & development of associated Action Plans.

- Appraiser/Appraisee Training programmes – Audit of attendance
- Audit of all Appraisal Forms
- Audit of Appraisee Feedback and Appraiser Feedback Questionnaires
- Aide memoire and Quality Assurance Tool on individual's appraisal/revalidation folder and forms
- Appraisal participation Audit

[5] Assuring the Quality of Medical Appraisal for Revalidation

- Appraiser structured reflective template
- For the 2013 calendar year - Organisational Readiness Self-Assessment tool (ORSA)

25 Equality

The appraisal scheme and process will comply with the Trust's Equal Opportunity Policy. It has also been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Using the Equality Commission's screening criteria, no significant equality implications have been identified. Similarly, this procedure has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

This document has been produced by the Senior Manager Medical Directorate on behalf of the Appraisal & Revalidation Group.

This Scheme has been agreed with the Local Negotiating Committee and will be reviewed after one year. In the meantime, it reflects national guidance and publications as closely as possible.

26 APPENDIX 1 STATEMENT OF SATISFACTORY EMPLOYMENT

Please click here for Statement.

27 APPENDIX 2 TRUST APPRAISAL FORMS

Please click here for the Appraisal Forms

28 APPENDIX 3 EDUCATION AND TRAINING COMPETENCIES FOR MEDICAL STAFF

This form is contained within the Appraisal Forms above.

29 APPENDIX 4 APPRAISEE FEEDBACK FORM

This form is contained within the Appraisal Forms above.

30 APPENDIX 5 APPRAISER FEEDBACK FORM

This form is contained within the Appraisal Forms above.

31 APPENDIX 6 AIDE MEMOIRE AND QUALITY ASSURANCE AUDIT TOOL

This is contained within the Appraisal Forms above.

GMC RESPONSIBLE OFFICER PROTOCOL GUIDE FOR RESPONSIBLE OFFICERS [DECEMBER 2012].

Please click here for the Guide.

33 APPENDIX 8 DEFERMENT APPLICATION FORM

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

Application for deferment of appraisal

Name:	
Address	
Telephone numbers :	
Email	
GMC number	
Date of Birth	
Please indicate the dates of your last 4 appraisals: (Month and year) and names of the appraisers	
Name of appraiser Date of appraisal (M/y)	

Please indicated WHY you wish to request a deferment of your appraisal and WHEN you would next like to be appraised	
Do you anticipate having any breaks in practice in the next 2 years ?	
If you have missed any in the last 4 years please: indicate the reasons why	
Are you currently under investigation by your employer, NCAS, or GMC for any issue regarding your clinical performance ?	
Any further comments	

Please submit copies of the form4 for the last appraisals carried out

Name:
Date:
Signature:

(This form can be sent electronically or posted)

Southern Health and Social Care Trust

GOVERNANCE COMMITTEE

Minutes of a meeting of the Governance Committee of the Southern Health and Social Care Trust held on Tuesday, 8th March 2011 at 9.30 a.m. in the Boardroom, Trust Headquarters, Craigavon

PRESENT:

Mrs D Blakely, Non Executive Director (Chairman)
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

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 B Dornan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs A McVeigh, Director of Older People and Primary Care Services
Mr P Morgan, Director of Children and Young People's Services
Mrs J Holmes, Board Secretary
Mrs D Burns, Assistant Director, Clinical and Social Care Governance
Dr T Boyce, Head of Pharmaceutical Services (item 5)
Mrs S Judt, Committee Secretary (Minutes)

APOLOGIES:

None

The Chairman welcomed Mr P Morgan and Mrs D Burns to the meeting and congratulated them on their respective appointments as Director of Children and Young People's Services and Assistant Director, Clinical and Social Care Governance.

1. MINUTES OF MEETING HELD ON 18TH JANUARY 2011

The minutes of the meeting held on 18th January 2011 were agreed as an accurate record and duly signed by the Chairman.

2. MATTERS ARISING FROM PREVIOUS MINUTES

a) Complaints

In response to Mr Joynes' query as to the definition of closure, Dr Loughran advised that there is no Departmental definition. It could happen that a complaint has been closed by the Trust and then the complainant contacts the Trust with additional information which would necessitate the Trust re-opening the case. The Trust has to exercise judgement in a small number of different cases in which a patient or client remains in constant or intermittent contact with an unresolved concern. The Trust has tended to lean towards keeping contact in these circumstances in an attempt to gain local resolution. It was noted that such cases may result in referral to the Ombudsman who will seek assurance that every effort for local resolution has been made.

Incidents

At the previous meeting, Mrs Mahood had asked for details on those incidents classified as infrastructure or resources (staffing, facilities, environment). Dr Loughran advised that the staff member completing the incident reporting form felt that the incident occurred as a result of infrastructure or resource issues. Many of these incidents are listed because of the (unlikely) potential of a serious adverse outcome rather than an actual adverse outcome.

b) NCEPOD Report 'A Mixed Bag'

Mr Dornan referred to the area identified as red in relation to audit activity to assess parenteral nutrition practice in Neonatal Units and explained that Dr C Murray is currently doing an audit, the results of which are expected in 1 month.

4. **UPDATE ON CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW (C&SCG) – IMPLEMENTATION PLAN**

The Chief Executive presented the Clinical and Social Care Governance Review Implementation Plan. She advised that the consultation process has now concluded. In terms of populating the C&SCG structure, Mrs D Burns has been appointed as Assistant Director, Clinical and Social Care Governance, and the recruitment of the 8B Directorate posts is underway, with interviews scheduled for week commencing 14th March 2011. The handover date for responsibility from the Medical Directorate to Chief Executive's office is 1st April 2011.

5. **MEDICINES GOVERNANCE REPORT**

Dr Boyce presented the Medicines Governance Report for the third quarter of 2010/11. During this period, 229 medication incidents were reported. The average number of reports received per month was 76, representing an increase from 69 per month in the previous quarter. This remains less than the highest average of 114 reports per month achieved during 2008/09. Most reported incidents were of insignificant or minor impact on patients and there were no trends of specific concern amongst the reports.

Dr Boyce outlined the following actions taken as a result of the Trust's incident monitoring:-

- Request for primary care warfarin guidelines to express dose as a daily rather than weekly dose. In response to a query from Mr Joynes, Dr Boyce agreed to follow this up with Jo Brogan as to how this dosage is addressed in primary care.
- Review of lorazepam stockholding during supply shortage.
- Admission booklet to include reminder to inform patient not to self-administer medication during admission.
- Review of Guidelines for peri-operative management of diabetes.

Dr Boyce drew members' attention to medicines governance activities within the Trust. She noted the ongoing work in relation to medicines management in the supported living sector. The Chief Executive referred to the corporate risk in relation to the RQIA recommendations on the management of medicines in Domiciliary Care settings and asked if this work was part of the Trust's actions to manage this risk. Dr Boyce advised that the HSCB has not yet established the working groups to address the regional systems wide/issues which are delaying the Trust's full compliance with the RQIA standards. In the meantime, the Trust continues to train domiciliary care workers in medicines management, with approximately 800 staff having now completed the OSCE training. In response to a query from Mrs Brownlee on the blister packs, Dr Boyce advised that work is ongoing with Community Pharmacists to resolve this. Mr Rice stated that much work has been done

within the Trust to meet the RQIA recommendations, but a level of risk remains and, as outlined by Dr Boyce, requires regional action. In response to a query from Mrs Blakely, Dr Boyce advised that work is progressing to harmonise procedures across learning disability, physical disability and elderly divisions.

Dr Boyce advised of 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.

6. **CORPORATE RISK REGISTER**

The Chief Executive advised of a request under Freedom of Information for the Trust's Corporate Risk Register. Directors regularly review and update their risk areas and the most recent information approved by Trust Board will be released. Trusts have agreed to share their respective Corporate Risk Registers to ensure consistency. Context and briefing will accompany the release of the Register under FoI.

Mrs Holmes advised that the corporate risks are kept under regular review by the Senior Management Team and the register has been further updated following the previous week's SMT meeting.

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

Dr Loughran presented the above-named report which provides a summary analysis of activity and trends for the period October – December 2010.

Complaints

Dr Loughran advised 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 or no recognisable trends arising from a particular staff group.

Dr Loughran informed members that tailored communication training for medical staff is being arranged with the Beeches in response to a significant number of complaints recording dissatisfaction with communication. He also advised that it has been agreed within the Appraisal scheme that the appraiser and the appraisee would get a list of complaints and incidents in which the consultant (appraisee) had been mentioned. The appraisal discussion will only include cases which were immediately connected to the consultant, rather than general complaints from the consultant's department or service. Dr Loughran also described that the above would be achieved through a structured learning process for one complaint and one incident

during each annual appraisal, the intention being to learn from such feedback.

Patient/Client Safety Programme

Dr Loughran advised that the Patient Safety Intervention Programme continues with positive outcomes both from the PfA targets and targets selected by the Trust. The high number of Crash Calls at Craigavon Area Hospital compared to Daisy Hill Hospital was queried and Dr Loughran agreed to investigate and provide a response at the next meeting.

In relation to Venous Thrombo Embolism (VTE), whilst there is a high level of compliance with the overall bundle, there is a low level of compliance with completion of the risk assessment documentation. A request has been made to the Chief Medical Officer requesting that the risk assessment form and prescription is on one sheet.

Incidents

Mrs Brownlee raised the high level incident involving the unavailability of tourniquets for procedures on digits to which Dr Rankin provided assurance that this issue has now been addressed. The backlog of reported incidents to be entered onto DATIX was raised. Mrs Burns explained that incident reporting will be moving to a web-based format with DATIX web currently being piloted in Delivery Suites in both Craigavon and Daisy Hill Hospitals and the Willows Ward in the Bluestone Unit. This will provide real time ability to record, grade, manage and monitor incidents in the Trust.

8. **SERIOUS ADVERSE INCIDENTS REPORT FOR THE PERIOD 1.4.10 – 31.12.10**

Mrs Holmes advised that this report provides a summary of the SAIs reported during the period April – December 2010 and the position of outstanding reports referenced in previous SAI reports to Governance Committee. She stated that during the period, 33 SAIs were reported and the nature and source of these incidents is presented by Directorate in the report. Mrs Holmes drew members' attention to the Trust's good performance against the 12 week timeframe and advised that this is discussed with the HSCB at performance meetings. The Trust is the best performing Trust in that regard.

SAIs are a standing item at the Senior Management Team Governance meetings when the investigation reports are considered. Mrs Mahood sought clarity on the Directorate processes for disseminating the recommendations to which Directors explained that SAIs would be a standing item at Directorate Governance meetings. The Chief Executive stated that the 8B posts would be a further support to this monitoring

process. Mrs Brownlee highlighted the number of suspected suicides and stated that she would welcome a discussion on the process when an individual with Mental Health issues presents at A&E. It was agreed that Mrs Brownlee and Mr Rice would discuss this matter outside the meeting. The Chief Executive advised that a progress report on the Protect Life Strategy will be presented to Trust Board on 21st April 2011.

9. **OMBUDSMAN UPDATE**

Mrs Holmes presented a summary report on the number and nature of cases with the Ombudsman at the end of February 2011. She stated that it was interesting to note that there were 2 cases from 2007 and 2008 still outstanding. The Chief Executive advised that the Ombudsman has allocated additional resources to address some of these longstanding cases and there will be a higher number of decisions in the coming months.

10. **FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REQUESTS – SUMMARY REPORT FOR THE PERIOD OCTOBER – DECEMBER 2010**

Mrs Clarke presented the above-named summary report for the period 1st October – 31st December 2010. She advised that a total of 67 requests were responded to during this period. Of these responses, 41 were processed within the 20 day deadline and 26 were processed outside the 20 day deadline. Most of the requests were received from members of the public.

11. **REPORT ON REVIEW OF TRUST LITIGATION SYSTEMS AND PROCESSES**

The Chief Executive set the context of this report in terms of the Trust's self assessment against guidance provided in the DHSSPS Circular HSC (SQSD) 5/10 'Handling Clinical and Social Care Negligence and Personal Injury Claims'. The self assessment was conducted by the Trust's Litigation Services Manager and the Board Secretary in discussion with the Medical Director and Director of Human Resources and she commended all those involved in this comprehensive piece of work.

Mrs Holmes referred members to the Trust's position and noted its strong performance in terms of compliance against the requirements of Circular HSC (SQSD) 5/10. She drew members' attention to the gaps to be addressed as detailed in the Action Plan. Mrs Holmes took members through the detail of the Action Plan and highlighted the need to develop procedures and linkages with operational Directorates, Audit, Risk Management and Health and Safety across the Trust. To that end, meetings have been held with Directors and the reporting arrangements agreed have been documented within the Trust procedures and discussed by the SMT. More

work remains to be done and a further update will be provided at the Governance Committee meeting on 10th May 2011.

Dr Mullan suggested that alternative approaches to settling clinical negligence disputes, such as mediation, should be explored. Mrs Holmes stated that the timescales in relation to the Pre-action Protocols are challenging and this will be an ongoing area of work.

12. **PROFESSIONAL GOVERNANCE REPORTS**

i) **Social Work and Social Care**

Mr Dornan spoke to a paper outlining key areas of activity in social work and social care. He referred to the Quality Standards for Approved Social Work and highlighted the significant progress made towards compliance. In terms of the Annual Report on Delegated Statutory Functions, this is required by the HSCB in May 2011. To that end, Mr Dornan proposed presenting the report for endorsement at the Governance Committee meeting on 10th May 2011 and the Trust Board meeting in June 2011.

13. **HCAI IMPROVEMENT PLAN**

Members discussed the detail of the detailed HCAI Improvement Plan and associated workstreams 2010-2011. In response to a query from Mrs Kelly on uniformity across Trusts, Mrs Holmes advised that there would be similarities with the Northern H&SC Trust's Action Plan. Dr Loughran highlighted recommendation 4.4 and the requirement for Trust wide roll out of safe insertion of Peripheral Intravenous Cannula. To that end, a short video/training programme has been produced which incorporates testing competencies during insertion. This will be introduced with the new in-take of Doctors in August 2011.

14. **UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE**

Mrs Brownlee provided an update on the recent meeting held on 10th February 2011 which was attended by a representative of the Patient Client Council Advisory Committee. Areas discussed were complaints, commendations and the PPI strategy. She advised that recurrent funding for the 2 PPI Development Officers posts has come to an end and the SMT is looking at alternative options.

15. **ANY OTHER BUSINESS**

15.1 Appointment of Chairman

Mrs Mahood informed members of the appointment of Mrs Brownlee as Chairman of the SH&SC Trust. On behalf of members, she congratulated Mrs Brownlee and wished her well in her new role.

The next meeting of the Governance Committee will take place on Thursday, 10th May 2011 9.30 a.m. in the Boardroom, Trust Headquarters, Craigavon.

Southern Health and Social Care Trust

Consultant Job Planning Steering Group Meeting

Meeting of the Steering Group held on the 17 November 2010 in the Boardroom, Trust Headquarters

Presentation by Pat Kilpatrick/HSCB Project Team on Capacity Evaluation and Modelling Project

Present: CHAIR – Mrs. M McAlinden, Chief Executive
Mr. K Donaghy, Director HR & Organisational Development
Dr. P Loughran, Medical Director
Dr. G Rankin, Interim Director Acute Services
Mr. F Rice, Director MH&D
Mr. B Dornan, Director C&YPS
Mrs. P Clarke, Acting Director of P&R
Mrs. A McVeigh, Acting Director of OPPC
Dr. B Aljarad, ADM, C&YPS
Dr. M Hogan, AMD, IM&WH
Mr. D Sim, Lead Clinician, Obstetrics & Gynaecology
Dr. B Adams, Consultant, Obstetrics & Gynaecology
Mr. E Mackle, AMD S&EC
Ms. S Sloan, CD S&EC
Mr. R Brown, CD Acute Surgery
Dr. P Murphy, AMD M&UC
Dr. P McCaffrey, CD Geriatric Medicine
Dr. C McAllister, AMD Anaesthetics, Theatres & ICU
Dr. S Hall, AMD, C&CS
Dr. N Damani, CD Infection Prevention & Control
Dr. G McCusker, CD Laboratory Services
Mr. R Carroll, CD C&CS
Mr. B Conway, AD M&UC
Mrs. H Trouton, AD S&EC
Mrs. G Maguire, AD of Specialist Child Health & Disabilities
Ms. R Toner, Acting AD OPPC
Mrs. J Morton, P&R Rep, Core Working Group
Mrs. L Lappin, P&R Rep, Core Working Group
Mrs. Z Parks, HR Rep, Core Working Group
Mr. M Clegg, HR Rep, Core Working Group
Mrs. L Leeman, Acting Director of Performance & Reform

Note Taker: Mrs. H Mallagh-Cassells, Senior Medical Staffing Officer

Mrs. McAlinden welcomed everyone to the meeting and explained that Ms. Pat Kilpatrick had been invited to give a presentation on the Capacity Evaluation and Modelling Project. Dr. Rankin provided a brief introduction in respect of the project details and expected outcomes emphasising the importance of clinical engagement.

During Ms. Kilpatrick's presentation the following questions were raised and clarity provided:

- **Regional PA time – how being assessed**
  Board will seek details with any queries between Trusts being raised for clarity.

- **Assessment of Travel Time – on site v off site**
  When looking at clinic times will need to understand if travel time is required and, therefore, base clinic time against actual capacity.

- **Variability of Junior Doctors**
  To be taken into consideration as may not have the same number of doctors on a constant basis with variable levels of contribution to capacity.

- **Training Requirements**
  The need for possible reduction in clinical sessions in order to be able to deliver training to be taken into consideration.

- **Clinical Leadership and Clinical and Social Care Governance**
  Arrangements are in place for patient safety. Trust to be modelled against what information is given in terms of breakdown of duties.

- **Sharing of Information**
  All information collated will be shared amongst all Trusts and will be broken down by hospitals.

- **Published Guidance/Planning Assumptions**
  If difference in information, would take back to Reference Group for decision.
  Where information is not available, information will be taken from different units and reviews, then assessed to get baseline/comparative data.
  Percentage times for lists have been validated using benchmarked Theatre data by the consultancy agency.

- **Benchmarking**
  Benchmarking will be against clinical activity and planning assumptions only – not outcome commissioned.

- **Utilisation Time**
  Concerns were expressed with regard to the accuracy of information provided by the Theatre Management System and it was agreed to take such on board when collating information.

- **Independent Sector**
  To be taken into consideration activity undertaken and what capacity needed if to be provided in baseline.

Mrs. McAlinden spoke of the important work already completed in relation to capacity/demand analysis and consultant job planning (team and individual) and advised that this put the Trust in a strong position to provide accurate input into the Regional Board's Project (Capacity Evaluation and Modelling Project). She emphasised the need to complete any outstanding internal work on consultant job planning so that assumptions made by the Regional Board Project can be properly assessed and challenged with evidence if required.

Mrs. Clarke circulated a copy of the proposed Project Structure for comment and asked that Associate Medical Directors and Assistant Directors meet on Wednesday 24 October 2010 at 5.00 pm.

In conclusion, Mrs. McAlinden asked that Ms. Kilpatrick take place the concerns expressed and indicated that the Trust would be commenting on the Trust's physical infrastructure in terms of delivery of service and investment.

Consultant Job Planning Steering Group

Present: CHAIR – Mrs. M McAlinden, Chief Executive
Mr. K Donaghy, Director HR & Organisational Development
Dr. P Loughran, Medical Director
Dr. G Rankin, Interim Director Acute Services
Mr. F Rice, Director MH&D
Mr. B Dornan, Director C&YPS
Mrs P Clarke, Acting Director of P&R
Dr. B Aljarad, ADM, C&YPS
Dr. M Hogan, AMD, IM&WH
Mr. D Sim, Lead Clinician, Obstetrics & Gynaecology
Mr. E Mackle, AMD S&EC
Ms. S Sloan, CD S&EC
Mr. R Brown, CD Acute Surgery
Dr. P Murphy, AMD M&UC
Dr. C McAllister, AMD Anaesthetics, Theatres & ICU
Dr. S Hall, AMD, C&CS
Dr. G McCusker, CD Laboratory Services
Mr. R Carroll, CD C&CS
Mr. B Conway, AD M&UC
Mrs. H Trouton, AD S&EC
Mrs. G Maguire, AD of Specialist Child Health & Disabilities
Ms. R Toner, Acting AD OPPC
Mrs. J Morton, P&R Rep, Core Working Group
Mrs. L Lappin, P&R Rep, Core Working Group
Mrs. Z Parks, HR Rep, Core Working Group
Mr. M Clegg, HR Rep, Core Working Group

Note Taker: Mrs. H Mallagh-Cassells, Senior Medical Staffing Officer

1. Welcome and note of any apologies

Apologies were noted as follows:

Mr. S McNally, Acting Director of Finance & Procurement
Mrs. A McVeigh, Acting Director OPPC
Dr. J Simpson, AMD, MH&D
Mr. N Heasley, CD Obstetrics & Gynaecology

2. Additional SPA Activities

Dr. Loughran summarized the process undertaken and presented the final considered view in respect of the allocation of additional SPA activities. He suggested that this should be the resolved position.

Mrs. McAlinden questioned if the Associate Medical Directors were content to accept this position. In response to questions, Mrs. McAlinden confirmed:

- Allocation would be reviewed annually.
- Would anticipate that the process would be easier at review.
- If through job planning a need for additional SPA activities is highlighted, a request should be made to the Steering Group for approval.
- The Steering Group would meet on a quarterly basis.

Mrs. McAlinden indicated that she would assume that silence is consent to agree the allocation. No further comment was made.

Mrs. McAlinden suggested that since this was one of the barriers to job planning that she would now expect the process to move forward.

3. AMD Job Planning status update

Dr. Loughran advised that he had met individually with Associate Medical Directors. He indicated that there were some concerns with matching the role with service requirements.

ACTION: To be taken forward between the Associate Medical Director, Medical Director and Service Director.

Dr. Loughran reported that Mr. Donaghy had written to the Associate Medical Directors to formally offer the role to them. Mr. Donaghy confirmed that all Associate Medical Directors had responded.

4. Update on progress with Consultant Job Planning from Associate Medical Directors

Mrs. Lappin circulated an amended progress report with Associate Medical Directors providing a verbal summary:

i. Medicine & Unscheduled Care
Demand & Capacity process well underway as documented in the progress report

ii. Surgery & Elective Care
ENT – demand & capacity exercise complete – job planning to be taken forward
Urology – demand/capacity with Consultants for comment.
T&O – demand/capacity with Consultants for comment.
Surgery – basic demand/capacity complete although had embarked on how to cover 2 sites which may then mean changes would be necessary.

iii. Integrated Maternity & Women's Health
Progress halted due to Additional SPA issues. Job Plans can now be progressed.

iv. Cancer & Clinical Services
Capacity and demand in Radiology agreed. Job Plans are old. Group Job Plan to be progressed.

Labs/Haematology – capacity and demand to be signed off and then current Job Plans to be updated.

v. Children & Young People
Capacity and demand to be finalized.

vi. Mental Health & Disability Services
All Job Plans are completed.

vii. Anaesthetics, Theatres & Intensive Care Services (Atics)
Chronic Pain demand & capacity completed – Job planning to be taken forward. .

Mrs. McAlinden thanked everyone for their hard work and asked for a final push to complete the process and ensure individual job plans signed and implemented.

5. Study leave, training and development

Dr. Loughran reported that he had made amendments to the Study Leave Policy which he would discuss with the Associate Medical Directors and bring back to SMT.

In terms of the external duties v study leave, Dr. Loughran advised that guidance was required and that he would draft such and share with the Associate Medical Directors for agreement.

ACTION: Dr. Loughran

6. Any other business - None

7. Date of Next Meeting

Next meeting to take place in Early February 2011.

Southern Health and Social Care Trust

CONSULTANT JOB PLANNING STEERING GROUP

AGENDA

Wednesday 28 September 2011 at 5pm
Boardroom, Trust Headquarters, Craigavon Area Hospital

1. Welcome and Introductions

2. Matters Arising

3. Update on Capacity Planning (P Clarke)

4. Sign off on Prospective Job Plans - Update from Associate Medical Directors (via template circulated) to include a summary on how all job plans in the team deliver/under deliver capacity to meet service demands:

   - Mr E Mackle, Surgery & Elective Care
   - Dr P Murphy, Medicine & Unscheduled Care
   - Dr S Hall, Cancer & Clinical Services
   - Dr C McAllister, ATICS
   - Dr M Hogan, Maternity & Women's Health
   - Dr B Aljarad, Children & Young People
   - AMD, Mental Health & Disability

5. Electronic Job planning (Zircadian)
   - Update on collating the Job Planning Language by specialty for electronic job planning
   - Agree timescales for implementation

6. Any other business

7. Date of next meeting

Southern Health and Social Care Trust

Local Trust Framework on Job Planning for Medical Managers

Southern Health and Social Care Trust

FINAL VERSION – Management document agreed by the Senior Management Team & Associate Medical Directors

This guidance document does not replace the Regional guidance on Job Planning but should be read as background information to be discussed between clinical manager and the Director within the Southern Health and Social Care Trust.

Please also refer also to:

- *Regional Guidance on Job Planning for Medical & Dental Consultants in Northern Ireland*
- *SHSCT Medical Staff Annual Leave Guidance,*
- *NI Code of Conduct for Private Practice*
- *SHSCT procedural guidelines on the use of accommodation for private medical practice.*

Local Trust Framework for Job Planning

Southern Health and Social Care Trust

1.0 Direct Patient Care – Personal & Team Capacity – *Refer to Section 8 in Regional Guidance*

1.1 Prediction of an indicative number of fixed clinical PA's delivered per year will facilitate accurate capacity and workforce planning. A consultant job plan should deliver a predicable number of clinical PA's each year based upon agreed annual leave, study leave and professional leave allocations. There may be some individual variation, particularly for individuals with specific agreed responsibilities.

1.2 This information should be recorded clearly on the job planning template as part of individual and/or team job planning objectives.

1.3 The content of each Direct Clinical Care PA should be reviewed e.g. new patients per clinic, start and finish time and a time allocation for dictation/letter writing.

1.4 The number of fixed activities (such as outpatient clinics or theatre lists) appearing in a weekly job plan is multiplied by the number of weeks in the working year, 42 weeks to establish an indicative number of sessions per year, i.e. 52 weeks minus bank holidays, annual leave and study/professional leave.

1.5 Those responsible for scheduling PA's should note that any consultant wishing to complete their 42 weeks commitment (e.g. if 2 theatre PA's/wk = 84 theatre PA's/year) in *significantly* less time than the 42 working weeks may not be able to carry this out for the following reasons:

1.5.1 In order to carry out a DCC, a resource, usually involving other staff, will be required and it is unlikely that such resources will be available to accommodate a consultant wishing to work their annual commitment in a short time.

1.5.2 On a full time contract with DCCs and SPA's, the only way to work an annual commitment in less than the agreed weeks would be to exceed the EWTD.

1.5.3 The idea behind these changes to the job plan are to spread out the work evenly across the year to the mutual benefit of both the Trust and the consultants, resulting in a safer environment for patients and a healthy life/work balance for the consultants.

1.5.4 If the AMD / CD feel that a service will be better supported/delivered through such an arrangement, then such flexibility may be agreed in these circumstances.

1.6 An example of building in capacity into job plans would be as follows: if there are 3 PA's of outpatient clinics, per week on the job plan, then the indicative annual clinic contribution should be 3 x 42 = 126 expected clinics per year. If clinics have been cancelled for reasons of SPA (educational events or urgent meetings), then replacement clinics should take place in designated time which was previously SPA time or time off.

1.7 The inclusion of an indicative number of sessions per year in a job plan is to facilitate better capacity and workforce planning. Where a consultant does not deliver the expected number of sessions per year for reasons outside their control, the Trust will not use this as criteria for deferring pay progression. For example, factors which may affect this could include the impact of sick leave, planned or unplanned. These issues should be discussed and agreed at job planning.

2.0 Direct Patient Care - Productivity

2.1 For outpatient clinics and operating theatre sessions, an indicative estimate of the number of patients per fixed clinical PA should be included in the job plan template under individual/team job plan objectives. Justification will be from agreed levels of service for clinic and theatre capacity or from retrospective data including new to follow up ratio.

2.2 A clinical manager can use national norms or accepted best practice to determine/alter new and review ratios. Clinicians will be encouraged to find new ways to discharge/review patients e.g. telephone reviews, letters to patients or GP's agreeing primary care follow-up etc.

2.3 An individual's or teams' capacity should be agreed with clinical teams and signed off by the divisional management. Issues which are outside the control of the consultant must be discussed and recorded at job planning. This might include the impact of sick leave, planned or unplanned and the impact of any significant deficiencies in supporting infrastructure.

3.0 Direct Patient Care – Additional Points

3.1 In all instances, consultants and clinical managers should ensure there is no double counting of time within job plans. One example of this might be where a consultant is undertaking teaching whilst in an outpatient clinic such activity should only be counted once for programmed activity purposes. The clinical manager and the consultant should agree the appropriate split between DCC and SPA.

3.2 It is the Trust's intention that job planning should work towards no consultant being contracted to work more than an average total of 48 hours in order that the Southern Trust fulfils its responsibilities regarding standards set out in the European Working Time Directive. In practice this normally translates to a 10 + 2 PA contract - if the additional PA's are paid for actual working time and not responsibility payments.

3.3 Direct patient care should generally comprise:

3.3.1 Depending on agreed SPA's and Clinical Administration; normally between 6.5 -7.5 PA's (26-30 hours) for Patient related activities including ward rounds, theatre lists, procedure lists, MDT meetings, consultations, outpatient clinics, emergency reviews and labour ward. Within the 1PA allocated to an outpatient clinic, it would be expected this would include an agreed time allocation of direct patient contact with time allowed for immediate letter writing /dictation in specialties where this is customary.

3.3.2 An agreed PA allocation for Clinical Administration e.g. letters, review of results, discussions with GP's and relatives.

4.0 Team Job Planning – *Refer to Section 4 in Regional Guidance*

4.1 The presence of a team job plan is entirely acceptable so long as each individual agrees to participate without coercion and that they still retain the right to sign an individual job plan agreement with the Trust.

4.2 The total workload (DCC, SPA, On-call) for a group of consultants should be estimated and then each element factored into individual job plans. The principal of team job planning is that all DCC and SPA activity is seen as shared and collective responsibility.

4.3 The following should be considered when developing a team job plan:

4.3.1 Determine what direct patient care activities are required to deliver the service.

4.3.2 Identify the number of consultant hours required to deliver each activity

4.3.3 Determine the number of weeks in the year when each activity occurs (e.g. 42)

4.3.4 Determine the annualized hours for each activity (based on point 4.2.1 & 4.2.3)

4.3.5 Quantify how many consultants are available week to week to deliver the service (taking account of absences for annual/study leave)

4.3.6 Divide the annualized hours by the figure identified in 4.2.5 to determine the average DCC working week per full time consultant

4.3.7 Quantify the total SPA commitment as well as any additional duties (e.g. Additional Responsibilities/External Duties) across the team.

4.3.8 Add the figures identified in 4.2.6 and 4.2.7 together to determine the total weekly PA figure. If this figure lies outside 10 PA's basic contract, discussions will be needed about how to manage the gap – e.g. additional Programmed activities, consultant expansion, new ways of working.

4.3.9 Individuals within the team should have personalized job plans based on their individual commitments. It would be good practice that the team agree and sign a statement about how they work as a team defining their shared objectives. Where objectives are team based, the role of each individual consultant needs to be clear.

4.4 Please refer to the Appendix Section for a working example of team job planning.

5.0 Annualised Job Planning – *Refer to Section 15 in Regional Guidance*

5.1 There may be some consultants who have activities that do not fall on a regular weekly basis and therefore do not lend themselves to preparing a weekly job plan. Therefore it will be necessary to have an element of their job plan annualized. However, the principles of job planning remain unchanged.

5.2 Where a consultant undertakes irregular clinics or additional roles, this will need to be annualized. For example, if a consultant has been approved to take on an examining role (EPA's) which will involve approximately 5 days per year – this is annualized as follows: 5 full days per year equate to 40 hours/yr, or 10 programmed activities. 10 PA's divided by 52 weeks = 0.19 PA per week. (No prospective cover).

6.0 On-call Activity

6.1 Allocations for unpredictable emergency work must be evidenced by a diary data on a team basis. For example:

6.1.1 A diary analysis indicates 37 hours of unpredictable on-call activity worked by the team in 1 week.

6.1.2 37 hours / 3 = 12.3 PA's of unpredictable on-call activity per week for the team

6.1.3 To allow for prospective cover – 12.3 x 52 weeks / 42 working weeks = 14.5 PA's

6.1.4 This must be divided by the number of consultants on the on-call rota e.g. 16 consultants on rota = 0.91 PA each for on-call.

6.1.5 Therefore if a consultant team was offered 0.91 PA for unpredictable on-call, this equates to approximately 37 hours. It is useful to ask if this represents the actual workload. If not, a re-diary card exercise may need to be undertaken.

6.2 **Change to workload/New Appointment** - It is essential that if there has been a change to the workload or following a new consultant appointment, the unpredictable on-call activity for the team must be reviewed and changes notified appropriately.

6.3 **Frequency of the on-call rota** – If there has been a change to the on-call frequency e.g. High frequency (1 in 1 to 1 in 4); Medium frequency (1 in 5 to 1 in 8); Low frequency (1in9 or less frequent) which takes it from one category to another, a notification (Proforma attached) of this change must be completed.

6.4 **Predictable On-call** - should be agreed in advance (e.g. weekend ward rounds or fixed operating which are scheduled and include other resources i.e. nursing/other clinicians joining the activity.) Time allocated should be on the basis of the number and complexity of the activities or sound diary exercise to account for the time allocation. The above calculation to include prospective cover can also be included.

Method for calculating on-call

1	Determine the total number of emergency out of hours worked by the team of consultants, identified via a diary card exercise.
2	Divide the total hours by three to determine premium time PA's
3	Multiply by 52 weeks per year
4	Divide by 42 working weeks per year (as this includes prospective cover)
5	Divide the weekly PA's by the number of consultants working on the on-call rota
6	This weekly PA figure will represent the on-call to be allocated to each consultant.

7.0 Supporting Professional Activities – *Refer to Section 9 in Regional Guidance*

7.1 ***Please refer to further guidance on Supporting Professional Activities in Appendix Section***

7.2 A minimum of 1.5 PA's for supporting professional activities should be allocated to all consultants and considered as the minimum time resource for maintaining a professional career. This allocation will be the same for full and part time consultants. This allocation will require evidence of full participation in mandatory training programmes evidenced at appraisal and copies available for the Job Plan meeting. Evidence of CPD must also be presented at appraisal.

7.3 This SPA activity should include as a minimum CPD outside study /professional leave, requirements for licensing & recertification and mandatory training, appraisal and job planning, basic teaching, training and supervision of junior staff, administration related to these duties and attendance at audit meetings and clinical governance activity to meet minimum standards required i.e. average 1 hour per week.

7.4 Additional SPA allocation over 1.5 must be evidenced and timetabled into the job plan and agreed by the Clinical Director/Associate Medical Director. It is expected that this additional activity would deliver quality improvements and align with Trust objectives.

7.5 It is expected that SPA's should normally be worked onsite. Clinical Managers should work to ensure adequate space/facilities are available to encourage protected time for all consultants.

7.6 Any clinical activity lost due to scheduled SPA (e.g. the rolling governance programme) should be re-provided flexibly at a time agreed by the consultant and clinical manager. Where this is not possible, this should be discussed with the clinical manager and service director.

7.7 Clinical managers should be careful to ensure that SPA's are evenly divided between members of a team and that individual SPA's do not rise year on year.

8.0 Travel Time

8.1 Travelling time between a consultant's main place of work and home (for purposes other than emergency work) or private practice premises will not be regarded as part of working time.

8.2 Where consultants are expected to spend time on more than one site during the course of a day, travelling time to and from their main base to other site(s) will be included as working time. Such working time (for travel) will be deemed to fall within the same category of Programmed Activity as the work undertaken at the other site(s).

8.3 All regular travel times to external sites from base hospital should be included in the job plan using the current suggested travel times (See Appendix Section for SHSCT Travel Time Chart)

8.4 Job Plans should be designed to minimize disruption of fixed clinical episodes by time spent traveling between sites e.g. arranging for a full day in one clinical area rather than movement between site A&B during the day.

8.5 Travel to and from work for HPSS emergencies, and 'excess travel' will count as working time. 'Excess travel' is defined as time spent travelling between home and a working site other than the consultant's main place of work, after deducting the time normally spent travelling between home and main place of work.

8.6 **Working Example** - If a consultant normally takes 45 minutes to travel from their base hospital (e.g. CAH) to an outlying clinic (e.g. DHH) and a consultant doesn't travel to base but goes straight from home to the outlying clinic, then they can claim for "excess time" in their job plan if it takes them longer to travel from home. Therefore if consultant X lives in Belfast and it takes them 1 hour to travel to DHH, then they could claim 15 minutes in their job plan. However if they lived further away and it took them 1.5 hours to travel to DHH straight from home (or they had to come to base first for clinical reasons) then they would claim 45 minutes in their job plan.

9.0 External Duties & Additional HPSS Responsibilities – *Refer to Sections 10 and 11 in Regional Guidance.*

9.1 **External Duties** - The Trust would seek to facilitate consultants wherever possible for such work that is not directly for the Trust but is relevant to and in the interests of the wider HPSS. External duties should normally be connected to activities relevant to clinical medicine.

9.1.1 All these roles require Trust approval and the SHSCT External Duties & Additional HPSS Responsibilities approval proforma must be completed prior to acceptance.

9.1.2 Consultants must have approval from their Associate Medical Director before accepting external duties. Service Directors must also been involved and advised of the commitment and its impact on delivering the job plan The timing and duration of the role and an indication on whether the role is funded externally MUST accompany this request.

9.1.3 Where possible all external HPSS duties MUST be included within the job plan with a clear time allocation and set within an agreed timeframe with a specific end date. It may be necessary to annualize due to the nature/irregular timing of the work.

9.1.4 Clinical managers should seek to spread this work equitably across consultant teams and the Trust where possible. Any agreement should acknowledge the importance of the priority of consultants' commitments to direct clinical care and supporting professional activities. Measurable objectives for External Duties MUST be discussed, agreed and be clearly specified on the job plan template.

9.1.5 Facilitating consultants for external duties must be governed by the need to retain a balance between different elements of the job plan in a way that maintains the required delivery of services to patients in terms of both activity and quality. It is reasonable for the clinical manager to seek to secure/maintain required direct clinical care commitments.

9.1.6 Clinical Managers must keep detailed records of external commitments and provide an annual report of such commitments to the Medical Director and the Senior Management Team in the Trust.

9.1.7 External duties that do not contribute to the interests of the HPSS should either be carried out during professional or study leave or where the consultant so chooses, during his/her annual leave.

9.2 **Additional HPSS Responsibilities** – These are activities agreed between a consultant and the Trust and which cannot be absorbed within the time that would normally be set aside for SPA's e.g. Clinical Director, Clinical Tutor, Regional Education Advisor etc

9.2.1 All these roles require Trust approval and the SHSCT External Duties & Additional HPSS Responsibilities approval proforma must be completed prior to acceptance.

9.2.2 Where a clinical director post becomes available, the Trust will undertake an internal appointment process. This will set out the nature of the role including time/PA allocation and the terms and conditions associated.

9.2.3 Each clinical manager needs to be aware of the roles of the consultant and how the roles are funded to ensure appropriate job planning. In some cases the allocation will vary among specialties, depending upon the required commitment and in some circumstances (e.g. Clinical Tutors), the number of junior doctors. Further guidance and support should be sought regarding teaching roles, their time commitments and job planning for them.

9.2.4 An appropriate PA allocation for Additional HPSS Responsibilities should be agreed between the clinical manager and the individual consultant and included on the job plan template.

10.0Job Planning Objectives – *Refer to section 3 in Regional Guidance*

10.1 Job Plan Objectives are an essential part of the new consultant contract (Schedule 3 paragraph 10). These should be set out in the job plan and tailored to reflect local service development plans and priorities.

10.2 Objectives should state specifically what an individual consultant (or team) will be expected to deliver and how these objectives will be measured on an annual basis. It is recommended that the SMART framework is adopted. (i.e. Specific, Measurable, Achievable, Relevant, Timed and tracked.)

10.3 Objectives may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these must be reasonable and agreed by the consultant and his/her clinical manager. The consultant and his/her clinical manager should use job planning to identify resources that are likely to be needed to help the consultant carry out his/her job plan commitments over the year and achieve his/her agreed objectives for that year.

10.4 Sample Objectives may incorporate the following: waiting list targets, quality of service as measured by PFA targets to balance capacity and demand, safer patient issues arising from patient safety issues, professional standards, lessons' learned from national, regional and local incidents & CHKS information.

10.5 Examples of "Hard Objectives" in relation to direct patient care should include the indicative capacity/productivity information discussed and agreed e.g. "Annual clinic contribution will be 126 expected clinics per year" (where there are 3 PA's of outpatient clinics per week in a job plan) Or "Annual operating theatre contribution will be 84 expected theatre PA's per year" (where there are 2PA's of theatre PA's per week in a job plan).

11.0 Private Practice – *Refer to Section 13 in Regional Guidance*

11.1 Regular work for other providers should be identified on the job plan indicating time and location. Such work should not occur in remunerated direct patient care or SPA time contracted to the Trust. It is the responsibility of the Clinical Director and the Consultant to ensure there is no double counting of time.

11.2 All consultants are expected to conform to the Northern Ireland Code of Conduct for Private Practice and the handbook concerning the management of private practice in Health Service Hospitals in Northern Ireland. In addition to these documents, it is also important to note that any private practice done when on-call should not prevent immediate return to the hospital to attend emergencies if required.

11.3 Consultants should also refer to the Southern Trust procedural guidelines on the use of accommodation for private medical practice.

11.4 The notification of private patients using the agreed paperwork e.g. PP1, PP4 and undertaking to pay forms should be agreed.

11.5 If a consultant undertakes regular Domiciliary visits then this should be allocated time in his/her job plan and no fee will be paid other than travel expenses.

11.6 If a consultant undertakes occasional domiciliary visits outside his/her job plan, he or she may claim the appropriate fee and travel expenses.

11.7 Family Planning fees are not paid for by SHSCT to consultants or non training grades.

12.0Overarching Principles

12.1 Work outside of the contracted job plan will be reimbursed in a way that is mutually agreeable between the Chief Executive and the individual consultant. Please refer to further guidance in relation to payment of waiting list initiative payments, which has been agreed with the Local Negotiating Committee.

12.2 Clinical Managers must ensure they meet with their Service Manager and Performance and Review team prior to job planning to obtain relevant demand and capacity information for their specialty. See Job Planning Flowchart in the Appendix Section.

13.0 Job Planning Timeline

See Appendix Section for Job Planning Summary and Timeline

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 20 September 2010 22:48
To: Stinson, Emma M
Subject: FW: Strictly Private and Confidential - Briefing for Trust Board Confidential
Attachments: Clinical Issues in Urology Service.doc

Importance: High

From: McAlinden, Mairead
Sent: Monday, September 20, 2010 10:48:05 PM
To: Rankin, Gillian
Cc: Loughran, Patrick; Donaghy, Kieran
Subject: Fw: Strictly Private and Confidential - Briefing for Trust Board Confidential
Importance: High
Auto forwarded by a Rule

Gillian, this is an excellent and factual briefing, however perhaps given that this information will be new to Trust Board a bit more detail is needed on the circumstances which led to our identification of the risk around the IV therapy, the actions taken over the past year to cease this practice and the numbers of patients in the original cohort and how their treatment regime has now been changed (to what).

Given that this was before your time in many ways perhaps Paddy would assist in providing the detail.

Mairead

----- Original Message -----
From: Stinson, Emma M
To: McAlinden, Mairead; Loughran, Patrick; Donaghy, Kieran
Sent: Mon Sep 20 16:28:41 2010
Subject: Strictly Private and Confidential - Briefing for Trust Board Confidential

Dear All

Please see attached a draft briefing for your comments prior to Trust Board.

Many thanks

Emma

Emma Stinson

PA to Dr Gillian Rankin, Interim Director of Acute Services

Admin Floor

Craigavon Area Hospital

Tel: Personal Information redacted by USI

Fax: Irrelevant information redacted by

Email: Personal Information redacted by USI Personal Information redacted by the USI Personal Information redacted by USI Personal Information redacted by the USI >

Southern Health and Social Care Trust

Quality Care - for you, with you

Minutes of the confidential meeting of the Board of Directors held on Thursday, 30th September 2010 at 10.00 a.m. in the Boardroom, Daisy Hill Hospital, Newry

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 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 Performance and Reform
Mrs A McVeigh, Acting Director of Older People and Primary Care
Mrs J Holmes, Board Secretary
Mrs R Rogers, Head of Communications
Mrs S Judt, Committee Secretary (Minutes)

1. APOLOGIES

Apologies were recorded from Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing.

2. **MINUTES OF PREVIOUS MEETING**

The minutes of the meeting held on 26th June 2010 were agreed as an accurate record and duly signed by the Chairman.

3. **MATTERS ARISING**

i) **Coroner's Inquest –** [redacted]

Dr Rankin advised that the Coroner's Inquest into the death of [redacted] was held on 28th June 2010 when the Coroner reported *'From the evidence I am satisfied, on the balance of probabilities, that the tragic consequences of co-sleeping were the underlying causes of this'.* Dr Rankin reported on the actions taken following the Coroner's Inquest:-

- All mothers continue to be advised of the risks associated with co-sleeping through verbal and written information. Bed-sharing is acceptable in cases where the mother is breastfeeding or to comfort a baby for a short period of time.
- Cot sides are only now used when transferring a mother and baby from one ward/department to another.

4. **UNTOWARD EVENT ID:** [redacted]

Mr Dornan outlined the incident involving a [redacted] old child who died on [redacted]. Believed cause of death was [redacted] from 14.1.10. He confirmed that staff continue to provide support to the various family members.

5. **TV PROGRAMME 'IN COLD BLOOD'**

Mr Dornan referred to the documentary on the Crymble case broadcast recently by the BBC and [redacted]

Irrelevant information redacted by the USI

6. **COVERAGE IN LURGAN MAIL – TRUST DOMICILIARY CARE SERVICE**

The Acting Chief Executive spoke of the recent negative media coverage in the Lurgan Mail, primarily as a result of a client directly contacting this paper which was followed up by supporting comments from a number of home care workers. The Trust has met with the Editor and a statement from the Trust, together with an article on a Trust's homecare worker and an appreciative client, has since been published in the Lurgan Mail as rebuttal. The client concerned has also been contacted in relation to their issues of complaint.

7. **CLINICAL ISSUES IN UROLOGY SERVICE**

Dr Rankin outlined the clinical issues in the Urology Service as detailed in the briefing note and the action being taken:-

IV Fluids and Antibiotics

An immediate review is underway of a cohort of 10 patients who are receiving IV therapy.

Cystectomies

The Commissioner had drawn to the Trust's attention a slightly increased rate of cystectomy for benign pathology in Craigavon Hospital compared with the rest of the NI region. The Associate Medical Director for Surgery and Elective Care has commenced a review, which includes a case note review of each patient who has undergone cystectomy in the past 10 years.

Regional Urology Review

One of the requirements of the implementation of the review is that all radical pelvic urological surgery is moved to the Belfast

Trust. There are currently 5 patients within the Southern Trust whose care is being transferred to the Belfast H&SC Trust.

8. **ASR MONO-BLOCK CUP HIP REPLACEMENT**

Dr Rankin advised that the process has commenced whereby each patient will be contacted to explain the situation and what action they can expect. She noted, however, that whilst the patients were operated on in this Trust, a number of these patients are from outside the Trust. Discussions are ongoing with the Commissioner and manufacturer regarding funding for replacement of the ASR prothesis.

9. **FINANCIAL STABILITY PROGRAMME – RATINGS**

The Chairman noted the outcome of the assessment review. The Southern Trust was assessed as 'amber/green' and she stated that this demonstrates a high degree of confidence in the Trust's systems, processes and ability to deliver the agreed cost savings. On behalf of Board members, the Chairman paid tribute to the Acting Chief Executive, Directors, Mrs Magwood and staff involved in this process.

10. **OUTSTANDING MEDICAL NEGLIGENCE CASES**

The Acting Chief Executive advised of a recent Assembly debate on a Sinn Fein motion at the delay in resolving some medical negligence cases. Dr Loughran stated that the Southern Trust has 10 medical negligence cases outstanding for 10 years or more and he assured members that these are being dealt with appropriately and there were no undue delays in their processing by the Trust.

11. **UPDATE ON DR [redacted] (GP OUT OF HOURS)**

Mrs McVeigh spoke to the preliminary report of the investigation into concerns about the clinical performance of Dr [redacted], who has been employed by the Trust as a GP within the Out of Hours Service since 2005. Dr [redacted] remains excluded from practising as a salaried GP within the Out of Hours Service and a decision by an Interim Order Panel of the GMC on 25th June 2010 suspended Dr [redacted]'s registration and this remains in place. The

Trust is processing this case under the Maintaining High Professional Standards Policy. The Trust has taken the decision to proceed through the Trust's formal investigation procedures. The Non Executive Director representative on this group is Mrs E Mahood.

12. **ANY OTHER BUSINESS**

i) **Update on NNU/MRSA events**

Mrs G Maguire, Assistant Director, Specialist Child Health and Disabilities, Dr Damani, Clinical Director, Infection Prevention and Control and Mr C Clarke, Lead Nurse, Infection Prevention and Control, joined the meeting for a discussion on this item. Mrs Maguire advised that there are currently four babies in the neo-natal unit at Craigavon Area Hospital who have been identified as carrying MRSA on the skin. The MRSA was identified during routine screening that is carried out on all babies in the unit. All babies are well, with three of them due for discharge very shortly. She also advised of three babies who had also been identified as carrying MRSA and who have been discharged home. Dr Damani explained the range of extra infection control measures put in place, in addition to existing measures and these include:-

Segregating the babies with MRSA;
Additional deep cleaning of the Unit;
Increasing the daily clean to three times a day;
Continued awareness raising of infection control procedures for all staff.

All affected babies (a total of 7) were colonized. Staff screening has commenced and 84 staff have been screened; three were positive for MRSA and decolonization therapy has been started.

The Acting Chief Executive paid tribute to the staff in the NNU and the Infection Control Team for their management of this outbreak.

ii) **MLU, Lagan Valley Hospital**

Dr Rankin advised that discussions continue with the Commissioner in relation to the movement of births from Lagan Valley Hospital to Craigavon Area Hospital upon cessation of the Consultant led service to be replaced by a MLU. The issue for this Trust is how to manage the potential number of deliveries in Craigavon Area Hospital safely given that the funding which may be provided could be significantly less that what is required to deliver the estimated additional 200 births.

iii) **Administrative Error in Breast Screening Programme**

Dr Rankin reported on an administrative error that occurred in February 2009. This came to light in July 2010 when the patient presented with breast cancer. A Root Cause Analysis is nearing completion on this incident.

iv) **Maternal Death**

Dr Rankin advised of the death of a mother in the maternity ward, Craigavon Area Hospital the previous day. She assured members that all appropriate clinical interventions were carried out for the mother and that the baby had been delivered safely and is well. The case has been referred to the Coroner and there will be a post-mortem.

v) **Case of suspected TB**

Dr Rankin advised of a healthcare worker in A&E with suspected Tuberculosis. A review group has been established, involving the Public Health Agency, to assess the potential risk to patients and staff. GPs in the Trust area have been notified. There was some coverage on this issue in the Irish News at the week-end.

HPSS Health&CareNI

RPA

Candidate
Information
Booklet

CHIEF EXECUTIVE - DESIGNATE

(5 Posts)

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Northern HSS Trust
Southern HSS Trust
Belfast HSS Trust
South Eastern HSS Trust

Completed Application Forms must be returned no later than 12 noon on Friday 23rdJune 2006

HPSS HR RPA

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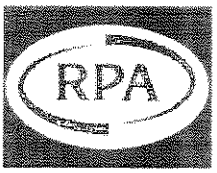

Information Pack
TRUST CHIEF EXECUTIVE

Background

About the Department:

The Department of Health, Social Services and Public Safety was established by the Departments (NI) Order 1999. The Department administers the business of:

- Health and Personal Social Services (HPSS), which includes policy and legislation for hospitals, family practitioner services, community health and personal social services;
- Public Health, which covers responsibility for policy and legislation to promote and protect the health and well-being of the population of Northern Ireland
- Public Safety, which encompasses responsibility for the policy and legislation for the Fire and Rescue Service, food safety and emergency planning.

The Department's mission is to improve the health and social well-being of the people of Northern Ireland. It endeavours to do so by supporting programmes of health promotion and education to encourage the community to adopt activities, behaviours and attitudes which will lead to better health and well-being and by ensuring the provision of appropriate health and social care services, both in clinical settings, such as hospitals and GPs' surgeries, and in the community, through nursing, social work and other professional services.

The Department is embarking on an unprecedented period of strategic change and investment, in terms of HPSS structures, capital investment in hospital and community facilities and in the development of staff. We have outlined our aspirations for the next twenty years in a new Regional Strategy, "A Healthier Future". This describes how our need for health and social services will change as new ways of working, new technologies and new treatments are developed. All of these changes take place within an environment of substantial political interest in the delivery of health and social services, and greater accountability for results and shortfalls.

The Department will:

- determine the standards and guidelines which the HPSS is expected to achieve;
- set the strategic outcome targets and specific Ministerial targets for the Authority and hold the Authority to account for their delivery;

- allocate resources within which strategic outcomes and targets are to be achieved and approve the capitation methodology for resource distribution;
- approve the Authority's plan to achieve outcomes and targets and monitor regularly through reporting and accountability meetings;
- prescribe a Payment by Results regime;
- determine what performance information must be published;
- hold the Authority to account addressing RQIA recommendations;
- hold the Authority to account for benefits realisation of pay reform;
- work with the Authority, Local Commissioning Groups and providers to improve the information base;
- hold the Authority to account for the effective control of financial resources and the delivery of efficiency targets.

Background to the Health and Social Services Authority:

The review of Public Administration has concluded that major reform is required in the administrative structures of health and social services. In addition the Appleby Review has pointed to the need for reform and modernisation of the delivery of these services.

Following the Review of Public Administration, the Secretary of State and his Ministerial team announced details of proposals for the future management of the HPSS. Central to this will be the establishment of a new Health and Social Services Authority (HSSA), responsible for promoting public health and ensuring that the HPSS performs efficiently, effectively and economically. The HSSA will have responsibility for promoting the health and well-being of the public and the short to medium term operational planning of health and social services for the population of Northern Ireland.

It is intended that five integrated Health and Social Services (HSS) Trusts will be established to replace 18 of the existing 19 Trusts. Together with the existing Northern Ireland Ambulance Services HSS Trust, they will be performance managed by the HSSA.

In addition seven Local Commissioning Groups (LCGs) will be established co-terminus with the areas of the seven new District Councils. These Local Commissioning Groups will work in conjunction with the local primary care practitioners and the HSSA to commission services from Trusts. These will be formally within the HSSA, but will in practice have delegated authority and responsibility for local commissioning.

Responsibilities of the Health and Social Services Authority

The Authority will be responsible for the overall day-to-day performance management of the HPSS by:

- developing and overseeing the implementation of key public health plans;

- developing system-wide HPSS service plans;
- managing the performance of the HSS Trusts and Agencies, using a comprehensive package of standards and targets for improvement in services to patients and clients, ensuring adherence to budget allocations and monitoring the delivery of outcomes;
- human resource planning;
- making sure regional priorities – for example programmes for improving cancer services – are integrated into local plans while promoting real delegation to a local level within that framework;
- facilitating and supporting Local Commissioning Groups in their role of achieving effective locality based commissioning, managing their performance, and holding them to account so that they can exercise their delegated authority (which is integral to the policy of local commissioning), within an effective framework of regional priorities and standards;
- ensuring local health and social services are of a high quality and performing well;
- monitoring delivery against Ministerial targets/standards/budget allocations;
- applying incentives and sanctions as necessary including the replacement of Trust/Agency management;
- management and financial controls – a clear strategic control framework for the LCGs and the Trusts to ensure sufficient and appropriate controls are in place to safeguard public funds;
- overseeing the agreed publication of performance information;
- encouraging the involvement of alternative service providers where this will improve value for money;
- taking lead responsibility for the ongoing development of effective clinical governance; and
- taking lead responsibility for the achievement of efficiency targets and the introduction of efficient, effective and economic procurement arrangements.

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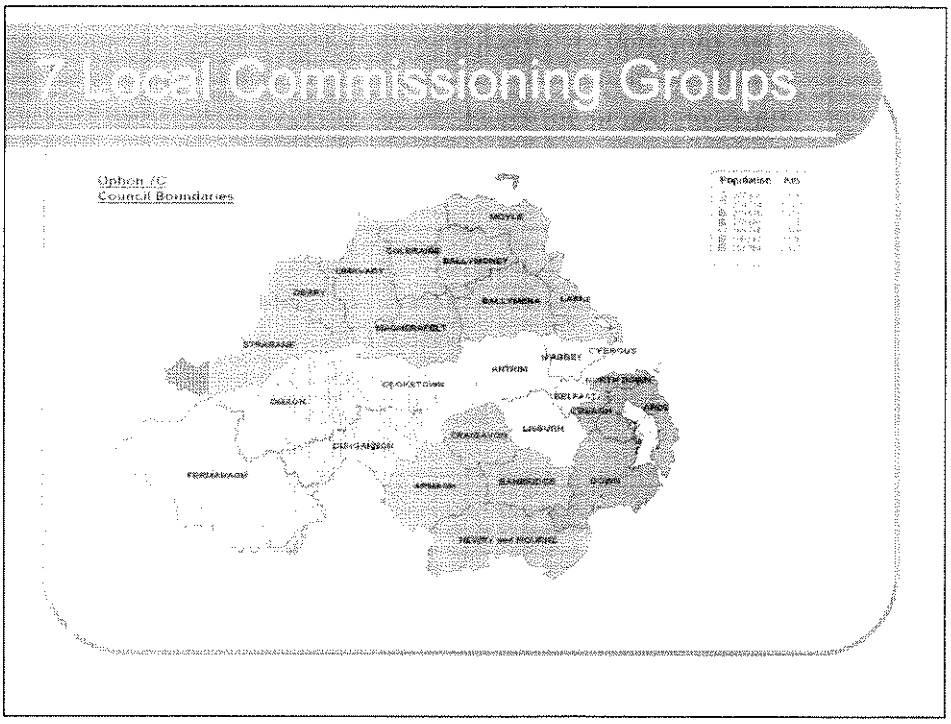
TRUST CHIEF EXECUTIVE

The Role of Local Commissioning Groups

Local Commissioning groups will:

- contribute to the development of standards, guidance and strategic targets;
- contribute to the development of region-wide operational plans and local targets;
- assess local needs and capacity and identify local priorities within the overall strategic outcomes to be achieved;
- negotiate service and budget arrangements with providers, applying principles of "choice" and "money following patients" to determine which providers can provide services most effectively and economically, while ensuring that regional and local targets set by the Department and the Authority are met;
- put in place strong governance arrangements covering contractual responsibilities, incentives, quality and patient satisfaction to ensure that targets and expectations are met; and
- contribute to the central data collection and performance information processes.



Background to the Trusts

The review of Public Administration has concluded that major reform is required in the administrative structures of health and social services. In addition the Appleby Review has pointed to the need for reform and modernisation of the delivery of these services.

It is intended that five integrated Health and Social Services (HSS) Trusts will be established to replace 18 of the existing 19 Trusts. Together with the existing Northern Ireland Ambulance Services HSS Trust, they will be performance managed by the HSSA.

These changes are designed to ensure that the patient comes first by establishing and promoting links between hospitals and community based services. Larger Trusts will promote integration within and across Trusts. Integration across professional groupings. Integration across geographical areas. Integration between health and social services.

The new geographical coverage of the Five Health and Social Services Trusts is still subject to consultation and awaiting the Minister's decision:

- The Western Area – covering Sperrin Lakeland, Foyle and Altnagelvin HSS Trusts;
- The Northern Area – covering Homefirst Community, Causeway and United Hospitals HSS Trusts;
- The Southern Area – covering Craigavon Area Hospital Group, Craigavon and Banbridge Community, Newry and Mourne and Armagh and Dungannon HSS Trusts;
- The Belfast Area – which will amalgamate the Belfast City Hospital, Royal Group of Hospitals, Mater Infirmorum and Greenpark Trusts and North and West Belfast and South and East Belfast Community Trusts;
- The South Eastern Area – covering the Ulster Community and Hospitals Trust and Down and Lisburn Trust.

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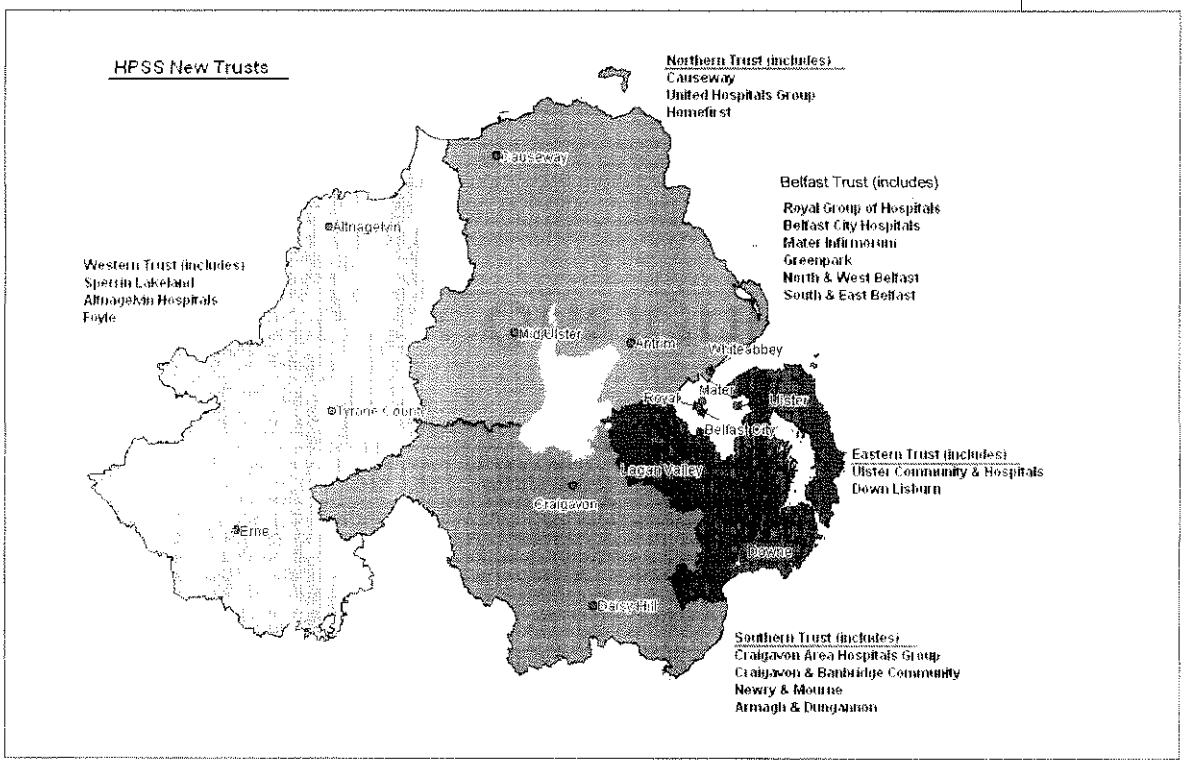
New Trust Configuration



Please note Trust Boundaries are still subject to consultation and awaiting the Minister's decision

The Trusts will:

- contribute to the development of standards guidance, strategic targets and region-wide operational plans;
- ensure that they are fit for purpose to deliver services commissioned, adjusting internal resource allocations as appropriate; and
- establish effective internal performance management systems.

Department and Trust links

Further details may be obtained on the Department of Health, Social Services and Public Safety and each of the current Trusts' using the following links:

Department of Health, Social Services and Public Safety www.DHSSPS.Gov.uk

Western Health and Social Services Trust:
- www.sperrin-lakeland.org
- www.foyletrust.n-i.nhs.uk
- www.altnagelvin.n-i.nhs.uk
- www.westcare.org

Northern Health and Social Services Trust:
- www.homefirst.n-i.nhs.uk
- www.chsst.n-i.nhs.uk
- www.unitedhospitlas.org

Southern Health and Social Services Trust:
- www.cbct.n-i.nhs.uk
- www.cahgt.n-i.nhs.uk
- www.adhsst.n-i.nhs.uk
- www.newryandmournetrust.n-i.nhs.uk

South Eastern Health and Social Services Trust:
- www.dlt.n-i.nhs.uk
- www.n-i.nhs.uk/ucht

Belfast Health and Social Services Trust:
- www.bch.n-i.nhs.uk
- www.royalhospitals.org
- www.n-i.nhs.uk/mater
- www.greenpark.n-i.nhs.uk
- www.nwb.n-i.nhs.uk
- www.sebt.n-i.nhs.uk

Performance Management Arrangements

Performance in the HPSS is managed under four main areas:

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

Under the new arrangements, performance management and improvement in the HPSS will include:

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

Within these arrangements there will be an expectation of Trust Chief Executives to deliver against the challenging agenda set by the Minister, the HSSA and local commissioners.

Transitional Responsibilities

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

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

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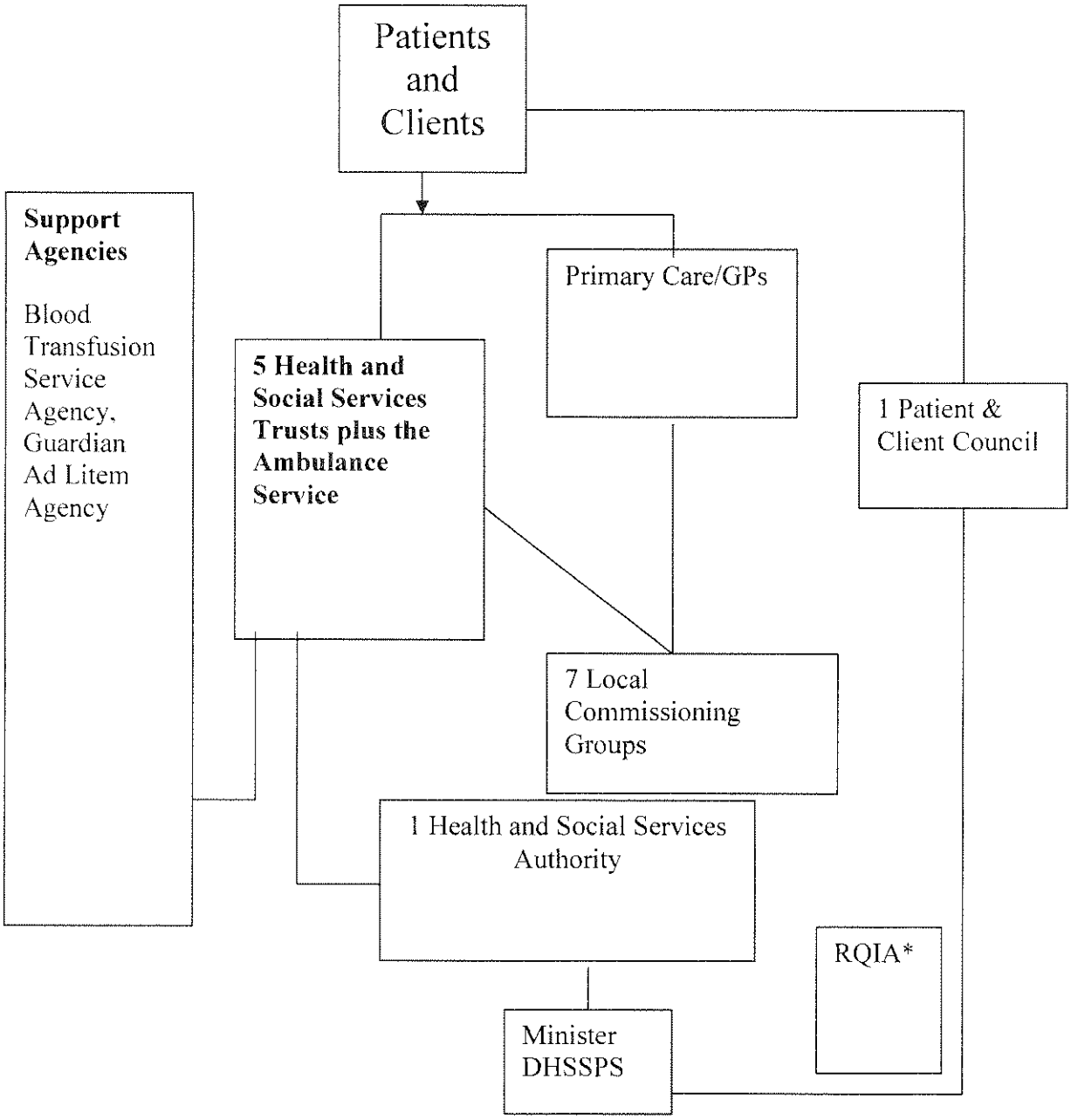
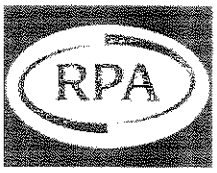
TRUST CHIEF EXECUTIVE

ORGANISATIONAL STRUCTURE

New organisational structure of the HPSS



*Regulation and Quality Improvement Authority



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TRUST CHIEF EXECUTIVE

Chief Executive (Designate) (5 POSTS) HSS TRUSTS

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

Job Description:

JOB SUMMARY

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

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

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

KEY RESULT AREAS

DELIVERY

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

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

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

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

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

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

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

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

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

STRATEGIC LEADERSHIP

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

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

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

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

CORPORATE MANAGEMENT

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

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

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

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

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

GOVERNANCE

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

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

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

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

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

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

EXTERNAL RELATIONSHIPS

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

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

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

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

FINANCES

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

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

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

STAFF RESOURCES

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

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

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

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

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

DEVELOPMENT OF SELF

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

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

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

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

TRANSITIONAL RESPONSIBILITIES

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

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

GENERAL RESPONSIBILITIES

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

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

RECORDS MANAGEMENT

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

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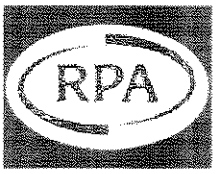
TRUST CHIEF EXECUTIVE

Terms and Conditions

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

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



Information Pack
TRUST CHIEF EXECUTIVE

Chief Executive (Designate) (5posts)

Personnel Specification:

Knowledge, skills and experience required:

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

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

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is, therefore, essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified.
The following additional desirable criteria may be introduced dependant upon the number of applications received.
-Experience of leadership in health or social care.

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

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

The following additional clarification is provided:

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

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

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

Selection Process

The Merit Principle

In accordance with Recruitment good practice all appointments to the Chief Executive (Designate) will be made under the 'merit principle' where the best person for any given post is selected in fair and open competition.

Making your application:

The application form is designed to ensure that applicants provide the necessary information to determine how they meet the essential criteria.

Please note:

To ensure equality of opportunity for all applicants

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

Application Form submission

- We will not accept incomplete application forms, application forms received after the closing deadline or reformatted application forms
- Applicants using Royal Mail should note that 1st class mail does not guarantee next day delivery. It is the responsibility of the applicant to ensure that sufficient postage has been paid to return the form to the RPA Unit;

Equal Opportunity Monitoring Form

Please note that this information is regarded as part of your application and failure to compete and return this part of you application will result in disqualification.

Disability requirements

We ask on the application form if you require any reasonable adjustments, due to disability, to enable you to attend the interview. Details of any disability are only used for this purpose and do not form any part of the selection process. If you wish to discuss you disability requirements further, please contact the RPA Unit on 02890 Irrelevant information redacted by the USI

Expression of Interest

Candidates must complete the Expression of Interest form indicating the Trusts in which they would accept appointment.

Interview information

It is intended that interviews for this post will take place in Belfast on 10th, 11th and 14th July 2006.

Candidates will be required to give a 10-minute presentation as part of their interview. Candidates will be advised of the presentation topic and given time to prepare prior to their interview.

Order of Merit

The interview panel will assess candidates against the interview criteria. Those candidates who meet the required standard and pass mark will be deemed suitable for appointment. The interview panel will then rank those suitable for appointment 'in order of merit'. The offer of appointments will be based on the highest ranking applicant being offered their choice from the Trusts indicated on their expression of interest form. This process will be repeated with subsequent ranked candidates. In the event that all the expressions of interest of a candidate have been allocated and the remaining position(s) was not indicated on their expression of interest form an offer of appointment will not be made to that candidate. The interview panel will then consider the next ranked candidate for appointment.

Protection of Children and Vulnerable Adults Check (POCVA)

You have applied for a position in an organisation providing care to patients and vulnerable adults. Before appointing anyone to such a post, it is our policy to ask for a POCVA (NI) Service check to be carried out by the Department of Health, Social Services and Public Safety (DHSSPS). This check is to make sure that people who might be a risk to vulnerable adults and children are not appointed.

The check will tell us if you have a criminal record, or if your name is included in the DHSSPS Disqualification from Working with Children and Vulnerable Adults List or the Department of Education list of those unsuitable to work with children. Any information which we get will be treated confidentially and we will talk to you about it before we make a final decision. After the decision is made the information will be destroyed.

Please ensure that you complete the POCVA form attached to your application form.