Urology Services Inquiry

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

Ms Eileen Mullan
Chair of Southern Health and Social Care Trust Board
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

5 July 2023

Dear Madam,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

Issued by the Urology Services Inquiry on 05 July 2023. Annotated by the Urology Services Inquiry.

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

Chair's Notice

[No 15 of 2023]

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

WARNING

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

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

TO:

Ms. Eileen Mullan
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

Issued by the Urology Services Inquiry on 05 July 2023. Annotated by the Urology Services Inquiry.

IMPORTANT INFORMATION FOR THE RECIPIENT

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

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

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

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

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

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by noon **on 16th August 2023.**

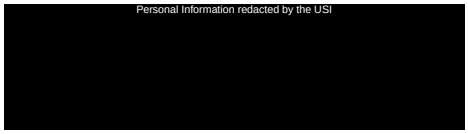
APPLICATION TO VARY OR REVOKE THE NOTICE

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

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by noon **on 9th August 2023**.

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

Dated this 5th day of July 2023

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE

[No 15 of 2023]

General

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

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Please also provide or refer to any documentation, held by you or the SHSCT, which you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

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

Qualifications

4. Please set out all professional roles held by you and your qualifications.

Roles

5. Please set out the dates of your tenure as Member of the Southern Trust Board and your duties, responsibilities and roles as a Member of the Board.

6. Please set out the dates of your tenure as Chair of the Governance Committee of the Southern Trust Board and your duties, responsibilities and roles as the Chair of the Governance Committee.

7. Please set out the dates of your tenure as Chair of the Southern Trust Board and your duties, responsibilities and roles as Chair of the Board.

Training

8. Who was responsible for (i) identifying, and (ii) organising training for Board members?

9. What, if any, training did Board members receive during your tenure? Please provide all dates and an outline of the purpose and nature of the training received.

10. What, if any, training did you receive to assist you in carrying out your role as Member of the Board?

11. Do you consider that the training provided to (i) you and (ii) other Board members was adequate in enabling you to properly fulfill your roles? Please explain your answer by way of examples, as appropriate.

Board

12. Please set out the frequency and duration of your engagement, and if different, the Board's engagement, whether formal or informal, with senior members of the Trust's management team, including the Chief Executive. Please provide notes and minutes of any of these engagements involving urology or Mr. O'Brien.

13. How is the Board informed of concerns regarding patient safety and risk?

14. How is the Board assured that the clinical governance systems in place are adequate?

15. How do you ensure that the Board is appraised of both serious concerns as well as current Trust performance against applicable standards of clinical care and safety? What is your view of the efficacy of these systems?

16. During your tenure, how did the Board assure the HSCB and the Department of Health that the governance structures in place are effective (or otherwise)? Please provide examples.

17. How did the Board assure itself regarding governance issues (i) throughout the Trust generally and (ii) within urology services in particular?

18. How did the Board monitor and quality assure the governance actions and action plans of the Trust? If possible, please illustrate your answer by reference to examples of Board monitoring and quality assurance throughout the Trust and most particularly within urology?

19. What were the lines of management providing information on governance issues to the Board? How did this information reach the Board? What, if anything, was in place to bring governance concerns to the Board on an urgent basis?

20. Is the Board appraised of those departments within the Trust which are performing exceptionally well or exceptionally poorly and how is this done? Is there a committee which is responsible for overseeing performance, where does it sit in the managerial structure and hierarchy and how does the Trust Board gain sight of these matters?

21. What was the Board's attitude to risk and risk management? What processes were in place to assist the Board in identifying and responding to risks related to clinical concerns and patient safety?

22. Who provided information on governance issues to the Board? How did this information escalate to the Board? Please answer by way of examples, particularly in relation to urology. Please also attach all documents relevant to your answer.

23. How was this information recorded and communicated to the Board? How did the Board assure itself of the accuracy and completeness of this information?

24. How, if at all, does the Board communicate with the Department regarding issues of patient safety and risk?

25. Are the issues of concern and risk identified in urology services of the type the Board would be expected to have been informed about at an early stage? Was the Board informed of concerns regarding urology, and Mr. O'Brien in particular, at the appropriate time? If not, what should have happened, when, and why did it not?

Urology services

26. Save for concerns in relation to Mr. O'Brien (which are addressed in questions below), please detail all concerns and issues brought to your attention and the Board's attention (if different) regarding the provision of urology services during your tenure. You should include all relevant details, including dates, names of informants, personnel involved and a description of the issues and concerns raised. Please also include all documents relevant to your answer.

27. Please set out in full what, if anything, was done to address the concerns raised. What did you specifically do once the concerns became known to you?

28. How, if at all, did the Board monitor and evaluate any decisions or actions taken to address concerns? What did the Governance Committee do specifically once concerns were raised?

29. How, if at all, did the (i) Board and (ii) the Governance Committee assess whether patients were safe and what level of risk existed at that time? What, if anything, was done in response to these assessments?

30. Was it your view and the view of the Board that actions taken were effective? If yes, please explain why. If the actions taken were not effective, explain why, and outline what, if anything, was done subsequently?

Board actions regarding urology and Mr. O'Brien

31. Please provide full details of when, how and by whom (i) you and (ii) the Board (if different or at different times) were first made aware of issues and concerns regarding the practice of Mr. O'Brien, to include all information about what was said and/or documentation provided?

32. Please detail all subsequent occasions any concerns and issues regarding Mr. O'Brien were discussed by or with (i) you and (ii) the Board, to include the detail of those discussions, including dates and who those discussions were with.

33. Please provide all notes and minutes of any and all meetings, conversations and/or decisions made by (i) you and (ii) the Board regarding Mr. O'Brien and urology generally.

34. Were you/the Board made aware of any concerns raised by Mr. O'Brien? If so, what were those concerns? Were those concerns reflected in Board governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were not reflected in governance documents and raised in Board meetings relevant to governance, please explain why not.

35. How, if at all, were the concerns raised about Mr. O'Brien by others reflected in Board governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were neither reflected in

governance documents nor raised in Board meetings relevant to governance, please explain why not.

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

Governance Committee

37. How does the Governance Committee provide assurance to the Trust Board?

38. How is the Governance Committee informed of concerns regarding patient safety and risk?

39. How is the Governance Committee assured that the clinical governance systems in place are adequate?

40. How do you ensure that the Governance Committee is appraised of both serious concerns as well as current Trust performance against applicable standards of clinical care and safety? What is your view of the efficacy of these systems?

41. How did the Governance Committee monitor and quality assure the governance actions and action plans of the Trust? If possible, please illustrate your answer by reference to examples of Board monitoring and quality assurance throughout the Trust and most particularly within urology?

42. What were the lines of management providing information on governance issues to the Governance Committee? How did this information reach the

Governance Committee? What, if anything, was in place to bring governance concerns to the Board on an urgent basis?

43. Who provided information on governance issues to the Governance Committee? How did this information escalate to the Governance Committee? Please answer by way of examples, particularly in relation to urology. Please also attach all documents relevant to your answer.

44. What procedures and policies are in place to allow concerns around governance issues to be escalated to the Board as a matter of urgency? Please explain how these procedures and policies work in practice, providing examples, as relevant.

45. Are the issues of concern and risk identified in urology services of the type the Governance Committee would be expected to have been informed about at an early stage? Was the Governance Committee informed of concerns regarding urology, and Mr. O'Brien in particular, at the appropriate time? What is your view generally of the timing and manner in which the Governance Committee and the Board were informed of concerns regarding urology and Mr O'Brien? What, in your view, should have happened, when, and why did it not?

Learning

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

47. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any

governance concerns which fall into this category and state whether you could and should have been made aware and why.

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

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

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

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

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

NOTE:

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

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 15 of 2023
Date of Notice: 5th July 2023

Witness Statement of: Eileen Mullan

I, Eileen Mullan, will say as follows:-

General

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

1.1 I believe that I have set out all of my involvement in relevant matters across the answers I have provided to Questions 4 to 52 below.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry ("USI"). Please also provide or refer to any documentation, held by you or the SHSCT, which you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. The following new documents are reference within this Section 21.

2.1. I have referred to documents throughout my statement which I have exhibited to this statement. The documents can be located in 'S21 15 of 2023 – Attachments'.

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

Qualifications

4. Please set out all professional roles held by you and your qualifications

4.1 I have worked across the community, voluntary, public and private sectors over the last 27 years. These roles have crossed a range of disciplines from officer to management to Director level.

4.2 Board roles

Date	**Organisation**	**Role**
September 2009 – September 2011	Northern Ireland Environment Agency	Non-Executive Director
February 2009 – 10th December 2013	Age NI	Trustee
11th December 2013 – 31st March 2018	Age NI	Chair (& Trustee)
April 2011 – June 2015	Audiences NI	Chair and Trustee
01st January 2015 – 31st December 2020	Health and Care Professions Council	Senior Council Member

15th February 2016- 30th November 2020	Southern Health and Social Care Trust	Non-Executive Director
01st November 2014 – 31st October 2021	National Lottery Community Fund	Committee Member (Northern Ireland)
01st December 2020 – current	Southern Health and Social Care Trust	Non-Executive Chair

4.3 Employed roles

Dates	**Organisation**	**Role**
March 2000 – March 2003	Citywide Training Consortium	Project Manager
March 2003 – October 2005	Training for Women Network	Business Operations Manager
March 2007 – July 2007	Belfast Metropolitan College	Merger, Project Manager
November 2005 – March 2010	Belfast Metropolitan College	Associate Lecturer
April 2010 – 31st August 2020	Eileen Mullan	Self-Employed Trainer & Facilitator
01st September 2020 - current	Strictly Boardroom Ltd	Director

4.4 Qualifications

Year	**Qualification**
1996	BA Hons Degree in Business Studies
1998	Post Graduate Certificate in Management
2001	Diploma in Management Practice

2010	MSc Management and Corporate Governance
2013	IOD Certification in Company Direction
2014	IOD Diploma in Company Direction

5. Please set out the dates of your tenure as Member of the Southern Trust Board and your duties, responsibilities and roles as a Member of the Board.

5.1 I commenced my tenure as a Member of the Southern Trust Board on the 15th February 2016, was reappointed from the 15th February 2020, and completed my tenure on the 30th November 2020. *Please see:*

1. DoH Public Appointment NED Information Pack 2016
2. 20160308 - Ltr - Ms Eileen Mullan NED Min of Appt
3. 20191022 - Ltr - Ms Eileen Mullan NED Min of Re-appt
4. 20170525 - Doc - Ms Eileen Mullan Perf Appraisal 16-17
5. 20180625 - Doc - Ms Eileen Mullan Perf Appraisal 17-18
6. 20190919 - Doc - Ms Eileen Mullan Perf Appraisal 18-19
7. 20200731 - Doc - Ms Eileen Mullan Perf Appraisal 19-20
8. 20220124 - Doc - Ms Eileen Mullan Perf Appraisal 20-21

5.2 The main duties of the role and responsibilities of the Non-Executive Director, as detailed in my letter of appointment of the 8th March 2016 and my letter of re-appointment of the 22nd October 2019, were as follows:

a) share in the independent Non-Executive oversight, scrutiny and stewardship of the HSC Trust's work;
b) hold Executive Directors to account; including assessing the performance of, and appointing, senior management;
c) sit on Board Committees such as the Governance and Audit Committee;

d) participate in professional conduct and competency inquiries as well as staff disciplinary appeals;
e) scrutinise decision making on major procurement issues;
f) scrutinise the handling of complaints.

6. Please set out the dates of your tenure as Chair of the Governance Committee of the Southern Trust Board and your duties, responsibilities and roles as the Chair of the Governance Committee.

6.1 I commenced my tenure as Chair of the Governance Committee on the 8th September 2016 and completed it on the 30th November 2022. *Please see:*

9. 20200326 Terms of Reference Governance Committee
10. 20230525 Terms of Reference Governance Committee

6.2 There was, to the best of my knowledge, no specific role specification for the Chair of a Committee. The Committee is delegated its authority by the Trust Board through its Terms of Reference (see the 2020 and 2023 Terms of Reference of the Governance Committee). My role, as I carried it out, was to ensure that the Committee fulfilled its remit as outlined in its Terms of Reference.

6.3 The Terms of Reference detail that the remit of the Committee is to ensure that:

a) There are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated governance across the Trust.
b) Assessment of assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.
c) Principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to Trust Board

d) Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services.
e) There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance.
f) Recommendations considered appropriate by the Committee are made to the Trust Board recognising that financial governance is primarily dealt with by the Audit Committee.

6.4 I endeavoured to ensure that the Committee fulfilled its remit by working with the Board Assurance Manager in preparation on agreeing the Committee Agenda, Annual Work Plan, and the contributors and attendees at the Committee's meetings. My role at the meetings was to ensure all agenda items were discussed and outcomes/actions reached and then to provide assurance on behalf of the Committee to the Trust Board. In practice, this was about providing structure to the meetings, ensuring appropriate time was allocated, and being able to manage the flow of the meeting on the day and create the environment for those attending to be open and honest in their contributions.

6.5 There is an annual work plan for the Governance Committee which sets out the governance area to be covered, the report details, the lead person, frequency of reports, month expected and its purpose. This work plan provides the structure for the Committee in delivering on its role throughout the year. I have outlined below the types of reports received by the committee in 2017 and 2023 to show how the Committee and its work have evolved across the period of my tenure. These reports are presented by Directors from within their realm of responsibility. The Agenda is shared with the Senior Leadership Team approximately 3 weeks ahead of the meeting with a call for their papers.

02nd February 2017	09th February 2023
Medicines Governance Clinical and Social Care Governance Corporate Risk Register	**Confidential Meeting** Maintaining High Professional Standards report

Information Governance Revised Terms of Reference Annuals Schedule of Reporting	Nurses in Difficulty Process – Nurse & Midwives fitness to practice report **Open meeting** Claims Management Clinical and Social Care Governance Management of Trust Standards and Guidelines Mortality Report RQIA review of RQIA report recommendations – Implementation of NICE CG 174 – IV Fluids Medication safety report Information and IT Governance Estate Governance Corporate Risk Register Unscheduled Care – Deep dive Functional support services annual report Director visits Non-Executive Director visit to Children Homes Mid-Year Ground Clearing

See:

11. 2nd February 2017 Governance Committee Agenda

12. Confidential Governance Committee Agenda 09th February 2023

13. Governance Committee Agenda 9th February 2023

14. 14. Governance Committee Work Plan 2023

7. Please set out the dates of your tenure as Chair of the Southern Trust Board and your duties, responsibilities and roles as Chair of the Board.

7.1 I commenced my tenure as Chair of the Board of the Southern Health and Social Care Trust on the 1st December 2020 and I continue to hold this role currently. My tenure is due to complete on the 30th November 2024. *Please see:*

15. Public Appointments Information Booklet Southern Health & Social Care Trust (SHSCT 1/19)
16. 20201118 – Ltr – Ms Eileen Mullan Chair Min of Appt
17. 20221122 – Doc – Ms Eileen Mullan Perf Appraisal 21-22

7.2 The main duties and responsibilities of the role of the Non-Executive Chair, as detailed in the letter of appointment dated the 18th November 2020, are:

a) The Non-Executive Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.
b) The Non-Executive Chair shall ensure that the SHSCT policies and actions support the wider strategic policies of the Minister and that the SHSCT affairs are conducted with probity.

7.3 The Non-Executive Chair has a particular leadership responsibility on:

a) Formulating the Board's strategy for discharging its duties;
b) Ensuring that the Board, in reaching decisions, takes proper account of guidance provided by the Minister, the sponsor Department, the HSCB and/or the PHA;
c) Ensuring that risk management is regularly and formally considered at Board meetings;
d) Promoting the efficient, economic and effective use of staff and other resources;
e) Encouraging and delivering high standards of regularity *[sic]* and propriety;
f) Representing the views of the Board to the general public;

g) Ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual Board members;

h) Ensuring that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training;

i) Advising the Department of the needs of the SHSCT when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise;

j) Annually assessing the performance of individual Board Members.

k) Ensuring the completion of the Board Governance Self-Assessment Tool on an annual basis.

l) Ensuring that Board Members are made aware of the Code of Conduct for Board Members of HSC Bodies (2012) including the Nolan "seven principles of public life", and the requirement for a comprehensive and publicly available register of Board Members' interests.

m) Communications between the Board, Ministers and the Department shall normally be through the Non-Executive Chair who shall ensure that the other Board Members are kept informed of such communications on a timely basis.

n) Operating the Board and chairing all Board meetings when present. The Non-Executive Chair has certain delegated executive powers and must comply with the terms of appointment and with the SHSCT Standing Orders; and

o) Working closely with the Chief Executive and ensuring that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

Training

8. Who was responsible for (i) identifying, and (ii) organising training for Board members?

8.1 The Non-Executive Chair is responsible for identifying and organising training for Board Members. Non-Executive Directors also have a personal responsibility to identify training needs at least annually through the appraisal process.

8.2 Organisation of training for Board Members would be carried out through the Office of the Chair and CEO. This can be arranged as a result of discussions at Trust Board and Committees, through discussions with Chair, CEO and/or all Board and Operational Directors. Currently as Chair I discuss with the Board Assurance Manager training and how best to provide it. Training can be provided in a number of ways:

a) provision of a training course such as 'On-Board', as was prescribed by the Department of Health for newly appointed members;
b) through Board workshops in developing the Board's understanding of a given area;
c) mandatory training provided by the Trust for all staff and Board Members.

8.3 An annual Board Governance Self-Assessment Exercise (requested by the Department of Health) requires the Board to show evidence of training and/or development undertaken by the Board. An example of this can be seen in Section 2.3 of the Board Governance Self-Assessment for 2018/2019 at page 66. This details the undertaking of a Board Development Day on the 15th November 2018 with the King's Fund. *Please see 18. Item 14b. Board Governance self assessment 201819.*

8.4 The Board Assurance Manager would make the specific arrangements and preparations in respect of training on behalf of the Office of the Chair and CEO.

9. What, if any, training did Board members receive during your tenure? Please provide all dates and an outline of the purpose and nature of the training received.

9.1 Training for Board Members would have been either formally, through a training programme, or informally, through Board Workshops and contributions made to Trust Board/Committee meetings. For example, 'On-Board' Training was a requirement for all Board Members appointed to Boards of public sector bodies, so all Non-Executive and Executive Members of the Board were required to attend that training once appointed.

9.2 I have outlined below in 9.3 Training provided to Non-Executive Members of the Trust Board. I have identified my attendance as follows:

	I was present
	I was not present

9.3 Training provided to Non-Executive Board Members during my tenure has been as follows:

Date	**Training**
21st March 2016	Trust Board Induction Induction into Trust Board. Committee Structure. What is expected of a SHSCT Board Member.
13th April 2016	Communications Induction Information session from the Communications Team.
01st June 2016	The external training programme called 'On Board Content' focused on roles, responsibilities and management of key relationships for Board Members.
08th September 2016	Acute Services Induction Information session on the Acute Services Directorate.

15th September 2016	Children and Young Peoples Services Induction Information session on the Children and Young Peoples Services Directorate.
15th September 2016	Mental Health and Learning Disability Induction Information session on the Mental Health and Learning Disability Directorate.
19th September 2016	Performance and Reform Induction Information session on the Performance and Reform Directorate.
13th October 2016	Finance Induction Information session on the Finance Directorate.
20th October 2016	Older People and Primary Care Induction Information session on the Older People and Primary Care Directorate.
30th November 2016	Human Resources Induction Information session on the Human Resources Directorate.
10th March 2017	Medical Directorate Induction Information session on the Medical Directorate.
27th March 2017	Performance and Reform Induction Information session on the Performance and Reform Directorate.
13th April 2017	Children and Young Peoples Services Induction Information session on the Performance and Reform Directorate.
02nd May 2017	Mental Health and Learning Disability Induction Information session on the Mental Health and Learning Disability Directorate.

23rd June 2017	Older People and Primary Care Induction Information session on the Older People and Primary Care Directorate.
29th August 2017	Finance Induction Information session on the Finance Directorate.
29th August 2017	Acute Services Induction Information session on the Acute Services Directorate.
30th August 2017	MHPS Training by June Turkington, Solicitor, of DLS.
30th August 2017	Recruitment and Selection Training Training for Non-Executives on the Trusts recruitment and selection processes and policies.
21st September 2017	Human Resources Induction Information session on the Human Resources Directorate.
17th April 2018	Non-Executive Director Development Session (NICON)
24th May 2018	Understanding Medical Data Workshop for Non-Executive Directors.
12th March 2019	Recruitment and Selection Training Training for Non-Executives on the Trusts recruitment and selection processes and policies.
01st December 2021	Regional Training on MHPS Procedure for HSC Non-Executive Directors – Led by June Turkington, Solicitor, of DLS.
16th February 2022	Recruitment and Selection Training Training for Non-Executives on the Trust's recruitment and selection processes and policies.

Please see:

19. February 2016 NED Induction Programme

20. January 2017 NED Induction Programme
21. 20160601 On Board Training Programme
22. 20160101 - NED Directorate Training Sessions
23. 20170101 - NED Directorate Training Sessions
24. Training on MHPS Procedure for HSC NEDS 2021
25. MHPS slides_DLS to NEDS
26. 20170829 Acute Presentation for NEDs
27. Chair-NED Training Record

9.4 Training provided to all Trust Board Members (i.e., both Non-Executive & Executive Directors) with Operational Directors is outlined below. I have identified my attendance as follows:

	I was present
	I was not present and had given my apologies.

Date of Trust Board Workshop	Agenda Items
25th February 2016	Non-Executive Director Induction Programme Chief Executive's business – Overview of SH&SCT Introduction and overview of Directorates Finance Report and Financial Plan 2016/17 update Performance Report Quality Improvement Framework update
28th April 2016	Update on Whistleblowing Survey including Training Standards and Guidelines – *Presentation* Board Governance Self-Assessment Projected Outturn 2015/16 (verbal) Performance Report
15th December 2016	Confidential Section ED, DHH Update Open Section Research & Development Annual Report 2015/2016 Update on Emergency Department, Daisy Hill Hospital Draft SH&SCT Management Statement and Financial Memorandum Action Plan from Board Development Day Board Effectiveness - A Good Practice Guide Endowments & Gifts Committee - Promotional Video Clip and associated Press Release Integrated Passenger Transport Project Presentation
23rd February 2017	Confidential Section

Urology Services Inquiry

Date of Trust Board Workshop	Agenda Items
	ED, DHH Update Personal Information redacted by the USI Update Open Section New Non-Executive Director Induction Programme Acting Chief Executive's business – Overview of SHSCT Introduction and overview of Directorates Development of SHSCT Guidelines for the Use of Restrictive Interventions and Restrictive Practices Progress update on draft Corporate Plan 2017/18 – 2020/21 Finance Report (for noting) Performance Report (for noting)
27th April 2017	Sharing the SH&SCT pledge with our young people Board Governance Key Lessons Learned from NIAO Report and Pac Hearing into the Northern Ireland Events Company and elsewhere Board Effectiveness – A Good Practice Guide
31st May 2017	HFMA Northern Ireland branch The Role of Non-Executive Directors in HSC
26th October 2017	Sharing the SHSCT pledge with our young people
25th January 2018	Organisational Structures Review
26th April 2018	Community Information System Project Update: - Corporate Risk Register Quality Improvement - What does it mean for Trust Board? Board Governance Self-Assessment
18th October 2018	Effective Board Reporting
13th December 2018	Living our values, out loud
21st February 2019	Culture, Values and Behaviours. Board Governance and Effectiveness: BSO Internal Audit Review 2018-19
18th April 2019	Strategic Direction Board Behaviours (approval) Direction of Travel of HSC and Trust: Key challenges and opportunities. Reflection on Corporate Plan 2017/18 – 2020/21 Board Assurance Framework
13th June 2019	(Meet with DoH Representatives 2-3pm) Board Effectiveness Internal Audit Report on Board Effectiveness 2018/19 Board Governance Self-Assessment Partnerships between Departments and Arm's Length Bodies: NI Code of Good Practice
17th October 2019	Reflection and learning from SAI Personal Information redacted by the USI and correspondence from the family to the Chair Roles and Responsibilities of Board members as Trustees of Charitable Trust Funds (Ms June Turkington, Directorate of Legal Services)

Urology Services Inquiry

Date of Trust Board Workshop	Agenda Items
	Chief Executive's Accountability arrangements and Accountability Dashboard
27th February 2020	Clinical and Social Care Governance Review A qualitative analysis of how learning from Serious Adverse Incident reviews can contribute to reducing deaths by suicide of people in the care of Mental Health Services Young People's Pledge Integrated Care Prototype – Northern Trust Area Strategic Planning
27th August 2020	Chief Executive's business Board Governance Self-Assessment 2019/20 Rebuilding Health and Social Care Services Management Board update to include Stakeholder participation update Rebuild Plans Executive Summary Performance Monitoring Review of Arm's Length Bodies - Correspondence from the DoH dated 8.8.2020 Update from Executive Directors
15th October 2020	Mortality and Patient Safety Data – Training Session
29th April 2021	Muckamore Abbey Hospital – Report of the Independent Leadership and Governance Review Structures Review
17th May 2021	Delegated Statutory Functions (DSF) 2020-2021
26th August 2021	Southern Trust and the Year Ahead Covid-19 and delivering health and social care In conversation with Robin Swann MLA, Minister of Health Preparing for the Public Inquiry Board Governance Self-Assessment 2020/21
7th September 2021	People Plan
27th September 2021	Consultation on Future Planning Model – Integrated Care System NI – draft Framework
9th December 2021	Muckamore Abbey Hospital – Independent Leadership and Governance Review Update Independent Review into the circumstances of the RQIA Board member resignations Review of Operational Clinical and Social Care Governance
27th January 2022	Consultation on draft 3-Year Budget
24th February 2022	General Surgical Model for the Southern Trust Update on Appointment Processes for Chief Executive and Accounting Officer CYP Service pressures
28th April 2022	Southern Trust and the Year Ahead

Date of Trust Board Workshop	Agenda Items
	Daisy Hill Hospital – its role in the region Internal Audit Report on Board Effectiveness Ockenden Inquiry
13th December 2022	Whistleblowing Training for Trust Board & Senior Management Team
21st February 2023	Financial Planning 2023/24 Financial Sustainability and Productivity review
23rd March 2023	Update from the IHRD Team In conversation with the IHRD Team Implementation of IHRD recommendations in the SHSCT
27th April 2023	Draft Report from the Board Development Day on 25th August 2022 Review of Clinical and Social Care Governance Action Plan (Champion Recommendations) Update on the Clinical and Social Care Governance Structures Update on the Corporate Governance Structure including Steering Groups MHPS Training (*Full Board session)* MHPS – A facilitated discussion for Non-Executive Directors
18th May 2023	Communication and Complaints - Overarching view from the Ombudsman What is the Trust doing to improve communication? Patient and Client Experience/ Care Opinion/Bereavement Service Improving Communication with patients Organisational Development perspective What more can we do? Setting the Trust Board's Risk Appetite

10 What, if any, training did you receive to assist you in carrying out your role as Member of the Board?

10.1 Please refer to the tables at paragraphs 9.3 and 9.4 above where I have identified my attendance using Red or Green shading.

	I was present
	I was not present and had given my apologies.

11 Do you consider that the training provided to (i) you and (ii) other Board members was adequate in enabling you to properly fulfill your roles? Please explain your answer by way of examples, as appropriate.

11.1 During the 2016/2017 period I, along with other recently appointed Non-Executive Members, undertook an induction programme to provide information on the nature of the work of the various Directorates/functions within the Southern Health and Social Care Trust (see further details in the Table at para 9.3 above). This was helpful to me as a lay person having no previous direct experience within Health and Social Care at this level.

11.2 The external programme 'On Board' (again, see the Table at para 9.3 above) was a Departmental requirement for those appointed to public sector boards. This programme, which was delivered over the course of a morning, focused on Board roles, responsibilities, and management of key relationships. The programme was open to all newly appointed Board members across public bodies in Northern Ireland (not just those in the Health and Social Care sector). *Please see:*

21. 20160601 On Board Training Programme
28. PowerPoint slides 'On Board' Training

11.3 I found the Non-Executive Director induction to be helpful on two fronts: it provided us with a glimpse into the Directorates that we would be discussing at Committee and Board and it enabled the beginning of forming relationships with Directors and their teams. The external programme was never going to be enough to prepare a newly appointed Board Member for their work on a Health and Social Care Trust Board. These are extremely complex organisations and are not like other Arms Length Bodies. Whilst the principles of Board membership are the same, the nature of the work within a Health and Social Care Trust is, in my experience, on a different level. For example, Clinical and Social Care Governance Reporting, National Audits, Mortality and Morbidity reporting are all complex documents for a lay person to understand. I certainly struggled and would say that much of my learning has been in carrying out the role over my tenure

11.4 Whilst by 2016 I had several years of experience of sitting on Boards (see Question 4 above), I was motivated to serve on a Health and Social Care Board, and was very clear that I believed I had a set of skills to bring to the table, I was nonetheless on a steep learning curve in regard to knowledge and understanding of the workings of a Health and Social Care Trust. I therefore attended the NI Confederation for Health & Social Care / HFMA NI branch 'NED Development Day' on Wednesday 31st May 2017. Following that, I emailed Diane Taylor (Health and Social Care Leadership Center) and Heather Moorhead (Northern Ireland Confederation) to connect them both with my thoughts regarding the need for support for Non-Executive Directors within Health and Social Care at a regional level. *Please see 29. email EM to DT HSC Leadership Centre re Non-Executive Directors.*

11.5 As the Current Chair, I delivered a training session to newly appointed Executive / Operational / Interim Directors on the 1st September 2022. The focus of the session was on:

a) Understanding the foundations;
b) Southern Trust Corporate Governance;
c) Preparing for Trust Board/Committee Meetings;
d) Boardroom dynamics and protocol.

11.6 As Chair, I have utilised Trust Board Workshops to support learning and understanding for all Board members in line with reports, national reports and/or inquiry outcomes. Some examples of this are as follows:

a) Muckamore Abbey Hospital – Independent Leadership and Governance Review (April 2021). This workshop, held on the 22nd April 2021, explored the recommendations from the Independent Review and explored lessons for the Southern Trust as a result.

b) The Ockenden Inquiry (April 2022). This workshop, held on the 28th April 2022, provided a summary of the Inquiry findings and their relevance to the Southern Trust.

c) Whistleblowing (December 2022). This workshop, held on the 13th December 2022, covered key concepts, identifying whistleblowing *versus* grievances, 'speak up' culture, and handling the whistleblower.

Please see:

29. 22 April 2021 doh-mah-review

30. 28 April 2022 7. Director's Workshop Presentation from IMWH

31. 13 Dec 2022 WB Rebecca Durkin

32. SHSCT Board September 2022 HO

11.7 From my perspective, there needs to be a wider and ongoing level of training and support for newly appointed Non-Executive Directors for Health and Social Care Trusts. This needs to capture Health and Social Care both regionally ('the big picture') and locally ('under the bonnet'), so that the Non-Executive Director can understand the workings of the Trust. A balance must also be struck between providing sufficient training and support to enable a Non-Executitve Director to carry out the role effectively whilst also recognizing that it is not the Non-Executive Directors' role to delve in detail into operational matters. An example of this would be providing training on interpreting national audits such as Mortality and Morbidity reports. This is a quarterly report prepared by CHKS (provider of healthcare intelligence and quality improvement products and services). The mortality report is a clinical and quality indicator for the Trust. This is a complex and important report. Whilst Executive Directors will be very familiar with, and understand, it, as a Non-Executive Director that would not always, or even often, be the case.

11.8 I am a strong advocate for continuous learning as a Board Member and, in particular, within the sphere of Health and Social Care. When I reflect back to when I was appointed in 2016, I was very daunted as I tried to 'get my head around' some of the data and the reporting. Traditionally, training for Board Members is about their roles and responsibilities. In the environment of Health and Social Care, I believe

that it needs to focus on the business we are in and ensure that Board members are able to perform their roles and responsibilities with knowledge and understanding. As a Non-Executive Director, I raised with the Chair and Chief Executive (via email on the 27th August 2020) that the Muckamore Report provided a great opportunity for the Trust Board to take a look at its blind spots. I asked if a workshop could be planned (see para 11.6.a above). I have, as Chair, tried to utilise Board Workshops as an avenue for delving deeper into a report or by bringing in a subject matter expert to enable the Board to reflect, learn and develop. *Please see 33. 20200827 E to RB and SD re Blind Spots.*

11.9 An outworking of the Hyponatremia Inquiry was the creation of a Board Member Handbook by the Department of Health (May 2021). Within this document under section 6, Training and Development, it stated as follows:

'*It is recognised that for ALB Board Members to meet all the requirements set out in summary in this guide considerable training and support is needed, both at the time of engagement and throughout the term of appointment. In practice this means that there are several levels of training and development that need to be addressed. These include but are not limited to:*

- *Induction;*
- *Appraisal and identification of individual learning needs;*
- *Training in core functions, leadership, statutory functions etc.;*
- *Support and mentorship.'*

11.10 At the point of writing, a recruitment exercise is underway for up to 16 Non-Executive Directors across the 6 Health and Social Care Trusts in Northern Ireland. It is my understanding that the current Permanent Secretary is very supportive of ensuring that there is training, development, and support provided to Non-Executive Directors and Chairs. *Please see 34. 01052021 DoH HSC Board Member Handbook*

11.11 It is my view that training and development should never be a one-off event, but rather a continuous programme that Board members access during their full tenure so that they can build up their knowledge, understanding, and experience.

The world of Health and Social Care changes every day, so the Board needs to remain up to date and relevant in order to be able to fulfill their role. I refer to the training provided to Trust Board 2016 – 2023 in the table referred to at paragraph 9.4

Board

12 Please set out the frequency and duration of your engagement, and if different, the Board's engagement, whether formal or informal, with senior members of the Trust's management team, including the Chief Executive. Please provide notes and minutes of any of these engagements involving urology or Mr. O'Brien.

12.1 There is an annual schedule of meetings of Trust Board (confidential and public), Trust Board Committees and Director workshops. My level of engagement is primarily through these meetings and workshops.

12.2 Trust Board meets six times per year, with Committees meeting quarterly, depending on the Committee. I have outlined, in the attached schedule of Trust Board and Committee Meetings, my attendance at meetings where the CEO and/or Senior Management Team members attended. I also refer the Inquiry to paragraph 9.3 above where I have outlined my attendance at Trust Board Workshops. I believe that all of these Workshops would have been attended by the CEO and members of the Senior Management Team. *See attached:*

35. Eileen Mullan Public Trust Board Attendance 2016 – Present
36. Chair CX and SLT Governance Committee Attendance
37. Chair and SLT Patient and Client Experience Committee Attendance
38. Eileen Mullan Attendance Audit Committee 2016 to 2023
39. CEX and SLT Audit Attendance 2016 to 2023
40. Eileen Mullan Attendance E_G Committee 2016 to 2023
41. CEX and SLT E_G Committee Attendance 2016 to 2023.docx
42. Eileen Mullan Attendance 2021 – 2023 Remuneration TS Committee

12.3 As Chair (from the 1st December 2020 onwards) I would meet with the CEO formally and informally. With both Chief Executives (Mr. Shane Devlin and Dr Maria O'Kane) we aimed to meet formally weekly but, due to operational pressures, this might not always have happened. For the 2020/2021 period, Covid 19 was still very much in play and impacting upon the Trust. Meetings were often virtual and only where safe were held face to face. Meetings would typically last 1-2 hours, depending on the agenda. Formal notes were not taken at these meetings. The Chair and CEO offices are beside each other in the Trust Headquarters. Other members of the Senior Management/Leadership Team are situated there too. This provides the opportunity for frequent brief informal interactions due to the proximity of the offices.

12.4 Dr Maria O'Kane and I tried to meet weekly following her appointment, although this was not always feasible due to organisational pressures. We have put in place a structured meeting since January 2023 (which is still evolving) and now meet fortnightly (from April 2023). An action log is kept and I have included a copy of the log up until the 30th June 2023.

12.5 I have also attached the following documents where Urology and/or Mr O'Brien was detailed on the agenda or in note book entries made by me:

43. 20201217 Notebook entry
44. 20210114 Notebook entry
45. 20210121 Notebook entry Pg1
46. 20210121 Notebook entry Pg2
47. 20210310 Notebook entry
48. 20210316 Notebook entry
49. 20210603 Notebook entry
50. 20220301 Notebook entry
51. Agenda 30.01.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1
52. Agenda 28.02.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1
53. Agenda 14.03.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1
54. Agenda 27.03.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1

55. Agenda 20.04.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1
56. Agenda 02.05.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1
57. Agenda 16.05.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1
58. Agenda 30.05.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1
59. Agenda 09.06.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1
60. Agenda 18.07.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1
61. Agenda 25.07.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1
62. Agenda 08.08.2023 Dr Maria O'Kane Chief Executive Eileen Mullan Chair 1-1

12.6 As Chair of the Governance Committee, I met with the Chair of the Trust Board, Chief Executive, and Board Assurance Manager after each Committee Meeting. To the best of my knowledge, there were no formal notes or minutes from these meetings. *Please see:*

63. 20170511 Governance Committee outcomes note from meeting held on 11 May 2017
64. 20170907 Governance Committee outcomes note from meeting held on 07 September 2017
65. 20171207 Governance Committee outcomes note from meeting held on 07 December 2017
66. 20180208 Governance Committee Outcomes Note from Meeting held 08 February 2018
67. 20180511 Governance Committee outcomes note from meeting held on 11 May 2018
68. 20180906 Governance Committee outcomes note from meeting held on 06 September 2018
69. 20181206 Governance Committee outcomes note from meeting held on 06 December 2018
70. 20190207 Governance Committee outcomes note from meeting held on 07 February 2019
71. 20190521 Governance Committee Chair's Notes 21 May 2019
72. 20190905 Governance Committee Chair's Notes 05 September 2019
73. 20200213 Governance Committee Chair's Notes 13 February 2020

12.7 Chair and Non-Executive Director meetings with the Chief Executive were held frequently during Covid 19 (weekly, two weekly, and finally moving to monthly). These are not Trust Board meetings.

Date	**Involving Urology or Mr. O'Brien**	**E Mullan present**
08th October 2020	Agenda Item 5	Present
15th October 2020	Agenda Item 3	Present
05th November 2020	Agenda Item 6	Present
19th November 2020	Agenda Item 8	Present
26th November 2020	Agenda Item 7	Present
03rd December 2020	Agenda Item 6	Not Present
17th December 2020	Agenda Item 7	Present
07th January 2021	Agenda Item 7	Present
14th January 2021	Agenda Item 7	Present
21st January 2021	Agenda Item 7	Present
04th February 2021	Agenda Item 7	Present
11th February 2021	Agenda Item 8	Present
04th March 2021	Agenda Item 7	Present
11th March 2021	Agenda Item 7	Present
18th March 2021	Agenda Item 6	Present
17th May 2021	Agenda Item 5	Present
07th June 2021	Agenda Item 5	Present

12.8 Confidential Trust Board Meetings where I was present and Urology concerns and/Mr O'Brien was discussed began on the 27th August 2020.

When	How	By Whom	Information
27th August 2020	Through an Executive Director Update at a Trust Board workshop	Medical Director Dr Maria O'Kane	Notes from Trust Board workshop held on the 27th August *Dr O'Kane brought to the Board's attention SAI investigations into clinical concerns involving a recently retired Consultant Urologist. Members asked that this matter be discussed at the confidential Trust Board meeting following the Workshop.*
27th August 2020	Through Agenda Item Any Other Business.	Medical Director Dr Maria O'Kane	Minute from Trust Board workshop held on the 27th August *Dr O'Kane brought to the Boards attention SAI investigations into concerns involving a recently retired Consultant Urologist. Members request a written update for the next confidential Trust Board Meeting.*

Further updates and discussions took place on the following dates:

a) 27th August 2020
b) 24th September 2020
c) 22nd October 2020
d) 12th November 2020
e) 10th December 2020
f) 25th February 2021
g) 25th March 2021
h) 27th May 2021
i) 30th September 2021
j) 28th October 2021
k) 27th January 2022
l) 31st March 2022
m) 26th May 2022
n) 23rd June 2022
o) 29th September 2022
p) 27th October 2022

Please see 75. 20200827 Directors Workshop Notes

12.9 Meetings of the Chair, Chief Executive and Non-Executive Directors where the MHPS process and role of the Non-Executive Director were discussed are detailed below.

Date	Agenda Number	Area discussed
29th September 2016	7	Training on MHPS
29th November 2018	4	Role of NED in MHPS
21st May 2019	3	Role of NED in MHPS
22nd January 2020	3	Role of NED in MHPS
08th July 2020	8	Allocation of NEDs to MHPS processes
22nd June 2021	6	Role of NED in MHPS

Please see notes from the meetings held:

76. 20160929 - Notes of a meeting of the Non Executive Directors and Chair
77. 20181129 - Notes of a meeting of the Non Executive Directors and Chair
78. 20190521 - Notes of a meeting of the Non Executive Directors and Chair
79. 20200122 - Notes of a meeting of the Non Executive Directors ref MHPS
80. 20200708 - Notes of a meeting of the Non Executive Directors ref MHPS under Any Other Business
81. 20210622 - Notes of a meeting of the Chair - Non Executive Directors ref MHPS

13 How is the Board informed of concerns regarding patient safety and risk?

13.1 The Board can be informed of concerns regarding patient safety in a number of formal ways set out below.

a) Early Alerts	Issued by the relevant Directorate and sent through to the Department of Health and shared across the Trust Board

	Membership (from 18th September 2020) and Operational Directors.
b) Confidential Trust Board Meetings	Confidential meetings allow for the Board to be alerted on issues of serious concern and performance with clinical care and safety. These meetings are minuted but are not held in public so that issues of concern in relation to individual staff and patients can be raised.
c) Governance Committee	Governance Committee allows for issues of serious concern or performance issues that are identified to be raised and discussed directly with Committee Members and accountable Directors. These include incident reporting, overview of progress on serious adverse incidents, the corporate risk register, patient safety concerns, and complaints. The Committee then reports to the Trust Board with a Chair's Update and a copy of the minutes.
d) Patient Client Experience Committee	Reports to this Committee involve service user feedback – complaints and compliments. The Committee then reports to the Trust Board with a Chair's Update and a copy of the minutes.
e) Performance Committee	Reports to this Committee include the Performance Report, Corporate Performance Scorecard, and Infection Prevention and Control. The Committee then reports to the Trust Board with a Chair's Update and a copy of the minutes.
f) Audit Committee	Internal Audit Reports are presented to this Committee on a range of service areas (clinical and non-clinical). The Committee then reports to the Trust Board with a Chair's Update and a copy of the minutes.
g) Trust Board Workshops	Trust Board Workshops provide for development and training opportunities. Workshops are attended by Trust Board and Operational Directors.
h) Trust Board	At the end of each Trust Board Meeting Executive Directors of Medicine, Social Work, Nursing and Finance are asked if there are any other issues relating to their professional roles they wish to bring to the Board's attention. Trust Board is attended by Trust Board and Operational Directors.

13.2 The above formal routes do not prevent anyone from bringing a concern directly to Trust Board Members informally.

14 How is the Board assured that the clinical governance systems in place are adequate?

14.1 The Board receives its assurance through its standing Committees, internal controls (such as the Corporate Risk Register), external assurance through internal audit (such as Safeguarding/statutory responsibilities for Looked After Children) as well as national audits (such as the National Audit Assurance Report), and Director reporting (such as Claims Management).

14.2 During my time as both Member and Chair of the Governance Committee, work was undertaken to review the Clinical and Social Care Governance systems within the Trust. This work was commissioned by the then Chief Executive, Mr. Shane Devlin, at the request of the then Medical Director, Dr Maria O'Kane. The resulting report is referred to as the 'Champion Report' (2019). It provided a revised framework to strengthen Clinical and Social Care Governance to provide assurance to the Trust Board. I welcomed this review.

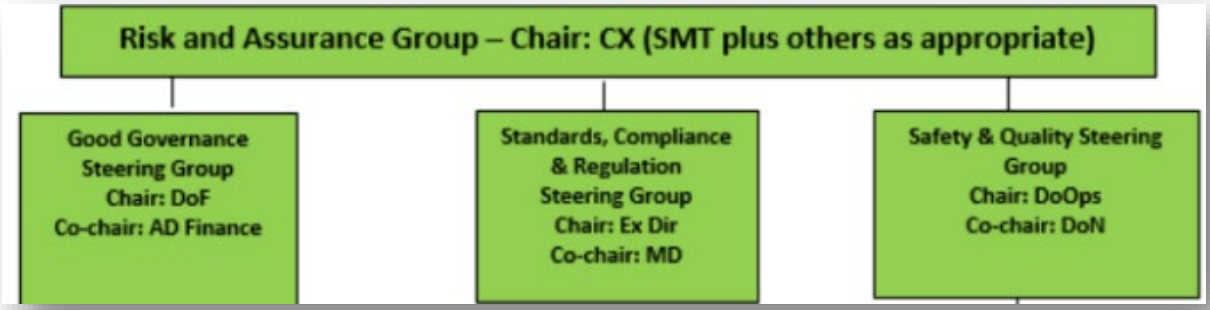
14.3 The outworking of the Champion Report saw three key areas focused on immediately; Standards and Guidelines, Serious Adverse Incidents, and Complaints.

14.4 Since 2019, the Champion Report's outworkings were hampered due to the pandemic unfolding and the system having to focus on responding to it. At a Directors' workshop in 2021, the next area of improvement work was agreed as Clinical Audit, integration of the Clinical and Social Care Governance Leads, and the establishment of a Quality and Safety Oversight Group. Please see in this regard the notes from the Directors' workshop on 09th December 2021. *Please see 82. Approved Directors Workshop Notes 9.12.21*

14.5 February 2022 saw the then Chief Executive, Mr. Shane Devlin, leave his post and Dr Maria O'Kane was then appointed to succeed him on the 1st May 2022. At a Board Development Day on the 25th August 2022, Dr O'Kane presented her thoughts on the further roll out of the Champion Report by way of restructuring and

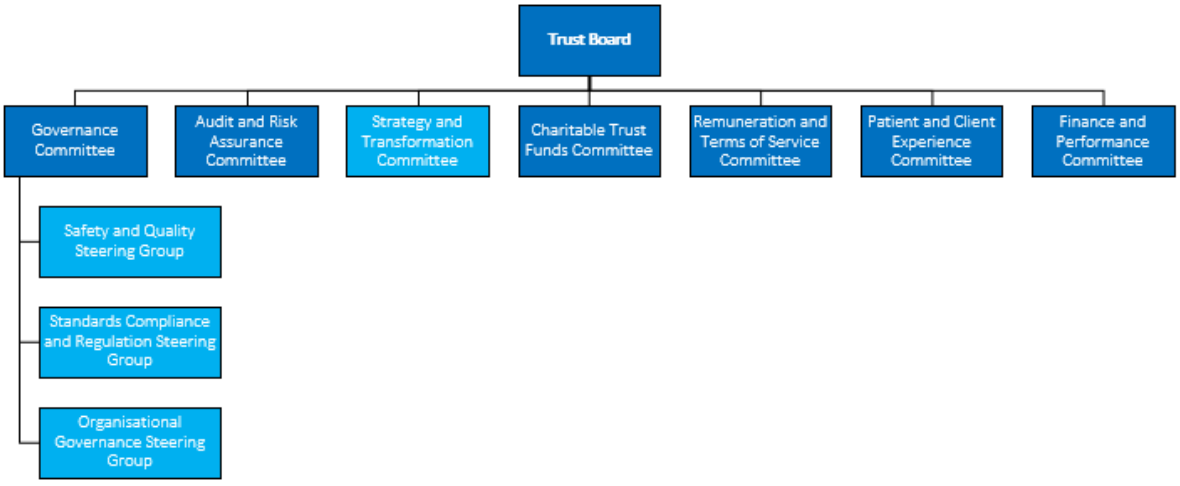
governance reporting at an operational and corporate level. *Please see in this regard 83. Final Combined Presentation of 25th August 2022.*

14.6 Work has now been completed on the establishment of the revised operational assurance structure as shown below.



14.7 At a corporate level revised Committees have been agreed as:

a) Governance
b) Audit Risk and Assurance
c) Charitable Trust Funds
d) Remuneration and terms of service
e) Patient Client Experience Committee
f) Finance and performance
g) Strategy and Transformation



Please see 84. Revised Structure 2023

14.8 The revised corporate committee structure came into effect from the 1st September 2023.

14.9 This revised approach is intended to enable a deeper system view of governance, along with the ability to triangulate information which will allow for the committees to be focused on the areas that need attention and not to be overwhelmed by information (such that they are not seeing the wood for the trees).

15 How do you ensure that the Board is appraised of both serious concerns as well as current Trust performance against applicable standards of clinical care and safety? What is your view of the efficacy of these systems?

15.1 As Chair of the Trust Board I ensure that the Board is appraised of both serious concerns as well as current Trust performance against applicable standards of clinical care and safety through the mechanisms outlined in my response to Question 13 above.

15.2 As Chair I have adopted a firm position on the need for the Trust Board to be notified first of any significant issues arising outside of the scheduled Board meetings. I understand fully that a balance needs to be struck in that a certain level of validated information is required before escalation of a concern to Board. Nevertheless, I have operated a 'no surprises' approach with the current and previous Chief Executives. Chair and CEO meetings provide for a formal and informal space for CEO to raise concerns or issues. I am content with this approach.

15.3 Prior to the 18th September 2020, Early Alerts were shared only with the former Chair. These Alerts are issued through the Corporate Governance Team by email. Since the 18th September 2020, Early Alerts are now shared with all Board Members. I have set out below some examples of Early Alerts received by the former Chair which were shared with the Non-Executive Directors (along with the date of such sharing).

Early Alert Reference	Sent to Roberta Brownlee	Forwarded to Non-Executive Directors
20200804 EA Aug 2020 02	04th August 2020	04th August 2020
21072020 EA July 2020 16 Update	21st July 2020	27th July 2020
23072020 EA July 2020 17	23rd July 2020	23rd July 2020
2020.07.07 Early Alert UPDATE EA JULY 2020.05	07th July 2020	07th July 2020

Please see:

85. 20200804 E re Early Alert

86. 20200804 E re Early Alert A1

87. 20200727 E re Early Alert

88. 20200727 E re Early Alert A1

89. 20200723 E re Early Alert

90. 20200723 E re Early Alert A1

91. 20200707 E re Early Alert

92. 20200707 E re Early Alert A1

15.4 Prior to the 18th September 2020, the sharing of Early Alerts with Non-Executives other than the Chair was *ad hoc* and appeared to depend on the personal judgement of the Chair. This meant that members of the Board were sometimes unaware of issues that were notified to the Department about the workings of the Trust under the following categories:

a) Urgent regional action;
b) Contacting patients/clients about possible harm;
c) Press release about harm;
d) Regional media interest;
e) Police involvement in investigation;
f) Events involving children;

g) Suspension of staff or breach of statutory duty.

15.5 In my view, this was not an adequate approach. As indicated above, however, as of the 18th September 2020 all Board Members have been copied into Early Alerts.

15.6 The corporate governance structure and, in particular, meetings with the CEO provide the opportunity to raise with the Board and members of it issues of concern and progress on those. The expectation is that Executive and Operational Directors will bring forward areas of concern at the earliest moment. The Early Alert in respect of some of the issues giving rise to this Public Inquiry was issued on the 31st July 2020. The next formal meeting of the Trust Board was not until the 27th August 2020 and that is when Dr Maria O'Kane alerted us to concerns in respect of a recently retired Consultant Urologist (initially at the Trust Board workshop and then at the confidential Trust Board meeting that day). I believe that the Early Alert should, in fact, have been shared with all Board Members on the 31st July 2020, although I acknowledge that the August confidential meeting might have been the first formal meeting at which concerns relating to Mr O'Brien could have been considered. I believe Dr O'Kane rightly brought the concerns to the attention of Trust Board on the 27th August (albeit that the fact that an Early Alert had been issued in respect of concerns relating to Mr O'Brien was not revealed to the Board until 24th September 2020 – see further paragraph 22 below). At subsequent Board meetings detailed papers and further information were provided as matters unfolded.

15.7 Having an open, honest and psychologically safe environment is critical to enabling the bringing of issues early to the Trust Board without fear or worry. I believe that I have worked in creating this environment since taking up the post of Chair from the 1st December 2020. I shared a 'thought paper' as the newly appointed Chair with Board Members and Operational Directors on 3rd February 2021. This was my platform for changing the culture within and outside the Boardroom. I have just completed a review of that paper and, on 6th July 2023, shared a revised document, 'The Next 18 Months', with Trust Board and broader leadership team and support staff. *Please see:*

93. 20210201 Putting Trust back into the Southern Trust

94. 20230601 A Time of Change Presentation

16 During your tenure, how did the Board assure the HSCB and the Department of Health that the governance structures in place are effective (or otherwise)? Please provide examples.

16.1 The Trust Board is accountable to the Minister and Department through its Permanent Secretary. As detailed in the Management Statement: 'The Southern Trust Board has corporate responsibility for ensuring that the Trust fulfills the aims and objectives set by the sponsor Department and approved by the Minister in the light of the Department's wider strategic aims, current PFG objectives and targets and the CPD, and for promoting the efficient, economic and effective use of staff and other resources by the Trust'.

16.2 There are a number of documents provided throughout the year to the Department of Health, such as the annual and midyear Governance Assurance Statements and the Annual Board Governance Self-Assessment.

16.3 The draft annual and midyear Governance Assurance Statement is reviewed by the Audit Committee and then presented to the Trust Board for approval before sending through to the Department of Health.

16.4 The Chair and CEO attend accountability meetings with the Department of Health Permanent Secretary on a twice yearly basis. As Chair of the Board, my first accountability meeting took place on 25th January 2023 with Dr O'Kane as CEO – it was a mid-year accountability meeting. The next accountability meeting is on the 25th September 2023. Please see:

95. 20230125 SHSCT Mid Year Accountability Meeting

16.5 An Annual Board Governance Self-Assessment is required to be undertaken and a copy of the report shared with the Department of Health. Once in every three years, this exercise should be conducted via an external provider. In 2019 and 2022 therefore the Business Services Organisation's Internal Audit undertook the assessment as part of the internal audit programme of work. *Please see:*

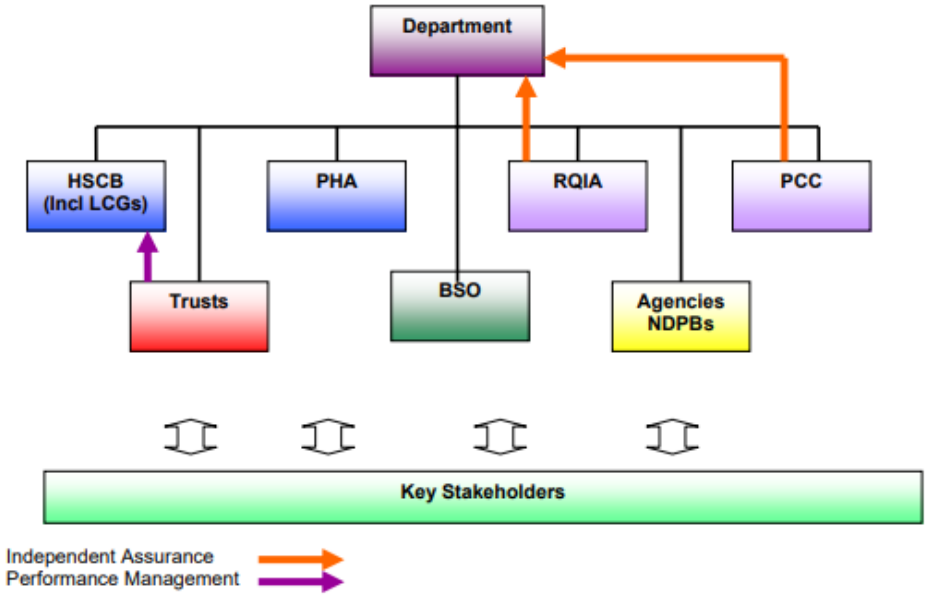
97. 1819 IA Board Effectiveness
98. IA Final Report - Board Effectiveness 21-22
99. See Management Statement SHSCT

16.6 The 2021/2022 Board Governance Self-Assessment recognised the risk to the stability and effectiveness of Trust Board as a direct consequence of vacancies at Senior Executive and Non-Executive Director level. Actions to address this included: all Senior Executive positions to be advertised and appointed by December 2022 and Non-Executive Director positions competition programme, including SH&SCT vacancies, to be advertised by Public Appointments Unit in October 2022.

16.7 In my experience, having instability in the Board and Senior Executive Team directly impacts on the effectiveness of the governance structures. During the period 2016 – 2018 there were interim Chief Executives and interim Executive Directors who were members of the Trust Board. In addition, six out of eight Non-Executive Directors were newly appointed during the 2016/2017 year. The appointment of Mr Shane Devlin as Chief Executive in 2018 allowed for the beginning of a process to make substantive appointments to the Senior Team. August and November 2020 saw the end of tenures for two long-standing Non-Executive Directors. This created two vacant positions which, as I write, remain vacant. The appointment of Dr Maria O'Kane as Chief Executive in 2022 has seen the follow through on completing the restructure and recruitment of permanent and substantive posts across the Senior Leadership Team. *Please see 100. 20230802 Trust Board Membership 2010 – Present.*

16.8 In relation to the Health and Social Care Board (the former commissioner of services), reporting on governance of the Trust goes directly from the Trust to the

Department of Health. As per the HSC Board Member handbook the accountability and reporting line from Southern Trust is to the Department of Health. Through the Department of Health, Social Services and Public Safety Framework document version September 2011 the Department states:



Key: HSCB = Health and Social Care Board
LCGs = Local Commissioning Groups
PHA= Public Health Agency
BSO = Business Services Organisation
RQIA = Regulation and Quality Improvement Authority
PCC = Patient and Client Council
Agencies = Special Agencies (Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency and Northern Ireland Guardian ad Litem Agency)

Please See 101. DHSSPS Framework Document September 2011

17 How did the Board assure itself regarding governance issues (i) throughout the Trust generally and (ii) within urology services in particular?

(i) Throughout the Trust generally

17.1 The Board assures itself through the corporate governance structures that are in place as set out in attachment *102. 20211029 High Level Governance Structure*

17.2 The Trust Board has a scheme of delegation in place for its standing committees. This document sets out the decisions/duties delegated by the Board to Committees. *Please see 103. Trust Board Scheme of Delegation to Committees _ March 2022*

17.3 All Committees have a role in the governance of the Southern Trust. The Governance Committee itself deals with areas of clinical and social care governance and reports to the Trust Board by way of the Committee Chair report and draft Committee minutes.

17.4 The role the standing committees play in governance and assurance has also been touched upon in my answers to Questions 13 to 15 above and I rely upon those answers here too.

17.5 The Board also obtains assurance in other ways. For example, in undertaking 'leadership walks' which, unfortunately, had to be stood down for a period of time during the pandemic. These walks provide a meaningful touch point allowing Non-Executive Board members to engage directly with staff and teams with how things are with their Unit or Directorate. These walks gave me, as a Non-Executive and now as Board Chair, a feel for the culture of the organisation.

a) 2016–2020 - Leadership Walks 3 times per year and involved Non-Executive Directors.
b) 2020–2022 - Leadership Walks were stood down due to the pandemic.

c) 2022-2023 - Leadership Walks occur every month and are undertaken by Non-Executive, Executive, and Operational Directors. *Please See 104. Leadership Walkabout Summary Report for Period 01 October 2019 – 31 March 2020.*

17.6 Leadership walks are reported through to the Governance Committee on a six-monthly basis. Leadership walks, since 2023, are carried out by Non-Executive Directors, Executive Directors, and Operational Directors in person. These are done individually or in pairs.

17.7 Trust Board also receives assurance through its Committees from National Audits, RQIA Reports, and Internal Audit Reports.

17.8 Trust Board also receives its assurance from Executive and Operational Directors on their specified areas of responsibility. In practice, this means that the Board has the ability to question Directors on the content of their reports and to seek assurance and clarity from them.

(ii) Within urology services in particular

17.9 As I have touched upon in the preceding paragraph, Executive and Operational Directors, in reporting to Committees and Trust Board, are required to provide assurance on those areas within their particular realms of responsibility. This is done, in practice, by way of a written update or report provided for all members. Directors also attend Trust Board and Committee meetings where they can, as discussed above, be questioned by the Committee or Board Members.

17.10 During my tenure I recall two points where urology services (not related to Mr O'Brien) came to Trust Board either directly or by way of the committee structure. These are summarised below.

Meeting	Agenda Item	Statement

Trust Board Meeting 28 March 2019	Performance Dashboard (Ministerial Targets) at February 2019	The Trust has engaged with HSCB and agreed that urology referrals from patients residing in the Western area should no longer come to the Southern Trust in an attempt to rebalance demand and capacity and improve local waiting times
Performance Committee 03rd September 2020	Corporate Performance Scorecard	Mrs Magwood stated that the Trust has received in-year investment for the 07th Urology Consultant. Recruitment is currently ongoing and it is anticipated that the 07th Consultant will be in post in quarter 4. She did note that the additional capacity created by this post will be targeted to the red flags and urgent cases with little anticipated impact on routine waits.

17.11 I have set out elsewhere in this statement (Question 31 below) the issues in respect of Mr O'Brien that came to Trust Board and/or Board Committee.

18 How did the Board monitor and quality assure the governance actions and action plans of the Trust? If possible, please illustrate your answer by reference to examples of Board monitoring and quality assurance throughout the Trust and most particularly within urology?

18.1 Governance actions and action plans can, in my experience, be the result of a number of different processes. These include audits (internal/national), Serious Adverse Incident (SAI) Reviews, commissioned reviews (such as the Champion Review), or as a result of a Public Inquiry (such as Hyponatremia).

18.2 The Audit Committee plays an important role in overseeing the outcomes of internal and external audits. An internal audit schedule is agreed a year in advance, with flexibility to change items if more pressing matters emerge. At times, Audit Committee would share audit reports with the Governance Committee where there is a clear alignment with the work of the Governance Committee. This was seen in the case of a Limited Assurance Internal Audit report on Adult Safeguarding which was presented by the Audit Committee Chair to the Governance Committee on the 13th May 2021. A copy of the management response and action plan was shared also.

18.3 External regional/national audits also provide an important level of assurance to Trust Board. An example of this is the Stroke Services Sentinel Stroke National Audit (SSNAP). Mrs Pauline Leeson, Chair of the Performance Committee, wrote to me by email on the 11th March 2022 to raise her concerns in regard to the Stroke Services Sentinel Stroke National Audit (SSNAP). The Performance Committee had received a presentation and, as a result, Mrs Leeson as its Chair was sharing her deep concern on what the Committee heard regarding the marked deterioration in the service. Mrs Leeson's email was sent to me as Board Chair, to Non-Executive Directors, to the Chief Executive, and to the Director of Acute Services. I raised this with Dr O'Kane and placed it on the next CEO - Non-Executive Director meeting as an agenda item. This meeting took place on the 13th June (see notes and papers from the meeting). This then moved to the Trust Board at its meeting on the 27th October 2022. (see notes from the meeting). From that, further updates would then have been provided to the Performance Committee. *Please see*

105. 20220311 E from PL to EM and NEDS re Stroke Services
106. APPROVED Notes of Chief Executive update meeting with NEDs 13.6.2022
107. 20220309 External Assurance Stroke Services
108. SMT Paper on Stroke Services
109. Stroke Services Presentation to Performance Committee March 2022
110. Stroke Services Presentation to Performance Committee March 2022 A1
111. Approved Trust Board minutes 27.10.22

18.4 Moving beyond actions and action plans arising from audits, the Board also plays a role in respect of actions and action plans resulting from significant SAI Reviews. The Board has an oversight role which sees it reviewing relevant materials at a macro, as opposed to operational/granular detail, level. Serious Adverse Incidents would be reviewed in totality (the number, the themes, and the timelines for completion) by the Governance Committee, whilst responsibility for reviewing them, as well as ownership of the resulting action plans, sits with the responsible Executive and Operational Directors. The Committee and Trust Board seek assurance from the Executive and Operational Directors on progress in respect of these issues.

18.5 An example of this can be seen in the SAI in relation to ' Personal Information redacted by the Mrs. Vivienne Toal presented to the Confidential Trust Board on the 30th September 2021 a summary of the SAI Review and Independent review of the HR/Line Management in relation to Personal Information redacted by the An action plan was provided along with the summary report paper. *Please see:*

Trust Board 30.09.2021 SAI Personal Information redacted by the *(should already be in discovery)See Trust Board 30.09.2021 Action Plan SAI* Personal Information redacted by the *should already be in discovery)*
111a. 04iiia. Trust Board Cover Sheet 30.9.2021 SAI Personal Information redacted by the
111b. 04iiib. Confidential brief for TB members SAI 30.9.2021
111c. 04iiic. Action Plan for ED SAI 2.6.21 Personal Information redacted by *-DrMcM*

18.6 An example of Board-level monitoring of actions relating to Urology Concerns can be found in a review of the Compliance by 'Mr A' with Relevant Authorities/Guidance in terms of his Private Work in 2020/2021, undertaken by Business Services Organisation's Internal Audit.

18.7 This was presented to the Governance Committee at its Confidential Meeting on the 16th November 2021 (remitted to it by the Audit Committee from its meeting on the 14th October 2021). An action plan was presented along with the report in full. Committee Members were also provided with an update from the Chief Executive and Medical Director. In concluding its deliberations, the Committee agreed that the Audit Committee would monitor the implementation of the internal audit

recommendations with progress updates being provided at the next confidential Governance Committee meeting (note: confidential updates are not provided to Trust Board as it is a public meeting, however, all members of the Trust Board are either members of, or in attendance at, Governance Committee as outlined in the table below).

Trust Board Members	**Member of Governance Committee 16th November 2021**	**In Attendance at Governance 16th November 2021**
Non-Executive Directors Eileen Mullan Martin McDonald Pauline Leeson Hilary McCartan John Wilkinson Geraldine Donaghy Executive Directors Shane Devlin (CEO) Dr Maria O'Kane (MD) Catherine Teggart (DOF) Heather Trouton (DON) Colm McCafferty (DOSW)	Non-Executive Directors Eileen Mullan Martin McDonald Pauline Leeson Hilary McCartan John Wilkinson Geraldine Donaghy	Shane Devlin Dr Maria O'Kane Catherine Teggart Heather Trouton Colm McCafferty

Please see:
112. Internal Audit Mr A Private Work
113. 20211116 Confidential Governance Committee Minutes

18.8 As a result of going through this process of engaging with the Public Inquiry I have identified that confidential Committee meetings are not reporting directly to the confidential Trust Board meetings. I therefore raised this issue at the Governance Committee held on the 7th September 2023 and issued a direction to Committee Chairs and Board Members on the 19th September 2023 that all confidential

Committee meetings must report to the next confidential Trust Board meeting with the Chair's update to include items for escalation to Trust Board. Please see:

113a. 20230919 E Committee Chair Reporting To Trust Board

113b. 20230919 E Committee Chair Reporting To Trust Board A1

19 What were the lines of management providing information on governance issues to the Board? How did this information reach the Board? What, if anything, was in place to bring governance concerns to the Board on an urgent basis?

19.1 Trust Board is made up of Non-Executive Directors (currently 6 out of 8 in post) along with 5 Executive Directors. The Executive Directors include the Chief Executive, Medical Director, Director of Nursing & AHP, Director of Finance, and Director of Social Work.

19.2 The lines of management for providing information to the Board on governance issues include the following:

a) *from* Committees *to* Trust Board (via Chair's report and copy minutes);
b) *from* Chief Executive and/or their Senior Management Team *to* Committees and Trust Board (via reports and papers);
c) *from* Non-Executive Directors *through to* the Board Chair and/or raised with the Chief Executive at the Chair - CEO - Non-Executive Director meetings, or through the Chair - Non-Executive Director Meetings.

19.3 The information would be received either by email or verbally depending on the situation and timing. Where meetings were being arranged to discuss the issues, any papers would be uploaded on to 'Decision Time' (the online portal for all Trust Board papers) in advance or provided on the day for all members to review.

19.4 What was in place to bring urgent issues to the Trust Board was through the Committee Structure, Directors' Workshops, Confidential Trust Board, and Trust Board itself.

19.5 In my capacity as Chair, the following communication lines currently exist in tandem with the formal touch points outlined in my response to Question 13 above:

a) Confidential Trust Board meetings, allowing for the CEO and Directors to alert the Trust Board to any issues;
b) Chief Executive briefings with Non-Executive Directors (which happen every two months), providing the CEO with the opportunity to bring urgent matters to the Non-Executive Directors;
c) As Chair I can alert the Board on an urgent issue through email or through arranging a meeting of the Board, if required.
d) Any Board Member or Operational Director can bring to the attention of the Chair or CEO any concern on an urgent basis.

20 Is the Board appraised of those departments within the Trust which are performing exceptionally well or exceptionally poorly and how is this done? Is there a committee which is responsible for overseeing performance, where does it sit in the managerial structure and hierarchy and how does the Trust Board gain sight of these matters?

20.1 Before 2019 performance reporting was part of the Public Trust Board Agenda. Areas of underperformance were highlighted frequently. All reports operate on a 'RAG' (i.e., red, amber or green) status and focus was primarily on those areas which were identified as RED.

20.2 A Performance Committee was established in 2019 to give due time and consideration to matters of performance. The remit of the Committee is to: -

a) Provide oversight of the Trust's Performance Management Framework ensuring that there are effective and regularly reviewed structures in place to support the

effective implementation and continued development of integrated performance management arrangements across the Trust:

b) Ensure there is sufficient independent and objective assurance as to the robustness of key processes across all areas of performance;
c) Identify risks and gaps in control and assurance and seek assurance that risks are mitigated and being managed effectively;
d) Highlight potential risks that could impact on the Trust's ability to deliver on its strategic direction and bring these to the attention of the Trust Board and the HSCB and PHA;
e) Review the monitoring information in sufficient detail to advise the Trust Board, with confidence, concerning the performance of the Trust;
f) Receive reports on significant performance improvement initiatives within the Trust and review progress;
g) Ensure timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed with timeframes, if there is an internal failing in systems or services;
h) Ensure recommendations considered appropriate by the Committee are made to the Trust Board .

20.3 The Performance Committee is a standing committee of the Trust Board as outlined in my response to Question 17 above.

20.4 The Committee reviews the performance of the Trust in line with the commissioned targets set by (previously) HSCB and (currently) SPPG. Standards and targets set out in the 2019/2020 Commissioning Plan Direction (CPD) continue to be rolled forward into 2022/2023 as a result of the pandemic. I am not a member of the Performance Committee. The Committee is (as mentioned at Question 18 above) Chaired by Pauline Leeson, Non-Executive Director.

20.5 The Chair of the Performance Committee prepares a Chair's report which is presented at the next Trust Board meeting along with a copy of minutes of the Performance Committee meeting. Trust Board are invited to consider the report and the minutes at each meeting.

21 What was the Board's attitude to risk and risk management? What processes were in place to assist the Board in identifying and responding to risks related to clinical concerns and patient safety?

21.1 The Governance Committee has been the committee that receives and discusses the Corporate Risk Register at its quarterly meetings. During my tenure as Chair of the Governance Committee, 'deep dives' on Corporate Risks were instigated from 2019. These allow for risks and mitigations to be further explored to ensure that the right measures are in place in relation to a risk. Senior Management Team review the Risk Register on a regular basis and update it accordingly. Each Directorate carries its own Risk Register and, where risks can no longer be managed at Directorate level, they are escalated to the Senior Management Team.

21.2 The Board receives the Chair's Report from the Governance Committee and, yearly, receives the Corporate Risk Register in full.

21.3 The Chief Executive and Accounting Officer is the Accountable Director and holder of the Risk Register.

21.4 The Risk Register should be a fluid document which should (and does) change as risks are mitigated and removed and as new risks come into existence.

21.5 The Trust has not in my time had a 'Risk Appetite Statement'. However, work has begun on this, with a dedicated workshop in November 2021 externally facilitated by Dr John Bullivant FRCPE. This has been further developed through a Trust Board workshops on the 18th May 2023 and 18th September 2023The current work on establishing an appropriate level of risk appetite will further support the Board.

21.6 Although there is, as yet, no Risk Appetite Statement, my experience on the Board has been that it takes the question of risk generally very seriously and that it has no appetite for any risks that relate to clinical concerns and patient safety.

22 Who provided information on governance issues to the Board? How did this information escalate to the Board? Please answer by way of examples, particularly in relation to urology. Please also attach all documents relevant to your answer.

22.1 The Chief Executive, Non- Executive/Executive Directors, Operational Directors and those charged with reporting at Trust Board and its committees can, and do, provide information on governance issues to the Trust Board.

22.2 There was, to the best of my knowledge, no formal policy in respect of escalation to Trust Board from its committees. However, the following are methods for escalation that, in my experience, are used:

a) Early Alerts go to the Department of Health and are shared with all Trust Board Members since 18th September 2020. Previous to that, and as mentioned earlier, Early Alerts were shared by the Chair of the Board (or by the Chair's or the CEO's PA) to Non Executives only on request from the Chair.
b) Confidential Trust Board meetings allow for bringing of governance issues to the Board. These meetings are minuted but not held in public so that issues of concern in relation to individual staff and patients can be raised.
c) Governance Committee allows for issues of internal governance to be raised and discussed directly with Committee Members and responsible and accountable Directors.
d) Chief Executive briefings with Non-Executive Directors, which happen monthly/bio-monthly (during the pandemic they occurred weekly), also allow for such issues to be raised.
e) Internal Audit Reports (which report through to the Audit Committee and then to Trust Board through the Chair's report) similarly allow for such issues to be brought to the Board. Where necessary, Audit Committee reports are shared with the Governance Committee. Both Committee Chair's Reports then go to the Trust Board along with a copy of the minutes of that Committee's meeting.

f) Executive and Operational Directors attend Audit Committee to update on Internal Audit Reports and recommendations where limited assurance has been given.
g) Trust Board workshops also provide an opportunity to raise governance issues.
h) At the end of each Trust Board Meeting Executive Directors of Medicine, Social Work, Nursing and Finance are asked if there were any other issues relating to their professional roles they wish to bring to the Board's attention.

22.3 A non-urology example of escalating an issue to Trust Board was in relation the Invited Review into Bluestone and Gillis in 2019 conducted by the Royal College of Psychiatrists.

22.4 This began in 2018 with Mrs. Carmel Harney, Interim Director Mental Health and Disability, bringing a paper to the Confidential Trust Board at its meeting on the 27th September 2018. The paper was entitled 'Bluestone and Dorsy Workforce Action Plan to support safe care and whole system patient flow'. A formal Early Alert had already been issued in respect of the matter on the 24th August 2018.

22.5 The journey of this concern from the 27th September 2018 onwards was as follows. It then was on the Confidential Board Agenda for 29th November 2018 and 24th January 2019, and was then discussed at a confidential Directors' workshop on the 21st February 2019. The new Director of Mental Health and Disability Services, Mr. Barney McNeany, then presented to the Confidential Trust Board in respect of it on the 28th March 2019. The presentation was entitled 'Building a progressive Inpatient Mental Health Service'. The Director outlined his concerns and that he was seeking to bring in the Royal College of Psychiatrists to undertake an Invited Review. He was requesting this to provide assurance as to the safety and effectiveness of the service.

22.6 What the above shows, is a concern being raised through the confidential Trust Board meeting and it being monitored and progressed over a number of months to an action in the form of an invited review to provide assurance (or not) on the safety and effectiveness of the relevant service. Following the invited review, the

Trust Board were provided with updates and actions plans in respect of the outworking's of the review. *Please see:*

114. Item 6. Bluestone Dorsy update TB 270918 (3)
115. Item 3. Final confidential minutes - 27.9.2018
116. Item 4i. Bluestone Dorsy revised update TB 251018 (3) Final
117. Confidential minutes - 25.10.2018
118. Item 4. Patient 10 *In-Pt Units WF pressures revised update TB 291118 (3)*
119. Item 4. Confidential minutes - 29.11.2018
120. Item 5i. Bluestone and Dorsey Update
121. Item 4. Confidential minutes - 24.1.2019
122. Item 6. Building a progressive Inpatient Mental Health Service
123. Item 4. Confidential minutes - 28.3.19
124. Item 3. Draft Confidential minutes - 29.8.2019
125. Item 7a. Bluestone Dorsy update TB 260919
126. Item 11iia. Report Template Bluestone Dorsy update TB 300120
127. Item 11iib. Bluestone Action Plan Jan 2020 Update
128. Item 11iic. NHS Safety Thermometer Bluestone

22.7 In relation to urology specifically (and as mentioned at Question 15 above), an Early Alert was issued on 31st July 2020. I have no record of receiving this Early Alert during July or August. However, I have received confirmation that the former Chair, Roberta Brownlee, was notified with a copy of the Early Alert on the 3rd August 2020.

22.8 As also mentioned above at Question 15, at a Trust Board workshop on the 27th August 2020, under Agenda Item 6 'Update from Executive Directors (Verbal)', the (then) Medical Director, Dr Maria O'Kane, brought a governance issue to the Board's attention, namely, an SAI investigation into clinical concerns involving a recently retired Consultant Urologist. Members asked that this matter be discussed at the confidential Trust Board meeting immediately following the Workshop.

22.9 At the ensuing confidential Trust Board meeting on the 27th August 2020, Dr O'Kane brought to the Board's attention the SAI investigation into concerns involving

the Urologist in question. Members requested a written update for the next confidential Trust Board Meeting.

22.10 This item was then brought to the next Confidential Trust Board Meeting on the 24th September 2020, with a detailed paper provided by Dr O'Kane and presented by Dr Damian Gormley. This is also when Board Members (other than the Chair) were first notified that an Early Alert had been submitted (although the date of its submission was not clarified until the meeting of 22nd October). Further updates were provided to the Board on the 12th November 2020 and 10th December 2020 and the issue has subsequently remained on the confidential Trust Board agenda. *Please see:*

129. 20200803 - E - S Wallace re Early Alert
75. 20200827 Directors Workshop Notes
131. 20200924 Confidential TB minutes
132. 20201022 Confidential TB Minutes
133. 20201112 Confidential TB minutes
134. 20201210 Confidential TB Minutes

23 How was this information recorded and communicated to the Board? How did the Board assure itself of the accuracy and completeness of this information?

23.1 The way in which information on governance issues is communicated to the Trust Board can be:

a) Verbally, as in the case of Dr O'Kane raising urology concerns at the confidential Trust Board workshop on the 27th August 2020 (see further Questions 15 and 22 above);
b) In written format, as in the Case of Mrs. Carmel Harney raising concerns (regarding the Bluestone and Dorsy workforce) at the confidential Trust Board meeting on the 27th September 2018 (see further Question 22 above);
c) By notification from a Committee Chair, as in the Case of Mrs. Pauline Leeson (email of the 11th March 2022) raising concerns from the Performance

Committee on the Stroke Services Sentinel Stroke National Audit (SSNAP) (see further Question 18 above).

23.2 Reflecting back over my tenure from 2016, papers provided to Trust Board would have been uploaded through 'Decision Time' in some cases or given out at the meeting in hard copy in other cases. Where no papers were provided, verbal briefings were given. From when I took up the post of Chair on 1st December 2020, Decision Time has been used as the primary source of all information provided to Trust Board, its committees, meetings of the Chief Executive - Chair - Non-Executive Directors, and meetings of the Chair - Non-Executive Directors.

23.3 Reports to Trust Board and Committees are presented with a cover sheet detailing a summary of the key issues. At meetings, the Chief Executive and Directors would verbally present their papers and respond to questions posed by Board or Committee Members.

23.4 The meetings are recorded by either workshop notes or meeting minutes, whichever is applicable.

23.5 Such records are not verbatim transcripts but they do record verbal interactions following the presentation of papers or verbal briefings to the Board. For example, the minutes of the 24th September 2020 Confidential Trust Board Meeting in regard to Urology record the following:

'Members discussed the fact that there is likely to be significant media interest in this case with the potential for significant reputational risk to the Trust. Members emphasised the Trust's duty of care to patients and the importance of the Trust completing its investigative work to ensure that the information it provides is complete and accurate'

24 How, if at all, does the Board communicate with the Department regarding issues of patient safety and risk?

24.1 In my experience, the Department can be appraised of any issues of patient safety and risk by or on behalf of the Board in any one or more of the following ways.

24.2 The Trust Board Chair and the Chief Executive attend accountability meetings with the Permanent Secretary.

24.3 Members of the Senior Management Team attend 'ground clearing' meetings in advance of Chair and CEO accountability meetings with the Department.

24.4 The Chief Executive (both the former and current Chief Executives, in my experience) would also keep in reasonably regular contact with the Permanent Secretary.

24.5 Early Alerts, as referenced in previous answers, go to the Department and, since the 18th September 2020, have been shared by the Trust with all Board Members. Whilst the Trust Board as an entity does not issue Early Alerts, the Trust Board is nonetheless aware of what has been communicated by the Trust to the Department through the Alert.

24.6 The Chair has the ability to write to the Department should the Board have concerns and wish to raise them with the Department.

24.7 A few examples of communications about potential patient safety or risk from the Trust to the Department using some of the above methods (and not already referenced in earlier Questions) are as follows:

Reference	**Details**	**Communication issued by**
Letter from Southern Trust to Department on Health Permanent Secretary dated 18th January 2017	Letter to Permanent Secretary outlining concerns on ability to maintain existing services and at the same time secure break even.	Francis Rice Interim Chief Executive

Letter from Southern Trust to the Permanent Secretary DOH and Chief Executive HSCB – see confidential minutes of 14th March 2017	Request from Trust Board Chair for letter to be sent to the DOH and HSCB outlining concerns regarding Daisy Hill Hospital Emergency Department.	Stephen McNally Acting Chief Executive

25 Are the issues of concern and risk identified in urology services of the type the Board would be expected to have been informed about at an early stage? Was the Board informed of concerns regarding urology, and Mr. O'Brien in particular, at the appropriate time? If not, what should have happened, when, and why did it not?

25.1 Significant issues in respect of Patient Safety and Clinical Concerns are indeed the type of matters about which the Board would expect to be informed by its Chair and/or by the Chief Executive and/or by one of the relevant Executive or Operational Directors.

25.2 The Trust Board were made aware of a Consultant being excluded from practice at its meeting on the 27th January 2017 (I now know the Consultant in question was Mr. O'Brien, but did not know that in January 2017). This was, I believe, an appropriate point at which to raise an issue of potential concern with the Board. The issue having been raised, Trust Board members, including me, did not question or dig deeper into the situation and, on reflection, perhaps we ought to have been more curious, if not on the 27th January then perhaps in the months that followed, when no further updates were provided.

25.3 Between 2016 and 2018 there was a churn in Interim/Acting CEO and Interim Directors. I am not sure whether this churn impeded the flow of information to the Board about the progress and outcome of the matter we were advised of on the 27th January 2017. The fact is that I do not believe that any further updates were provided and my view is that this was unsatisfactory. We ought to have received at least some periodic updates regarding the progression of the matter (including the

fact that there were related SAI Reviews) as well as details of its outcome including, in particular, any recommendations made and the subsequent implementation of them.

25.4 Moving ahead to the Early Alert issued on the 31st July 2020, it stated that, on the 7th June 2020, the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist.

25.5 The Trust Board was not alerted to this concern until its Trust Board workshop on the 27th August 2020. This was 27 days after the Early Alert was sent to the Department and it was the first meeting of the Trust Board since that time. Even then, he Early Alert was not shared with all Trust Board Members. In my opinion, this was not appropriate given the severity of the Early Alert, and the clinical concerns and patient safety issues raised. My view is that, had the Early Alert been shared promptly with the Board, this would have triggered a response, particularly from Non-Executive Members, and the Trust Board Confidential Meeting scheduled in August would likely then have had this as an Agenda item for discussions with papers. In my view, if the Early Alert had been shared fully, it could have triggered earlier discussions as well as potential actions such as the management of any conflicts of interest.

25.6 As mentioned above, the practice that persisted at the time regarding Early Alerts changed in September 2020 and they are now usually shared promptly with all Board members.

Urology services

26. Save for concerns in relation to Mr. O'Brien (which are addressed in questions below), please detail all concerns and issues brought to your attention and the Board's attention (if different) regarding the provision of urology services during your tenure. You should include all relevant details, including dates, names of informants, personnel involved and a

description of the issues and concerns raised. Please also include all documents relevant to your answer.

26.1 During my tenure Urology concerns and issues (other than in respect of Mr O'Brien) brought to my attention and the Board's attention are summarised below:

Meeting	Agenda Item	Detail
Trust Board Meeting 30th November 2017	9 Operational Performance Director of Performance and Reform • OGI Performance Summary at the end of October 2017 (report summary sheet)	Waits on Cancer pathways: 62-days- patient continue to be in excess of the 62-day pathway target, associated with demand in excess of capacity with the majority of breaches of the pathway related to urology and upper and lower gastro-intestinal (GI) specialties. In September 18 patients breached the 62-day, with the majority within **Urology 44%** (8 out of 18) and the in the Lung; Skin; UGI; Colorectal; and Gynae tumour site.
	• Corporate Dashboard	Cancer Pathway 62 Days (Reported one month in arrears) Performance in 2016/2017 demonstrated a decrease in comparison to 2015/2016 (88.30%) and based on the performance projects this year an improvement is not anticipated. This is associated with an increased level of patients on the pathway with increased demand on the resources available, include red flag out-patient and diagnostic capacity. The percentage of confirmed cancers has not demonstrated a disproportionate increase. The majority of 62-day pathway breaches for the Trust continues to be within **Urology**,

		one of the four tumor sites with greatest demand.
Trust Board Meeting 25th January 2018	12.i Operational Performance Director of Performance and Reform • Performance Dashboard (Ministerial Targets) as at December 17 Report Summary Sheet	Waits on the Cancer Pathway: (31 and 62 day targets 62-day pathway - suspected cancer patients continue to wait in excess of the 62 days for their first definitive treatment associated with demand in excess of capacity. At the end of November, 23 patients waited in excess of 62 days. Whilst urology continues to have the largest volume of patients waiting over 62 days on the pathway there has been no increase in this trend over the past 3 months
Trust Board Meeting 24th May 2018	12 Performance Report (yearend) Director of Performance and Reform • Performance Year End Assessment	Performance against the 62-day cancer pathway in 2017/2018 demonstrated a decrease in comparison to 2016/2017. This less favorable performance is associated with the total volume of patients on these pathways which present increased demand on the resources available including red flag out-patient and diagnostic capacity. The two predominant breaching specialties in 2017/2018 were **Urology (46%)** and Breast Surgery (14%) which was reflective of workforce pressures demonstrated throughout 2017/2018. Outpatient assessments: Waits over 52-weeks, for SHSCT specialties, are reported across 13 specialties: Breast Family History; Cardiology; Diabetology; ndocrinology; ENT; Gastro-enterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine and **Urology**. All of which have established

		capacity gaps and/or accrued backlogs.
Trust Board Meeting 29th November 2018	Agenda Item 12i. Performance Report Director of Performance and Reform • Corporate Dashboard	Waits on the Cancer Pathway (62-day (D) target) 12 patients waited between D-62 and D-85, and 9 patients waited in excess of D-85 for their first treatment. The majority of those waiting more than 62-days were **urology** (10). The longest waits were in urology and lower gastrointestinal surgery at D-213 and D-195 respectively.
Trust Board Meeting 24th January 2019	Agenda Item 9.i. Performance Report Director of Performance and Reform • Performance Dashboard (Ministerial Targets) as at December 2018 Report Summary Sheet	In patients and Day Cases In-Patient (IP) and Day Case (DC) waits over 52-week at the end of December has increased with 2,662 people waiting across 7 specialty areas – Breast Surgery; ENT; General Surgery; Orthopaedics; Paediatrics; Pain Management; and **Urology**. This increasing trend in waits over 52-weeks continues to be demonstrated Regionally as illustrated in Graph 6 overleaf:
	• Corporate Dashboard	Cancer pathways 62 Days 62 day pathways remain challenged with 20 patients waiting longer than 62-days to commence their first treatment in November. Majority of breaches occurred within **Urology** associated with capacity less than demand. Staff sickness absence; delays in first/review appointments and diagnostic delays have contributed to the breaches experienced across all areas. **Urology** continues to experience difficulties across the Region with an increase in referrals also experienced across the Region

Trust Board Meeting 28th March 2019	Agenda 10i. Performance Report Director of Performance and Reform • Performance Dashboard (Ministerial Targets) at February 2019 Report Summary Sheet	Cancer Care Capacity for first assessment (red flag and urgent referrals) has been increased where possible, via non recurrent funding, to meet the increased demand in a number of specialty areas, including breast assessment, general surgery, and gastroenterology and to a smaller extent in urology and respiratory services. The Trust has engaged with HSCB and agreed that urology referrals from patients residing in the Western area should no longer come to the Southern Trust in an attempt to rebalance demand and capacity and improve local waiting times.
Trust Board Meeting 23rd May 2019	Agenda Item 8 Performance Report Director of Performance and Reform • Performance Dashboard (Ministerial Targets) at April 2019 Report Summary Sheet	Elective Care In-Patient (IP) and Day Case (DC) waits over 52-week largely ontinue to increase in line with regional trends. At the end of March 2019 2,700 people were waiting across 9 specialty areas, for over 1 year (Breast Surgery; Cardiology; ENT; General Surgery; Gynaecology; Orthopaedics; Paediatrics; Pain Management; and **Urology**). Whilst the Average waiting time is 37-weeks, with the 95th percentile wait at 119-weeks (Pain Management) the longest routine wait remains within **Urology** at 269-weeks.
	• Corporate Dashboard	Cancer Pathwasy 62 Days 16 patients waitied longer than 62-days to commence their first treatment in March. The majority of breaches continue to occur within **Urology** and patients

		transferring between Trusts. Reasons for breaches include insufficient capacity for assessment, diagnostics and surgery and complex diagnostic pathways in the context of increasing demand. Of the completed waits on the 62-day pathway in March, the longest wait was a Urology patient of 182 days (this reflects the actual wait in the period and not the chronological time period). During 2018/19, there has been an increase in referrals for the 62-day and 31-day pathways which continues to impact the ability to meet the target.
Trust Board Meeting 28th August 2019	Agenda Item 11.i Performance report Director of Performance and Reform • Corporate Performance Dashboard	Cancer Pathways (62 days) During 2019/2020 as at June 2019, 66 patients have waited more than 62-days to commence their first treatment with the majority of breaches occurring within **Urology**. Of the completed waits on the 62-day pathway in June, the longest completed wait was a Urology patient at 148 days (this reflects the actual wait in the period and not the chronological time period). Reasons for breaches include insufficient capacity for assessment, delays to diagnostics tests and referrals between Trusts as well as complex diagnostic pathways. Since March 2019, referrals on the 62- day and 31-day pathways have increased by +9% which impacts on the ability to meet this target. Work is ongoing to assess the impact of reduced additional activity on the cancer pathway waits. Average regional performance is 54%. The Performance Team are working

		with the Acute Cancer Performance Group to explore more detailed analysis of capacity and demand.
Trust Board 30th January 2020	Agenda Item 8 Performance Committee Committee Chair report	b) Elective Care Key Issues demand, capacity, workforce and unscheduled care pressures and growing waiting lists/waiting times. Red flag and urgent priorities, competing pressures for diagnostics. Concerns re reviews beyond clinically indicated timescales Funding –short term nature non – recurrent funding Focus of discussion was on **Urology** and Endoscopy.
Performance Committee 3rd September 2020	Director Performance and Reform • Corporate Performance Scorecard	"Mrs Magwood stated that the Trust has received in-year investment for the 7th **Urology** Consultant. Recruitment is currently ongoing and it is anticipated that the 7th Consultant will be in post in quarter 4. She did note that the additional capacity created by this post will be targeted to the red flags and urgent cases with little anticipated impact on routine waits".
Trust Board 22nd October 2020	Agenda Item 13i Performance Committee Committee Chair Report • Mrs. Pauline Lesson	In-Patient/Day Case waits and Planned Repeat Treatments – - increasing volumes of patients waiting beyond their clinically indicated timescale for planned repeat treatment. The Trust has received in-year investment of £200,000 for the **Urology** 7th Consultant. Recruitment is currently ongoing and it is

		anticipated that the 7th Consultant will be in post in Quarter 4. The additional capacity created by this post will be targeted to the red flags and urgent with little anticipated impact on routine waits.

Urology mentions within Corporate Risk Register – during my tenure	
May 2020 Page 51 August 2020 Page 50	Clinical teams worked closely with regional Clinical Reference Groups to ensure consistent approach to cancer work across tumor sites
May 2022 Page 6	Review options of attracting temporary consultants without CCT into Consultant roles with support from Trust to obtain GMC certification (radiology/urology)

26.2 I do not recall, across my tenure, being informed of any Urology Concerns unrelated to Mr O'Brien outside of the formal Board and Committee meetings. *Please see:*

134a. Item 9i a. Performance Summary PagePerformanceReport_TB_Final
134b. Item 9i b. Copy of 20171201_CorporateDashboard(OctoberforNovember)TB_Amendment at TB 301117
134c. Item 12i a. PerformanceReport Summary Template_TB_V1_0_AMagwood-LLeeman
134d. Performance Year End Assessment - Item 11i a. TBSummaryPagePerformanceReport_TB_V1_0_LLeeman-LLappin
134e. Item 12ib. 20181122_CorporateDashboard(OctoberforNovember)_TB_V1_0_CRafferty-LLappin
134f. Item 9ia. 20190118_TBSummaryPerformance(DecemberPosition)TB_Report_Final

134g. Item 9i. 20190118_CorporateDashboard(DecemberforJanuary)_V1_0_CRafferty-LLappin-LLeeman

134h. Item 10ia. 20190322_TBSummaryPerformance(FebruaryPosition)TB

134i. Item 5. Approved Trust Board minutes 28.3.19 and

134j. Item 8ia. TBSummaryPerformance(May 19 TB_April 19 Position_TB

134k. Item 8ib. Performance_CorporateCPDScorecard(April for May)_Final_TB

134m. Item 11ib. 20190823_CorporateCPDScorecard(July for August)_v1.0 Final TB

134n. Item 8ia. Performance Committee_Chair Report

193. 20200903 Approved Performance Committee Minutes

134o. 6a. Performance Scorecare Cover Template (JulyforAugust), 6b. Corporate CPD Scorecard (July for August)

134p. Item 13i. Performance Committee_Chair Report

134q. Item 9b. Corporate Risk Register May 2020 to Trust Board _ 4th June 2020

134r. Corporate Risk Register August 2020

134s. Summary Corporate Risk Register to Governance Committee 12052022

27. Please set out in full what, if anything, was done to address the concerns raised. What did you specifically do once the concerns became known to you?

27.1 I have summarised our response to the concerns raised in the table below (note: I have summarised the response against each Board or Committee meeting date appearing in the table at Question 26).

Meeting	What the Board did in response to the concerns raised
Trust Board Meeting 30th November 2017	Board Members heard from the Directors on a range of issues within the full report. No discussion recorded in the minutes specifically in relation to Urology. A question was raised in regard to additional funding to support improvement in performance. The Acting Chief Executive stated "it is difficult to project at this stage reliant on non-recurrent funding

	allocations, however, it is hoped the new financial year will lead to improvements which is reliance on recurrent investment" The Board approved the Performance Report
Trust Board Meeting 25th January 2018	Board Members heard from the Directors on a range of issues within the full report. No discussion recorded in the minutes specifically in relation to Urology. A question was raised regarding the postponement of 222 elective patients (including a number of red flags). Mrs Gishkori provided assurance that those patients categorized as red flag who did not have their surgery carried out as planned have been rescheduled in. The Board approved the Performance Report
Trust Board Meeting 24th May 2018	Board Members heard from the Directors on a range of issues within the full report. No discussion recorded in the minutes specifically in relation to Urology. The Board approved the Performance Report
Trust Board Meeting 29th November 2018	Board Members heard from the Directors on a range of issues within the full report. No discussion recorded in the minutes specifically in relation to Urology. The Board approved the Performance Report
Trust Board Meeting 24th January 2019	Board Members heard from the Directors on a range of issues within the full report. Urology specifically: "Mrs McCartan (Non-Executive Director) referred to the longest wait in terms of inpatient and day case waits within Urology at 257 weeks. Members recognised challenges within Urology regionally. Mrs. Magwood assured members controls are in place to review and manage lengthening access times" The Board approved the Performance Report

Trust Board Meeting 28th March 2019	Board Members heard from the Directors on a range of issues within the full report. Director of Performance and Reform highlighted the challenges on elective due to pressure on unscheduled care. Mrs Rooney (Non-Executive Director) referred to the Trust experiencing 5 breaches against the 31-day for Cancer Pathway and asked if those patients are regularly reviewed to which Mrs Magwood advised that each patient is tracked from Day 1. No discussion recorded in the minutes specifically in relation to Urology. The Board approved the Performance Report
Trust Board Meeting 23rd May 2019	Board Members heard from the Directors on a range of issues within the full report. No discussion recorded in the minutes specifically in relation to Urology. The Board approved the Performance Report
Trust Board Meeting 28th August 2019	No discussion on urology.
Trust Board 30th January 2020	No discussion on urology
Performance Committee 3rd September 2020	Committee member questioned Directors on the Corporate Performance Scorecard in particular: • Impact of Covid 19 on performance • In year investment of £200k for the 7th Urology Consultant • Trust yearend performance in line with regional performance
Trust Board 22nd October 2020	Trust Board received the Committee Chair report of the Performance Committee held on the 3rd September 2020.

27.2 The mismatch between demand and capacity has been a constant theme in the Trust during my tenure. Issues have included challenges in recruiting staff, the reliance of non-recurrent funding, annual budgets, recruitment of locums and agency staff to fill gaps, and using the private sector to undertake work to support waiting lists (referred to as waiting list initiatives). These waiting list initiatives have been provided as a result of monitoring rounds undertaken by the NI Executive and allocated spend given to the Department of Health and previously the Health and Social Care Board. Examples where the Board were notified of additional funding to address waiting times/lists through performance reporting are outlined below:

Meeting	**Paper referred**	**Extract from report**
Trust Board 26th May 2016	Agenda Item 10i Monthly performance management report	HSCB has provided additional non-recurrent funding in Q1/2 for additional capacity in diagnostic imaging to continue to improve access times and the Trust is working to secure the additional capacity both in- house and in the independent sector. Formal communication of non-recurrent funding for endoscopy is awaited however the Trust has commenced a level of additional activity in anticipation of this
Trust Board 29th November 2018	Agenda Item 12ia Performance Dashboard (Ministerial Targets) at October 2018	Additional capacity, provided via the Confidence and Supply funding, for red flag and urgent out-patient capacity, endoscopy and key diagnostics will support the management of demand on the cancer pathway. However, longer term sustainable improvement will not be demonstrated without the recurrently

		funded provision of capacity levels, including workforce, sufficient to meet the demand.

Please see:

135. 010i. MonthlyPerfReportMay(AprilPerf)_TB_V1_0_LLappin

136. Item 12ia. TBSummaryPerformance(OctforNov)TB_Report_V1_0 Final

27.3 The reporting to Trust Board in the period 2016 – 2020, as outlined in paragraphs 26 and 27.1 above, shows the continuing challenges presented to the Trust Board. From 2020 to the present time the demand capacity issues across the Southern Trust have persisted in a wide range of disciplines. These have been compounded by the pandemic, and the fact remains that the Trust continues to struggle to meet demand due to resource constraints.

28. How, if at all, did the Board monitor and evaluate any decisions or actions taken to address concerns? What did the Governance Committee do specifically once concerns were raised?

28.1 Each Committee of the Trust Board has delegated to it a specific remit and role. In essence, they undertake the deeper dive into their respective areas (performance, governance or audit) and report up to the Trust Board through the Committee Chairs' Reports and draft minutes.

28.2 Where concerns are raised these can then become a matter arising for that Committee with the request for further information and/an action plan.

28.3. Monitoring and evaluating any actions taken to address concerns is the remit of the Committee, with escalation to Trust Board where appropriate.

28.4 The Governance Committee in particular receives the Corporate Risk Register on a quarterly basis. This, along with Clinical and Social Care Governance Reports,

allows the Committee to assess the risks to patient safety and actions being taken to address them.

28.5 On reflection, and when I consider the Board's response to concerns as summarised in paragraph 27.1 above, there appears to have been an acceptance on our part that the Trust was continually reliant on securing additional staff and budget to effect change. Both of these matters were challenges that the Trust was unable to address itself.

29. How, if at all, did the (i) Board and (ii) the Governance Committee assess whether patients were safe and what level of risk existed at that time? What, if anything, was done in response to these assessments?

29.1 Through its Committees (Performance and Governance), the Board receives reports that would highlight concerns that would have an impact on patient safety.

29.2 Demand:capacity issues, such as those outlined above, all posed a risk to patient safety, such as elective surgeries being cancelled, breaches in cancer pathway timelines, and delays in diagnosis and treatment, including patients deteriorating and becoming acutely unwell whilst on a waiting list.

29.3 The Board was, and remains, alert to the risk to patient safety from delays in access to services, diagnosis, and treatment. The Governance Committee reviews the Risk Register on a quarterly basis, where access to services is principal risk domain number 3.

29.4 The Corporate Risk Register is a key tool for the Trust Board in identifying the risks, mitigations and actions required. This is a fluid document which changes as new risk comes on and risks which are downgraded come off. Consistent themes across Risk Registers during my tenure have been workforce shortages and patient safety risks due to long waits. I have detailed below two examples of such risks within the Corporate Risk Registers as well as the actions to address demand:capacity risks in 2016 and 2017.

Risk Register	Risk Number	Actions
Corporate Risk Register February 2016	Risk No 2 Outpatient review and planned treatment backlogs	Internal resources continue to be directed to increase capacity for consultant review activity as this becomes available. Further non recurrent funding allocated for Quarter 3 & 4
Corporate Risk Register 07th September 2017	Risk No 14 Clinical risk associated with inability to see urgent/red flag patients within clinically indicated timelines	Non recurrent funding as available will be allocated to provide additional activity to address the risk to patient safety associate with inability to manage patient care within clinically indicated timescales. The Trust will continue to redirect any available internal resources to areas of greatest risk.

29.5 Reflecting back on my tenure from 2016, I do not believe that the patient safety risk associated with the demand:capacity mismatch and delays in access to services was as explicit in the early part of my tenure as it has been in recent years. As the Inquiry is aware, the demand:capacity mismatch has been intensifying and, as a Trust the Board, I believe that we are now acutely aware of the likely impact on the patient, whether they be a patient waiting in the Emergency Department or a patient on a waiting list for diagnostics. *Please see:*

114. Item 6. Bluestone Dorsy update TB 270918 (3)

115. Item 3. Final confidential minutes - 27.9.2018

116. Item 4i. Bluestone Dorsy revised update TB 251018 (3) Final

117. Confidential minutes - 25.10.2018

118. Item 4. MH In-Pt Units WF pressures revised update TB 291118 (3)

119. Item 4. Confidential minutes - 29.11.2018

120. Item 5i. Bluestone and Dorsey Update

121. Item 4. Confidential minutes - 24.1.2019

122. Item 6. Building a progressive Inpatient Mental Health Service

123. Item 4. Confidential minutes - 28.3.19

124. Item 3. Draft Confidential minutes - 29.8.2019

125. Item 7a. Bluestone Dorsy update TB 260919

126. Item 11iia. Report Template Bluestone Dorsy update TB 300120

127. Item 11iib. Bluestone Action Plan Jan 2020 Update

128. Item 11iic. NHS Safety Thermometer Bluestone

30. Was it your view and the view of the Board that actions taken were effective? If yes, please explain why. If the actions taken were not effective, explain why, and outline what, if anything, was done subsequently?

30.1 The Trust has been reliant on non-recurrent funding and the diversion of internal resources as actions to address the risks mentioned above.

30.2 These were short term measures and, in my view, do not provide for a longer-term approach to fully address the underlying problem of the demand:capacity mismatch which has been increasing year on year.

30.3 In addition, challenges in the recruitment of permanent consultants and nurses have impacted greatly on the ability to deliver the service at the right time for the patients.

30.4 International recruitment has been a pathway the Trust Board has supported and continues to support as the outworkings of the pandemic have further impacted on workforce shortages.

30.5 In short, the actions taken by the Trust have been a mixture of steps that the Trust could take for itself (e.g., international recruitment) along with short term actions reliant upon non-recurrent funding which have temporarily addressed a symptoms but not the root cause of the problem. On reflection, these actions have had limited effect as the issues have continued to develop. Fundamentally, the whole system of health and social care needed reform in line with the Bengoa Report 2016 (Systems Not Structures) and the 10 year plan published by the Department of Health in response to it "Health and Wellbeing 2026: Delivering Together".

Board actions regarding urology and Mr. O'Brien

31. Please provide full details of when, how and by whom (i) you and (ii) the Board (if different or at different times) were first made aware of issues and concerns regarding the practice of Mr. O'Brien, to include all information about what was said and/or documentation provided?

31.1 At a Confidential Trust Board Meeting on the 27th January 2017, Mrs Vivienne Toal raised (under agenda item 6, Maintaining High Professional Standards) the following:

'Mrs Toal advised that under the MHPS framework, there is a requirement to report to Trust Board any medical staff who have been excluded from practice. She reported that one Consultant Urologist was immediately excluded from practice from 30th December 2016 for a four-week period. Mrs Toal reported that the immediate exclusion has now been lifted and the Consultant is now able to return to work with a number of controls in place. Dr Wright explained the investigation process. He stated that Dr Khan has been appointed as the Case Manager and Mr C Weir, as Case Investigator. Mr J Wilkinson is the nominated Non-Executive Director. Dr Wright confirmed that an Early Alert had been forwarded to the Department and the GMC and NCAS have also been advised.'

31.2 The Consultant's name was not disclosed to us at that time.

31.3 There were no documents provided to us either. Information was provided verbally by Mrs Toal and Dr Wright.

31.4 I know now that the Consultant being referred to at this meeting was Mr O'Brien. I believe that I only became aware of this in or about August/September 2020.

31.5 Up until that point – 27th January 2017 - I was not aware of any issues or concerns regarding the practice of Mr O'Brien.

31.6 After that, I do not believe that I or the Board was made aware of any other issues and concerns until the Board Workshop and Confidential Meeting held on the 27th August 2020 (mentioned in various answers above).

When	How	By Whom	Information
27th August 2020	Through an Executive Director Update at a Trust Board workshop	Medical Director Dr Maria O'Kane	Notes from Trust Board workshop held on the 27th August *Dr O'Kane brought to the Board's attention SAI investigations into clinical concerns involving a recently retired Consultant Urologist. Members asked that this matter be discussed at the confidential Trust Board meeting following the Workshop.*
27th August 2020	Through Agenda Item Any Other Business at the Confidential Trust Board Meeting.	Medical Director Dr Maria O'Kane	Minute from Trust Board workshop held on the 27th August *Dr O'Kane brought to the Board's attention SAI investigations into concerns involving a recently retired Consultant Urologist. Members request a written update for the next confidential Trust Board Meeting.*

32 Please detail all subsequent occasions any concerns and issues regarding Mr. O'Brien were discussed by or with (i) you and (ii) the Board, to include the detail of those discussions, including dates and who those discussions were with.

Discussions by or with me

32.1 At 1:1 meetings between myself, as Chair, and Shane Devlin, as CEO, during 2020 and 2021 urology would have been discussed, usually in terms of brief updates. I have summarised these in the table below:

Date	Notebook entry
17th December 2020	Chief Executive confirmed Anything else found will go to the Public Inquiry.
14th January 2021	Update on SAI's, early learning, and Chief Executive meeting with the urology team.
21st January 2021	Confirmation received from AOB solicitors not to destroy records from private practice. Inquiry Chair not appointed. All SAI's complete.
10th March 2021	SAI updates, timeline for sharing with families and AOB, for comment.
16th March 2021	AOB not responding.
19th April 2021	Increasing cases. Director of Nursing now director responsible for Urology Inquiry. Lookback, delivery improvement relationships with inquiry.

32.2 At meetings between myself, as Chair, and Dr Maria O'Kane, as CEO, Urology would have been discussed in terms of brief updates in regard to the Urology Services Inquiry, External Reference Group (ERG), and/Lookback review:

Date of meeting	Agenda item
01.03.2022	Notebook entry Urology
30.01.2023	3 Urology Services Inquiry
28.02.2023	5 Urology Services Inquiry

14.03.2023	6 Urology Services Inquiry
27.03.2023	5 Urology Services Inquiry
20.04.2023	5 Urology Services Inquiry
02.05.2023	5 Urology Services Inquiry
16.05.2023	6 Urology Services Inquiry
30.05.2023	6 Urology Services Inquiry
09.06.2023	7 Urology Services Inquiry
18.07.2023	5 Urology Services Inquiry
25.07.2023	5 Urology Services Inquiry
08.08.2023	5 Urology Services Inquiry

Please see:

43. 20201217 Notebook entry

44. 20210124 Notebook entry

45. 20210121 Notebook entry Pg1

46. 20210121 Notebook entry Pg2

47. 20210310 Notebook entry

48. 20210316 Notebook entry

49. 20210603 Notebook entry

181. 20220301 Notebook entry

51. Agenda 30.01.2023 Dr Maria 'O'Kane Chief Executive Eileen Mullan Chair

53. Agenda 14.03.2023 Dr Maria 'O'Kane Chief Executive Eileen Mullan Chair

54. Agenda 27.03.2023 Dr Maria 'O'Kane Chief Executive Eileen Mullan Chair

55. Agenda 20.04. 2023 Dr Maria 'O'Kane Chief Executive Eileen Mullan Chair

56. Agenda 02.05.2023 Dr Maria 'O'Kane Chief Executive Eileen Mullan Chair

57. Agenda 16.05.2023 Dr Maria 'O'Kane Chief Executive Eileen Mullan Chair

58. Agenda 30.05.2023 Dr Maria 'O'Kane Chief Executive Eileen Mullan Chair

59. Agenda 09.06.2023 Dr Maria 'O'Kane Chief Executive Eileen Mullan Chair

60. Agenda 18.07.2023 Dr Maria 'O'Kane Chief Executive Eileen Mullan Chair

61. Agenda 25.07.2023 Dr Maria 'O'Kane Chief Executive Eileen Mullan Chair

Discussions by or with the Board

32.3 The Board monitored the Urology concerns through its confidential Trust Board meetings from September 2020 onwards. At these meetings, a verbal and written update was generally provided for all members on progress. The Board evaluated any decisions or actions taken to address concerns through questioning the Chief Executive and relevant Directors at these meetings and sought clarification where needed. These meetings were minuted but a summary of them is offered in the table below to assist the Inquiry.

Date	Discussion detail	Who discussions were with
24th September 2020 Agenda Item 7 Urology	Deputy Medical Director presented paper (obo Medical Director Dr Maria O'Kane) on Clinical Concerns within Urology. Board Members discussed the report and raised questions. Update provided in regard to the SAI's, MHPS and future reporting to Trust Board.	Trust Board (excluding Board Chair)
22nd October 2020 Agenda Item 7 Urology	Chief Executive provided an update on discussion with the Department. Deputy Medical Director presented paper on the Clinical Concerns. Acute Director spoke to the SAI process since 2016. Board Members discussed the reports, contributions and raised questions. Report to Department of Health on Consultant A Appendix One Detail on Previous Concerns with timeline details.	Trust Board (including Board Chair)

12th November 2020 Agenda Item 6 Urology	Medical Director presented a progress update on ongoing review of urology services. An update on the progress of identified SAI and family engagement. Assurance was received from the Acute Director of the review process. Chief Executive update on the Department led Urology Assurance Group. Board Members discussed the reports, contributions and raised questions.	Trust Board (including Board Chair)
10th December 2020 Agenda Item 3 Urology	Members received a paper providing an update on the ongoing review of urology services relating to Consultant A. Acute Director provided further update on the SAI Process and family engagement. Medical Director updated on engagement with GMC, RCS invited review and securing of subject matter experts. Board Members discussed the reports, contributions and raised questions.	Trust Board & Operational Directors
25th February 2021	Update provided on SAI and engagement with DOH and HSCB.	Trust Board & Operational Directors
25th March 2021	Members received a paper. Review progress to dates. Progress on SAI. Backlog patients GMC and Private Practice.	Trust Board & Operational Directors
27th May 2021	Members received a paper. Update on review progress Update on SAI progress	Trust Board & Operational Directors

	Update on GMC and private practice Update on urology and cancer services quality improvement work.	
30th September 2021	Members received a paper Update on work on Patient Reviews. Focus on improvement Lookback structure.	Trust Board & Operational Directors
28th October 2021	Members received a number of papers including summary of Patients AOB Letter template First update for families Report of the Review of the Stage One Grievance Panel decision in the case of Mr. AOB.	Trust Board & Operational Directors
27th January 2022	Members received a update paper along with the Letter of activity as of 17th January 2022.	Trust Board & Operational Directors
31st March 2022	Members received an update paper which included Urology Services Inquiry Public Inquiry response Urology Oversight Group Urology Assurance Group Patient involvement AOB private practice.	Trust Board & Operational Directors
26th May 2022	Members received an update paper which included: Urology Services Inquiry Urology Oversight/Lookback Steering Group Patient involvement GMC.	Trust Board & Operational Directors
23rd June 2022	Members received an update paper which included: Urology Services Inquiry Patient Lookback Process.	Trust Board & Operational Directors

29th September 2022	Members received an update paper which included: Public Inquiry Urology Lookback Review RQIA Review of the Urology Structured Case Record Review Southern Health and Social Care Trust.	Trust Board & Operational Directors
27th October 2022	Members received an update paper which included Public Inquiry Urology Lookback Review Quality assurance and learning.	Trust Board & Operational Directors
13th December 2022	Members received an update paper which included Public Inquiry Urology Lookback Review Quality assurance and learning.	Trust Board & Operational Directors
26th January 2023	Members received an update paper which included Public Inquiry External reference group Lookback Review Quality assurance and learning.	Trust Board & Operational Directors
30th March 2023	Members received an update paper which included Public Inquiry External reference group Lookback Review.	Trust Board & Operational Directors
25th May 2023	Members received an update paper which included Public Inquiry External reference group Lookback Review.	Trust Board & Operational Directors
22nd June 2023	Members received an update paper which included Public Inquiry External reference group Lookback Review.	Trust Board & Operational Directors

Please see:

131. 20200924 Confidential TB minutes

140. 20200924 Trust Board Urology Report

141. 20201022 Confidential TB Minutes

142. 20201022 Trust Board Urology Report

143. 20201112 Confidential TB minutes

144. 20201112 Trust Board Urology Report

145. 20201210 Confidential TB Minutes

146. 20201210 Trust Board Urology Report

147. 20210225 Confidential TB Minutes

148a. 20210325 Confidential TB Minutes & 148b.Urology update paper

149. 20210527 Confidential TB Minutes & 149b. Urology update paper

150a. 20210930 Confidential TB Minutes & 150b. Urology Update paper

151a. 20211028 Confidential TB Minutes & 151b. Urology Update paper

152. 20211028 SHSCT Summary of Pats AOB

153. 20211028 Letter template

154. 20211028 First update for families

155. 20211028 Report on the Review of the Stage One Grievance panel decision in the case of Mr AOB

156a. 20220127 Confidential TB Minutes & 156b. Urology update paper

157. 20220127 Urology letter activity

158. 20220331 Confidential TB Minutes & 158b. Urology update paper

159a. 20220526 Confidential TB Minutes & 159b. Urology update paper

160. 20220526 S21 notices final

161. 20220526 Risk Assessment Public Inquiry update

162a. 20220623 Confidential TB Minutes & 162b. Urology update paper

163a. 20220929 Confidential TB Minutes & 163b. Urology update paper

164. 20220929 RQIA Review of Urology Structured Case Record Review

165a. 20221213 Confidential TB Minutes & 165b. Urology update paper

167a. 20230126 Confidential TB Minutes & 167b. Urology update paper

168a. 20230330 Confidential TB Minutes & 168b. Urology update paper

169a. 20230525 Confidential TB Minutes & 169b. Urology update paper

32.4 There were also a number of email communications from former Chair of the Board, Mrs Brownlee, to me along with some (but not all) other Board members and some Trust personnel. These are summarised in the table below.

Date	**Details of the discussions**	**Who the discussions were with**
22nd September 2022	Chair referred to meeting with CEO that morning regarding the upcoming Confidential Agenda Item. She noted she had read and understood paper was to be shared with NEDS later that day. "I will leave the meeting for Agenda item 7 and this part will be chaired by Pauline Leeson in my absence NEDS. This is an urgent matter of high risk and I ask that you read this paper thoroughly and come prepared with questions."	Email from Roberta Brownlee, Board Chair, to Shane Devlin, CEO, Non-Executive Directors Geraldine Donaghy, Pauline Leeson, Hilary McCartan, Martin McDonald, Eileen Mullan, John Wilkinson, and support staff Jennifer Comac, Sandra Judt and Elaine Wright. Please note the above does not constitute the full Board.
23rd September 2020	Email from Chair, Roberta Brownlee, outlining her questions and concerns around the Summary for Trust Board Clinical Concerns 24th August 2020 vt.pdf	Email from Roberta Brownlee, Board Chair, to Non-Executive Directors John Wilkinson, Martin McDonald, Hilary McCartan, Pauline Leeson, Geraldine Donaghy, Eileen Mullan, and support staff Jennifer Comac and Sandra Judt.

		Please note the above does not constitute the Trust Board.

Please see:

171. 20200922 E from RB Re Confidential Section Agenda 7

172. 20200923 - E - R Brownlee TB Confidential

33 Please provide all notes and minutes of any and all meetings, conversations and/or decisions made by (i) you and (ii) the Board regarding Mr. O'Brien and urology generally.

33.1 I refer the Inquiry to the following:

Excerpts from Chair's notebook

43. 20201217 Notebook entry
44. 20210114 Notebook entry
45. 20210121 Notebook entry Pg1
176. 20210121 Notebook entry Pg2
47. 20210310 Notebook entry
48.. 20210316 Notebook entry
49. 20210603 Notebook entry
180. 20210608 Notebook entry
181. 20220301 Notebook entry
183. Copy of Item 1A Action Log Chair CEO 1-1

Board Minutes and Other Board Documents

184. 20171130 Trust Board Meeting Minutes
185. 20180125 Trust Board Meeting Minutes
186. 20180524 Trust Board Meeting Minutes

187. 20181129 Trust Board Meeting Minutes

188. 20190124 Trust Board Meeting Minutes

134i. 20190328 Trust Board Meeting Minutes

190. 20190523 Trust Board Meeting Minutes

191. 20190829 Trust Board Meeting Minutes

192. 20200130 Trust Board Meeting Minutes

193. 20200903 Performance Committee Meeting Minutes

131. 20200924 Confidential TB minutes

140. 20200924 Trust Board Urology Report

132. 20201022 Confidential TB Minutes

142. 20201022 Trust Board Urology Report

133. 20201112 Confidential TB minutes

144. 20201112 Trust Board Urology Report

134. 20201210 Confidential TB Minutes

146. 20201210 Trust Board Urology Report

147. 20210225 Confidential TB Minutes

148a. 20210325 Confidential TB Minutes & 148b. Urology update paper

149a. 20210527 Confidential TB Minutes & 149b. Urology update paper

150a. 20210930 Confidential TB Minutes & 150b. Urology Update paper

151a. 20211028 Confidential TB Minutes & 151b. Urology Update paper

152. 20211028 SHSCT Summary of Pats AOB

153. 20211028 Letter template

154. 20211028 First update for families

155. 20211028 Report on the Review of the Stage One Grievance panel decision in the case of Mr AOB

156a. 20220127 Confidential TB Minutes & 156b. Urology update paper

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158a. 20220331 Confidential TB Minutes & 158b. Urology update paper

159a. 20220526 Confidential TB Minutes & 159b. Urology update paper

160. 20220526 S21 notices final

161. 20220526 Risk Assessment Public Inquiry update

162a. 20220623 Confidential TB Minutes & 162b. Urology update paper

163a. 20220929 Confidential TB Minutes & 163b. Urology update paper
164. 20220929 RQIA Review of Urology Structured Case Record Review
165a. 20221213 Confidential TB Minutes & 165b. Urology update paper
167a. 20230126 Confidential TB Minutes & 167b. Urology update paper

34 Were you/the Board made aware of any concerns raised by Mr. O'Brien? If so, what were those concerns? Were those concerns reflected in Board governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were not reflected in governance documents and raised in Board meetings relevant to governance, please explain why not.

Concerns Raised by Mr O'Brien

34.1 I received by email (from Sandra Judt Board Assurance Manager on instruction form Mrs.Roberta Brownlee) on the 11th June 2020), with other Non-Executive Directors, a copy of a letter sent by Mr O'Brien to the former Chair, Mrs. Roberta Brownlee, on the 10th June 2020. This letter raised concerns in relation to the ongoing HR process, Mr O'Brien's request for retirement and his request to return on a part-time basis post retirement. This was an operational HR issue which was being dealt with through the Director of HROD, Mrs. Vivienne Toal, in conjunction with the Medical Director, Dr Maria O'Kane.

34.2 The former Chair Mrs. Roberta Brownlee raised receiving the letter at the Confidential Meeting dates 22nd October 2020.

Other Potentially Relevant Concerns Regarding Urology

34.3 In my answer to Questions 26 to 30 I have provided details of all the points in time of which I am aware where urology concerns or issues (other than those related to Mr O'Brien) were raised through Trust Board Meetings, Confidential Trust Board Meetings, and Performance Committee Meetings. It is clear that some of those

concerns related to, or were a product of, what has been described by other witnesses as the demand:capacity mismatch in Urology Services in the Southern Trust. I am now aware, through Inquiry hearings, that Mr O'Brien says that he was raising concerns about resources and the demand:capacity mismatch whilst employed by the Trust. Thus, although I am not aware of such concerns being raised by him or on his behalf with the Board or its committees, it is clear from my answers to Questions 26 to 30 that the demand:capacity mismatch is a concern that was being brought to our attention. In terms of the detail of those concerns and the Board's receipt of, and response to, them, I would simply refer to my answers to Questions 26 to 30 above. *Please see 194a – 194d. 194a. 20200611 - E - S Judt to R Brownlee, A1-A4.*

35 How, if at all, were the concerns raised about Mr. O'Brien by others reflected in Board governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were neither reflected in governance documents nor raised in Board meetings relevant to governance, please explain why not.

35.1 Urology Concerns raised regarding Mr O'Brien are reflected in the minutes of Confidential Trust Board meetings and Confidential Governance Committee meetings, in notes form Trust Board workshops and Chief Executive and Non-Executive Director meetings, and in any papers that were presented at meetings. I have outlined in the table below the meetings where Urology was discussed and reflected in the relevant minutes and/or notes.

Meeting	Date	Agenda Item
Confidential Trust Board	27th January 2017	Agenda Item 6 MHPS
Trust Board Workshop	27th August 2020	Agenda Item 6 Executive Directors Update
Confidential Trust Board	27th August 2020	Agenda Item Any Other Business
Confidential Trust Board	24th September 2020	Agenda Item 7 Urology

Chair & NED Meeting with CEO	08th October 2020	Agenda Item 5
Chair & NED Meeting with CEO	15th October 2020	Agenda Item 3
Confidential Trust Board	22nd October 2020	Agenda item 7 Urology
Chair & NED Meeting with CEO	05th November 2020	Agenda Item 6 Urology
Confidential Trust Board	12th November 2020	Agenda Item 6 Urology
Chair & NED Meeting with CEO	19th November 2020	Agenda Item 8 Urology
Chair & NED Meeting with CEO	26th November 2020	Agenda Item 7 Urology
Chair & NED Meeting with CEO	03rd December 2021	Agenda Item 6 Urology
Confidential Trust Board	10th December 2020	Agenda Item 3 Urology
Chair & NED Meeting with CEO	17th December 2020	Agenda Item, 7 Urology
Chair & NED Meeting with CEO	07th January 2021	Agenda Item 7 Urology
Chair & NED Meeting with CEO	14th January 2021	Agenda Item 7 Urology
Chair & NED Meeting with CEO	21st January 2021	Agenda Item 7 Urology
Chair & NED Meeting with CEO	04th February 2021	Agenda Item 8 Urology
Chair & NED Meeting with CEO	11th February 2021	Agenda Item 8 Urology
Confidential Trust Board	25th February 2021	Agenda Item 6 Urology
Chair & NED Meeting with CEO	04th March 2021	Agenda Item 7 Urology
Chair & NED Meeting with CEO	11th March 2021	Agenda Item 7 Urology

Chair & NED Meeting with CEO	18th March 2021	Agenda Item 6 Urology
Confidential Trust Board	25th March 20221	Agenda Item 5 Urology
Chair & NED Meeting with CEO	17th May 2021	Agenda Item 6 Urology
Confidential Trust Board	27th May 2021	Agenda Item 5 Urology
Chair & NED Meeting with CEO	07th June 2021	Agenda Item 5 Urology
Confidential Trust Board	30th September 2021	Agenda item 5 Urology
Confidential Trust Board	28th October 2021	Agenda Item 7 Urology
Confidential Governance Committee	16th November 2021	Agenda Item 3 The Committee received th Internal Audit report on the review of Mr. A's Private Work
Confidential Trust Board	27th January 2022	Agenda Item 8 Urology
Confidential Governance Committee	10th February 2022	Agenda Item 4 The Committee received th Updates from the internal audit report on Mr. A's Private Work
Confidential Trust Board	31st March 2022	Agenda Item 10 Urology
Confidential Trust Board	26th May 2022	Agenda Item 7 Urology
Confidential Trust Board	23rd June 2022	Agenda Item 5 Urology
Confidential Trust Board	29th September 2022	Agenda Item 8 Urology
Confidential Trust Board	27th October 2022	Agenda Item 8 Urology
Confidential Trust Board	26th January 2023	Agenda Item 10 Urology
Confidential Trust Board	30th March 2023	Agenda Item 10 Urology
Confidential Trust Board	25th May 2023	Agenda Item 8 Urology
Confidential Trust Board	22nd June 2023	Agenda Item 7 Urology

35.2 I have included below any references within the Corporate Risk Register that I could find during my tenure (2016 – 2023) in regard to Urology:

Corporate Risk Register • August 2016 • Page 21	Risk No 6 Workforce Risk – workforce shortages SAS Medical Staff in Anesthetic, General Surgery, GP Out of Hours, **Urology**, Dermatology, Emergency Medicine and Pediatrics.
Corporate Risk Register • August 2016 • Page 46	Risk No 13 Waiting time in excess of Commissioning Plan Standards/Targets Planned Patient Backlog As at 01st August 2016, there were a total of 1560 patients on the planned treatment backlog. The longest waiting patient dates back to October 2014 and relates to **Urology.**
Corporate Risk Register • May 2020 • Page 51	Risk No 12 Clinical Risk associated with inability to manage patient care within clinically indicated timescales. Covid Factors: Inclusion Clinical teams have worked closely with regional Clinical Reference Groups to ensure a consistent approach to prioritization of cancer work across tumor sites with cancer surgery being focused ir DHH also links to IS (mainly for Breast **Urology** and Gynae to date).

Urology Services Inquiry

Corporate Risk Register • August 2020 • Page 50	Risk No 12 Clinical Risk associated with inability to manage patient care within clinically indicated timescales. Covid Factors: Inclusion Clinical teams have worked closely with regional Clinical Reference Groups to ensure a consistent approach to prioritization of cancer work across tumors sites with cancer surgery being focused in DHH also links to IS (mainly for Breast, **Urology** and Gynae to date).
Corporate Risk Register • January 2022 • Page 7	Risk No 1 People D: following the successful implementation of the Clinical Fellow model on the Junior Tier, we recruited 9 Gen Med, 4 T&O, 5 ED CAH, 2 **Urology**, 2 ED DHH (3 of which are international Doctors
Corporate Risk Register • May 2022 • Page 6	Review options of attracting temporary consultants without CCT into Consultant roles with support from Trust to obtain GMC certification (radiology/**urology**)
Corporate Risk Register • September 2022	Risk Number 7 **Urology** Services Public Inquiry

Please see:

195. 20160908 CRR

134q. Item 9b. Corporate Risk Register May 2020 to Trust Board _ 4th June 2020

134r. Corporate Risk Register August 2020

199. Summary Corporate Risk Register January 2022

134s. Summary Corporate Risk Register to Governance Committee 12052022

201. 20220922 - Corporate Risk Register

35.3 There is no specific risk named in regard to Mr O'Brien or his issues. This is not surprising as I would not expect a specific risk in relation to any individual clinician or his issues to be within the Corporate Risk Register.

35.4 It is the case that SMT reviewed the Corporate Risk Register in advance of the Governance Committee on the 10th February 2022. They provided a risk assessment in relation to the Urology Services Inquiry which included the Lookback exercise. As a result, our response to the Public Inquiry became the seventh corporate risk on the Register from March 2022.

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

36.1 The direct provision of such support is not the role of the Trust Board. Support to Urology staff would be provided directly through their line manager and/or relevant Director. Whilst the role of the Trust Board would not be to provide direct support to staff, our role is to ensure that, where support is needed, others are enabled to provide it.

36.2 In this regard, my understanding is that the support provided can be considered under two broad heads: first, support with workload and, second, support of the individual staff members.

36.3 In terms of workload support, I am aware of a number of initiatives including the following:

a. There was investment for a 7th Urology consultant as well as periodic additional resources to support waiting list initiatives. Unfortunately, demand:capacity issues have been applicable across a range of disciplines in the Trust during my tenure including Emergency Medicine, General Internal Medicine, Psychiatry of Old Age, Stroke Services and Emergency General Surgery. These have all been brought to the attention of the Board by the Executive Team. I do not recall Urology pressures being raised to the same extent with the Board during 2016-2020 as the above mentioned.

b. At the Board's confidential meeting on the 30th September 2021, Dr O'Kane (then Medical Director) indicated, with her update on urology, that a service specification was being prepared for the provision of urology outpatient reviews from the Independent Sector to support the Urology Team in seeing patients identified as needing reviewed. *Please see 150a.20210930 Confidential TB Minutes.*

c. Heather Trouton provided an update at the Board's confidential meeting on the 27th January 2022 noting that the Trust had written to the Department of Health for regional support for the Lookback exercise. *Please see 202. 20220127 Confidential TB Minutes.*

36.4 Efforts like these were designed, in part, to support Urology staff in practical terms by managing their workload.

36.5 In terms of support of individual staff, I am aware of the following:

a. All of the following services have been available:
   i. Care Call;
   ii. Psychological Support;

iii. Occupational Health.

b. I understand that the (then) Chief Executive, Shane Devlin, the (then) Medical Director, Dr O'Kane, and Director of Acute Services, Melanie McClements, undertook staff engagement meetings with clinical teams, for example, as seen in the update paper provided to the confidential Trust Board meeting on the 25th March 2021. Such meetings were to offer a range of support on an individual basis or as a team going forward. *Please see 148a. 20210325 Confidential TB Minutes.*

c. The Trust recognises its duty of care to all staff. Staff health and wellbeing has been a constant concern and focus from the onset of the Covid pandemic and the rising pressures in the delivery of services across the Trust. Against this backdrop, the Trust Board approved a People Framework at its meeting on the 29th September 2022, the key priorities of which are: Wellbeing, Belonging and Growing.

Governance Committee

37. How does the Governance Committee provide assurance to the Trust Board?

37.1 The remit of the Committee, as outlined in its Terms of Reference, is to ensure that:

a) There are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated governance across the Trust.
b) Assessment of assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.
c) Principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to Trust Board

d) Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services.
e) There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance.
f) Recommendations considered appropriate by the Committee are made to the Trust Board recognising that financial governance is primarily dealt with by the Audit Committee.

37.2 In carrying out its work, the Committee utilises information from the following:

a) Clinical and Social Care Governance systems;
b) Risk Assessment and Risk Management systems;
c) Health and Safety;
d) Medicines Management systems;
e) Information Governance systems;
f) Litigation systems;
g) National Audit outcomes;
h) Whistleblowing process;
i) Maintaining High Professional Standards and Nurses in Difficulty processes.

37.3 The Governance Committee currently receives internal and external reports from across the Trust Directorates on a range of areas which include the areas outlined in paragraph 37.2 above.

37.4 Reports on the above areas are presented by the accountable Director. Committee members would then raise questions (e.g., arising out of the paper and/or the presentation) of the relevant Director to seek clarity and/or assurance. The fact that papers have been presented for assurance and/or information is noted at the meeting and in the minutes for the record.

37.5 After the meeting, the Chair of the Committee prepares an outcomes note or, more recently, a Chair's notes document that goes forward to the next Trust Board meeting for information. For example:

a) In 2017, 2018 and 2019 Governance Committee outcomes notes were prepared by me as Chair;
b) In 2019 and 2020 Governance Committee Chair's Notes were prepared by me as Chair.

37.6 Prior to my tenure as Chair of the Trust Board, the practice had been that a meeting of the Trust Board Chair, Governance Committee Chair, Chief Executive, and Board Assurance Manager took place after each Governance Committee meeting. No formal notes or minutes were taken at these meetings. When I became Chair of the Trust Board, I stood these meetings down and implemented a Chair's Report that goes to Trust Board for Board consideration along with a copy of the draft minutes of the Committee, its Terms of Reference, and its Committee Annual Work Plan. The Chair's Report details the agenda items discussed, any key points for raising with Trust Board, and any recommendations for Trust Board. *Please see:*

Governance Committee outcomes notes 2017 – 2020
63. 20170511 Governance Committee outcomes note from meeting held on 11 May 2017
64. 20170907 Governance Committee outcomes note from meeting held on 07 September 2017
65. 20171207 Governance Committee outcomes note from meeting held on 07 December 2017
66. 20180208 Governance Committee Outcomes Note from Meeting held 08 February 2018
67. 20180511 Governance Committee outcomes note from meeting held on 11 May 2018
68. 20180906 Governance Committee outcomes note from meeting held on 06 September 2018

69. 20181206 Governance Committee outcomes note from meeting held on 06 December 2018

70. 20190207 Governance Committee outcomes note from meeting held on 07 February 2019

71. 20190521 Governance Committee Chair's Notes 21 May 2019

72. 20190905 Governance Committee Chair's Notes 05 September 2019

73. 20200213 Governance Committee Chair's Notes 13 February 2020

74. 20200910 Governance Committee Chair Notes 10 September 2020

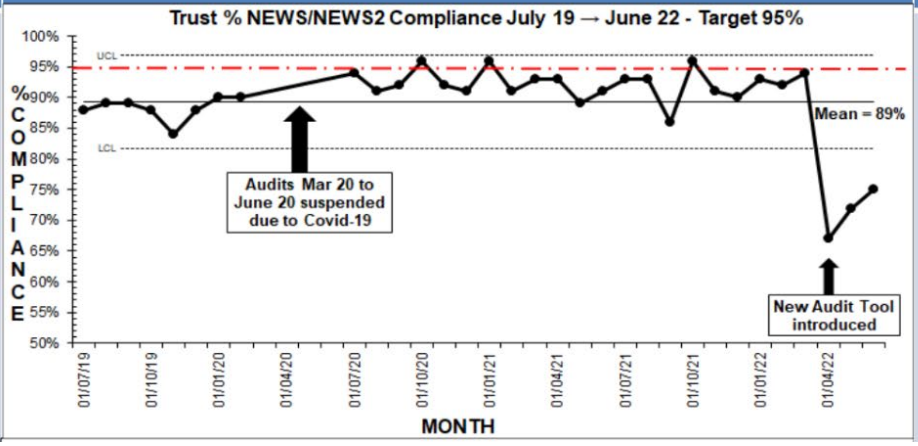
38. **How is the Governance Committee informed of concerns regarding patient safety and risk**?

38.1 Concerns regarding patient safety and risk can come before the Governance Committee through any of the reports that are presented to it. Directors can also raise any concern about patient safety or any risk that may not be covered in a report within the meeting.

38.2 The majority of items that come before the Governance Committee have a link to patient safety. For example, raising concerns, litigation, Corporate Risk Register, and Medicines Governance Reports will link to patient safety.

38.3 The substantive part of the Governance Committee agenda is a detailed Clinical and Social Care Governance Report. Within this, the Committee receives a Patient Safety Report which uses regional patient safety indicators.

38.4 The below chart is a visualisaton of patient safety data in regard to 'NEWS2' (National Early Warning Score). This is presented to the Governance Committee as part of a larger bundle of documents that focus on clinical and social care governance.

Patient Safety intervention	DATA	Observations and analysis
1. NEWS/ NEWS2: **Process Measure –** **Compliance with NEWS2 Bundle**		❖ NEWS – Q1 20/21 (Apr 20 → June 20) Audit was suspended by PHA due to Covid-19 ❖ NEWS2 replaced NEWS in May 21 ❖ NEWS Compliance Q1 22/23 (Apr 22 → June 22) was **71%**, down from **93%** in Q4 21/22 ❖ Significant decline in compliance in Q1 22/23 attributed to the introduction of a new more robust Audit Tool, which is more compatible along side NEWS2

38.4 The areas covered within the Patient Safety Report are:

Area	**What it covers**
Compliance with NEWS2 Bundle	National Early Warning Score which is designed to identify acutely ill patients though observations, recording and escalation.
Fall Safe Bundle Compliance	Fall Safe Bundle **A** elements looks to the patient, history of falling, footwear, urinalysis and areas free from slip or trip hazards. Fall Safe Bundle **B** elements include cognitive screening, bedrail assessment. Lying and standing blood pressure.
Hospital Acquired Pressure Ulcers	Skin Bundle (Pressure Ulcers) elements include skin bundle plan of care completed, risk assessment completed within 7 days , mattress suitable for the level of skin damage, pressure relieving cushion supplied, current mattress surface fit for purpose, skin inspected at least twice daily

Trust VTE Risk Assessment	Compliance with Venous Thromboembolism (VTE) risk assessment.

38.5 The purpose of this report is to provide assurance on how safe patients are within the hospital. Trends on all of the above give a sense of how safe it is for patients and provides intelligence for the Executive Team to deploy resource to improve where needed. *Please see:*

215. 11ia. Appendix A Q3 22-23 Patient Safety Interventions Apr 23

38.6 The Corporate Risk Register, which is presented to the Governance Committee by the Chief Executive, includes risks and mitigations in regard to the delivery of the Corporate Objectives.

38.7 Under the Corporate Objective, 'Promoting safe, high quality care', risks are stated in regard to 7 key corporate risks:

1: People;
2: Estates and Infrastructure;
3: Access to Services;
4: Technology Enablement;
5: Finance;
6: Infection Prevention and Control;
7: Urology Services Public Inquiry.

38.8 The Chief Executive and Directors review the Register and present updates and any changes to the Committee. The Committee also undertakes a 'deep dive' on risk areas. Examples of recent deep dives are:

a) Estates and Infrastructure, which is recorded in the minutes of the Governance Committee held on the 16th November 2021.
b) Unscheduled Care, which is recorded in the Governance Committee minutes of the 9th February 2023.

Urology Services Inquiry

39. How is the Governance Committee assured that the clinical governance systems in place are adequate?

39.1 The Governance Committee receives papers on clinical governance form the Executive/Operational Directors, External Agencies, and National Audits such as the following:

Director	Report	Assurance
Medical Director Internal Assurance	Clinical and Social Care Governance	Provides assurance on all aspects of clinical and social care governance performance indicators, namely, patient safety and quality measures, incident monitoring (to include reporting timeframes), and complaint and compliment monitoring.
Medical Director Internal Assurance	Management of Standards and Guidelines	Report provides assurance on the dissemination and implementation of regionally endorsed standards and guidelines received by the Trust.
Medical Director External Assurance	National Audit Assurance Report (NAAR)	The NAAR provides assurance on the Trust's participation in the NHS England Quality Accounts list of national audits (annually), progress on previous recommendations, SHSCT programme of clinical audits, and work to strengthen the clinical audit function.
CHKS External Assurance	Quarterly mortality reports	This report provides information on hospital death rates and is an important quality indicator.
Director of Pharmacy Internal Assurance	Medicines Safety Report Report from the Accountable Officer responsible for Controlled Drugs	Medicines Safety Report is focused on providing assurance to the Governance Committee regarding medicines management within the Trust. Accountable Officer Report is focused on providing assurance to the Governance Committee on the work of the Trust's Accountable Officer, under the post-Shipman

		legislation, on the management of controlled drugs.
NICE CG 174 External and Internal	RQIA Review of the implementation of the NICE CG 174 – IV Fluid Therapy in adults in hospitals in Northern Ireland	This report provides assurance on the Trust's implementation of NICE CG 174 – IV Fluid therapy in adults in hospitals in Northern Ireland.

39.2 These papers are presented for assurance/information at the Committee. Members will discuss/interrogate the papers and seek clarity (e.g., by asking questions of the relevant Executive/Operational Director, where applicable) where needed to get to a position where they are assured. Cover sheets for the papers provide for a summary, areas of improvement/achievement, and areas of concern, risk, and/or challenge.

39.3 I have included below a report cover sheet for the Governance Committee meeting held on the 12th January 2023 in relation to the National Audit Assurance Report (NAAR) 2022. *Please see 216. 11va. 20230112_National Audit Assurance Summary Report.*

Southern Health and Social Care Trust

Quality care – for you, with you

COVER SHEET

Meeting and Date of meeting	Governance Committee 12th January 2023	
Title of paper	National Audit Assurance Report (NAAR) 2022	
Accountable Director	Name	Dr Stephen Austin
	Position	Medical Director
Report Author	Name	Fiona Davidson, Head of Clinical Audit & Clinical Leads for National Audits
	Email	Fiona.davidson Personal Information redacted by the USI
This paper sits within the Trust Board role of:		Accountability
This paper is presented for:		Assurance

Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	√	Improving our services
	☐	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

This report cover sheet has been prepared by the Accountable Director.

Its purpose is to provide the Trust Committee with a clear summary of the paper being presented, with the key matters for attention and the 'ask' of the Committee.

It details how it impacts on the people we serve.

Urology Services Inquiry

1. Detailed summary of paper contents:
The purpose of this paper is to provide: • An annual overview of the SHSCT's participation in the *NHS England Quality Accounts List* of national audits together with the rationale for any non-participation. • An updated SHSCT position on the progression of recommendations arising from participation in national audits, including those relevant from previous years. • The composite SHSCT programme of clinical audits centrally registered in the previous 12 month period. • An update on progress work to strengthen the Trust's clinical audit function
2. Areas of improvement/achievement:
• Increased participation in National Audit Programmes across all Directorates
3. Areas of concern/risk/challenge:
• The on-going impact of service pressures on the ability to progress the implementation of recommendations and action plans for improvement. • Section 4 – details specific issues highlighted across 26 audits regarding a range of organisational issues; from infrastructure and accommodation, clinical specialism availability, data sharing and staff pressures • To ensure that all audits (international, national, regional and local) are reported; action planned and monitored on a regular basis within operational directorate governance arrangements. • To ensure adequate representation of all Directorates / Divisions across national and local clinical audit programmes. • Lack of regional direction on compliance with data sharing and GDPR requirements • Strengthening the clinical audit function for assurance and improvement.

4. Impact: Indicate if this impacts with any of the following and how:	
Corporate Risk Register	This work primarily drives improvement in clinical effectiveness or highlights areas of risk and as a result provides an aspect of assurance to the Senior Management Team, Governance Committee and Trust Board on standards of safe and quality care. Currently the Trust's clinical audit capacity is item 3.8 on the Trust's CRR
Board Assurance Framework	The role of clinical audit as a tool for governance sits in context of the SHSCT Board Assurance framework. Clinical audit has a key role to play across the three lines of defence at departmental, organisational oversight and independent external review levels. These three lines of defence provide assurance to Trust Board on the quality and safety of care
Equality and Human Rights	

40. How do you ensure that the Governance Committee is appraised of both serious concerns as well as current Trust performance against applicable standards of clinical care and safety? What is your view of the efficacy of these systems?

40.1 Responsible Directors (Executive/Operational) are required to attend Governance Committee Meetings to present on matters within their remit. Papers are expected to be prepared to inform Committee Members to enable discussion to take place at the meeting.

40.2 The Governance Committee has an annual work plan which sets out when items are to be presented to the Committee. Clinical and Social Care Governance is a standing item at each meeting.

Governance Area	Report details	Lead Person	Frequency	Month	Purpose
Clinical and Social Care Governance	Clinical and Social Care Governance Report	Medical Director / Assistant Director C&SCG	Quarterly	February 2023 May 2023 September 2023 November 2023	Information
	Management of Trust Standards and Guidelines	Medical Director / Assistant Director C&SCG	Quarterly	February 2023 May 2023 September 2023 November 2023	Assurance
	Mortality Report	Medical Director / Assistant Director C&SCG	Quarterly	February 2023 May 2023 September 2023 November 2023	Assurance
	National Audit Assurance Report	Medical Director / Assistant Director C&SCG	Annually	November 2023	Assurance

Please see 14. Governance Committee Work Plan 2023.

40.3 In the reporting to the Committee, the data and information provided allows for identification of trends (improvements and decline). Each Director also has the opportunity to raise any concerns they have at any point. An example of this is a concern raised by Dr O'Kane, as Medical Director, to the Committee at its meeting of the 5th December 2019. This resulted in a whistleblowing investigation and the committee being updated at its meetings over the next 2 years (as summarised below).

Meeting	**Detail**
Governance Committee 05th December 2019	Agenda Item 2 Presentation: Obstetrics and Gynaecology

	In responding to a question asked by Mrs McCartan as regards peer comparisons, the Chief Executive explained the data is not released as a league table, but is a learning tool for the Trust. Complaints were discussed. Dr O'Kane reported the top 4 complaint subjects correlate to the same pattern across other Directorates. Mrs Magwood pointed out an increase in complaints in MHLD and asked if there was a pattern emerging. Mrs Reid advised this quarterly comparison will be ongoing to establish if Directorate patters are emerging. In relation to Litigation, Dr O'Kane noted between 1999 and 2019, the Obstetrics rnance Committee Minutes 5th December 2019 Page 2 [redacted] DRAFT and Gynaecology division has received 178 claims, of which 140 remain open. Dr O'Kane informed members that a raising concerns process is underway in relation to a whistleblowing complaint. NIMDTA have commenced a review in response to concerns raised by Doctors in training. Dr O'Kane added management will be meeting with staff to gain a better understanding of the issues which will be carried out in a confidential setting with staff. Dr O'Kane proposed to the committee the trusts intention to request an Invited Service Review from the Royal College Obstetricians and Gynaecologists.
10th September 2020	Agenda Item 2 Presentation: Obstetrics and Gynaecology Agenda Item 6 Matters arising Members sought update on the invited review.
11th February 2021	Agenda Item 6: Report of Obstetrics and Gynaecology Whistleblowing Investigation
13th May 2021	Agenda Item: Matters arising – up date provide
09th September 2021	Agenda Item 5: Matters arising – update provided with action plan

Please see:

218. 20191205 Approved Governance Committee Minutes 05.12.19

74. 20200910 Approved Governance Committee Minutes 10.09.20

219. 20210211 Approved Governance Committee Minutes 11th February 2021

220. 20210513 Approved Governance Committee Minutes 13th May 2021

221. 20210909 Approved Governance Committee Minutes

40.4 Whilst the primary source of concerns being raised at Governance Committee would be reporting by Directors, the Committee itself can raise concerns based on the information provided to it. It can do this of its own motion or in response to an issue referred to it by the Trust Board or shared with it by another Committee of the Board. An example of this would be the Performance Committee's concerns on Stroke Services as a result of a presentation being given to that Committee at its meeting on the 10th March 2022. As a result of that presentation the Committee Chair wrote to me as Chair to raise concerns on the deterioration of the service (see further Question 18 above). *Please see 105. 20220311 E from PL to EM and NEDS re Stroke Services.*

40.5 The Governance Committee during my time on the Board has seen the agenda of areas covered by it, and the volume of information coming to it, increase.

40.6 During the period of 2016 – 2023, there have been a very significant number of changes in the personnel occupying the Executive and Operational Director roles who attend and report to our Committee, as summarised below:

Chief Executive	Mr. Frances Rice (Interim) April 2016 – March 2018 Mr. Stephen McNally (Acting Interim) January 2017 – July 2017 + November 2017 – March 2018 Mr. Shane Devlin March 2018 – February 2022 Dr Maria O'Kane May 2022 - Present
Medical Director	Dr Richard Wright July 2016 – August 2018 Dr Ahmed Khan (Interim) April 2018 – December 2018 Dr Maria O'Kane December 2018 – April 2022 Dr Stephen Austin November 2022 - Present

Director of Acute Services	Mrs Esther Gishkori August 2017 – April 2020 Mrs Anita Carroll (Acting) July 2018 – September 2018 Mrs Melanie McClements June 2019 – August 2022 Mrs Trudy Reid (Interim Director of Surgery & Elective Care, Cancer & Clinical Services and Integrated Maternity & Women's Health) – August 2022 – January 2023 Mrs Cathrine Reid (Interim Director of Unscheduled Care – August 2022 – January 2023 Mrs Trudy Reid (Director of Medicine and Unscheduled Care) – January 2023 – Present Mrs Cathrine Reid (Director of Surgery and Clinical Services) – January 2023 - Present
Director of Mental Health and Disability Services	Mr Bryce McMurray (Acting) (also Interim Executive Director of Nursing and AHP's) May 2016 – December 2017 Mrs Carmel Harney (Acting) January 2018 – December 2018 Mr Barney McNeany January 2019 – March 2021 Dr Maria O'Kane March 2021 – February 2022 Jan McGall March 2022 - Present

40.7 The system for reporting is only as good as those that are doing the reporting, who have full ownership and responsibility. The number of personnel changes in key reporting roles (as summarised above) did not, in my opinion, provide for the consistency needed. When Mr. Shane Devlin joined the Trust as substantive CEO, followed then by Dr Maria O'Kane as substantive Medical Director, this provided the opportunity to review 'the how and the what' and make improvements as necessary. I welcomed the external 'Champion Review' that had within its focus the corporate, clinical and social care governance of the Trust.

41. How did the Governance Committee monitor and quality assure the governance actions and action plans of the Trust? If possible, please illustrate

your answer by reference to examples of Board monitoring and quality assurance throughout the Trust and most particularly within urology?

41.1 The Governance Committee monitored the governance actions of the Trust through reports and updates provided by the accountable Director. In practice, the annual schedule of business for the Committee (referred to at Question 40) sets out the plan for the year ahead including what reports are expected and when. Within that plan, external assurance reports would be provided such as the National Audit Assurance Programme.

41.2 The Committee, in its deliberations, may ask for action plans (depending on the outcome of the report before it) in order to assure itself that management had measures in place for improvements where needed.

41.3 The example I referenced in response to Question 40 regarding Obstetrics and Gynaecology summarises, in respect of a concern that was raised in December 2019, the follow through from the Committee in respect of investigation and the presentation of an action plan.

41.4 In regard to Urology matters specifically, the Trust Board, through its confidential meetings, monitors the progress being made in regard to actions in respect of the SAIs, Lookback Review, and service improvement. The Governance Committee does not monitor these; they sit solely with the Trust Board.

41.5 The Department of Health established a Urology Assurance Group in November 2020, The Trust Senior Management Team attend these meetings to present on the progress being made in regard to the SAIs, Lookback Review, and service improvement. The fact that membership of this group includes personnel external to the Trust also provides an element of independent assurance in respect of the Trust's actions.

41.6 The Trust Chief Executive, Dr Maria O'Kane, commissioned an external Expert Reference Group to act as a critical friend to provide an independent

challenge and support role to the Chief Executive and Directors leading the Southern Trust's Improving Organisational Effectiveness Programme. This is a direct result of the outworking of the Urology Services Public Inquiry. This is another level of assurance for the Trust.

41.7 A specific example of quality assurance being provided to the Governance Committee is the Report on the Quality Assurance Visit to the Southern Area Breast Screening Unit. This was presented to the Committee at its meeting on the 9th September 2021. External reports like this are an important part of the assurance framework for the Trust because they involve an external lens being applied that measures the Trust's actions against the standards that have been set.

42 What were the lines of management providing information on governance issues to the Governance Committee? How did this information reach the Governance Committee? What, if anything, was in place to bring governance concerns to the Board on an urgent basis?

42.1 The lines of management providing information on governance issues to the Governance Committee were through the Chief Executive and the Executive and Operational Directors. Those in attendance at the Governance Committee are as follows:

a) Chief Executive;
b) Medical Director;
c) Director of Finance, Procurement and Estates;
d) Interim Director of Children and Young People's Services / Executive Director of Social Work;
e) Director of Mental Health and Disability Services;
f) Executive Director of Nursing, Midwifery and AHPs & Functional Support Services;
g) Director of Acute Services;
h) Director of Medicine and Unscheduled Care;
i) Director of Surgery and Clinical Services;

j) Director of Adult Community Services;
k) Director of Human Resources and Organisational Development;
l) Interim Director of Performance and Reform;
m) Interim Assistant Director, Clinical and Social Care Governance;
n) Head of Pharmacy and Medicines Management.

42.2 The information would be received either by email or verbally depending on the situation and timing. Where meetings were being arranged to discuss the issues any papers would be uploaded on to 'Decision Time' in advance or provided on the day for all members to review.

42.3 Previously (see Question 37), meetings of the Trust Board Chair, Governance Committee Chair, and Chief Executive (with the Board Assurance Manager in attendance) took place after each Governance Committee meeting. Escalation of anything urgent could have been raised there.

42.4 Currently, anything urgent can be escalated to the Chair and Chief Executive between meetings. If it is a concern in relation to patient safety and/or clinical concerns, these can be escalated to the Trust Board or any of its committees in particular the governance committee.

42.5 The Governance Committee Chair can raise any urgent issue with the Board Chair and CEO at any point, as too can any Non-Executive, Executive and Operational Director.

42.6 Examples of urgent issues being brought to the Committee which are not urology related are as follows:

Confidential Governance Committee 11th May 2017	Agenda item 4: Update on investigation into Dr Duffins Concerns Email received referencing several issues in relation to patient safety and the DATIX system

Governance Committee 13th May 2021	Agenda Item 7ii. Third Party Cyber Incidents. Recent cyber-attacks and the increase risk to the Trust of future attacks
Governance Committee 16th November 2021	Agenda Item 11a. Corporate Risk Register New risk added: Risk to the Trust due to overdue servicing of medical equipment as highlighted in Internal Audit of Management of Medical Equipment 21/22

Please see:

63. 20170511 Confidential Governance Minutes 11th May 2017

220. 20210513 Approved Governance Committee Minutes 13th May 2021

223. 20211116 Approved Governance Committee Minutes

43 Who provided information on governance issues to the Governance Committee? How did this information escalate to the Governance Committee? Please answer by way of examples, particularly in relation to urology. Please also attach all documents relevant to your answer.

43.1 The Governance Committee is a 'Non-Executive only' Committee (currently). I have outlined below the attendance as per the Committee's Terms of Reference dated 13th February 2020 and 09th February 2023. Information is provided to the Committee from the majority of these attendees.

13th February 2020	**09th February 2023**
Chief Executive Medical Director Director of Finance, Procurement and Estates Director of Children and Young People's Services / Executive Director of Social Work	Chief Executive Medical Director Director of Finance, Procurement and Estates Interim Director of Children and Young People's Services / Executive Director of Social Work

Director of Mental Health and Disability Services Executive Director of Nursing, Midwifery and AHPs & Functional Support Services Director of Acute Services Director of Surgery and Clinical Services Director of Older People and Primary Care Director of Human Resources and Organisational Development Director of Performance and Reform Assistant Director, Clinical and Social Care Governance Director of Pharmacy	Director of Mental Health and Disability Services Executive Director of Nursing, Midwifery and AHPs & Functional Support Services Director of Medicine and Unscheduled Care Director of Surgery and Clinical Services Director of Adult Community Services Director of Human Resources and Organisational Development Interim Director of Performance and Reform Interim Assistant Director, Clinical and Social Care Governance Head of Pharmacy and Medicines Management

43.2 Information comes to the Committee by way of reports and updates which form the meeting pack uploaded onto 'Decision Time'.

43.3 All report cover sheets provide all Directors with an opportunity to identify areas of concern/risk/challenge. Directors are also asked to indicate the impact on the Corporate Risk Register, Board Assurance Framework and Equality and Human Rights.

44 What procedures and policies are in place to allow concerns around governance issues to be escalated to the Board as a matter of urgency? Please explain how these procedures and policies work in practice, providing examples, as relevant.

44.1 There is a very significant overlap between (a) those who are either members of or attendees at Governance Committee and (b) those who are members of the Trust Board. Therefore, in practical terms if an urgent concern is brought before the Committee it will come to the attention of a large part of the Board at that point.

44.2 As for escalating an urgent concern to the full Board, to the best of my knowledge there is no formal written escalation procedure. In practice, if an urgent

issue arises there will be an action to bring it to either the Confidential or Public parts of the next Trust Board meeting, whichever is appropriate, and a 'matter arising' created for it. There is also nothing to prevent urgent matters being escalated to Trust Board between its meetings, for example, by email. An example would be an email from the Chair of the Performance Committee to me as the Board Chair on the 11th March 2022. The email was raising concerns in regard to Stroke Services. I refer in this regard to my earlier answers to Questions 18 and 40.

44.3 Extraordinary or unscheduled meetings are also another means of advising Trust Board in respect of urgent matters. I have outlined in the table below two such meetings which occurred in 2017. However, from taking up post as Chair of the Trust Board, either Confidential or Public Trust Board Meetings have been the main avenue for governance concerns to be escalated.

Date	Type of meeting	Agenda Item(s)
24th August 2017	Extraordinary Trust Board	SHSCT Savings Plan 2017/2018
13th October 2017	Extraordinary Trust Board	SHSCT Savings Plan 2017/2018

44.4 From 2016 – 2020, I prepared notes as Chair of the Governance Committee. for a meeting with the Trust Board Chair and Chief Executive (with the Board Assurance Manager in attendance). This meeting typically took place within 1-to-2 weeks of the Committee meeting. If there was anything urgent it could be raised there also.

44.5 Since 2020, a Committee Chair's report is provided for the Trust Board along with draft minutes from Committee Meetings.

45 Are the issues of concern and risk identified in urology services of the type the Governance Committee would be expected to have been informed about at an early stage? Was the Governance Committee informed of concerns

regarding urology, and Mr. O'Brien in particular, at the appropriate time? What is your view generally of the timing and manner in which the Governance Committee and the Board were informed of concerns regarding urology and Mr O'Brien? What, in your view, should have happened, when, and why did it not?

45.1 Issues of concern and risk identified in urology services are of the type I would expect to be raised at the Governance Committee. This includes:

a. the MHPS process, challenges experienced in respect of it (e.g., non-compliance with the return to work action plan), and its outcome;
b. the demand:capacity issue and its impact on service delivery and patient safety; and
c. the significant SAI outcomes and assurance from management in respect of its actions in response.

45.2 The MHPS reporting in 2017 (which was to the Board rather than the Governance Committee) was very limited, as was the probing and questioning by the Board at that time. Looking back, and having experienced the fullness of the quarterly MHPS reporting through the Confidential Governance Committee meetings that now occurs, my view is that the Governance Committee was not kept as informed as they ought to have been.

45.3 As mentioned in earlier answers, the Trust Board (rather than the Governance Committee) was notified of further concerns about Mr O'Brien (i.e., concerns other than those that had been reported to it in January 2017) on the 27th August 2020. Due to the significant level of concern about patient safety, the Confidential Trust Board Meetings (rather than Governance Committee meetings) were where discussions thereafter took place and where updates were provided. The role of Governance Committee has, instead, been to look at developing improvements in reporting of the MHPS process – which it has done during the 2022/2023 period. It

has also received from the Audit Committee an internal audit report on Mr O'Brien's private practice where governance matters related to this Committee.

45.4 In my view, knowing what I know now, the Trust Board and the Governance were not kept appropriately informed in the period 2016 – 2020. This included explicitly detailing the patient safety risk arising as a result of the demand:capacity mismatch. Since Dr O'Kane, as Medical Director, raised matters at the Trust Board in August 2020, I believe that the Trust Board and the Governance Committee has been kept appropriately informed. The Governance Committee has also been kept informed in regard to improvements being made in reporting, in particular in respect of the MHPS process and professional governance.

Learning

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

46.1 Looking back across my tenure, through the lens of what has evolved to my knowledge since 2020, it is clear to me now that the Trust's governance systems were not fit for purpose.

46.2 At the center of this unfitness is what appears to me to have been a lack of triangulation of information and/or a culture of working in silos. Separate processes were being undertaken with no joining up of the intelligence – MHPS, Appraisal, and Serious Adverse Incident investigations. There was also an unhealthy churn in the key roles of CEO, Medical Director, and Acute Director over the period 2016 – 2020, which did not help matters.

46.3 I did not raise any specific concerns about the governance systems at the time. However, I did raise the below areas for consideration because I believed that

they would support the Trust Board in its learning from others and in its development of the Board Team.

Concern	Raised with	When	What was done
Knowing our blind spots	Roberta Brownlee and Shane Devlin.	27 August 2020	Workshop -Muckamore Abbey Hospital – Report of the Independent Leadership and Governance Review.
Email and note sent to Chair and NEDs as I would not be in attendance at the meeting. NED Sub Committee Membership/Other interested areas/Roles and responsibility	Roberta Brownlee, all Non-Executive Directors, and copied in Shane Devlin.	20th May 2019	No reference in the minutes that this was discussed.
Chief Executive performance targets	Roberta Brownlee and Non-Executive Directors.	28 October 2018	I requested Culture be placed as part of the CEO performance targets.

46.4 As Chair of the Governance Committee, I also sought improvements to reporting, in particular in respect of clinical and social care governance. This was ongoing with each Committee meeting highlighting the need for additional/different information to support its work. Each of the three Medical Directors (2016 – 2019) had their own way of reporting. Dr Maria O'Kane brought significant changes to reporting and practice with the outworking's of the Champion Review. This included Standards and Guidelines, SAI Process, and Complaints.

Please see:

33. 20200827 E to RB and SD Re Blind Spots

225. 20190520 E From EM to Chair SD and NEDs re NED Mtg 21st May 2019

226. 20190520 E From EM to Chair SD and NEDs re NED Mtg 21st May 2019 A1

78. 20190521 - Notes of a meeting of the Non Executive Directors and Chair

228. 20181028 E from EM to RB and NEDS re CX Performance Targets 1718 and 1819

229. 20190201 E re Governance Mtg and Papers

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

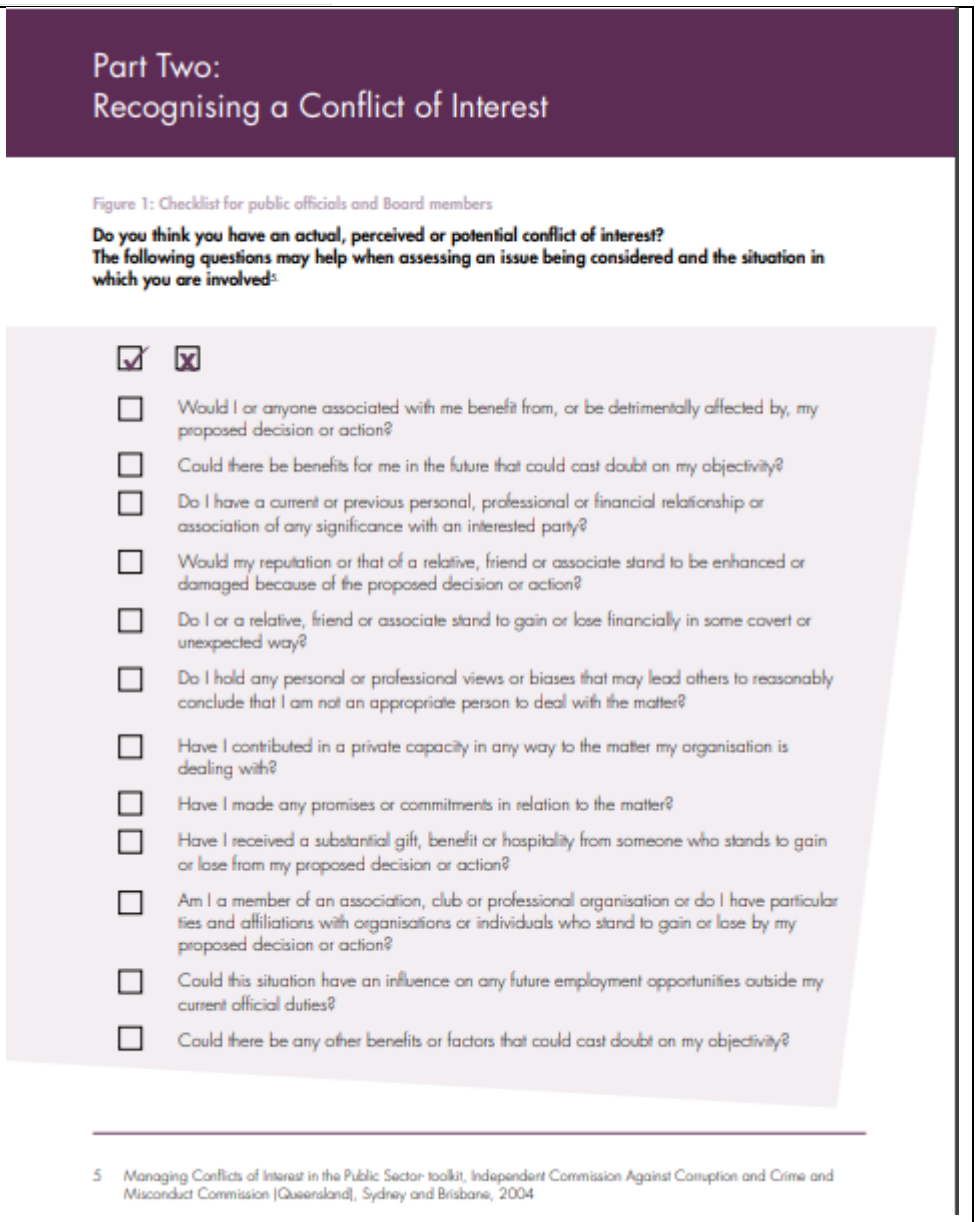
47.1 I am now aware of governance concerns arising out of the provision of urology services as follows:

Concern	Summary
Concerns regarding Mr O'Brien prior to the MHPS Process	I am now aware that there had been concerns about aspects of Mr O'Brien's practice for several years prior to the institution of the MHPS process in late 2016 / early 2017. It appears that there was a failure to grapple successfully with these issues or to escalate them. I am unsure as to whether these concerns in and of themselves ought to have made their way up to Trust Board or its Committees. However, the failure of Trust systems to resolve the concerns, and their continuation for years as a result, probably ought to have come to the attention of the Governance Committee at an appropriate point.

MHPS Process	The absence of detailed reporting of MHPS cases, and providing the right route for this information to make its way to the Trust Board, is a concern of which I am now aware. The Trust Board or its Governance Committee should have been made aware of the progress of the MHPS process, the difficulties experienced in the MHPS process, the issues with Mr O'Brien's adherence to his action plan, the outcome of the MHPS process, the implementation of the Case Manager's recommendations, and the issues with Mr O'Brien's adherence to the action plan after the Determination.
Under-resourcing with governance support functions	Whilst it is correct that the Chief Executive (Shane Devlin) had raised concerns about under-investment in governance within the Trust and that the Champion Review along with Dr O'Kane had started the process to identify where governance needed strengthening and change, I believe that I wasn't aware of the scale of governance deficit that has become apparent through the Inquiry. This information ought to have been brought to the attention of the Trust Board.
Early Alerts	Early Alerts were not consistently issued to all Board Members prior to September 2020. I believe that the Early Alert system is as important to the Trust Board as it is to the Department of Health. The Trust Board should therefore have received all Early Alerts including, in particular, that dated 31st July 2020.
Declaration of conflict of interest and	I was unaware of the extent and depth of the relationship between Mrs Brownlee and Mr O'Brien. When I now consider the

management of it	Confidential Trust Board meetings and the meetings between Chair, CEO, and NEDs, between August 2020 and the end of November 2020, I see an inconsistent approach by the former Chair - from making no declaration of interest at one meeting to declaring an interest and leaving another meeting to denying an interest yet still leaving yet another meeting. As a result of evidence now before the Inquiry, it appears to me that there was a clear conflict of interest for the former Chair. The Trust Board should have been made aware of the extent and fullness of the relationship between her and Mr O'Brien. At the October 2020 meeting, when I realised there was more to this issue, a very simple Google search revealed to me that the former Chair and Mr. O'Brien had governance roles in a charity. At this point, the Chief Executive (Shane Devlin) raised the conflict with the former Chair. The Northern Ireland Audit Office defines a conflict of interest as: *"A conflict of interest involves a conflict between the public duty and the private interest of a public official in which the official's private-capacity interest could improperly influence the performance of his/her official duties and responsibilities."* It further explains: a) *The interest in question need not be that of the public official or Board member themselves. It can also include the interests of close relatives or friends and associates who have the potential to influence the public official or Board member's behaviour.*

	b) *As a benchmark a 'close relative' would usually refer to the individual's spouse or partner, children (adult and minor) , parent, brother, sister, in-laws and the personal partners of any of these . For other relatives it is dependent upon the closeness of the relationship and degree to which the decisions or activity of the public entity could directly or significantly affect them.* c) *Where an individual has to declare interests of this nature they may wish to seek advice from a senior public official or the Board Chairman to ensure all potential conflicts are identified.* d) *A 'friend or associate' should be considered as someone with whom the individual has a longstanding and/or close relationship, socialises with regularly or has had dealings with which may create a conflict of interest.* The NIAO provides a checklist in their good practice guide as shown below:



Part Two:
Recognising a Conflict of Interest

Figure 1: Checklist for public officials and Board members

Do you think you have an actual, perceived or potential conflict of interest?
The following questions may help when assessing an issue being considered and the situation in which you are involved[5]

- ☑ ☒
- ☐ Would I or anyone associated with me benefit from, or be detrimentally affected by, my proposed decision or action?
- ☐ Could there be benefits for me in the future that could cast doubt on my objectivity?
- ☐ Do I have a current or previous personal, professional or financial relationship or association of any significance with an interested party?
- ☐ Would my reputation or that of a relative, friend or associate stand to be enhanced or damaged because of the proposed decision or action?
- ☐ Do I or a relative, friend or associate stand to gain or lose financially in some covert or unexpected way?
- ☐ Do I hold any personal or professional views or biases that may lead others to reasonably conclude that I am not an appropriate person to deal with the matter?
- ☐ Have I contributed in a private capacity in any way to the matter my organisation is dealing with?
- ☐ Have I made any promises or commitments in relation to the matter?
- ☐ Have I received a substantial gift, benefit or hospitality from someone who stands to gain or lose from my proposed decision or action?
- ☐ Am I a member of an association, club or professional organisation or do I have particular ties and affiliations with organisations or individuals who stand to gain or lose by my proposed decision or action?
- ☐ Could this situation have an influence on any future employment opportunities outside my current official duties?
- ☐ Could there be any other benefits or factors that could cast doubt on my objectivity?

5 Managing Conflicts of Interest in the Public Sector toolkit, Independent Commission Against Corruption and Crime and Misconduct Commission (Queensland), Sydney and Brisbane, 2004

Below is a summary of the Chair's declaration or non-declaration of interests:

Confidential Trust Board Meetings	Declaration or Non-declaration of Conflicts of interest
Confidential Trust Board 27th August 2020	No declaration made by Chair.

24th September 2020	Chair declared an interest in item 7 urology and left the meeting at that point.
22nd October 2020	No declarations of interest made by Chair.
12th November 2020	Chair declared an interest in item 7 Urology and left the meeting for that discussion.

Meetings with Chair, CEO and Non-Executive Directors	Declaration of conflicts of interest
08th October 2020	No declarations of interest by made by the Chair.
15th October 2020	No declarations of interest made by Chair.
05th November 2020	Chair advised that in relation to item 6 Urology, whilst she had no interest to declare in the subject matter, she would not remain in the meeting for personal reasons.
19th November 2020	Chair advised that, in relation to item 8 Urology, whilst she had no interest to declare in the subject matter, she would not remain in the meeting for personal reasons.
26th November 2020	Chair advised that in relation to item 7 Urology, whilst she had no interest to declare in

		the subject matter, she would not remain in the meeting for personal reasons.

In my view, the declaration of a conflict of interest because of the relationship between the former Chair and Mr O'Brien should have been declared to the Trust Board as early as its meeting on the 27th January 2017. The previous Medical Director, Dr Richard Wright, met with the Chief Executive (Mr. Francis Rice) in December 2016 where he requested a Non-Executive Director be assigned to the MHPS process. That process involves asking the Chair of the Board to assign a Non-Executive Director to the MHPS case. It is clear from the communication between Mrs. Vivienne Toal and Mrs. Brownlee (06th January 2017 16:41), Mrs. Brownlee and Mr. Wilkinson (06th January 2017 20:14) that Mrs. Brownlee was fully aware that the Consultant in question was Mr. A O'Brien. In my view, she ought to have declared her interest by the 27th January 2017 meeting and absented herself from any discussion about him then and in those parts of meetings the relevant meetings in 2020 mentioned above.

Serious adverse incidents	I am now aware that an ongoing Serious Adverse Incident (SAI) investigation undertaken in the autumn of 2016 identified a urology patent ([Patient 10]) who may have had, or at least risked, a poorer clinical outcome because a GP referral was not triaged by Mr O'Brien. I believe that this information ought to have made its way to the Board along with the MHPS information and information about Mr O'Brien's previous issues (e.g., regarding triage and patient notes) by January 2017.

Please see:

230. NIAO Conflict of Interest Good Practice Guide 2015

231. 20170109 Email trail between R Brownlee and J Wilkinson re Designated Board Member

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

48.1 I have attempted to summarise what I believe are a number of key problems in this regard below.

• Not dealing with the issues fully or in a timely way	➢ Issues in Mr O'Brien's practice, which were known about prior to 2016, appear never to have been properly addressed in the period prior to 2016. ➢ On the 30th March 2016, whilst Mr. O'Brien was advised in writing by both his AMD and AD of clinical governance and patient safety concerns, the issues raised with him continued to go unresolved. ➢ An MHPS process, not commenced until very late 2016 / early 2017, was protracted and failed to examine what we now believe were all of the issues with Mr O'Brien's practice. ➢ A number of related SAI investigations (those chaired by Dr Johnston) appear also to have been unnecessarily protracted. ➢ There appear to have been delays in addressing and/or escalating issues with Mr O'Brien following completion of the MHPS process in late 2018 including, for example, his failure to adhere to the standards expected of him in his return-to-work action plan.

	➢ Across all of this time, there appears to have been a failure to triangulate information about issue with Mr O'Brien's practice.
• Doctor unwilling to be managed	➢ It appears to me that Mr O'Brien did not want to be managed and was resistant to changing any of his problematic practices. ➢ I believe he attempted to thwart processes that were begun to address some of his issues, including threatening legal action. ➢ I also believe that he used his close relationship with the Chair of the Board as a tool to directly/indirectly warn people off.
• Conflict of interest between Chair of the Board and the Consultant	➢ This conflict of interest was not declared in full and on time by the former Chair. ➢ The conflict of interest was not appropriately managed once it was known by both the Chair and the full Board. ➢ The Chair declared herself in and out of meetings, which she should not have been allowed to do. ➢ It is difficult to know what impact (if any) the mismanagement of this conflict of interest had on relevant events. It may be that it had none. It may be that affected some of the cultural issues mentioned below. It may also be that having a friend who was Chair of the Board and involved in at least some discussions relevant to him made Mr O'Brien feel protected or that he did not have to change. Ultimately, however, this issue is one for the Inquiry once it has explored

	all relevant evidence, including that from the former Chair and Mr O'Brien.
• Role of the Non-Executive in the MHPS process	➢ There was a clear absence of clarity and training in this role for Non-Executive Directors.
• Culture	➢ There was a culture of work arounds for Mr. O'Brien which allowed for issues not to be addressed. ➢ The culture was not sufficiently open, transparent, and safe to allow for the bringing forward of issues and raising of concerns without fear. This criticism applies both inside and outside the Boardroom.
• Instability at Senior Management Team Level	➢ Between 2016 and 2018, there was a series of interim/acting CEO and Director roles across the senior management team. Looking back, this created a risk that no one was taking proper ownership of and responsibility for issues. This, in my view, has been detrimental to the workings of the Southern Health and Social Care Trust.
• Escalation of issues of concern and patient safety	➢ Escalation of issues to Committees and Trust Board was not as prevalent in the past as it is now. Committees and Trust Board require Directors to be open and to raise issues and escalate appropriately. In my view, there were failures to raise with the Board and its Committees issues that ought to have been raised regarding Urology and Mr O'Brien.

	➢ Equally, I believe there were missed opportunities for the Board to be more curious and to probe Directors. For example, on the 27th January 2017 there was an opportunity for the Trust Board to ask questions regarding the consultant who had been excluded from practice. Similarly, after the 27th January 2017 there was no follow up or follow through on this issue from the Trust Board or any of its Committees.
• Demand outstripping supply	➢ The Southern Trust, like others HSC Trusts, has seen a decline in Consultant and Nursing staff over the last number of years. The pandemic has exacerbated this somewhat. There has also been an increase in demand for services. With this increase and the challenges of recruitment it meant that the Urology Service (as with other services) was under immense pressure. ➢ The impact on this is for the patient can be significant and wide-ranging - delay in being seen, delay in investigations being undertaken and diagnostics carried out, and delay in treatment when needed. Ultimately, if the above steps are not carried in a prompt way, (further) harm can be caused. I can also appreciate the potentially greater impact that can be caused by a shortcoming such as a failure to triage a referral letter in a service where there may be a very significant difference in the waiting times for red flag and routine patients.

	➢ I can also see now how the busyness of the service and the constant tension between demand and capacity meant there may have been little time or room to become aware of issues or to triangulate information about issues or even to address issues. The pressure on various services across the Trust (not only Urology) may also have had an impact on some of the processes involving Mr. O'Brien (such as the MHPS process) given that they often involved a range of people, all of whom were carrying significant workloads.

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

49.1

Culture	➢ An open and honest culture that is psychologically safe begins in the Boardroom. That culture then needs to penetrate throughout the organisation, no matter your role or perceived/actual level of authority or seniority. ➢ I have, since taking up the role of Chair, prioritised the issues of culture and how the Board works. I was very mindful that I was taking on a team of Directors who felt damaged and hurt. There was a need to build trust with each other and as a team. This work continues. ➢ The bringing of urgent issues to the attention of Trust Board can happen through a variety of ways.

	There should be no impediment to significant urgent issues, particularly those affecting patient safety, being raised. I am, since 2021, seeing issues/concerns being raised through Trust Board and Committees more readily than before.
Strengthening Internal Governance	➢ The vastness and complexity of the work of the Trust carries with it a number of risks. These risks include that of silo working and silo reporting. The apparent manifestation of this risk in the Trust's Acute Services Directorate allowed issues in Urology that had a single common denominator to go unconnected for some time. ➢ I believe in this regard that there were missed opportunities to triangulate information (e.g., from the MHPS process and SAI Reviews) to identify a single common denominator. ➢ The Champion Review has allowed for a meaningful change in corporate and clinical social care governance. The creation of revised operational governance provides for more triangulation of information so that no one event is seen in isolation as in the case of Mr. A O'Brien
Stable Board and Senior Leadership Team	➢ The recruitment of 6/8 Non-Executive Directors within a 12-month period meant the organisation lost institutional memory and experience. The inexperience of the new members in respect of the complexities of health and social care meant, for me at least, that we were not as prepared/equipped as we could have been. ➢ The implications for any organisation not having a stable and committed senior leadership team is a

	threat to any organisation. The churn in Interim and Acting CEOs and Interim Directors during the 2016 – 2018 period had a huge impact on the Southern Trust. Succession planning for Board and Senior Management is required to ensure the organisation does not experience this type of flux again. ➢ Having substantive Executive and Operational Directors provides for stability, ownership, and individual and collective responsibility.
Committee escalation to Trust Board	➢ Creating a written Committee Chair Role Specification, with guidance on escalation from Committee to Trust Board, has been a necessary development. ➢ As has been the specific inclusion within the Committee Chairs' Reports of items for escalation to Trust Boa
Oversight of the role of Chair of the Trust Board	➢ A Senior/Lead Non-Executive Director role should provide a designated point of contact for all Board Members and Directors who have concerns about the Chair as part of broader remit to provide a level of oversight of the role of Chair. This is common practice in Boards within Great Britain.

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

50.1 As a Non-Executive Director from 2016, and apart from the Board being advised on 27th January 2017 of an MHPS process being commenced against a Urology Consultant, I was not made aware of any clinical concerns or patient safety issues regarding urology services by the Chair of the Board, by any of the Chief Executives (interim/acting or substantive), by the Medical Directors or by the Operational Directors up until the 27th August 2020.

50.2 The Chief Executive is the most senior executive member of the Trust Board. As the Accountable Officer for the Trust, the Chief Executive is accountable to the Trust Board, the Department of Health, HSCB, and ultimately the Minister for the performance and governance of the Trust in the delivery of safe, high-quality care, responsive to the needs of the population in line with prevailing performance standards and targets. In this regard, I would have expected the Chief Executive to raise with Trust Board issues of concern such as the MHPS progress and outcome, the related SAI investigations and their outcomes, and the significance of the demand:capacity mismatch issues within Urology (in particular, the potentially significant impact the demand:capacity mismatch could have upon patient safety in a number of different ways). The Trust Board may then have delegated them to the appropriate Committee for oversight on progress. Such issues (save for the 27th January 2017 meeting mentioned above) were not raised by the interim Chief Executive Mr. Francis Rice, by the Acting Chief Executive Mr. Stephen McNally, or by Mr. Shane Devlin (until after Dr O'Kane had raised them in August 2020).

50.3. Dr Maria O'Kane did raise the concerns regarding Mr O'Brien from August 2020 during her tenure as Medical Director. As Chief Executive, she has continued to raise concerns to Trust Board.

50.4 The Medial Director, as an Executive Member of the Trust Board, has responsibility to advise the Trust Board and Chief Executive on all issues relating to the professional Medical workforce, clinical practice and quality and safety outcomes. The Medical Directors (Dr Wright and Dr Khan) were aware of the issues leading up to and post exclusion of Mr. O'Brien and did not raise these concerns with the Trust Board (save for the single instance on 27th January 2017). I believe that the issues and concerns should have been raised with the Trust Board by them

on more than this single occasion and they could then have been delegated to the Governance Committee for oversight on progress.

50.5 As a Board, there was an opportunity on or after the 27th January 2017 for us to raise questions when informed about a Consultant who had been excluded from practice for 4 weeks. The Board (which included me) asked no questions (or none of any significance that I can recall). At that time, I did not fully understand the MHPS process, nor the need for detailed reporting through to the Trust Board and/or its Committees. Nonetheless, we as a Board should have been more curious. This was a missed opportunity on our part.

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

51.1 I touched upon what I believe were mistakes and/or missed opportunities on my part and the part of others in previous answers such as those at Questions 47 to 50 above. To a large extent, what could or should have been done differently is apparent from my description of the relevant mistakes and/or missed opportunities above. Nonetheless, and in ease of the Inquiry, I have outlined below a number of particular points where I consider that things could have been done differently.

Concern	What should or could have been done
MHPS Process	A clear MHPS process, with clarity of understanding of roles and realistic timelines, could have supported an expedited process rather than protracted one. The inclusion of routes for escalation to Senior Management and the Trust

	Board, through its committee structure, ought to have been clear.
Under resourcing with governance support functions	The under resourcing of governance support functions should have been raised by the responsible Directors to the Senior Management Team and then with the Trust Board. This would have enabled discussions on budget allocation and the requirement for further support, if needed.
Declarations of conflict of interest and management of it	The conflict of interest should have been declared in January 2017 with the (then) Chair removing herself from all conversations and/or meetings regarding Mr O'Brien. I recall apologising to the then Chief Executive, Mr. Shane Devlin, after he had to deal with the conflict of interest on a virtual meeting we were on. I believe firmly he should not have had to do it. This should have been dealt with by the Trust Board. The good practice on conflicts of interest is simple. It is the individual's responsibility to raise the conflict and the Board's responsibility to decide what happens as a result. Where others are aware of the conflict and the individual does not raise it, they have a duty to raise it.
Not dealing with issues fully or in a timely way	Issues in respect of Mr O'Brien (such as his delays in dictation and triage and his tendency to take patient notes home) appear to have been known about by different persons at different times in the years prior to 2016. However, they were never grappled with effectively. Issues were escalated and raised with him in a more formal and coordinated way with in March 2016. Again, however, there was a lack of effective action. When an MHPS process then began in early 2017, it was protracted. The patient safety issues arising in respect of this clinician should have been escalated to the Chief Executive and Senior Management Team, and then on to Trust Board for oversight through its Governance Committee, at an earlier stage.
Role of the Non-Executive Director in the MHPS process	Clarity and training on the role of the Non-Executive Director was missing. This meant that, as Non-Executives, we were attempting to deliver on this role without knowing exactly the role we played. This left it open to interpretation and abuse. Clarity in respect of the role (to maintain momentum in the

	pace of the MHPS process) as well as a route to escalate issues through to the confidential Governance Committee should have been in place from the start.
Culture	In order for Trust staff at any level to speak up, raise a concern, or share an issue, we need to have the right culture so that people feel able to raise issues without fear. The appropriate culture was not in place in the Southern Trust. In order to minimise impact on patient safety and quality of care, it is important that the organisational culture is one that is open, honest, and just in its approach.
Instability at Senior Management Team level	Succession planning for these senior roles needs to be embedded within the Trust itself and the broader system of Health and Social Care. No Trust should be left without a substantive CEO and Directors.

51.2 Governance systems are only as good as the individuals applying them. On reflection, the systems during this time were not robust enough and that can be easily evidenced through the MHPS process (then and now) and its reporting through to the Governance Committee. However, a thread through all of this was individuals either not doing what was expected of them, or not being or feeling empowered to raise the issues or deal with them themselves. This comes back to having in place the right culture, and clear guidelines, to enable the raising and escalation of a concern, no matter who the subject of the concern is.

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

52.1 I am including below details of an exchange of emails/communication between Mrs. Roberta Brownlee and myself on the 8th and 9th September 2020. I do not recall the content of the voice message left on my phone that is referred to in the below email trail. Urology and Mr O'Brien are not mentioned in these emails, however, this happened between the Trust Board workshop on the 27th August and the next scheduled Trust Board meeting on the 24th September 2020.

Date	Details of the discussions	Who the discussions were with
7th September 2020 09:05	Email from Trust Board Chair Roberta Brownlee noting that she plans to attend Governance meeting on (most of) Thursday morning. Hopes this is acceptable.	Email from Roberta Brownlee to me as Governance Committee Chair Eileen Mullan
8th September 2020 08:55	Email sent from Roberta Brownlee, Trust Board Chair, asking *"at the beginning of the confidential section when all members present may I speak to the Board on a few areas. As Chair, and after you do the welcome, I need to speak"*	Email was sent to me as Chair of the Governance Committee and Sandra Judt, Board Assurance Manager.
8th September 2020 15:51	Email from me as Chair of Governance to Roberta Brownlee, Chair of the Board. I advised that there was not going to be a confidential section of the governance committee. I offered the Chair five minutes at the start of the meeting before moving on the agenda items.	Email advising no confidential governance committee taking place. Busy agenda, happy to give a few minutes but must move onto Covid 19 outbreak and other substantial items.
8th September 2020 18:41	Email from Roberta Brownlee, Chair of the Board to me, as Chair of the Governance Committee. *"Eileen*	

	Message noted. *I could not address my comments in 5 mins as Chair of the Board. Several serious matters. Will ensure my points is highlighted and asked to be addressed/actioned in the full agenda.* *Roberta"*	
9th September 2020	Missed telephone call from Roberta Brownlee, Board Chair, to me as Chair of the Governance Committee.	I did not speak with Roberta Brownlee by phone. I had missed the call and a vague memory of a message being left. I did return the call, however there was no answer. I then used my follow up email (summarised immediately below) as a guide to the message left. Chair indicated significant issues she wanted to bring to the Board's attention.
9th September 2020 15:23	I advised the Board Chair Roberta Brownlee that if she had several serious matters she wished to share as Chair of the Board then it might be prudent for her to hold an Emergency Trust Board Meeting. That would mean all Non-Executive and Executive Members	Email from me to Roberta Brownlee.

	would be in attendance. Governance Committee has other staff attending and two absent Executive Members.	
9th September 2020 20:25	Roberta Brownlee responded to my previous email that morning and copied in the Chief Executive and Board Assurance Manager. She noted that the the Chief Executive and she would be updating the following day's meetings on issues that were all well known to the Trust Board members at that time. Further, she went on to say she did not wish to delay the start of the meeting. She stated that she did not see the need for an emergency Trust Board meeting as all Trust Board Members would be present for the Confidential Section (excluding those on holidays and the absence of one NED).	Email from Roberta Brownlee to Eileen Mullan. CEO Shane Devlin and Board Assurance Manager Sandra Judt copied in.

52.2 It was not uncommon for the Chair of the Board to attend Governance Meetings. However, I found the above exchange strange at the time on a number of fronts:

a. First, there appeared to me to be an air of anxiousness from the Chair of the Board – e.g., "I need to speak" and referring to "several serious matters" but not being specific about what those matters were.

b. Second, the Chair emailed me from her personal email address initially.

c. Third, a meeting of the Governance Committee was not a meeting of the Trust Board and the Chair would have known this. This Committee is attended by other staff which included Dr Tracey Boyce, Dr Damian Gormley, Stephen Wallace and Marita Magennis. However, the full Trust Board would not be in attendance as the Medical Director and Executive Director of Social Work were on leave.

d. Fourth, I noted the timing of this exchange was between the Trust Board being notified on the 27th August 2020 about Urology Concerns and the next Trust Board meeting due to take place on the 24th September 2020, where the Urology concerns were an agenda item in the confidential section. *Please see:*

231b. 20200907 E from RB to EM re Govern Meeting
232. 20200908 E from RB To EM re Govern Meeting
233. 20200909 E from RB to EM re Phone Call this am

NOTE:

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

Statement of Truth

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

Urology Services Inquiry

Signed: ___ [redacted] _____

Date: 25th September 2023

1. DoH Public Appointment NED Information Pack 2016
2. 20160308 - Ltr - Ms Eileen Mullan NED Min of Appt
3. 20191022 - Ltr - Ms Eileen Mullan NED Min of Re-appt
4. 20170525 - Doc - Ms Eileen Mullan Perf Appraisal 16-17
5. 20180625 - Doc - Ms Eileen Mullan Perf Appraisal 17-18
6. 20190919 - Doc - Ms Eileen Mullan Perf Appraisal 18-19
7. 20200731 - Doc - Ms Eileen Mullan Perf Appraisal 19-20
8. 20220124 - Doc - Ms Eileen Mullan Perf Appraisal 20-21
9. 20200326 Terms of Reference Governance Committee
10. 20230525 Terms of Reference Governance Committee
11. 2nd February 2017 Governance Committee Agenda.pdf'"
12. Confidential Governance Committee Agenda 9th February 2023
13. Governance Committee Agenda 9th February 2023
14. Governance Committee Work Plan 2023
15. Public Appointments Information Booklet Southern Health Social Care Trust SHSCT 1 19
16. 20201118 - Ltr - Ms Eileen Mullan Chair Min of Appt
17. 20221122 - Doc - Ms Eileen Mullan Perf Appraisal 21-22
18. Item 14b. Board Governance self assessment 201819
19. February 2016 NED Induction Programme
20. January 2017 NED Induction Programme
21. 20160601 On Board Training Programme
22. 20160101 - NED Directorate Training Sessions
23. 20170101 - NED Directorate Training Sessions
24. Training on MHPS Procedure for HSC NEDS 2021
25. MHPS slides_DLS to NEDS
26. 20170829 Acute Presentation for NEDs
27. Chair-NED Training Record
28. Powerpoint slides On Board Training
29. Email EM - DT HSC Leadership Centre re Training for Non Executive Directors
30. 28 April 2022 7. Director's Workshop Presentation from IMWH
31. 13 Dec 2022 WB Rebecca Durkin
32. SHSCT Board Induction September 2022 HO
33. 20200827 E to RB and SD Re Blind Spots
34. 01052021 DoH HSC Board Member Handbook
35. Eileen Mullan Public Trust Board Attendance 2016 - Present
36. Chair CX and SLT Governance Committee Attendance
37. Chair and SLT Patient and Client Experience Committee Attendance
38. Eileen Mullan Attendance Audit Committee 2016 to 2023
39. CEX and SLT Audit Attendance 2016 to 2023
40. Eileen Mullan Attendance E_G Committee 2016 to 2023.docx
41. CEX and SLT E_G Committee Attendance 2016 to 2023
42. Eileen Mullan Attendance 2021 - 2023 Remuneration TS Committee
43. 20201217 Notebook Entry
44. 20210114 Notebook Entry
45. 20210121 Notebook Entry Pg1
46. 20210121 Notebook Entry Pg2
47. 20210310 Notebook Entry
48. 20210316 Notebook Entry
49. 20210603 Notebook Entry
50. 20230822 Notebook Entry

51. Agenda 30.01.2023 Notes - Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
52. Agenda 28.02.2023 Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
53. AGENDA - 14.03.2023 Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
54. AGENDA - 27.03.2023 Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
55. AGENDA - 20.04.2023 Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
56. AGENDA - 02.05.2023 Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
57. AGENDA - 16.05.2023 Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
58. AGENDA - 30.05.2023 Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
59. AGENDA - 09.06.2023 Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
60. AGENDA - 18.07.2023 Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
61. AGENDA - 25.07.2023 Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
62. AGENDA - 08.08.2023 Dr Maria OKane Chief Executive Eileen Mullan Chair 1-1
63. 20170511 Governance Committee outcomes note from meeting held on 11 May 2017
64. 20170907 Governance Committee outcomes note from meeting held on 07 September 2017
65. 20171207 Governance Committee outcomes note from meeting held on 07 December 2017
66. 20180208 Governance Committee outcomes note from meeting held on 08 February 2018
67. 20180511 Governance Committee outcomes note from meeting held on 11 May 2018
68. 20180906 Governance Committee outcomes note from meeting held on 06 September 2018
69. 20181206 Governance Committee outcomes note from meeting held on 06 December 2018
70. 20190207 Governance Committee outcomes note from meeting held on 07 February 2019
71. 20190521 Governance Committee Chair's Notes 21 May 2019
72. 20190905 Governance Committee Chair's Notes 05 September 2019
73. 20200213 Governance Committee Chair's Notes 13 February 2020
74. 20200910 Governance Committee Chair Notes 10 September 2020
75. 20200827 Directors Workshop Notes
76. 20160929 - Notes of a meeting of the Non Executive Directors and Chair
77. 20181129 - Notes of a meeting of the Non Executive Directors and Chair
78. 20190521 - Notes of a meeting of the Non Executive Directors and Chair
79. 20200122 - Notes of a meeting of the Non Executive Directors ref MHPS
80. 20200708 - Notes of a meeting of the Non Executive Directors ref MHPS under Any Other Business
81. 20210622 - Notes of a meeting of the Chair - Non Executive Directors ref MHPS
82. Approved Directors Workshop Notes 9.12.21
83. Final Combined Presentation 25 August 2022
84. Revised Structure 2023
85. 20200804 E re Early Alert
86. 20200804 E re Early Alert A1
87. 20200727 E re Early Alert
88. 20200727 E re Early Alert A1
89. 20200723 E re Early Alert
90. 20200723 E re Early Alert A1
91. 20200707 E re Early Alert
92. 20200707 E re Early Alert A1
93. 20210201 Putting Trust back into the Southern Trust
94. 20230601 A Time of Change Presentation
95. 20230125 SHSCT Mid Year Accountability Meeting
97. 1819 IA Board Effectiveness
98. IA Final Report - Board Effectiveness 21-22
99. Management Statement SHSCT
100. 20230802 Trust Board Membership 2010 - Present

101. DHSSPS Framework Document September 2011
102. 20211029 High Level Governance Structure
103. Trust Board Scheme of Delegation to Committees _ March 2022
104. Leadership Walkabouts - Summary report 01 October 2019 - 31 March 2020
105. 20220311 E from PL to EM and NEDS re Stroke Services
106. APPROVED Notes of Chief Executive update meeting with NEDs 13.6.2022
107. 20220309 External Assurance Stroke Services
108. SMT Paper on Stroke Services
109. Stroke Services Presentation to Performance Committee March 2022
110. Stroke Services Presentation to Performance Committee March 2022 A1
111. Approved Trust Board minutes 27.10.22
111a. 04iiia. Trust Board Cover Sheet 30.9.2021 SAI Personal Information redacted by
111b. 04iiib. Confidential brief for TB members SAI 30.9.2021
111c. 04iiic. Action Plan for ED SAI 2.6.21JMCG-DrMcM
112. Internal Audit Mr A Private Work
113. 20211116 Confidential Governance Committee Minutes
113a. 20230919 E Committee Chair Reporting To Trust Board
113b. 20230919 E Committee Chair Reporting To Trust Board A1
114. Item 6. Bluestone Dorsy update TB 270918 (3)
115. Item 3. Final confidential minutes - 27.9.2018
116. Item 4i. Bluestone Dorsy revised update TB 251018 (3) Final
117. Confidential minutes - 25.10.2018
118. Item 4. [redacted] In-Pt Units WF pressures revised update TB 291118 (3)
119. Item 4. Confidential minutes - 29.11.2018
120. Item 5i. Bluestone and Dorsey Update
121. Item 4. Confidential minutes - 24.1.2019
122. Item 6. Building a progressive Inpatient Mental Health Service
123. Item 4. Confidential minutes - 28.3.19
124. Item 3. Draft Confidential minutes - 29.8.2019
125. Item 7a. Bluestone Dorsy update TB 260919
126. Item 11iia. Report Template Bluestone Dorsy update TB 300120
127. Item 11iib. Bluestone Action Plan Jan 2020 Update
128. Item 11iic. NHS Safety Thermometer Bluestone
129. 20200803 - E - S Wallace re Early Alert
131. 20200924 Confidential TB minutes
132. 20201022 Confidential TB Minutes
133. 20201112 Confidential TB minutes
134. 20201210 Confidential TB Minutes
134a. Item 9ia. 20190118_TBSummaryPerformance(DecemberPosition)TB_Report_Final
134b. Item 9i b. Copy of 20171201_CorporateDashboard(OctoberforNovember)TB_Amendment at TB 301117
134c. Item 12i a. PerformanceReport Summary Template_TB_V1_0_AMagwood-LLeeman
134d. Item 11ia. 20190823_TB_CorporatePerformanceReportCoversheet_July for August_Final
134e. Item 12ib. 20181122_CorporateDashboard(OctoberforNovember)_TB_V1_0_CRafferty-LLappin
134f. Item 9i a. Performance Summary PagePerformanceReport_TB_Final
134g. Item 9i. 20190118_CorporateDashboard(DecemberforJanuary)_V1_0_CRafferty-LLappin-LLeeman
134h. Item 10ia. 20190322_TBSummaryPerformance(FebruaryPosition)TB
134i. Item 5. Approved Trust Board minutes 28.3.19

134j. Item 8ia. TBSummaryPerformance(May 19 TB_April 19 Position_TB
134k. Item 8ib. Performance_CorporateCPDScorecard(April for May)_Final_TB
134l. Item 11ia. 20190823_TB_CorporatePerformanceReportCoversheet_July for August_Final
134m. Item 11ib. 20190823_CorporateCPDScorecard(July for August)_v1.0 Final TB
134n. Item 8ia. Performance Committee_Chair Report
134o. 6a. Performance Scorecare Cover Template (JulyforAugust)
134p. Item 13i. Performance Committee_Chair Report
134q. Item 9b. Corporate Risk Register May 2020 to Trust Board _ 4th June 2020
134r. Corporate Risk Register August 2020
134s. Summary Corporate Risk Register to Governance Committee 12052022
135. 010i. MonthlyPerfReportMay(AprilPerf)_TB_V1_0_LLappin
136. Item 12ia. TBSummaryPerformance(OctforNov)TB_Report_V1_0 Final
140. 20200924 Trust Board Urology Report
144. 20201112 Trust Board Urology Report
146. 20201210 Trust Board Urology Report
147. 20210225 Confidential TB Minutes
148a. 20210325 Confidential TB Minutes
148b. 20210325 Trust Board Urology Report
149a. 20210527 Confidential TB Minutes
149b. 20210527 Trust Board Urology Report
150a. 20210930 Confidential TB Minutes
150b. 20210930 Trust Board Urology Report
151a. 20211028 Confidential TB Minutes
151b. 20211028 Trust Board Urology Report
152. 20211028 SHSCT Summary of Pats AOB
153. 07ic. Letter Template
154. 07id. First Update for Families
155. 07iib. Final report of the Stage 1 Grievance - Mr A O Brien
156a. 20221027 Confidential TB Minutes
156b. Urology update paper
157. 08b. Urology Letter Activity
158. 20220331 Confidential TB Minutes
158b. Urology update paper
159a. 20220526 Confidential TB Minutes
160. 20220526 S21 notices final
161. 07c. Risk Assessment Public Inquiry update 09052022 (006)
162a. 20220623 Confidential TB Minutes
162b. Urology update paper
163a. 20220929 Confidential TB Minutes
163b. Urology update paper
164. 20220929 RQIA Review of Urology Structured Case Record Review
165a. 20221213 Confidential TB Minutes
167a. 20230126 Confidential TB Minutes
168a. 20230330 Confidential TB Minutes
168b. Urology update paper
169a. 20230525 Confidential TB Minutes
169b. Urology update paper
170a. 20230622 Draft Confidential TB Minutes
170b. Urology update paper
171. 20200922 E from RB Re Confidential Section Agenda 7

172. 20200923 - E - R Brownlee TB Confidential
176. 20210121 Notebook Entry Pg2
180. 20210608-14 Notebook Entry
181. 20220301 Notebook Entry
183. Copy of Item 1A Action Log Chair CEO 1-1
184. Item 6b. Approved Trust Board minutes 30.11.17
185. Item 7a. Draft Trust Board minutes 25.1.18 (final)
186. Item 6a. Approved Trust Board minutes 24.5.18
187. Item 6. Approved minutes 29.11.18
188. 20190124 TB Public Minutes
190. Item 6a. Approved minutes 23.5.19
191. Item 6. Approved minutes 29.8.19
192. 20200130 TB Public Minutes
193. 20200903 Approved Performance Committee Minutes
194a. 20200611 - E - S Judt to R Brownlee
194b. 20200611 - E - S Judt to R Brownlee A1
194c. 20200611 - E - S Judt to R Brownlee A2
194d. 20200611 - E - S Judt to R Brownlee A3
195. 20160908 CRR
199. Summary Corporate Risk Register January 2022
201. 20220922 - Corporate Risk Register
202. 20220127 Confidential TB Minutes
212. 20190905 Governance Committee Chair's Notes 05 September 2019
215. 11ia. Appendix A Q3 22-23 Patient Safety Interventions Apr 23
216. 11va. 20230112_National Audit Assurance Summary Report
218. 20191205 Approved Governance Committee Minutes 05.12.19
219. 20210211 Approved Governance Committee Minutes 11th February 2021
220. 20210513 Approved Governance Committee Minutes 13th May 2021
221. 20210909 Approved Governance Committee Minutes
223. 20211116 Approved Governance Committee Minutes
225. 20190520 E From EM to Chair SD and NEDs re NED Mtg 21st May 2019
226. 20190520 E From EM to Chair SD and NEDs re NED Mtg 21st May 2019 A1
228. 20181028 E from EM to RB and NEDS re CX Performance Targets 1718 and 1819
229. 20190201 E re Governance Mtg and Papers
230. NIAO Conflict of Interest Good Practice Guide 2015
231. 20170109 Email trail between R Brownlee and J Wilkinson re Designated Board member
231b. 20200907 E from RB to EM re Govern Meeting
232. 20200908 E from RB To EM re Govern Meeting
233. 20200909 E from RB to EM re Phone Call this am

DH1/15/22403

June 2015

DEPARTMENT OF HEALTH, SOCIAL SERVICES & PUBLIC SAFETY

Public Appointments Information Pack

HEALTH & SOCIAL CARE TRUST
NHSCT 1/15 – SEHSCT 1/15 – SHSCT 1/15

NON-EXECUTIVE DIRECTOR POSTS

This information pack can be made available in other formats; please contact the address below for details

CPANI
The Commissioner for Public Appointments Northern Ireland
REGULATED

Appointments & Business Unit Room D1 Castle Buildings Stormont Estate Belfast BT4 3SQ
Tel: Irrelevant information redacted by the USI *Fax:* Irrelevant information redacted by the USI *Textphone:* Irrelevant information redacted by the USI
E-mail: public.appointments@dhsspsni.gov.uk

Dear

DHSSPS: APPOINTMENT OF NON-EXECUTIVE DIRECTORS TO THE HEALTH AND SOCIAL CARE TRUSTS (NHSCT 1/15 – SEHSCT 1/15 – SHSCT 1/15)

Thank you for your interest in the above posts. A copy of the application pack is enclosed for your information. In addition to completing the Application Form I would be grateful if you would also complete the enclosed Monitoring Form.

You may wish to take note of the Disqualifications section on pages 18 to 21 of the Information Pack.

The table below shows the key dates during the appointment process.

STAGE IN PROCESS	TIMESCALE
Closing time and date for applications	12:00 noon on Thursday 9th July 2015
Interviews	NHSCT – 7th, 8th, 14th and 16th September 2015 SEHSCT – 7th, 8th, 9th, 10th and 11th September 2015 SHSCT - 7th, 9th, 10th, 14th and 15th September 2015
Date of appointment	NHSCT - 1st October 2015 three posts 1st April 2016 two posts SEHSCT - 1st October 2015 four posts 1st April 2016 three posts SHSCT - 1st October 2015 three posts 1st April 2016 three posts

For applicants who wish to submit their application form electronically, please note that the Application form was created in Word 2007 running on Windows 2007. Apple users need to use "word" to complete form and transfer electronically.

If you have any general enquiries regarding this application pack, please do not hesitate to contact this office on **028 9052 2330**.

Yours sincerely

Personal information redacted by USI

Workforce Policy Directorate
Appointments

Please read this document carefully before you fill in your application form.

ROLE OF HEALTH AND SOCIAL CARE TRUST

Background

The Department of Health, Social Services and Public Safety (the Department) administers Health and Social Care (HSC), which includes policy and legislation for hospitals, family practitioner services, community health and personal social services. HSC provides an integrated system of health and personal social services to promote the health and social wellbeing of the people of Northern Ireland.

In terms of service commissioning and provision, the Department discharges this duty primarily by delegating the exercise of its statutory functions to the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and to a number of other HSC bodies created to exercise specific functions on its behalf. All these HSC bodies are accountable to the Department which in turn is accountable, through the Minister for Health, Social Services and Public Safety (the Minister), to the Assembly for the manner in which this duty is performed.

The Minister's vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support. Each year, the Minister's strategic priorities, targets and standards are communicated to the Health and Social Care Service through an annual Commissioning Plan Direction. In line with the Direction for 2015/16, services commissioned from HSC Trusts are required to deliver on the following three overarching strategic themes:

To improve and protect population health and wellbeing, and reduce health inequalities.,
To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.

To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

The Department's Quality 2020 strategy presents a clear vision for the future which aims to be recognised internationally, but especially by the people in Northern Ireland, as a leader for excellence in health and social care. The 10-year strategy will help tackle some of the biggest challenges faced by the health and social care sector and to move closer to delivering high quality services for everyone, all the time, everywhere.

The Health and Social Care Sector face a number of challenges with major demographic change, increasing public expectations, and a challenging fiscal

environment and needs to develop an accessible well understood health system which makes the best use of resources and ensures care is accessible, appropriate and closer to home.

The HSC Review Report "Transforming Your Care, a Review of Health and Social Care in Northern Ireland" was published in December 2011. Transforming Your Care, sets out an overarching road map for change in the provision of health and social care services in Northern Ireland. It focuses on reshaping how services are to be structured and delivered in order to make best use of all resources available to us, and in so doing, ensure that our services are safe, resilient and sustainable into the future. The implementation of Transforming Your Care is being led by the Health and Social Care Board in collaboration with the Health and Social Care Trusts and other providers. This work is overseen by a Transformation Programme Board which includes Trust representation.

In addition, the Department retains the normal authority and responsibilities of a parent Department as regards direction and control of an Arm's Length Body. The main principles, procedures etc are set out in the Department of Finance and Personnel guidance Managing Public Money Northern Ireland and are reflected in each body's Management Statement/Financial Memorandum (MSFM).

Trust Status

The five integrated Health and Social Care Trusts were established in April 2007. The Trusts are known as The Belfast HSC Trust, The Northern HSC Trust, The Southern HSC Trust, The South Eastern HSC Trust and The Western HSC Trust. The Northern Ireland Ambulance Service Trust functions independently of these five Trusts.

The five HSC Trusts were established as statutorily separate organisations within the HSC family, responsible for the delivery of responsive and effective health and care services and for the ownership and management of hospitals and other establishments and facilities. They provide health and social care services against Ministerial priorities, standards and targets. Services will be provided as specified in contracts with the commissioners of health and social care services, namely the HSC Board.

Although Trusts are statutorily separate organisations, they are an integral part of the HSC and are expected to deliver against an agenda set by the Minister and performance managed by the Department and the HSC Board**.**

The five HSC Trusts, are also responsible for exercising on behalf of the HSCB certain statutory functions which are delegated to them by virtue of authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994. Each HSC Trust also has a statutory obligation to put and keep in place arrangements for monitoring and improving the quality of health and social care which it provides to individuals and the environment in which it provides them (Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003).

Section 21 of the Health & Social Care (Reform) Act (Northern Ireland) 2009 places a specific duty on each Trust to exercise its functions with the aim of improving the health and social wellbeing of, and reducing the health inequalities between, those for whom it provides, or may provide, health and social care.

Each HSC Trust is managed directly by a board of Directors which has corporate responsibility for its operation. A board is made up of five executive Directors and seven Non-Executive Directors and a Non-Executive Chair. Non-Executive Directors and executive Directors are full and equal members of the board.

An HSC Trust Chair and the Non-Executive Directors are appointed with the approval of the Minister, in accordance with the Code of Practice of the Commissioner for Public Appointments for Northern Ireland. They are required to operate in a personal rather than a representative capacity.

The executive Directors of a HSC Trust board **must** include:

- the chief officer of the Trust; and
- the chief finance officer.

HSC Trusts that provide services directly to patients and clients (excluding ambulance and patient/client transport) should include the following professionals as executive Directors:

- a medical or dental practitioner; and
- a registered nurse or midwife: and
- a person holding a recognised qualification in social work.

Professional involvement on the Trust board is intended to support the principles of general management, and although the professional executive Directors are required to provide appropriate professional insights to the deliberations of the HSC Trust, there is no absolute requirement for them to have direct operational management responsibility for their profession within the Trust.

Personal Liability of Board Members (Code of Conduct and Accountability for Board Members of HSC Bodies July 2012)

Legal proceedings by a third party against individual Board members are very exceptional. A Board Member may be personally liable if he or she makes a fraudulent or negligent statement which results in a loss to a third party; or may commit a breach of confidence under common law or a criminal offence under insider dealing legislation, if he or she misuses information gained through their position. However, the Department has indicated that individual Board members who have acted honestly, reasonably, in good faith and without negligence will not have to meet out of their own personal resources any personal civil liability which is incurred in execution or purported execution of their Board functions. Board members who need further advice should consult the Department.

Accountability

HSC Trusts are accountable to a variety of groups and organisations:

- to **patients, clients, carers and the general public** for the delivery of effective, efficient and responsive services and for the stewardship of public funds. Good relationships with the local community are important, enabling Trusts to develop services that are responsive to local needs. HSC Trusts publish an Annual Report and hold an annual public meeting to allow the public to gauge their success in these areas. Other regular meetings of the Trust board are also open to the public;

- to the **Minister** through the Department and the HSCB for performance against Ministerial targets. HSC Trusts are also required to comply with a variety of statutory and other obligations in meeting those targets; and:

- to **commissioners** (HSCB) for the quantity, quality and efficiency of the services they provide against agreed resource allocations.

Freedoms

HSC Trusts have a number of managerial and operational freedoms. These include the freedom to:

- acquire, own and dispose of assets to ensure the most effective use is made of them;
- make their own cases for infrastructural investment;
- create their own management structures, consistent with principles established by the Department and subject to Departmental agreement;
- employ their own staff, determine their own staffing structures and, subject to any directions given by the Department, set their own terms and conditions of employment within national guidelines; and:
- advertise their services, within the guidelines set down on professional codes of practice on such advertising.

HSC Trusts are expected to use these freedoms to secure real improvements to the services they provide, for example, devising an improved out-patient appointment system, co-operative working with other HSC Trusts to secure continuity of care or the development of specialist transport links to make facilities more accessible. Service improvements should focus on providing benefits to patients and service users, HSC Trust staff and the general community.

Following consultation with employers and representatives of Staff Side organisations, the Department published, an overall regional HR strategy “The Employer of Choice” for managing and developing people in the Health and Personal Social Services. Within the parameters set by this regional strategy, Health and Social Care Trusts are free to develop their own human resource strategies.

ACCESS Northern Ireland (Access NI)

It is the Department's policy to carry out an "Enhanced Disclosure Check" for the appointment of Non-Executive Directors of the Northern, South Eastern and Southern HSC Trust.

The vetting check will be undertaken by Access NI, which is the responsibility of the Department of Justice in Northern Ireland and operates under the provisions of Part V of the Police Act 1997.

Access NI enables organisations in Northern Ireland to make more informed recruitment decisions by providing criminal history information about anyone seeking paid or unpaid work in certain defined areas, such as working with children or vulnerable adults.

POST DESCRIPTION/ROLE PROFILE

Post Title - Non-Executive Director

Accountable to

The Minister, through the Permanent Secretary of the Department of Health, Social Services & Public Safety.

Role

The Non-Executive Directors of the HSC Trusts are appointed by the Minister in order to bring an independent judgement to bear on issues of strategy, performance and executive appointments within the HSC Trusts. He/she will bring wide experience and critical detachment to the work of the board.

It is the role of each Non-Executive Director to:

- share in the independent Non-Executive oversight, scrutiny and stewardship of the HSC Trust's work;
- hold executive Directors to account; including assessing the performance of and appointing senior management ;
- sit on board Committees such as the Governance and Audit Committee;
- participate in professional conduct and competency enquiries as well as staff disciplinary appeals;
- scrutinise decision making on major procurement issues;
- scrutinise the handling of complaints.

Time commitment: 1 day per week

Remuneration £7,960 pa

NON-EXECUTIVE DIRECTOR - PERSON SPECIFICATION

ELIGIBILITY

General

There are no specific educational or professional requirements for these posts.

ESSENTIAL CRITERIA

Non-Executive Lay Director Post - Four criteria to be met

Non-Executive Finance Director Post - Five criteria to be met

ALL APPLICANTS

All applicants must demonstrate that they have the necessary skills, knowledge, experience and qualities required. They will need to show, both on the application form and at interview, how they meet the following criteria:

- **Business sense -** Exercising judgement and critical thinking about, issues that the HSC Trust Board considers as a matter of course, for example issues of business planning, resource allocation, risk management and organisational performance:

- **Corporate governance -** Working at or close to board level within a framework of corporate governance, demonstrating personal awareness of the importance of effective governance, including effective differentiation between executive and Non-Executive roles and the role of Non-Executive Directors in holding executive Directors to account;

- **Stakeholder engagement** – Promoting effective relationships within and without organisations, for example between investors or funders and managers or in partnerships between different organisations;

- **Self Awareness and personal contribution** – Maintaining a conscious sense of self and authority in a group in a way that mitigates 'group-think'.

NON-EXECUTIVE FINANCE DIRECTOR POST ONLY

Financial Management Responsibility and Experience – Applying financial management principles in an organisational setting with a financial turnover of greater than £10m per annum.

A Regulated Appointment

The procedure for this appointment is bound by the Code of Practice issued by the Commissioner for Public Appointments for Northern Ireland. This means that it is based on a fair, open and transparent process that involves independent scrutiny. The Minister responsible for Health, Social Services and Public Safety makes the final decision about who to appoint.

Your Application

Your application form is very important. You must therefore demonstrate clearly on your application form how you meet the published criteria. The selection panel can only assess your application based on the information you provide. Application forms and the Information Pack can be made available in other formats – please contact Appointments and Business Unit for details.

Monitoring Form

The Department is required to monitor the age, gender, ethnic origin, community background and disability of applicants to ensure that equal opportunity measures are effective. This information is gathered, maintained and processed, strictly in accordance with our Data Protection Registration, ***for public appointment purposes only***. This information will not be made available to the selection panel.

Criteria-based selection process

Criteria based selection is currently the most common method of making public appointments in Northern Ireland. What this means is that the onus is on the applicant to provide evidence of workplace or personal performance which demonstrates that they can perform to the specified standard.

Suitability for appointment – Section 3 of the Application Form

In this section you are asked to provide practical information against the selection criteria for appointees. The information you provide in section 3 of the application form **will** be used for short listing purposes.

Many people are not used to writing about themselves or thinking about what they have done as opposed to what a team has done. Before starting to complete this section, it is important that you think about ***your role*** and what ***you*** have done individually, either on your own or as a team member. To complete this section effectively, you need to understand the relationship between the examples you will use and the relevant selection criteria. In addition you should bear in mind the following points:

- You should use simple and easy to understand language in your examples to describe what you have done;
- Use actual examples, rather than ‘how you would do something’;
- You can use examples from your working life, where appropriate, or from your personal life, including any voluntary or community work you are or have been involved in;
- Avoid statements that describe your personal beliefs or philosophies – focus on specific challenges and results;
- If possible, quantify/qualify your accomplishments;
- Use specific examples which you think relate to the appointment in order to support how your skills, knowledge, experience and qualities meet the criteria. Describe ***your*** contribution – what ***you*** did, how ***you*** did it, why ***you*** did it and the ***outcome*** it had.

Completing Your Application Form

- You should write legibly using **black ink or** typescript **minimum font size 12** to complete the form.

- **All** sections of the application form must be completed. Please do not submit your Curriculum Vitae as it will not be taken into account. This is to enable us to consider all applications on an equal basis.

- Read each page carefully and answer every question that is relevant to you.

- Review the selection criteria before completing the application form.

- There may be several aspects to a criterion so ensure you provide evidence that shows how you meet all aspects.

Submitting Application Forms – Closing Date Noon Thursday 9th July 2015

Appointments and Business Unit will accept completed application forms delivered by hand, by post, by fax or by e-mail. It is the responsibility of the applicant taking into account their chosen method of delivery, to ensure that sufficient time is allowed for their application to arrive with the Department by **noon on the closing date**.

Applications delivered by hand – must be received by the Department on or before 12.00 noon on the closing date. **Please bring identification to gain access to the Stormont Estate and Castle Buildings reception area**. A receipt will be issued to those using this method of delivery.

Applications by post - when returning your application form by post please ensure it bears the correct value of postage as failure to do so may cause Royal Mail to delay your application thus causing you to miss the closing date.

Application by fax or e-mail - if you decide to send your application form by fax (FAX: 028 9052 8403) or e-mail (public.appointments@dhsspsni.gov.uk) you must ensure that it is faxed/e-mailed **in sufficient time** to arrive by 12.00 noon on the closing date. Electronic applications must be submitted in **'Word'** or, if completed on line, in the format provided. Applications received by fax or in the Appointments "inbox" after 12.00 noon on the closing date will be treated as **late applications and will not be accepted.**

The Department accepts no responsibility for application forms received after 12.00 noon on the closing date.

How we will handle your application

- Your application will be acknowledged by Appointments and Business Unit within five working days of receipt. If you do not receive an acknowledgement, please contact Appointments and Business Unit to ascertain whether or not

your application has been received.

- Please keep a copy of your Application Form for reference.

Appointment Process

This competition is seeking to appoint five Non-Executive Directors to the Northern HSCT, seven Non-Executive Directors to the South Eastern HSC Trust and six Non-Executive Directors to the Southern HSC Trust. Appointment dates are as follows:

NHSCT - 1st October 2015 three posts (including the Non-Executive Finance Director)
1st April 2016 two posts

SEHSCT - 1st October 2015 four posts (including the Non-Executive Finance Director)
1st April 2016 three posts

SHSCT - 1st October 2015 three posts (including the Non-Executive Finance Director)
1st April 2016 three posts

- A selection panel consisting of a Departmental official, the Chair of the appropriate HSC Trust and an Independent Assessor will assess your application.

- Short listing for interview is based on merit.

- When assessing each application against the criteria, the selection panel will use a Marking Frame with a scale of 1 – 7 to determine how an applicant's skills, knowledge, experience and qualities as displayed throughout the entire application form meet the criteria.

- Further short listing may be required and a further score may be introduced in circumstances where there is a high volume of applications received. A proportionate approach will be applied to this as agreed by the panel (the usual method is, of those who have met the initial short listing criteria, to rank them in numerical order, with the highest scores first etc). The selection panel are then presented with a factual summary of the outcome of the short listing process eg- 2 applicants awarded an overall score of 28; 5 applicants awarded an overall score of 27 etc. Based on these findings, the panel identify a sufficient number of applicants to be invited for interview whist ensuring that it is proportionate to the number of posts being filled.

- If you are dissatisfied with the panel decision or have any queries in relation to your non-selection for interview you should write to Appointments and Business Unit at the address provided within 10 working days from the date on the letter notifying you of the outcome of the short listing process. All correspondence will be acknowledged by return.

- All requests will be dealt with in a timely manner. Should the outcome of the enquiry result in the applicant being short listed for interview, the Department will make the necessary arrangements.

- The Minister is not involved in the short listing or interview stage of the process.

- Applicants whom the selection panel assess as not deemed suitable for appointment will be advised of the panel's decision following interviews.

- Applicants whom the selection panel assess as suitable for appointment and whose names are being presented to the Minister will be advised of this following interview.

- Following the interviews, the Minister is presented with an applicant summary of those deemed suitable for appointment by the selection panel. These are presented to the Minister in alphabetical (not rank) order.

- An Access NI check is then requested for the applicants Minister has identified for appointment.

- All documentation relating to Access NI will be destroyed by the Department once the appointment process has been completed.

- If you are successful you will be invited, by telephone, to accept the appointment.

- The appointment will then be formally confirmed in writing and you will confirm acceptance of the post and Terms of Appointment.

- All other interviewees will be advised in writing of the outcome of their interview once the appointment process has been completed.

- The Minister may create a reserve list to cover any unforeseen vacancies that arise within twelve months. Interviewees will be advised if they are on a reserve list.

Equality and Diversity

Accessibility to appointments is fundamental and the appointments process promotes and demonstrates equality of opportunity and equal treatment to all applicants at every stage of the appointment process.

The Department of Health, Social Services and Public Safety is committed to encouraging a diverse range of applicants for public appointments and to the principle of appointment on merit with independent assessment, openness and transparency of process. Applications are welcomed from all backgrounds regardless of religious belief, gender, disability, ethnic origin, political opinion, age, marital status, sexual orientation, or whether or not you have dependents. **Applications are particularly welcome from women, people under 30 years of age, members of ethnic minorities and people with disabilities as these groups are currently underrepresented on HSC Bodies.** Please visit the Department's website at www.dhsspsni.gov.uk for more information about Public Appointments.

Interview Expenses

Applicants invited for interview will be entitled to claim re-imbursement of reasonable travelling expenses incurred to attend for interview.

Publicising Appointments

A Press Release will be published to announce the appointment of new members to Public Bodies. The Commissioner for Public Appointments requires that announcements contain details of an appointee's recent political activity. Should you be appointed, you will be required to complete a political activity form. Details of any political activity, together with some of the information that you have provided in your application form, will be made public in the press announcement. The Press Release will include:

- Your name
- A short description of the body to which you have been appointed
- A brief summary of the skills and knowledge that you will bring to the role
- The period of appointment and any remuneration associated with the appointment
- Details of all other public appointments held and any related remuneration received
- Details of any political activity declared in the last 5 years.

Key dates and Contact Information

- Completed application forms must be received on or before **12.00 noon on Thursday 9th July 2015.**

- **Late applications will not be accepted.**

Interviews will take place as follows:

- NHSCT – 7th, 8th, 14th and 16th September 2015

- SEHSCT – 7th, 8th, 9th, 10th and 11th September 2015

- SHSCT - 7th, 9th, 10th, 14th and 15th September 20152015.

If you have any queries please:

Telephone: (028) Irrelevant information redacted by the USI
Fax: (028) Irrelevant information redacted by the USI
Text phone: (028) Irrelevant information redacted by the USI **(for those with hearing difficulties); *or***
E-mail: public.appointments@dhsspsni.gov.uk

Complaints

If you wish to make a complaint about any aspect of this appointment process, you should contact the Department of Health, Social Services & Public Safety, Appointments and Business Unit, who will investigate your complaint. If you are dissatisfied with the Department's response, you may wish to ask the Commissioner for Public Appointments for Northern Ireland to investigate the matter. Contact details can be found in the enclosed leaflet entitled "CPANI – The Commissioner for Public Appointments for Northern Ireland".

Codes of Conduct and Accountability

To ensure that public service values remain at the heart of the Health and Social Care system, the Non-Executive Directors of the HSC Trust are required, on appointment, to subscribe to the Codes of Conduct and Accountability. The high standards of corporate and personal conduct required of members are described more fully in the Codes.

Time Commitment

A HSC Trust Non-Executive Director will normally have to devote a minimum of **1 day per week** to the appointment. This may involve commitment both inside and outside normal working hours.

Remuneration

The annual rate of remuneration for the Non-Executive Directors to the HSC Trusts is **£7,960**. HSC Trust Non-Executive Directors are also eligible to claim allowances, at rates set centrally, for travel and subsistence costs necessarily incurred on HSC Trust business.

Double Paying

While each case will be examined on an individual basis, applicants who already work in the public sector need to be aware that:

- they may be ineligible for consideration for this appointment if in the Department's view there is a conflict of interest or the perception of a conflict, between the appointment and their existing commitments;

- where applicable they will be asked to confirm that they have permission from their employer to take up an appointment if one is offered; and

- no one can be paid twice from the public purse for the same period of time. As a result applicants who already work in the public sector may not be entitled to claim remuneration for this position if the duties are undertaken during a period of time for which they are already paid by the public sector.

In the interests of minimising the potential for double paying occurring the Department reserves the right to contact your employer regarding your candidature.

Period of Appointment
A HSC Trust Non-Executive Director is normally appointed for a four year term. An annual assessment of the performance of a HSC Trust Non-Executive Director will be required throughout the period of appointment. Re-appointment to the same post may be considered subject to an appropriate standard of performance having been achieved during the initial period of office, continued adherence to the Principles of Public Life and the approval of the Minister, however, re-appointment is not guaranteed.

Interviews for these posts will take place in September 2015, as listed above. Interviews will be held on all or some of these dates – applicants should ensure that they have reserved all these dates and make themselves available for interview.

DISQUALIFICATIONS

HOUSE OF COMMONS AND NI ASSEMBLY DISQUALIFICATIONS

Under the terms of the House of Commons Disqualifications Act 1975, the European Assembly Elections Act 1978 and the Northern Ireland Assembly Disqualification Act 1975, existing MPs, MEPs and MLAs cease to hold their elected office if they take up an appointment to a public body listed in the aforementioned legislation. A person appointed as a Non-Executive Chair or Non-Executive Member of a HSC Trust is disqualified from membership of the House of Commons.

The onus is on the person standing for election to state that they are aware of the provisions of the House of Commons Disqualification Act 1975, the European Assembly Elections Act 1978 or the Northern Ireland Assembly Disqualification Act 1975 and that, to the best of their knowledge and belief, they are disqualified from being an MP, MEP or MLA.

If an individual holding a public appointment decides to stand for election as an MP, MEP or MLA, it is their responsibility to check whether the public body to which they belong or the office that they hold is listed in the appropriate Disqualification Act.

If the public body to which an individual belongs or the office that they hold is listed in the Disqualification Act they must immediately notify the Department of their intention to stand for election. To avoid any disqualification issues from arising later they should resign their appointment **before** submitting their nomination as candidate in an election. If they have not resigned their public appointment before submitting their nomination as a candidate and are subsequently elected as an MP, MEP or MLA their election will be void.

HSC TRUST DISQUALIFICATIONS

DISQUALIFICATIONS

OTHER HEALTH & SOCIAL CARE BODY or ARMS LENGTH BODY

If you are currently serving as a Non-Executive of a Health and Social Care Body or any other Arms Length Body, **there is an onus of responsibility on applicants** to not only examine the disqualifications of the organisation to which they are applying, but also to be aware of any disqualifications which exist on the body to which they currently serve.

In some cases it is not possible to hold two concurrent appointments, however you should note that disqualification is from appointment to a post, not application. In the event of a relevant disqualification you may be required to resign from a current position in order to accept this post.

DISQUALIFICATION FROM APPOINTMENT TO TRUSTS

(Excerpt from the Health and Social Services Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994)

Disqualification for appointment of Chairman and Non-Executive Directors

11.- (1) Subject to regulation 12 a person shall be disqualified for appointment as the Chairman or Non-Executive Director of an HSS trust if -

(a) he has within the preceding five years been convicted in the United Kingdom, the Channel Islands or the Isle of Man of any offence and has had passed on him a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine; or

(b) he has been adjudged bankrupt or has made a composition or arrangement with his creditors; or

(c) he has been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body or health and social services body; or

(d) he is a person whose tenure of office as the Chairperson, member or Director of a health and social services body has been terminated because his appointment is not in the interests of the health and personal social services, for non-attendance at meetings or for non-disclosure of a pecuniary interest; or

(e) he is a Chairperson, member, Director or employee of a health and social services body; or

(f) he performs or provides primary medical services under Part VI of the Health and Personal Social Services (Northern Ireland) Order 1972, is a partner in a partnership that, or is the legal and beneficial owner of shares in a company that, provides primary medical services under Part VI of that Order, or is an employee of any of those, or is a general dental practitioner or an employee of one; or

(g) **removed**[1]

(h) he has had his name removed, by a direction under Schedule 11 of the Health and Personal Social Services (Northern Ireland) Order 1972,

1 Sub-paragraph (g) was omitted by Statutory Rule No 164 – Health and Social Care – The Health and Social Services Trusts (Membership and Procedure) Amendment Regulations (Northern Ireland) 2011

from any list prepared under Part VI of that Order and has not subsequently had his name included in such a list or a list prepared pursuant to Article57G of that Order; or

(i) he has applied for his name to be included in a list of a Health and Social Services Board, and a direction that his name should not be included in the relevant list has been given by the Tribunal under paragraph 4 of Schedule 1 to the Health Services (Primary Care) (Northern Ireland) Order 1997, and such disqualification has not been removed following an application to the Tribunal under regulation 12 of the Tribunal Regulations (Northern Ireland) 1995

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(2) For the purposes of paragraph (1)(a) the date of conviction shall be deemed to be the date on which the ordinary period allowed for making an appeal or application with respect to the conviction expires, or if such an appeal or application is made, the date on which the appeal or application is made, the date on which the appeal or application is finally disposed of or abandoned or fails by reason of it not being prosecuted.

(3) For the purposes of paragraph (1)(c) a person shall not be treated as having been in paid employment by reason only of his Chairpersonship, membership or Directorship of a health service body or a health and social services body.

(4) A person shall not be disqualified by paragraph (1)(e) from being the Non-Executive Director of an HSS trust referred to in paragraph 3(1)(d) of Schedule 3 to the Order * by reason of his employment with a health and social services body.

*The Health and Personal Social Services (Northern Ireland) Order 1991

Cessation of disqualification

12.- (1) Where a person is disqualified under regulation 11(1)(b) by reason of having been adjudged bankrupt -

(a) if the bankruptcy is annulled on the ground that he ought not to have been adjudged bankrupt or on the ground that his debts have been paid in full, the disqualification shall cease on the date of the annulment;

(b) if he is discharged the disqualification shall cease on the date of his discharge.

(2) Where a person is disqualified under regulation 11(1)*(b)* by reason of his having made a composition or arrangement with his creditors, if he pays his debts in full the disqualification shall cease on the date on which the payment is completed and in any other case it shall cease on the expiry of five years

from the date on which the terms of the deed of composition or arrangement are fulfilled.

(3) Subject to paragraph (4), where a person is disqualified under regulation 11(1)(c) (dismissed employees) he may, after the expiry of a period of not less than two years, apply in writing to the Department to remove the disqualification and the Department may direct that the disqualification shall cease.

(4) Where the Department refuses an application to remove a disqualification no further application may be made by that person until the expiration of two years from the date of the application.

(5) Where a person is disqualified under regulation 11(1)(d) (certain Chairmen and Directors whose appointments have been terminated), the disqualification shall cease on the expiry of a period of two years or such longer period as the Department specifies when terminating his period of office but the Department may on application being made to it by that person, reduce the period of disqualification.

DISQUALIFICATION FOR MEMBERSHIP OF THE NORTHERN IRELAND ASSEMBLY

A person appointed as Chair of a Health and Social Care Trust is disqualified from membership of the Northern Ireland Assembly.

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

Heather Stevens
Director of Workforce Policy

Personal Information redacted by the USI

Castle Buildings
Upper Newtownards Road
BELFAST
BT4 3SQ

Tel: Personal Information redacted by the USI
Fax:
Email: Personal Information redacted by the USI
Our Ref: DH1/16/54177

Date: 7th March 2016

Dear Ms Mullan,

NON-EXECUTIVE DIRECTOR OF THE SOUTHERN HEALTH AND SOCIAL CARE TRUST

I wish to confirm the Minister's offer of appointment made to you, as a Non-Executive Director of the Southern Health and Social Care Trust (SHSCT). The initial appointment will be for a four year period commencing on **15 February 2016 – 14 February 2020 as detailed in the Minute of Appointment enclosed.**

The principal terms and conditions governing your appointment are set out in the attached letter of appointment and associated documents at **Annex A**. I should be grateful if you would confirm in writing your willingness to accept the appointment on these terms by completing the proforma at **Annex B** and returning to the Department's Appointments and Business Unit.

You are required, as a condition of this appointment, to attend an induction course "Essential Skills for Board Directors" or the "On Board Training Programme for Board Members of Public Bodies in Northern Ireland" within 6 months of taking up appointment in addition to any Induction training provided by the SHSCT and you will be advised by the Chair regarding this – see http://www.cipfa.org/Events or http://www.onboard-training.co.uk for course details. You must notify the Department's Appointments and Business Unit when you have completed this course. You will also find enclosed a copy of the fourth edition of *'On Board: A Guide for Board Directors of Public Bodies'*. This guidance is an essential reference tool for all Board Directors and provides clarity on a wide range of corporate governance issues.

I hope you find your role as Non-Executive Director of the SHSCT interesting and fulfilling.

Yours sincerely

Personal Information redacted by the USI

Heather Stevens
Director of Workforce Policy

CPANI
The Commissioner for Public Appointments Northern Ireland
REGULATED

Appointments and Business Unit D1 Castle Buildings Stormont Estate Belfast BT4 3SQ
Tel: Irrelevant information redacted by the USI *Fax:* Irrelevant information redacted by the USI
E-mail: public.appointments@dhsspsni.gov.uk

Annex A

SOUTHERN HEALTH AND SOCIAL CARE TRUST
NON-EXECUTIVE DIRECTOR

LETTER OF APPOINTMENT

This letter sets out the principal terms and conditions of this Ministerial Appointment as a Non-Executive Director of the Southern Health and Social Care Trust (SHSCT).

Name of Parties: **Department of Health, Social Service and Public Safety**
Ms Eileen Mullan

1. Commencement of Appointment

1.1 Your appointment will commence on **15 February 2016**.

2. Duration of Appointment

2.1 The initial period of appointment will be for four years, commencing on **15 February 2016 and ending on 14 February 2020.**

2.2 A public appointee may be reappointed for a second term (or in exceptional circumstances, be extended for a short period) in the same role without open competition, subject to:
(a) evidence of effective performance;
(b) continued adherence to the principles of public life.

3. Title

3.1 You are appointed as a **Non-Executive Director** of the SHSCT. The five integrated Health and Social Care Trusts were established in April 2007. The Trusts are known as the Belfast HSC Trust, the Northern HSC Trust, the Southern HSC Trust, the South Eastern HSC Trust and the Western HSC Trust. The Northern Ireland Ambulance Service Trust functions independently of these five Trusts.

The five HSC Trusts were established as statutorily separate organisations within the HSC family, responsible for the delivery of responsive and effective health and care services and for the ownership and management of hospitals and other establishments and facilities. They provide health and social care services against Ministerial priorities, standards and targets. Services will be provided as specified in contracts with the commissioners of health and social care services, namely the HSCB.

4. Board Responsibilities

4.1 Each HSC Trust is managed directly by a board of Directors which has corporate responsibility for its operation. A board is made up of five executive Directors and seven Non-Executive Directors and a Non-Executive Chair. Non-Executive Directors and executive Directors are full and equal members of the board.

4.2 An HSC Trust Chair and the Non-Executive Directors are appointed with the approval of the Minister, in accordance with the Code of Practice of the Commissioner for Public Appointments for Northern Ireland. They are required to operate in a personal rather than a representative capacity.

4.3 The executive Directors of a HSC Trust board **must** include:

- the chief officer of the Trust; and
- the chief finance officer.

4.4 HSC Trusts that provide services directly to patients and clients (excluding ambulance and patient/client transport) should include the following professionals as executive Directors:

- a medical or dental practitioner; and
- a registered nurse or midwife: and
- a person holding a recognised qualification in social work.

4.5 Professional involvement on the Trust board is intended to support the principles of general management, and although the professional executive Directors are required to provide appropriate professional insights to the deliberations of the HSC Trust, there is no absolute requirement for them to have direct operational management responsibility for their profession within the Trust.

5. Non-Executive Director Role and Responsibilities

5.1 The Non-Executive Directors of the Southern HSC Trust are appointed by the Minister in order to bring an independent judgement to bear on issues of strategy, performance and executive appointments within the HSC Trusts. He/she will bring wide experience and critical detachment to the work of the board.

5.2 It is the role of each Non-Executive Director to:

- share in the independent Non-Executive oversight, scrutiny and stewardship of the Southern HSC Trust's work;
- hold executive Directors to account; including assessing the performance of and appointing senior management ;
- sit on board Committees such as the Governance and Audit Committee;

- participate in professional conduct and competency enquiries as well as staff disciplinary appeals;
- scrutinise decision making on major procurement issues;
- scrutinise the handling of complaints.

5.3 This public appointment does not constitute employment. Accordingly nothing in this letter shall be construed as, or taken to create, a contract of employment between you, SHSCT or the Department.

6. Accountability and Reporting responsibility

6.1 The Non-Executive Directors of the SHSCT are accountable to the Minister, through the Permanent Secretary of the Department of Health, Social Services and Public Safety.

6.2 The Non-Executive Directors of SHSCT report directly to the Chair of SHSCT.

7. Time Commitment

7.1 The activities mentioned under the Non-Executive Director role at paragraph 5.2 are estimated to involve a time commitment of **1 day per week**. This may involve considerable commitment both inside and outside normal working hours.

8. Remuneration

8.1 Your remuneration as a Non-Executive Director of the Board of SHSCT will be Personal Information redacted by the USI based on 1 day per week.

9. Travel, subsistence and other expenses

9.1 In carrying out your role as a Non-Executive Director you are entitled to claim allowances at rates set centrally by the Department, for costs necessarily incurred on SHSCT business.

9.2 Remuneration is taxable and it is the responsibility of the SHSCT to apply PAYE deductions in respect of income tax and National Insurance, unless instructed to the contrary by the Inland Revenue. If appropriate, it will be for you to arrange exemption from National Insurance Contributions by contacting HM Revenue and Customs in Newcastle.

10. Double Paying

10.1 The Department of Finance and Personnel (DFP) has issued guidance in relation to the remuneration of independent board Directors who are public sector employees. Each case will be considered individually, however, the guiding principle should be to avoid "double-paying". That is, if an individual is

drawing a full-time salary from the public purse, payment should not be made twice.

11. Training (including Induction Training)

11.1 Board Directors of public bodies are expected to undergo appropriate training in corporate governance and board Directorship.

11.2 You are required, as a condition of this appointment, to attend an induction course for example "Essential Skills for Board Directors" or the "On Board Training Programme for Board Members of Public Bodies in Northern Ireland" or similar course usually within 6 months of taking up appointment, this is in addition to any Induction training provided by the SHSCT.

11.3 You must notify the Department's Appointments and Business Unit of your attendance at the Induction course within the required timeframe.

11.4 The Chief Executives' Forum in Northern Ireland (NICON) provides access to training courses that provide invaluable training for newly appointed Board Directors in addition to any training SHSCT may offer.

12. Performance Appraisal

12.1 As a Director of the Board of SHSCT your performance will be appraised on an annual basis by the Chair of the SHSCT and a copy of the report passed to the Departmental Reporting Officer, for countersigning.

12.2 For your appointment to continue for the remainder of your term, or for you to be considered for re-appointment at the end of your term, your performance appraisal report must be satisfactory. An unsatisfactory appraisal report may contribute to certain actions being taken, which could ultimately lead to termination of your appointment.

12.3 Departments have a duty to satisfy themselves, as far as is practicable, that those they appoint to the boards of public bodies will carry out their duties in an efficient and effective manner. For candidates who have held other public appointments this means that the appointing department can seek information on previous performance as a Board Director.

12.4 In the event that you apply for another public appointment, we will, on request, provide the appointing department with information relating to your performance as a Director of the Board of SHSCT.

13. Attendance

13.1 Board Directors are expected to attend meetings regularly. Your appointment may be terminated if attendance becomes as erratic as to interfere with the good running of the SHSCT or its Board.

14. Termination of Appointment

14.1 Your appointment may be terminated if at any time you are considered unfit to continue in office or are incapable of performing your duties as a Director of the Board.

14.2 In order to maintain high standards in public life, an appointment may be terminated in the event that an appointee is convicted of a criminal offence and/or where the Minister believes that the appointee's conduct means that he or she is no longer a suitable person to hold office as a Director of the Board of SHSCT.

15. Indemnities for personal liability

15.1 The Government has indicated that an individual Board Director who has acted honestly and in good faith will not have to meet out of his/her own personal resources any personal civil liability which is incurred in the execution or purported execution of his/her board function, save where the person has acted recklessly.

16. Conduct

16.1 All public appointees have a duty in relation to conduct, propriety and confidentiality.

16.2 You will be required as a condition of your appointment to abide by the seven principles of public life and by the Code of Conduct and Code of Accountability enclosed with this letter. In addition you will be required to abide by the SHSCT Code of Conduct.

16.3 You must notify the Chair if you become the subject of a police investigation or are arrested by the police.

17. Conflicts of Interest

17.1 Conflicts of interest, whether real or perceived, can be damaging to the individual board Director, the board itself and the Department. If a conflict of interest arises or is identified it is essential that it is resolved as quickly as possible.

17.2 You must declare any personal or business interests, pecuniary or non-pecuniary which may, or may be perceived to, influence your judgement when performing your duties as a Director of the Board of the SHSCT. Failure to do so could lead to your appointment being withdrawn.

17.3 You are encouraged to register your own interests and the interests of close family Directors and persons living in the same household that appear closely related to your activities as a Director of the SHSCT. Should you be in any

doubt about what to disclose it is best to err on the side of caution and disclose the information. These interests will be included in an appropriate register of interests maintained by the SHSCT and you must ensure that your entries are kept up to date.

17.4 Should an issue arise subsequent to the completion of the register of interests, which could give rise to a potential conflict of interest you must inform the Chair.

17.5 If at a meeting of the Board an issue arises that could give rise to a potential conflict you should disclose your interest and withdraw from any discussion or consideration of the matter.

17.6 If a conflict of interest is identified the Department, in conjunction with the Chair (where appropriate) and the individual Board Director will need to give careful consideration to how the problem can be resolved. In extreme situations if a conflict of interest cannot be resolved dismissal may be the most appropriate option, however due process must be followed and the principles of natural justice applied.

18. Other Appointments

18.1 You must inform the Department and the Chair of the SHSCT in advance of taking up any new appointments which may impinge on your duties.

19. Political Activity

19.1 You should not occupy paid party political posts or hold particularly sensitive positions of responsibility in a political party. Subject to the foregoing, you are free to engage in political activities provided that you are conscious of your general public responsibilities and exercise proper discretion, particularly with regard to the work of the SHSCT. Be prepared to disclose any potential conflicts of interest.

19.2 You are expected to inform the Minister of any intention to accept a prominent position in any political party and to understand that your appointment as a Director of the Board of the SHSCT may be terminated if the Minister feels that, in the case of you accepting such a role, the positions are incompatible.

19.3 Under the terms of the House of Commons Disqualification Act 1975, the European Assembly Elections Act 1978 and the Northern Ireland Assembly Disqualification Act 1975, MPs, MEPs and MLAs cease to hold their elected office if they take up an appointment to a public body or office listed in the afore mentioned legislation.

19.4 Existing legislation puts the onus on the person standing for election to state that they are aware of the provisions of the House of Commons Disqualification Act 1975 or the Northern Ireland Assembly Disqualification Act 1975 and that, to the best of their knowledge and belief, they are not disqualified from being an MP, MEP or MLA.

19.5 Therefore, if you decide to stand for election as an MP, MEP or MLA you must ensure that the public body or office to which you belong is not listed in the House of Commons or Northern Ireland Assembly Disqualification Acts.

19.6 If the public body or office is listed in the relevant Disqualification Act you should notify the Department immediately and to avoid any disqualification issues from arising later, you should resign your appointment before submitting your nomination as a candidate in an election.

20. Bankruptcy

20.1 You may be removed from office before the end of your term of appointment if you become bankrupt or are made the subject of a Bankruptcy Restrictions Order.

21. Official Secrets Act

The provisions of the Official Secrets Act 1911 to 1989 apply to public appointees. Unauthorised disclosure of any information gained in the course of your appointment, or its use by you or others for personal gain or advancement, could result in your appointment being terminated early, or even criminal prosecution.

Annex B

DECLARATION OF ACCEPTANCE OF APPOINTMENT AS NON-EXECUTIVE DIRECTOR OF THE SOUTHERN HEALTH AND SOCIAL CARE TRUST (SHSCT)

MS EILEEN MULLAN

SHSCT – NON-EXECUTIVE DIRECTOR

I am willing to accept the appointment as a Non-Executive Director on the Board of the SHSCT for the period **15 February 2016 – 14 February 2020** on the basis of the terms and conditions set out in my letter of appointment dated **March 2016**.	Yes / No
I confirm that I have received a copy of the Code of Conduct and Code of Accountability (dated July 2012) and am committed to the seven principles of public life as defined by the Committee on Standards in Public Life (Nolan Principles).	Yes / No
I will confirm attendance at an Induction training course approved by the Department within 6 months of taking up appointment.	Yes / No

Name: **Ms Eileen Mullan**

Signature: _____

Date: _____

THE HEALTH AND PERSONAL SOCIAL SERVICES (NORTHERN IRELAND) ORDER 1991

THE SOUTHERN HEALTH AND SOCIAL CARE TRUST

MINUTE OF APPOINTMENT

The Department of Health, Social Services and Public Safety (a), in exercise of the powers conferred on it by Article 10 (4) of the Health and Personal Social Services (Northern Ireland) Order 1991 (b), hereby appoints the following person as a non-executive director of the Southern Health and Social Care Trust from 15 February 2016 to 14 February 2020.

Name: Ms Eileen Mullan

Address: Personal Information redacted by the USI

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety this 8th day of March 2016.

Personal Information redacted by the USI

Senior Officer of the Department of Health, Social Services and Public Safety

L.S.

(a) see Article 3(6) of S.I. 1999/283 (N.I. 1)

(b) S.I. 1991/194 (N.I. 1) as amended by Article 1 (3) (a) of the Health and Social Care (Reform) Act – see 2009 c.1 (N.I.)

Andrew Dawson
Director of Workforce Policy (Acting)

Ms Eileen Mullan
Personal Information redacted by the USI

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Tel: Irrelevant information redacted by the USI
Fax:
Email: public.appointments@health-ni.gov.uk

Our Ref: DH1-15-1024

Date: 22 October 2019

Dear Ms Mullan

SHSCT – REAPPOINTMENT OF NON-EXECUTIVE DIRECTOR

I am writing to advise you that the Department has approved the reappointment of your role as a Non-Executive Lay Director of the Southern Health and Social Care Trust. The appointment will commence on 15 February 2020 and end on a date not later than 14 February 2024.

It should be noted that the Department may give notice to terminate your appointment at any time. Please note, should you wish to end your term early the Department will require a minimum of 3 months' notice. A copy of your formal minute of appointment is enclosed.

I wish you continued success in your role, which I hope will be both challenging and rewarding.

Yours sincerely

Personal Information redacted by the USI

Andrew Dawson
Director of Workforce Policy (Acting)

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CPANI The Commissioner for Public Appointments Northern Ireland REGULATED

THE HEALTH AND PERSONAL SOCIAL SERVICES (NORTHERN IRELAND) ORDER 1991

SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST

MINUTE OF APPOINTMENT

The Department of Health (a), in exercise of the powers conferred on it by Article 10 (4) of the Health and Personal Social Services (Northern Ireland) Order 1991 (b), hereby appoints the following person as Non-Executive Lay Director of the Southern Health and Social Care Trust. The appointment will commence on 15 February 2020 and will end on a date not later than 14 February 2024.

Name: Ms Eileen Mullan

Address: Personal Information redacted by the USI

Sealed with the Official Seal of the Department of Health this 22nd day of October 2019.

Personal Information redacted by the USI

Department of Health

(a) See Article 3 (6) of S.I. 1999/283 (N.I.1)

(b) S.I.1991/194 (N.I 1) as amended by Article 1 (3) (a) of the Health and Social Care (Reform) Act – see 2009 c.1 (N.I)

DEPARTMENT OF HEALTH, SOCIAL SERVICES & PUBLIC SAFETY DH1/16/101766
PROTECT – PRIVATE (WHEN COMPLETED)

NON-EXECUTIVE MEMBER PERFORMANCE ASSESSMENT FORM

NAME: Ms Eileen Mullan **PUBLIC BODY: SHSCT**

PERIOD OF ASSESSMENT: 1 APRIL 2016 to 31 MARCH 2017

DATE OF FIRST APPOINTMENT: 15 February 2016

CURRENT APPOINTMENT EXPIRES: 14 February 2020

ASSISTANT SECRETARY REVIEWING: _____

The information contained in this performance appraisal may be shared with other Government departments in line with their policy on the use of references when making public appointments.

SELF-ASSESSMENT

You should set out your key achievements against the objectives for the year including those objectives which were not met and any relevant factors which arose in the course of the year.

MAKING AN IMPACT WITH OTHERS – Relations with Chair and other board members; Contributing to an effective team

Objective: To become an effective, cohesive member of the board team.

Process & Outcome:

During the 2016/2017 I spent a great deal of time in developing relationships across the Trust Board team. Through attendance at Trust Board, Committee, home visits and leadership walks these have allowed me the opportunity to build and maintain effective working relationships. I am a very self-aware and always reflect on how meetings have gone, and in particular how my contribution impacted on the meeting and attendees. I seek feedback from colleague and in particular to my role as Chair of the Governance Committee.

COMMITTING TO THE NON-EXECUTIVE ROLE – Corporate responsibility; Probity; Adherence to Codes of Conduct and Accountability

Objective: To fully commit to the idea of corporacy and demonstrate adherence to the Codes.

Process & Outcome:

I am very clear on the corporate role of the Non-Executive and can evidence through my contributions at meetings that the focus is on the SHSCT, its patients and service users. Whilst I live within the SHSCT catchment area, my focus since appointment has been on the SHSCT and all its areas of work. This also has included me getting to grips with the complex business of health and social care which is out with my area of knowledge and experience.

THINKING STRATEGICALLY – Making a significant contribution to the strategic direction and planning process of the organisation.

Objective: To contribute to organisational goals and objectives.

Process & Outcome:

I undertook six months induction which exposed me to the vast array of complex work undertaken with the SHSCT. Whilst this was operationally focussed, my job was then to bring that learning into the Board and Committee room at a strategic level. It took a good six months to start to fully understand the business of health and social care, the wider environment within which SHCST works and the political landscape and ministerial policy that shaped it.

My preparation and attendance at meetings helps me to apply myself strategically for the Trust.

ANALYTICAL THINKING – Making decisions and solving problems as a board member.

Objective: To demonstrate the ability to agree a decision or solve a problem as part of the board team.

Process & Outcome:

In preparing for meetings I read the information provided, and draft questions for exploring at the committee or board meetings. In making a decision I ensure that I have the information required to support that decision and if not I seek it. Where I am unsure as to what is actually been asked of me as a member of the Trust Board I ask for clarity.

There are many decisions made at Trust Board and many decisions which are operational in nature and therefore delegated to SMT. I ensure that my contributions to decision making is at a corporate strategic level.

LEARNING & SELF-DEVELOPMENT – Taking personal responsibility to further develop as a non-executive.

Objective: To pick up understanding and knowledge of issues quickly.

Process & Outcome:

Learning and development has been continual since joining the Trust Board. This is a highly complex organisation and I take every opportunity to engage further and learn more.

At the moment there is no formal training of interest, but I will keep a close watch on my learning needs and raise with Chair where appropriate.

Time Commitment

	Board meetings	Committee meetings
Meetings held during assessment period	**14** (includes Directors' Workshops; Board Development Day and one Extraordinary Confidential Trust Board Meeting)	**14**
Meetings attended	**11**	**10**
Estimate average time spent in the role of member per month		

Brief details of other events, activities and visits should be included in the box below:

Details of attendance at other events, activities and visits
Induction Training between March and September Meetings in relation to the Excellence Awards Meetings in relation the Integrated Transport Group Meeting with SMT to support thinking on the revised risk register Meeting with Finance Minister with Chairs Forum Meetings with the Chair Non Executive Director Meetings with the Chair (3) Children's Home Visits (4) Leadership Walkabouts (2) Director of Human Resources Shortlisting/Interviews Feedback Meetings with Chair, Chief Executive and Board Assurance Manager re Governance Committee (3) Maintaining High Professional Standards (MHPS) Training Senior Risk Owner Training Mentor meeting with new Non Executive Director Annual Service of Remembrance for Southern Trust patients and staff who have died

Notes on specific issues for the forthcoming year:
Undertake Leadership Walks outside of Craigavon Area Hospital Request to attend an accountability meeting Meet with Chairs of other HSC Trust Governance Committees to share learning, experiences and regional viewpoints

PRINCIPLES OF PUBLIC LIFE

Please confirm that you have adhered to the Principles of Public Life and Codes of Conduct and Accountability. If any failures in this area have been identified, please provide details:

YES

If NO provide details:

CONFLICTS OF INTEREST

Have you taken up any other appointments, employment, etc during the year?

NO

If YES, please provide details:

If other appointments, employment, etc have been taken up, are you satisfied that no conflict of interest arises as a result?

NOT APPLICABLE

If NO, please provide details:

DEPARTMENT OF HEALTH, SOCIAL SERVICES & PUBLIC SAFETY DH1/16/101766
PROTECT – PRIVATE (WHEN COMPLETED)

RE-APPOINTMENT ONLY TO BE COMPLETED BY MEMBERS IN OR ENTERING THEIR FINAL YEAR OF APPOINTMENT.

Members approaching the end of a **first** 4 year term of appointment may be offered to serve for a second term subject to a satisfactory performance. Please indicate if you would be willing to accept a second term of appointment if offered.

N/A

Chair's comments: Should include discussion on NEDs performance with relevant Committee Chairs to which NED is appointed, if appropriate. (also include endorsement of re-appointment if appropriate)

Eileen is a highly skilled and experienced Non Executive Director who at all times fulfils her role to the highest standards.

Eileen is able to challenge sensitively with meaning and comes to each meeting well prepared.

Eileen is highly respected for her knowledge, skills and experience in the boardroom. A strong Non Executive Director with a wealth of experience that adds enormous value to SHSCT. A most supportive colleague.

I consider performance to be * **Effective**

If performance is **ineffective**, has this been discussed with the member *Yes/No
Details of any measures/action taken:-

Are you willing to endorse re-appointment for a second term? **YES/NO**

SIGNED: Personal Information redacted by the USI DATE: 25/5/17

Member's comments:

Fully accept the Chair's comments and appreciate them. Trust Board Colleagues and Chair have been very generous in supporting my learning and development in this highly complex environment.

I **agree** with my performance appraisal

Signed [redacted] Date: 25/05/17

Senior Official's comments:

Noted

Signed: [redacted] Date: 27/7/17

Rec'd 18/10/18

DEPARTMENT OF HEALTH, SOCIAL SERVICES & PUBLIC SAFETY
PROTECT – PRIVATE (WHEN COMPLETED)

NON-EXECUTIVE MEMBER PERFORMANCE ASSESSMENT FORM

NAME: Eileen Mullan **PUBLIC BODY: SHSCT**

PERIOD OF ASSESSMENT: YEAR ENDING 31 MARCH 2018

DATE OF FIRST APPOINTMENT: 15 February 2016

CURRENT APPOINTMENT EXPIRES: 14 February 2020

ASSISTANT SECRETARY REVIEWING: _____

The information contained in this performance appraisal may be shared with other Government departments in line with their policy on the use of references when making public appointments.

SELF-ASSESSMENT

You should set out your key achievements against the objectives for the year including those objectives which were not met and any relevant factors which arose in the course of the year.

MAKING AN IMPACT WITH OTHERS – Relations with Chair and other board members; Contributing to an effective team

Objective: To become an effective, cohesive member of the board team.

Process & Outcome:

I have observed real team development and cohesion over the last year. My role in this has been to spend time with fellow NED's to understand and explore their skills and experiences. This has helped me in my learning and development, at the same time as a Committee Chair, understanding how each member plays their own distinct role and collectively as a Board Team.

COMMITTING TO THE NON-EXECUTIVE ROLE – Corporate responsibility; Probity; Adherence to Codes of Conduct and Accountability

Objective: To fully commit to the idea of corporacy and demonstrate adherence to the Codes.

Process & Outcome:

I fully understand what corpocracy is. When I make my contributions and inform discussions it is always from the position of the Southern Health and Social Care Trust.

Board and Committee meeting etiquette is upfront at each meeting. I adhere to the code of conduct and principles for public life as a Non-Executive Director.

THINKING STRATEGICALLY – Making a significant contribution to the strategic direction and planning process of the organisation.

Objective: To contribute to organisational goals and objectives.

Process & Outcome:

Forward thinking and planning is central to my thinking and approach as a Non-Executive. This has been a difficult year for the SHSCT and the wider HSC family. The future strategic direction lies with the delivering together 2021 and the SHSCT is eager and keen to embrace the transformation. Challenges on decision making at political level and impeded the progress to date. However, I am very proud of the work the SHSCT has done in regards to Daisy Hill over the last year.

My role in the last year is whilst to hold to account the SMT on operational targets, has also been to ensure that the future direction and decisions taken are considered and delivered through a strategic lens.

ANALYTICAL THINKING – Making decisions and solving problems as a board member.

Objective: To demonstrate the ability to agree a decision or solve a problem as part of the board team.

Process & Outcome:

Board, committee and workshop meetings have over the year explored many issues and areas for decision making. I have played my active role in all of these settings. I do this by being informed, having the right information and gauging in a constructive discussion with Board and Committee colleagues. I also played an active role in the Daisy Hill Pathfinder project in taking part in the community consultation events and discussions at Board and committee level.

LEARNING & SELF-DEVELOPMENT – Taking personal responsibility to further develop as a non-executive.

Objective: To pick up understanding and knowledge of issues quickly.

Process & Outcome:

I have a strong learning ethic and always keen to learn. Each meeting or event attended, activity undertaken allowed me to learn more about the Trust, my colleagues and the HSC family. This enabled me to be better informed to support discussions and decision making. There has been a number of NED Learning events held recently (2018) which have been very welcome. That time out, with peers to explore common issues and concerns is a very supportive option to have.

Time Commitment

	Board meetings	**Committee meetings**
Meetings held during assessment period	18 (includes Directors' Workshops and Board Development Day)	13
Meetings attended	16	10
Estimate average time spent in the role of member per month		

Brief details of other events, activities and visits should be included in the box below:

Details of attendance at other events, activities and visits
Children's Home Visits Mortality and Morbidity Regional Event Meeting with Chief Executive Hyponatraemia Oversight Group Meetings

NICON/HFMA Non Executive Director Development Day
Excellence Awards Ceremony
Daisy Hill Pathfinder Group Meeting
Leadership Walk
Financial Planning Savings Plan Consultation Public Meeting
Craigavon Paediatric Centre Open Day
Professor Mike West Seminar
Shortlisting/Interviews for Interim Director of Mental Health and Learning Disability
Chair's Christmas Reception

Notes on specific issues for the forthcoming year:

- Work on the Hyponatraemia Inquiry at both Trust and HSC wide is critical to restore Trust in the Trusts. I am keen that this remains a significant priority for the Trust Board.
- The whistleblowing policy and follow through work is also critical not just in relation to Hyponatraemia but as a cultural shift for the Trust.
- Would be keen to undertaken Consultant Interview observation so I can support the NED team to deliver on this.

PRINCIPLES OF PUBLIC LIFE

Please confirm that you have adhered to the Principles of Public Life and Codes of Conduct and Accountability. If any failures in this area have been identified, please provide details:

YES

If NO provide details:

CONFLICTS OF INTEREST

Have you taken up any other appointments, employment, etc during the year?

NO

If YES, please provide details:

If other appointments, employment, etc have been taken up, are you satisfied that no conflict of interest arises as a result?

NOT APPLICABLE

If NO, please provide details:

DEPARTMENT OF HEALTH, SOCIAL SERVICES & PUBLIC SAFETY
PROTECT – PRIVATE (WHEN COMPLETED)

RE-APPOINTMENT ONLY TO BE COMPLETED BY MEMBERS IN OR ENTERING THEIR FINAL YEAR OF APPOINTMENT.

Members approaching the end of a **first** 4 year term of appointment may be offered to serve for a second term subject to a satisfactory performance. Please indicate if you would be willing to accept a second term of appointment if offered.

YES/NO

Chair's comments: Should include discussion on NEDs performance with relevant Committee Chairs to which NED is appointed, if appropriate. (also include endorsement of re-appointment if appropriate)

Elleen is a well experienced and supportive colleague. She has a broad breadth of training and knowledge in governance and brings this experience to the Trust Board.
Eileen takes the lead in Governance issues and I look to her expertise for bringing about needed change and challenge.
Eileen has an extremely busy workload and tries to take on additional responsibly at the Trust as needs indicate and when she is available.
Eileen has a strong challenge function and has the ability to think analytically.

I consider performance to be **Effective**

If performance is **ineffective**, has this been discussed with the member ***Yes/No**
Details of any measures/action taken:-

Are you willing to endorse re-appointment for a second term? **YES/NO**

SIGNED: [redacted] DATE: 25/6/2018

Personal Information redacted by the USI

DEPARTMENT OF HEALTH, SOCIAL SERVICES & PUBLIC SAFETY
PROTECT – PRIVATE (WHEN COMPLETED)

Member's comments:

I acknowledge and appreciate comments from the Chair and am content with the completeness of this appraisal.

I agree with my performance appraisal

Signed: [redacted] Date: 21 – 06 – 18

Senior Official's comments:

Noted

Signed: [redacted] Date: 11/10/18

DEPARTMENT OF HEALTH, SOCIAL SERVICES & PUBLIC SAFETY
PROTECT – PRIVATE (WHEN COMPLETED)

NON-EXECUTIVE MEMBER
PERFORMANCE ASSESSMENT FORM

NAME: Eileen Mullan **PUBLIC BODY: Southern Health and Social Care Trust**

PERIOD OF ASSESSMENT: YEAR ENDING 31 MARCH 2019

DATE OF FIRST APPOINTMENT: 15 February 2016

CURRENT APPOINTMENT EXPIRES: 14 February 2020

ASSISTANT SECRETARY REVIEWING: MARTINA MOORE_____

The information contained in this performance appraisal may be shared with other Government departments in line with their policy on the use of references when making public appointments.

SELF-ASSESSMENT

You should set out your key achievements against the objectives for the year including those objectives which were not met and any relevant factors which arose in the course of the year.

MAKING AN IMPACT WITH OTHERS – Relations with Chair and other board members; Contributing to an effective team

Objective: To become an effective, cohesive member of the board team.

Process & Outcome:

We have undertaken a number of workshops focused on values and behaviours which have been helpful in landing on a baseline of expectations. This process has enabled the development of the Board team further.

I however still believe that there are a range of differing views as to who are the Trust Board and at times I can see the Non Exec/Exec Divide which is not creating a cohesive board team.

From my perspective I take time to build relationships and get to know my colleagues better, which helps in fostering a team culture.

I do challenge colleagues where appropriate and in return I am challenged also. This for me is healthy and is needed to avoid complacency.

COMMITTING TO THE NON-EXECUTIVE ROLE – Corporate responsibility; Probity; Adherence to Codes of Conduct and Accountability

Objective: To fully commit to the idea of corporacy and demonstrate adherence to the Codes

Process & Outcome:

My commitment to the Non-Executive role and the corporacy of that is front and centre to what I do.

In relations to codes – I adhere and standby the principles of public life and codes of practice.

THINKING STRATEGICALLY – Making a significant contribution to the strategic direction and planning process of the organisation.

Objective: To contribute to organisational goals and objectives.

Process & Outcome:

I feel my contributions around the values and behaviours in creating an appropriate culture within the Trust was at a strategic level.

I have noted on several occasions the need for the Trust Board to make time for strategic discussions within the context of the Trust Board meetings as well as workshops.

ANALYTICAL THINKING – Making decisions and solving problems as a board member.

Objective: To demonstrate the ability to agree a decision or solve a problem as part of the board team.

Process & Outcome:

I feel I contribute well on this. My approach at Board and Committee meetings is to seek with colleagues to solve problems using the skills knowledge available.

For decision making, I satisfy myself I have the information I need, but I am acutely aware that we all process information differently and I seek where I can to support others to get the information themselves.

LEARNING & SELF-DEVELOPMENT – Taking personal responsibility to further develop as a non-executive.

Objective: To pick up understanding and knowledge of issues quickly.

Process & Outcome:

I take the opportunity to back fill in understanding on issues relating to the Trust work. Where appropriate I meet with Directors/or members of their team to help to gain further knowledge.

I also seek to ensure I keep abreast of the external environment and where it applies directly or indirectly on health and social care.

Time Commitment

	Board meetings	Committee meetings
Meetings held during assessment period	**13**	**13**
Meetings attended	**13**	**8**
Estimate average time spent in the role of member per month	**3**	

Brief details of other events, activities and visits should be included in the box below:

Details of attendance at other events, activities and visits
Bocombra Children's Home Visits Leadership Walks Excellence Awards Hyponatraemia Trust Oversight Group Hyponatraemia Workstream 4 Visit to the Promoting Health and Well Being Team NED Meetings Meetings with CEO Daisy Hill Pathfinder Meetings with Board Assurance Manager Domiciliary Care Awards Ceremony Director shortlisting and Interviews Consultant shortlisting Interviews Recovery College event Dungannon NICON Event

Notes on specific issues for the forthcoming year:
Will keep abreast of internal and external opportunities to develop where applicable.

PRINCIPLES OF PUBLIC LIFE

Please confirm that you have adhered to
The Principles of Public Life and Codes of Conduct
And Accountability. If any failures in this area have
been identified, please provide details:

YES

If NO provide details:

CONFLICTS OF INTEREST

Have you taken up any other appointments?
employment, etc. during the year?

NO

If YES, please provide details:

If other appointments, employment, etc. have been taken up, are you satisfied that no conflict of interest arises as a result?

NOT APPLICABLE

If NO, please provide details:

DEPARTMENT OF HEALTH, SOCIAL SERVICES & PUBLIC SAFETY
PROTECT – PRIVATE (WHEN COMPLETED)

RE-APPOINTMENT **ONLY TO BE COMPLETED BY MEMBERS IN OR ENTERING THEIR FINAL YEAR OF APPOINTMENT.**

Members approaching the end of a **first** 4 year term of appointment may be offered to serve for a second term subject to a satisfactory performance. Please indicate if you would be willing to accept a second term of appointment if offered.

YES

Chair's comments: Should include discussion on NEDs performance with relevant Committee Chairs to which NED is appointed, if appropriate. (also include endorsement of re-appointment if appropriate)

Eileen is an excellent Non Executive Director and makes a significant contribution to Trust Board business.

I consider performance to be *** Effective**

If performance is **ineffective**, has this been discussed with the member ***Yes/No**
Details of any measures/action taken:-

Are you willing to endorse re-appointment for a second term? **YES**

SIGNED:_[redacted]_____ DATE:___19/09/19_____

Member's comments:

I am content with this Appraisal. I have appreciated the opportunity to serve as a Non-Executive Director and Chair of the Governance Committee.

I agree with my performance appraisal

Signed [redacted] Date: 09th October 2019

Senior Official's comments:

I am content that the assessment reflects the comments made.

Signed:_ [redacted]

_____Date:__01/07/20_____

DEPARTMENT OF HEALTH
PROTECT – PRIVATE (WHEN COMPLETED)

NON-EXECUTIVE MEMBER
PERFORMANCE ASSESSMENT FORM

NAME: EILEEN MULLAN **PUBLIC BODY: SHSCT**

PERIOD OF ASSESSMENT: YEAR ENDING 31 MARCH 2020

DATE OF FIRST APPOINTMENT: 15 FEBRUARY 2016

CURRENT APPOINTMENT EXPIRES: 14 FEBRUARY 2024

SENIOR OFFICIAL REVIEWING: _____

The information contained in this performance appraisal may be shared with other Government departments in line with their policy on the use of references when making public appointments.

SELF-ASSESSMENT

You should set out your key achievements against the objectives for the year including those objectives which were not met and any relevant factors which arose in the course of the year.

MAKING AN IMPACT WITH OTHERS – Relations with Chair and other board members; Contributing to an effective team

Objective: To become an effective, cohesive member of the board team.

Process & Outcome:

Relationship's across the Executive and Non-Executives continued to be enhanced.

Further work was undertaken to explore the Trust Board strategic role in partnership with the wider HSC system.

Time was spent exploring how best to monitor the performance of the Trust which resulted in a stand-alone Performance Committee. This then allowed more dedicated time to review performance and provide support across the board team.

COMMITTING TO THE NON-EXECUTIVE ROLE – Corporate responsibility; Probity; Adherence to Codes of Conduct and Accountability

Objective: To fully commit to the idea of corporacy and demonstrate adherence to the Codes.

Process & Outcome:

As a public servant I adhere to all relevant codes of conduct and the Nolan Principles. As a Non-Executive Director, this applies across all my work with the Southern Health and Social Care Trust.

Corpocracy is extremely important to me, and work with colleagues over the last few years has seen a better understanding of corpocracy. This not only applies with the Southern Health and Social Care Trust, but within the HSC family.

THINKING STRATEGICALLY – Making a significant contribution to the strategic direction and planning process of the organisation.

Objective: To contribute to organisational goals and objectives.

Process & Outcome:

I contributed to Board workshops focusing on the strategic in line with Departmental policy and Ministerial direction.

My contributions on the values and behaviours in creating an appropriate culture within the Trust was at a strategic level and remained so and was mirrored into the Governance Committee which I Chair.

ANALYTICAL THINKING – Making decisions and solving problems as a board member.

Objective: To demonstrate the ability to agree a decision or solve a problem as part of the board team.

Process & Outcome:

I feel I contribute well in regard to problem solving. My approach at Board and Committee meetings is to seek with colleagues to solve problems using the skills knowledge available.

For decision making, I satisfy myself I have the information I need, but I am acutely aware that we all process information differently and I seek where I can to support others to get the information themselves.

LEARNING & SELF-DEVELOPMENT – Taking personal responsibility to further develop as a non-executive.

Objective: To pick up understanding and knowledge of issues quickly.

Process & Outcome:

I continue to take the opportunity to back fill in understanding on issues relating to the Trust work. Where appropriate I meet with Directors/or members of their team to help to gain further knowledge.

I maintain a wider external view so that I can keep abreast of the external environment and where it applies directly or indirectly on health and social care.

Time Commitment

	Board meetings	Committee meetings
Meetings held during assessment period	12	13
Meetings attended	10	11
Estimate average time spent in the role of member per month	4 days per month	

Brief details of other events, activities and visits should be included in the box below:

Details of attendance at other events, activities and visits
Bocombra Children's Home Visits Leadership Walks Excellence Awards Hyponatraemia Trust Oversight Group Hyponatraemia Workstream 4 Mortality and Morbidity workshop Non-Executive Director Meetings Meetings with Chief Executive Meetings with Board Assurance Manager Director shortlisting and Interviews Consultant shortlisting Interviews

Notes on specific issues for the forthcoming year:
Covid-19 unfolding and its impact across the Trust and wide HSC system

PRINCIPLES OF PUBLIC LIFE

Please confirm that you have adhered to the Principles of Public Life and Codes of Conduct & Accountability. If any failures in this area have been identified, please provide details:

YES

If NO provide details:

CONFLICTS OF INTEREST

Have you taken up any other appointments, employment, etc during the year?

NO

If YES, please provide details:

If other appointments, employment, etc have been taken up, are you satisfied that no conflict of interest arises as a result?

YES / NO / NOT APPLICABLE

If NO, please provide details:

RE-APPOINTMENT ONLY TO BE COMPLETED BY MEMBERS IN OR ENTERING THEIR FINAL YEAR OF APPOINTMENT.

Members approaching the end of a **first** 4-year term of appointment may be offered to serve for a second term subject to a satisfactory performance. Please indicate if you would be willing to accept a second term of appointment if offered.

N/A

Chair's comments: Should include discussion on NEM's performance with relevant Committee Chairs to which NEM is appointed, if appropriate. (also include endorsement of re-appointment if appropriate)
The Chair of the Trust Board is no longer in post. It would be inappropriate for me as the current Chair to comment on my performance I consider performance to be *** Effective/ Ineffective** (*delete as appropriate) If performance is **ineffective**, has this been discussed with the member ***Yes/No** **Details of any measures/action taken:-**

Are you willing to endorse re-appointment for a second term? **YES/NO**
(If appropriate)

Note: I was reappointed on the 15th February 2020.

SIGNED [redacted] DATE:_____

Member's comments:

I agree/disagree* with my performance appraisal *(*Delete as appropriate)*

Signed:_____ Date:_____

Senior Official's comments:

Signed:_____ Grade _____ Date:_____

DEPARTMENT OF HEALTH
APPOINTMENTS – PROTECT (WHEN COMPLETED)

CHAIR PERFORMANCE ASSESSMENT FORM

NAME: EILEEN MULLAN PUBLIC BODY: SHSCT

PERIOD OF ASSESSMENT: YEAR ENDING 31 MARCH 2021

DATE OF FIRST APPOINTMENT: 01ST DECEMBER 2020

CURRENT APPOINTMENT EXPIRES: 30TH NOVEMBER 2024

DEPUTY SECRETARY REVIEWING: _____

The information contained in this performance appraisal may be shared with other Government departments in line with their policy on the use of references when making public appointments.

SELF-ASSESSMENT

You should set out your key achievements against the objectives for the year including those objectives which were not met and any relevant factors which arose in the course of the year.

STRATEGIC DEVELOPMENT AND DELIVERY – Developing Strategic Direction; Responding to HPSS Policies and Priorities; Monitoring Performance.

_____

Objective: To ensure the board sets the strategic direction of the organisation within the overall policies and priorities of the HPSS and to oversee the delivery of planned results by monitoring performance.

_____

Process & Outcome:

Upon appointment I met will all Non-Executives, Executive and Operational Directors to explore how the Trust Board and its committees could be more effective. In doing this I reviewed how the board delivers on its strategic role.

I undertook a review of the Trust Board agendas, report cover sheets and annual cycle of business.

Trust Board agendas now focus on strategy, accountability and culture.
Workshops and short bite information sessions have been built in to inform and provide a dedicated space for discussion on key items which will feed into Trust Board Agendas.

A dedicated performance committee has been established.

ACCOUNTABILITY AND GOVERNANCE - Probity; Corporate Responsibility; Adherence to Codes of Conduct and Accountability; Clinical Governance; Risk Management.

Objective: To have transparent, comprehensive systems of accountability set up and operating within the organisation.

Process & Outcome:

I uphold the principles of public life through all my roles. As Chair I expect all members of the Trust Board to uphold the same. When I took up this role and devised my vision for the Trust Board under my leadership it was based on these key principles. I set out clearly that the Trust Board is a place of openness and honesty. In order to achieve this it needs to be a psychological safe place for everyone. To achieve this, I had to create the right environment within all Trust Board Meetings so that our role of governance and accountability was strengthened and nothing could not be raised or talked about.

TEAMBUILDING - Leadership; Support and Development of Non-Executives; Relations with Chief Executive and Executive Team; Building an Effective Team.

Objective: To build and lead an effective, cohesive team at board level that provides a clear vision to the organisation.

When I took up post I met with all Directors to explore how the Trust Board and its Committees were working. Once I had met with everyone, I shared my vision for the Trust Board under my leadership. This included creating new agendas, refocusing Board attention on strategy, accountability and culture.

Board meeting timings, streamlined committees and purposeful workshops have played a role in developing the board team.

PUBLIC CONFIDENCE – Building constructive relationships outside the organisation; Representing the board in public; Developing networks and relationships with key stakeholders.

Objective: To manage at a strategic level the relationships and communications with a broad range of key stakeholders in order to maintain and encourage public confidence in the organisation.

Process & Outcome:

In my four months of appointment as Chair, at a time of significant levels of Covid infection and hospitalisations, my main focus on external relationships was with other Trust Chairs and the Minister. Internally I built in walk and talks with Directors to enable me to get a pulse check on them, their Directorate and the Trust. These engagements have proven important in building constructive relationship.

Stakeholder engagement is very important to me and as a result I put in place a planned approached for the 2021/2022 year of MP, MLA, and Local Government engagement.

TIME COMMITMENT

Please complete the table below giving details of attendance at board/committee meetings along with the overall amount of time spent in your Chair role – please state if this is on either a weekly or a monthly basis in accordance with the terms of your appointment.

	Board meetings	**Committee meetings**
Meetings held during assessment period	**12** (Non-Executive 8 Chair 4)	**13** (Non-Executive 9 Chair 4)
Meetings attended	**11** (Non-Executive 7 Chair 4)	**13** (Non-Executive 9 Chair 4)
TOTAL TIME SPENT IN CHAIR ROLE PER WEEK/MONTH		
Estimate total time spent in the role of Chair including Board/Committee meetings (per month or per week as appropriate)	**01/04/20 – 30/11/20 Non Executive** **01/12/20 – 31/03/21 Chair**	

Brief details of other events, activities and visits should be included in the box below.

Details of attendance at other events, activities and visits
• Health and Social Care (HSC) Chairs' Forum Ministerial Meetings (virtual) • Meeting with Queen's University Belfast and Commissioner for Public Appointments NI Mentee (virtual) • Meeting with Chairs - Northern, South Eastern Western, Belfast and Ambulance Trusts (virtual) • Meetings with CEO • Meetings with Non-Executive Directors • Meeting with Executive Directors • Speciality and Associate Specialist Doctors' Leadership Programme – Leading for Transformation Module panel member (virtual) • Chairing Consultant Panels (virtual) • Children's Home visits (virtual) • Trust Board Meetings (virtual) • Trust Committee Meetings (virtual)

Notes on specific issues for the forthcoming year:
• Recruitment of permanent CEO • Recruitment to permanent vacancies across the Senior Management Team • Recruitment of two Non-Executive Directors • Maintaining resilience across Trust Board Members • Maintaining delivery on cultural change programme • Steering the organisation through recovery

PRINCIPLES OF PUBLIC LIFE

Please confirm that you have adhered to the Principles of Public Life and Codes of Conduct & Accountability. If any failures in this area have been identified, please provide details.

YES

If NO provide details.

CONFLICTS OF INTEREST

Have you taken up any other appointments, employment, etc during the year?

/NO

If YES, please provide details:

If other appointments, employment, etc have been taken up, are you satisfied that no conflict of interest arises as a result?

YES/NO/NOT APPLICABLE

If NO, please provide details:

DEPARTMENT OF HEALTH
APPOINTMENTS – PROTECT (WHEN COMPLETED)

RE-APPOINTMENT

ONLY TO BE COMPLETED BY CHAIRS ENTERING THEIR FINAL YEAR OF APPOINTMENT

Chairs approaching the end of a first term of appointment may be offered to serve a second term. Please indicate if you would be willing to accept a second term of appointment if offered.

N/A

Deputy Secretary's comments:
(to include endorsement of re-appointment if appropriate)

I have no reason to believe Eileen has not discharged her role effectively.

I consider performance to be **Effective~~/Ineffective~~** (*delete as appropriate)

~~If performance is ineffective, has this been discussed with the member? **YES/NO**~~

~~**Provide details of any measures/action taken:**~~

Are you willing to endorse re-appointment for a second term? **N/A**

Signed: [redacted] Date: 24 January 2022

DEPARTMENT OF HEALTH
APPOINTMENTS – PROTECT (WHEN COMPLETED)

Chair's comments:

Thank you for your assessment.

I agree with my performance assessment *(*Delete as appropriate)*

Signed: Personal Information redacted by the USI Date 08th February 2022

Permanent Secretary's comments:

Signed:_____ Personal Information redacted by the USI _____Date:_____13/2/22_____

Southern Health and Social Care Trust

Quality Care - for you, with you

SOUTHERN HEALTH AND SOCIAL CARE TRUST

GOVERNANCE COMMITTEE

TERMS OF REFERENCE

CONTENTS

1. CONSTITUTION

The Board hereby resolves to establish a Committee of the Board to be known as the Governance Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. MEMBERSHIP OF THE COMMITTEE

The Committee shall be appointed by the Board from amongst the non-executive directors of the Trust following recommendation from the Trust Chair and shall consist of not less than three members. A quorum shall be two members. One of the members will be appointed the Chair of the Committee by the Board.

3. ATTENDANCE

The following senior staff shall be invited to attend meetings:

- Chief Executive
- Medical Director
- Director of Finance, Procurement and Estates
- Director of Children and Young People's Services/Executive Director of Social Work
- Director of Mental Health and Disability Services
- Executive Director of Nursing, Midwifery and AHPs
- Director of Acute Services
- Director of Older People and Primary Care Services
- Director of Human Resources and Organisational Development
- Director of Performance and Reform
- Assistant Director, Clinical and Social Care Governance
- Director of Pharmacy

Other members of Trust staff may be required to attend meetings as the Committee considers necessary.

The Board Assurance Manager, supported by the Committee Secretary, shall be secretary to the Committee and shall attend the meetings and provide appropriate support to the Chair and Committee members.

4. FREQUENCY OF MEETINGS

Meetings shall be held on a quarterly basis.

5. AUTHORITY

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, through the relevant Director, and will be given the resources necessary to carry out its role. The Committee will be given full access to any information within the Southern Health and Social Care Trust that it requires to fulfil its function. The Committee is authorised by the Board to obtain external professional advice and to invite external personnel with relevant experience and expertise if it considers this necessary.

6. REMIT

The remit of the Committee is to ensure that:

- There are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated governance across the Trust.
- Assessment of assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.
- Principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to Trust Board
- Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services.
- There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance.
- Recommendations considered appropriate by the Committee are made to the Trust Board recognising that financial governance is primarily dealt with by the Audit Committee.

In carrying out its work, the committee will utilise information from:

- Clinical and Social Care Governance systems
- Risk assessment and risk management systems
- Health and Safety
- Medicines management systems
- Information Governance systems
- Litigation systems
- National Audit outcomes
- Whistleblowing process

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to any reviews by Department of Health commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, other accreditation bodies, etc.).

The Committee will review the adequacy of all governance and risk management and control related disclosure statements (in particular the Governance Statement).

The Committee will work closely with the Audit Committee to provide comprehensive assurance to the Audit Committee's own scope of work.

The Committee will receive the minutes of the Trust's Mid-Year and End-Year Ground Clearing meetings for information.

7. REPORTING

The minutes of the Governance Committee shall be formally recorded by the Committee Secretary and submitted to the Trust Board following approval of the Governance Committee. The Chair of the Committee shall draw to the attention of the Board any issues that require executive action.

Any business conducted in a confidential session by the Governance Committee will be reported to a confidential session of the Trust Board.

The Chair of the Governance Committee will meet with the Trust Chair and Chief Executive following each Committee meeting and provide them with a written summary report on the meeting.

The Committee will report to the Board annually on its work in support of the Governance Statement.

OTHER MATTERS

The Committee shall be supported administratively by the Board Assurance Manager and the Committee Secretary, whose duties in this respect will include:

- Agreement of agenda with the Chair.
- Collation and distribution of papers no less than 5 working days in advance of the meeting.
- Producing the minutes of the meeting and taking forward matters arising and issues to be carried forward.
- Advising the committee on pertinent issues.

Southern Health and Social Care Trust

Quality Care - for you, with you

SOUTHERN HEALTH AND SOCIAL CARE TRUST

GOVERNANCE COMMITTEE

TERMS OF REFERENCE

CONTENTS

1. CONSTITUTION

The Board hereby resolves to establish a Committee of the Board to be known as the Governance Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. MEMBERSHIP OF THE COMMITTEE

The Committee shall be appointed by the Board from amongst the non-executive directors of the Trust following recommendation from the Trust Chair and shall consist of not less than three members. A quorum shall be two members. One of the members will be appointed the Chair of the Committee by the Board.

3. ATTENDANCE

The following senior staff shall be invited to attend meetings:

- Chief Executive
- Medical Director
- Director of Finance, Procurement and Estates
- Interim Director of Children and Young People's Services / Executive Director of Social Work
- Director of Mental Health and Disability Services
- Executive Director of Nursing, Midwifery and AHPs & Functional Support Services
- Director of Medicine and Unscheduled Care
- Director of Surgery and Clinical Services
- Director of Adult Community Services
- Director of Human Resources and Organisational Development
- Interim Director of Performance and Reform
- Interim Assistant Director, Clinical and Social Care Governance
- Head of Pharmacy and Medicines Management

Other members of Trust staff may be required to attend meetings as the Committee considers necessary.

The Board Assurance Manager, supported by the Committee Secretary, shall be secretary to the Committee and shall attend the meetings and provide appropriate support to the Chair and Committee members.

4. FREQUENCY OF MEETINGS

Meetings shall be held on a quarterly basis.

5. AUTHORITY

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, through the relevant Director, and will be given the resources necessary to carry out its role. The Committee will be given full access to any information within the Southern Health and Social Care Trust that it requires to fulfil its function. The Committee is authorised by the Board to obtain external professional advice and to invite external personnel with relevant experience and expertise if it considers this necessary.

6. REMIT

The remit of the Committee is to ensure that:

- There are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated governance across the Trust.
- Assessment of assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.
- Principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to Trust Board
- Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services.
- There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance.
- Recommendations considered appropriate by the Committee are made to the Trust Board recognising that financial governance is primarily dealt with by the Audit Committee.

In carrying out its work, the committee will utilise information from:

- Clinical and Social Care Governance systems
- Risk assessment and risk management systems
- Health and Safety
- Medicines management systems
- Information Governance systems
- Litigation systems
- National Audit outcomes
- Whistleblowing process
- Maintaining High Professional Standards and Nurses in Difficulty processes

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to any reviews by Department of Health commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, other accreditation bodies, etc.).

The Committee will review the adequacy of all governance and risk management and control related disclosure statements (in particular the Governance Statement).

The Committee will work closely with the Audit Committee to provide comprehensive assurance to the Audit Committee's own scope of work.

The Committee will receive the minutes of the Trust's Mid-Year and End-Year Ground Clearing meetings for information.

7. REPORTING

The minutes of the Governance Committee shall be formally recorded by the Committee Secretary and submitted to the Trust Board following approval of the Governance Committee. The Chair of the Committee shall draw to the attention of the Board any issues that require executive action.

Any business conducted in a confidential session by the Governance Committee will be reported to a confidential session of the Trust Board.

Following each Committee meeting, the Chair of the Governance Committee will provide a written summary report on the meeting to the next Trust Board meeting.

The Committee will report to the Board annually on its work in support of the Governance Statement.

8. OTHER MATTERS

The Committee shall be supported administratively by the Board Assurance Manager and the Committee Secretary, whose duties in this respect will include:

- Agreement of agenda with the Chair.
- Collation and distribution of papers no less than 5 working days in advance of the meeting.
- Producing the minutes of the meeting and taking forward matters arising and issues to be carried forward.
- Advising the committee on pertinent issues.

Southern Health and Social Care Trust

GOVERNANCE COMMITTEE

DATE: **Thursday, 2nd February 2017**
TIME: **10.30 a.m. – 12.30 p.m.**
VENUE: **Boardroom, Trust Headquarters, Craigavon**

AGENDA

TIME		ITEM	DIRECTOR
10.30 - 10.45am	1.	Welcome and apologies	Ms E. Mullan
	2.	Declaration of Interests	Ms E. Mullan
	3.	Chairman's Business	Ms E. Mullan
	4.	Minutes of meeting held on 8th December 2016 *(for approval)*	Ms E. Mullan
	5.	Matters Arising from previous minutes	Ms E. Mullan
10.45 – 11.00am	6.	Medicines Governance i. Medicines Governance Report ii. Report from the Accountable Officer responsible for Controlled Drugs	Dr T. Boyce "
11.00 – 11.30am	7.	Clinical and Social Care Governance i. Complaints reporting ii. Incident/Complaints/Patient Safety Report	Dr R. Wright / Mrs M. Marshall
		COFFEE BREAK	
11.45 – 12.00 noon	8.	Corporate Risk Register	Mr S. McNally

12.00 – 12.15 pm	9.	Information Governance Reports Freedom of Information, Environmental Information and Subject Access Requests: 1st October 2016 – 31st December 2016	Mrs A. Magwood
12.15 – 12.25pm	10.	Revised Terms of Reference	Ms E. Mullan
12.25 – 12.30 pm	11.	Annual Schedule of Reporting	Ms E. Mullan
	12.	Any other Business	Ms E. Mullan
The next meeting of the Governance Committee will take place on Thursday, 11th May 2017 at 9.30 a.m., in the Boardroom, Trust Headquarters.			

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

GOVERNANCE COMMITTEE MEETING

DATE: **Thursday 9th February 2023**
TIME: **9.00 a.m. – 9.20 a.m.**
VENUE: **New Boardroom, Trust HQ**

CONFIDENTIAL AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.00 – 9.20 a.m.	1.	Welcome and apologies: • Ms C. Teggart, Director of Finance, Procurement and Estates *(Mrs Alison Rutherford, Assistant Director deputising)*	Mr M. McDonald	
	2.	Declaration of Interests	Mr M. McDonald	
	3.	Matters arising from previous meeting	Mr M. McDonald	Information
	4.	Maintaining High Professional Standards Report	Dr S. Austin / Mrs V. Toal	Information
	5.	Nurses in Difficulty Process • Nurses and Midwives – Fitness to Practice Report	Mrs H. Trouton	Information
	6.	Any other Business	Mr M. McDonald	

Southern Health and Social Care Trust
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GOVERNANCE COMMITTEE MEETING

DATE: **Thursday 9th February 2023**
TIME: **9.30 a.m. – 1.00 p.m.**
VENUE: **New Boardroom, Trust HQ**

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies: • Ms C. Teggart, Director of Finance, Procurement and Estates *(Mrs A Rutherford, Assistant Director deputising)*	Mr M. McDonald	
	2.	Declaration of Interests	Mr M. McDonald	
	3.	Chair's Remarks	Mr M. McDonald	Information
	4.	Matters Arising from previous meeting	Mr M. McDonald	Information
9.40 a.m. 9.55 a.m.	5.	**Litigation** i. Claims Management	Mrs V. Toal	Assurance
9.55 – 10.15 a.m.	6.	**Clinical and Social Care Governance** i. Clinical and Social Care Governance Report	Dr S. Austin / Mrs C. Doyle	Information
10.15 – 10.30 a.m.		ii. Management of Trust Standards and Guidelines	" "	Assurance
10.30 – 10.45 a.m.		iii. Mortality Report	" "	Assurance
10.45 – 10.55 a.m.		iv. RQIA Review of the implementation of NICE CG 174 – IV Fluid Therapy in adults in hospitals in NI	" "	Assurance
Coffee Break				
11.05 – 11.20 a.m.	7.	**Medicines Governance** i. Medication Safety Report	Ms A. McCorry	Assurance
11.20 – 11.35 a.m.		ii. Report from the Accountable Officer responsible for Controlled Drugs	Ms A. McCorry	Assurance
11.35 – 11.50 a.m.	8.	**Information Governance** i. Information and IT Governance Report: 1st October 2022 – 31st December 2022	Mrs L. Leeman	Information
11.50 – 12.05 p.m.	9.	**Estates Governance** i. Estates Governance Group - Summary Report	Mrs A. Rutherford	Assurance
12.05 – 12.15 p.m.	10.	**Risk Management** *i.* Corporate Risk Register	Dr M O'Kane	Approval
12.15 – 12.30 p.m.		ii. Unscheduled Care - Deep Dive	Mrs T. Reid	Assurance

TIME		ITEM	DIRECTOR	Purpose
12.30 – 12.40 p.m.	11.	**Annual Reports** i. Functional Support Services Annual Report 2021/22	Mrs H. Trouton	Assurance
12.40 – 12.45 p.m.	12.	Director Visits	Mr M. McDonald	Information
12.45 – 12.55 p.m.	13.	Non-Executive Director's Visits to Children's Home Report	Mr C. McCafferty	Information
12.55 – 1.00 p.m.	14.	Committee Terms of Reference 2022	Mr M. McDonald	Approval
	15.	Mid-Year Ground Clearing Minutes	Mrs L. Leeman	Information
	16.	Any other Business	Mr M. McDonald	
The next meeting of the Governance Committee will take place on 11th May 2023				

Southern Health and Social Care Trust

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Governance Committee
Committee Work Plan 2023

Governance Area	Report details	Lead Person	Frequency	Month	Purpose
Clinical and Social Care Governance	Clinical and Social Care Governance Report	Medical Director / Assistant Director C&SCG	Quarterly	February 2023 May 2023 September 2023 November 2023	Information
	Management of Trust Standards and Guidelines	Medical Director / Assistant Director C&SCG	Quarterly	February 2023 May 2023 September 2023 November 2023	Assurance
	Mortality Report	Medical Director / Assistant Director C&SCG	Quarterly	February 2023 May 2023 September 2023 November 2023	Assurance
	National Audit Assurance Report	Medical Director / Assistant Director C&SCG	Annually	November 2023	Assurance
RQIA Reports	RQIA Review of the Implementation of NICE CG 174 – IV Fluid Therapy In Adults In Hospitals In NI	Medical Director	Quarterly	February 2023 May 2023 September 2023 November 2023	Assurance

Governance Area	Report details	Lead Person	Frequency	Month	Purpose
Risk	Corporate Risk Register	Chief Executive / Board Assurance Manager	Quarterly	February 2023 May 2023 September 2023 November 2023	Approval
Medicines Governance	Medication Safety Report	Head of Pharmacy and Medicines Management	Quarterly	February 2023 May 2023 September 2023 November 2023	Assurance
	Report from the Accountable Officer responsible for Controlled Drugs	Head of Pharmacy and Medicines Management	Annually	February 2023	Assurance
	Compliance with the Royal Pharmaceutical Society (RPS) Professional Standards Report	Head of Pharmacy and Medicines Management	Annually	May 2023	Assurance
Information Governance	Information and IT Governance Report	Director of Performance &Reform	Quarterly	February 2023 May 2023 September 2023 November 2023	Information
	Information Governance Framework: Personal Identifiable Data (PID) and Personal Sensitive Data (PSD) Audit Report	Director of Performance &Reform	Annually	November 2023	Information

Governance Area	Report details	Lead Person	Frequency	Month	Purpose
	Information Governance Annual Report *(to include Cyber Security Update)*	Director of Performance &Reform	Annually	May 2023	Assurance
Research Governance	Research and Development Annual Report	Medical Director	Annually	May 2023	Assurance
Emergency Planning	Emergency Planning Annual Report	Medical Director	Annually	May 2023	Assurance
Organ Donation	Organ Donation Annual Report	Director of Acute Services	Annually	September 2023	Assurance
Health and Safety Governance	Health and Safety Update	Director of Finance, Procurement and Estates	Six Monthly	May 2023 November 2023	Assurance
	Health and Safety Annual Report	Director of Finance, Procurement and Estates	Annually	November 2023	Assurance
Functional Support Services	Functional Support Services Annual Report	Director of Nursing Midwifery AHPs and Functional Support Services	Annually	November 2023	Assurance
Hyponatraemia	Hyponatraemia progress update report	Medical Director / Executive Director of Nursing, Midwifery, AHPs and Functional Support Services	Quarterly	~~February 2023~~ deferred May 2023 September 2023 November 2023	Assurance

Governance Area	Report details	Lead Person	Frequency	Month	Purpose
Litigation	Claims Management	Director of HROD Medical Director	Quarterly	February 2023 May 2023 September 2023 November 2023	Assurance
Raising Concerns	Raising Concerns (Whistleblowing)	Director of HROD	Six Monthly	May 2023 November 2023	Assurance
Professional Governance *(anonymised formal cases under confidential section)*	• Maintaining High Professional Standards for Doctors and Dentists	Medical Director	Quarterly	February 2023 May 2023 September 2023 November 2023	Assurance
	• Supporting Nurses and Midwives in Practice Report	Executive Director of Nursing, Midwifery, AHPs and Functional Support Services	Quarterly	February 2023 May 2023 September 2023 November 2023	Assurance
External / Internal Inspections / Independent Reviews	As and when reports are available	Directors			
Governance Statement	Draft Governance Statement	Chief Executive	Annually	May 2023	Assurance
Director Visits *(Executive / Operational and Non-Executive Directors)*	Summary Report	Committee Chair	Six Monthly	May 2023 November 2023	Information
Non-Executive Director's visits to	Summary Report	Director of CYP	Six Monthly	May 2023 November 2023	Information

Governance Area	Report details	Lead Person	Frequency	Month	Purpose
Children's Homes Report					
Effectiveness of Governance Committee	Review and update the Committee's Terms of Reference	Members	Annually / as required	February 2023	Approval
	Draft Annual Report of the Governance Committee	Committee Chair / Board Assurance Manager	Annually	May 2023	Approval
	Self-Assessment	Members	Annually	May 2023	Information
	Meetings Dates for 2024	Committee Chair / Board Assurance Manager	Annually	September 2023	Approval
	Schedule of Reporting for 2024	Committee Chair / Board Assurance Manager	Annually	November 2023	Approval
Feedback from other Fora/meetings	Learning from Experience Forum	Medical Director	Six Monthly	May 2023 November 2023	Information
	Minutes of Trust's Mid-Year and End-Year Ground Clearing meetings with the DoH	Director of Performance and Reform	Six Monthly	When available (Mid Year – February 2023)	Information

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Public Appointments Information Booklet

SOUTHERN HEALTH & SOCIAL CARE TRUST (SHSCT 1/19)

NON-EXECUTIVE CHAIR

This information pack can be made available in other formats, such as Braille, large print, audio etc. To request this or any other information on the appointment process please contact:

DoH Public Appointments Unit
Room D1
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Tel: Irrelevant information redacted by the USI

Email your request to: public.appointments@health-ni.gov.uk

CPANI The Commissioner for Public Appointments Northern Ireland REGULATED

INVESTOR IN PEOPLE

Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

CONTENTS OF THIS BOOKLET

KEY APPOINTMENT PROCESS STAGES

Stage in Process	**Timescale**
Closing Date for applications	10 January 2020 @ 12 noon GMT
Sift	*w/c 3 February 2020
Interviews	*w/c 9 March 2020
Planned date of appointment	*No later than the end of March 2020

* These dates may be subject to change

Privacy Notice

DoH will only process the personal data you provide us for the purpose of recruiting a Non-Executive Chair to the Board of the Health and Social Care Board and in line with the Commissioner for Public Appointments NI Code of Practice. For more information, please see our Privacy Notice at https://www.health-ni.gov.uk/publications/public-appointments-unit-privacy-notice

Section 1 – Introduction

1. The Department of Health (hereafter referred to as the Department) is committed to improving the diversity of the boards to which appointments are made. The Department values and promotes diversity and is committed to equality of opportunity for all and appointments made on merit. We particularly welcome applications from women, people from ethnic minority communities, and people with disabilities who we know are under-represented in Chair and Non-Executive roles. For this competition, we would also welcome applications from men who are currently under-represented on the Board of the Southern Health & Social Care Trust. Further information is available at **Section 7**.

2. The Department administers Health and Social Care (HSC) - which includes policy and legislation for hospitals, family practitioner services, community health and personal social services. HSC provides an integrated system of health and personal social services to promote the health and social wellbeing of the people of Northern Ireland.

3. In terms of service commissioning and provision, the Department discharges this duty primarily by delegating the exercise of its statutory functions to the Health and Social Care Board (HSCB) the Public Health Agency (PHA) and to a number of other HSC bodies created to exercise specific functions on its behalf. All these HSC bodies are accountable to the Department which in turn is accountable, through the Minister of Health, to the Assembly for the manner in which this duty is performed.

4. The Department's vision for the integrated HSC system is to drive up the quality of HSC for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support. Each year, the Minister's strategic priorities, targets and standards are communicated to the HSC Service through an annual Commissioning Plan Direction.

5. Applications are invited to fill the following post:

    - 1 Non-Executive Chair of the Southern Health and Social Care Trust (SHSCT)

6. It is expected that the successful applicant will take up appointment no later than the end of March 2020. Information on disqualifications can be accessed at **Annex A**.

Section 2 – Background Information on about the SHSCT

General

7. The Southern Health and Social Care Trust (hereafter referred to as the SHSCT) is an integrated organisation, with an annual budget of £716 million, employing 13,141 staff and managing an estate worth £384 million. The SHSCT provides health and social care services to a population of approximately 380,000 and covers the council areas of Armagh, Banbridge and Craigavon; Mid-Ulster; and Newry, Mourne and Down.

8. Its objectives are to:
   - Provide safe, high quality care;
   - Maximise independence and choice for patients and clients;
   - Support people and communities to live healthy lives and improve their health and wellbeing;
   - Be a great place to work;
   - Make the best use of resources; and
   - Be a good social partner within local communities.

9. Services provided include a wide range of hospital, community and primary care services. Main in-patient hospital services are located at Craigavon Area Hospital and Daisy Hill Hospital. Working in collaboration with GPs and other agencies, staff deliver locally based services in SHSCT premises, in people's own homes and in the community. The SHSCT purchases some services including domiciliary, residential and nursing care from independent and community/voluntary agencies.

10. Further information is available on the SHSCT's website: www.southerntrust.hscni.net

Freedoms

11. Health and Social Care (HSC) Trusts have a number of managerial and operational freedoms. These include the freedom to:
    - acquire, own and dispose of assets to ensure the most effective use is made of them;
    - make their own cases for infrastructural investment;
    - create their own management structures, consistent with principles established by the Department and subject to Departmental agreement;

- employ their own staff, determine their own staffing structures and, subject to any directions given by the Department, set their own terms and conditions of employment within national guidelines; and:
- advertise their services, within the guidelines set down in professional codes of practice on such advertising.

12. HSC Trusts are expected to use these freedoms to secure real improvements to the services they provide, for example, devising an improved out-patient appointment system, co-operative working with other HSC Trusts to secure continuity of care or the development of specialist transport links to make facilities more accessible. Service improvements should focus on providing benefits to patients and service users, HSC Trust staff and the general community.

HSC Transformation

13. In 2016, the Minister of Health launched a 10 year approach to transforming health and social care, 'Health and Wellbeing 2026:Delivering Together' (https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf) which provides a ten-year road map for the transformation of HSC services in Northern Ireland. This vision for HSC transformation was based on the 2016 report of an expert Panel, led by professor Rafael Bengoa, entitled, 'Systems not Structures: Changing Health and Social Care' (https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf).

14. 'Delivering Together' seeks to radically reform the way HSC care services are designed and delivered in Northern Ireland, with a focus on person-centred care, rather than buildings and structures. It also sets out a clear and unassailable case for change, which includes the system's inability to meet extraordinary demands and pressures created by an ageing population, the stark differential in health and social care outcomes between the most and least deprived areas, the current service delivery model being no longer fit for purpose, and the challenges in attracting and retaining staff to prop up an outdated system.

15. ‘Delivering Together’ is aligned with the aspirations set out within the Northern Ireland Executive’s draft Programme for Government, with the ambition to support people to lead long, healthy and active lives. Four key aims underpin this ambition:
    - Improving the health of our people;
    - Supporting and empowering staff;
    - Improving the quality and experience of care; and
    - Ensuring the sustainability of our services.

16. Working as part of the overall HSC system, each HSC Trust plays a vital role in this transformation journey.

Section 3 - SHSCT Non-Executive Chair Role Profile

Accountable to

17. The Minister, through the Permanent Secretary of the Department of Health.

Role

18. The Non-Executive Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

19. The Non-Executive Chair shall ensure that the SHSCT policies and actions support the wider strategic policies of the Minister and that the SHSCT affairs are conducted with probity.

20. The Non-Executive Chair has a particular leadership responsibility on:

- Formulating the Board's strategy for discharging its duties;
- Ensuring that the Board, in reaching decisions, takes proper account of guidance provided by the Minister, the sponsor department, the HSCB or the PHA;
- Ensuring that risk management is regularly and formally considered at Board meetings;
- Promoting the efficient, economic and effective use of staff and other resources;
- Encouraging and delivering high standards of regularity and propriety;
- Representing the views of the Board to the general public;
- Ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual Board members;
- Ensuring that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training;
- Advising the Department of the needs of the SHSCT when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise;

- Annually assessing the performance of individual Board Members.
- Ensuring the completion of the Board Governance Self Assessment Tool on an annual basis.
- Ensuring that Board Members are made aware of the Code of Conduct for Board Members of HSC Bodies (2012) including the Nolan "seven principles of public life", and the requirement for a comprehensive and publicly available register of Board Members' interests. Communications between the Board, Ministers and the Department shall normally be through the Non-Executive Chair who shall ensure that the other Board Members are kept informed of such communications on a timely basis.
- Operating the Board and chairing all Board meetings when present. The Non-Executive Chair has certain delegated executive powers and must comply with the terms of appointment and with the SHSCT Standing Orders; and
- Working closely with the Chief Executive and ensuring that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

Training

21. Appropriate induction training will be provided by the organisation to the new appointee.

Time Commitment & Remuneration

22. The Non-Executive Chair will be expected to devote **3 days per week** to the appointment. This may involve commitment both inside and outside normal working hours. The annual rate of remuneration for the Non-Executive Chair of the SHSCT is **£30,924 (under review)**.

Expenses

23. The Non-Executive Chair is also eligible to claim allowances, at rates set centrally, for travel and subsistence costs necessarily incurred on SHSCT business.

Period of Appointment

24. The Non-Executive Chair will be appointed for a period not longer than four years.

25. It should be noted that the Department may give notice to terminate the appointment at any time. If the successful applicant decides to end their appointment early, a minimum of 3 months' notice will be required. An annual assessment of the performance of a Non-Executive Chair will be required throughout the period of appointment.

26. It is the policy of the Department that there is no reappointment without a competition taking place. The outgoing Non-Executive Chair may be eligible to serve a second term by applying through open public competition. Any such application would depend on the applicant having demonstrated an appropriate standard of performance during the first term of appointment including evidence of continued adherence to the seven principles of public life.

Codes of Conduct and Accountability

27. To ensure that public service values remain at the heart of the HSC system, the Non-Executive Chair is required, on appointment, to subscribe to the Codes of Conduct and Accountability. The high standards of corporate and personal conduct required of members are described more fully in the Codes. Please see link to the DoH Code of Conduct & Code of Accountability for Board Members of Health and Social Care Bodies here.

Section 4 - Person Specification Non-Executive Chair

28. The Department encourages all individuals who wish to participate in public service and make a difference to the way in which health and social care services are delivered in Northern Ireland to submit an application form. The Department would also welcome applications from those who have not previously held a public appointment.

29. To generate the widest possible pool of talent for this appointment, the Department recognises the value of less traditional career patterns and experiences such as community involvement or voluntary work, as well as those experiences found within the employment field. Applicants can use examples from their working life or personal life.

30. The person specification addresses the qualities, experience, background and competencies sought. A criterion-based selection procedure will be used as part of this process.

31. The application form is an essential element of the process and is designed to require applicants to give specific examples of past performance to demonstrate their ability or competence.

32. You are advised to make sure that you take the opportunity to provide practical evidence and examples of why you believe you are suitable for this Public Appointment. **Please note that CVs will not be accepted**.

33. There are no specific qualifications or professional requirements for the SHSCT Non-Executive Chair post.

34. Applicants are limited to a **maximum of 500 words per essential criterion; any words over this limit will be redacted by the Public Appointments Unit and will not be seen by the Panel.**

35. All applicants must demonstrate that they have the necessary skills, knowledge, experience and qualities required.

ESSENTIAL CRITERIA

36. Applicants must show on their application form, and if invited for interview, how they meet the following essential criteria.

Criterion 1: Leadership

37. By way of practical examples, demonstrate evidence of providing strong leadership and direction in a complex and transforming strategic environment.

Examples of the type of evidence the Panel will be looking for are:

- Using well developed leadership skills to successfully impact on the performance of an organisation;
- An ability to act and think strategically with direct experience of leading the formulation of strategy and maintaining strategic direction during a period of substantial change;
- Understanding of and taking account of internal issues, the wider external environment and any operating frameworks or other set parameters (resources, policies, business models, etc) when planning for the future of the organisation;
- Effectively leading discussions, using your influencing and negotiation skills to foster debate among stakeholders and facilitate consensus at meeting; and
- An ability to offer constructive challenge and exercise effective judgement.

Criterion 2: Change Management

38. By way of practical examples, please demonstrate your experience of effectively and successfully leading or managing a significant organisational change programme or project.

Examples of the type of evidence the Panel will be looking for are:

- Experience of leading a challenging change programme or project within an organisation to a successful conclusion;
- An ability to develop and implement plans to effectively deliver an organisational change programme or project;
- Creating and contributing to a culture of flexibility and responsiveness, mobilising an organisation to respond swiftly to changing priorities;

- Identifying step changes that quickly transform flexibility, responsiveness and quality of service;
- Challenging the status quo to achieve value-adding improvements and change;
- Being able to make sound decisions on the basis of analysis, experience and judgement with the ability to clearly explain your thoughts and reasoning behind decisions taken; and
- Understanding and effectively managing the impact of implementing change on the culture, structure, service and morale within an organisation;

Criterion 3: Corporate Governance & Accountability

39. By way of practical examples, provide evidence that demonstrates your experience of working at or close to Board level within a framework of corporate governance.

Examples of the type of evidence the Panel will be looking for are:

- Personal awareness of your individual role and collective responsibilities in the promotion of good governance principles;
- Understanding the importance of effective governance in the operation of an organisation, including safeguarding its values and reputation and being accountable for its actions and decisions;
- Understanding best practice and principles around control and accountability in the management of assets, major projects and project management;
- Effectively exercising a constructive challenge function to achieve the best outcomes for the organisation;
- Direct experience of your involvement in improving and securing effective corporate governance in complex and transformational environments; and
- Understanding the differentiation between Executive and Non-Executive Board Members including the role of a Non-Executive Board member in holding the Chief Executive to account.

Criterion 4: Performance Management

40. By way of practical examples, provide evidence that demonstrates your effective contribution to monitoring, reporting and improving organisational performance.

Examples of the type of evidence the Panel will be looking for are:

- An understanding of how performance/service delivery needs to be managed within a complex organisation;
- Maintaining a strong focus on performance and priorities, providing support and encouragement during challenging and changing times;
- Building an effective performance culture to deliver desired outcomes;
- Holding others to account when required and swiftly responding to changing requirements;
- An ability to identify, evaluate and manage risks to an organisation's performance and reputation;
- Leading substantial and sustainable improvements in organisational performance, including fostering innovation and sharing good practice; and
- Managing the performance of individuals, addressing performance issues resolutely; fairly and promptly.

Criterion 5: Collaborative Working

41. By way of practical examples, provide evidence which demonstrates how you proactively create, maintain and promote a strong network of collaborative relationships within and outside organisations or in partnership between organisations to produce a positive result.

Examples of the type of evidence the Panel will be looking for are:

- An ability to communicate clearly either in the role of leader or in a working partnership;
- Building effective working relationships, either through working within, or leading a team, to build a consensus and secure ownership of team decisions;
- Encouraging and establishing principles of working effectively across boundaries, creating an inclusive environment to support an organisation;
- Confidently engaging with a variety of colleagues, delivery partners and stakeholders, listening to and acting on, feedback as necessary;

- Demonstrating an ability to secure commitment to a shared strategic vision; and
- Working collaboratively and flexibly with colleagues, delivery partners and stakeholders to achieve an organisation's strategic and operational priorities, and successfully deliver outcomes.

SHORTLISTING CRITERIA

42. Applicants should note that after the eligibility sift, should it be necessary to shortlist individuals to go forward to interview, the Panel will carry out an objective evaluation of the depth and breadth of information provided by applicants in response to the following eligibility criteria:

- Criterion 1: Leadership;
- Criterion 2: Change Management; and
- Criterion 4: Performance Management.

Section 5 - Application, Access NI and Selection Process

43. The Department is committed to the principles of public appointments based on merit with independent assessment, openness and transparency of process. The Department is also committed to equality of opportunity and welcomes application forms from all suitably qualified applicants irrespective of religious belief, gender, race, political opinion, age, disability, marital status, sexual orientation, or whether or not they have dependants.

44. The Department is committed to taking measures to improve the diversity of the Boards to which they make appointments. The Department wants to encourage more women, young people, ethnic minorities and people with disabilities to apply for appointments. Applications from these groups would be particularly welcome. For this competition, we would also welcome applications from men who are currently under-represented on the SHSCT Board.

45. This appointment is regulated by the Commissioner for Public Appointments for Northern Ireland (CPANI) and the competition may be examined by CPANI for compliance with the Commissioner's Code of Practice.

Application Procedure

46. Application forms or further information about the process can be obtained from Paul Bradley at the address on the cover of this document, by e-mailing a request to: public.appointments@health-ni.gov.uk or by contacting the Public Appointments Unit on Irrelevant information redacted by the USI. Alternatively you can download the information pack at: https://www.health-ni.gov.uk/topics/health-workforce-policy-and-management/doh-public-appointments

47. Hard copy or electronic versions of the application form are acceptable. You must not reformat the electronic application form. CVs, letters, or any other supplementary material in place of, or in addition to, completed application forms will not be accepted.

48. Applications must be fully completed and as clearly as possible using black ink or typescript **minimum font size of Arial 12, single-line spacing**.

49. Your application is very important. You must demonstrate clearly on your application form how and to what extent your experience is relevant to the published essential criteria for the post (including dates where appropriate). It is not enough simply to list the various posts that you have held. The Department will not make assumptions from the title of your post or the nature of the organisation as to the skills or experience gained.

50. The Department recommends that applicants read the 'Public Appointments Guide' published by the Executive Office. The guide provides an overview of Public Appointments in Northern Ireland and includes helpful information for those wishing to apply.
https://www.executiveoffice-ni.gov.uk/sites/default/files/publications/execoffice/public-appointments-guide.pdf

51. Applicants may also wish to read 'Partnerships between Departments and Arm's Length Bodies: NI Code of Good Practice' published by the Department of Finance in March 2019. This publication aims to set out principles of good practice which can be applied to derive greater value from, and bring consistency to, relationships between Departments and Arm's Length Bodies.
https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/daodof0319att.pdf

52. If all sections of the application form are **NOT** completed your application **WILL BE EXCLUDED.**

53. **You must NOT exceed the maximum 500 word count per essential criterion. Text beyond the allotted word count will be redacted by the Public Appointments Unit and not considered by the Panel carrying out the sift stage of the appointment process.**

54. The Information Booklet and Application Form can be provided in alternative formats. Any applicants who require assistance should contact Paul Bradley (contact details on cover sheet). All reasonable adjustments will be made to accommodate the needs of applicants with a disability. Further information on the Guaranteed Interview Scheme can be found at paragraph 76.

55. Application forms should be submitted by post, email or in person to arrive with Paul Bradley by **12 Noon GMT on 10 January 2020** (see contact details on cover sheet). The date and time of receipt will be formally recorded on all applications. It is the responsibility of the applicant, taking into account their chosen method of delivery, to ensure that sufficient time is allowed for their application to arrive with the Department on or before the deadline. **Late applications will not be accepted**. Please ensure that posted applications bear the correct amount of postage as any shortfall may lead to a delay in delivery, causing you to miss the deadline. The Department does not accept any application where they have been asked to pay any shortfall in postage. All applications will be acknowledged on receipt by email.

56. Please check your application form before submitting it as **the Department will not examine applications until after the closing date** and failure to fulfil the application requirements will result in your application form being excluded from the process.

ACCESS Northern Ireland (Access NI)

57. It is the Department's policy to carry out an "Enhanced Disclosure Check" for the appointment of the SHSCT Non-Executive Chair.

58. The criminal record check will be undertaken by Access NI, which is the responsibility of the Department of Justice in Northern Ireland and operates under the provisions of Part V of the Police Act 1997.

59. Access NI enables organisations in Northern Ireland to make more informed recruitment decisions by providing criminal history information about anyone seeking paid or unpaid work in certain defined areas, such as working with children or vulnerable adults.

Selection Process

60. Competence based interviewing tests applicants against the specific selection criteria for a particular appointment. The application form gives you an opportunity to provide examples relevant to the specific criteria. These examples provide the

Panel with information and evidence about you, and a deeper understanding of your ability.

61. The interview is a crucial part of the appointment process and thorough preparation is essential. You can prepare by:

- reading and thoroughly understanding the selection criteria;
- reminding yourself of the examples you used in your application form and being prepared to expand on these at interview, if asked;
- rehearsing how you might relate your experiences to the Interview Panel, emphasising your own role and responsibilities; and
- not assuming that your qualities and experience will speak for themselves.

62. Further general guidance on the Criteria Selection Based Process can be found at **Annex B**.

63. It will be the responsibility of either an Interview Panel comprising three members (two senior officers from the Department and one CPANI Independent Assessor) or an appointed Sift Panel to conduct the sift stage of the appointment process.

64. With the agreement of the Commissioner, the Department reserves the right to employ a Sift Panel comprising three CPANI Independent Assessors to conduct the sift stage of written applications. If the Department opts to use a Sift Panel, the Independent Assessor allocated by CPANI to sit on the Interview Panel will be appointed to the role of Lead Independent Assessor on the Sift Panel.

65. Application forms provided to the Panel responsible for conducting the sift exercise will be anonymised, which means that it will not include your name or personal details. The Panel will carry out a sift of all of the eligible application forms received to assess each applicant against the essential selection criteria.

66. The Panel conducting the sift exercise will reach a decision as to whether an applicant meets each criterion on the basis of the evidence supplied on the application form.

67. As noted at paragraph 45, should it be necessary to shortlist applicants to go forward to interview, the Panel will carry out an objective evaluation of the depth and breadth of information provided by applicants in response to the following eligibility criteria:

Criterion 1: Leadership;
Criterion 2: Change Management; and
Criterion 4: Performance Management.

68. Any applicant who is assessed as not meeting any **one** of the essential criteria will not be eligible to proceed to the next stage of the selection process. Feedback may be requested at any stage of the process.

69. If you are dissatisfied with the Panel decision or have any queries in relation to not being selected for interview, you should write to the Department at the address provided, within 10 working days from the date on the letter notifying you of the outcome of the shortlisting process. All correspondence will be acknowledged by return.

70. Applicants invited for interview will be eligible to claim reimbursement of reasonable travelling expenses incurred within the UK and Republic of Ireland in attending for interview. If you cannot make the interview time offered, we will try our best to reschedule your appointment. Any other appropriate expenses such as particular costs associated with disabilities or childcare can also be claimed. An expenses claim form will be issued with your invitation to interview letter.

71. At interview, all applicants must satisfy the Panel that they adequately meet all of the relevant criteria. Presently, it is the Department's intention that the list of those judged suitable for appointment will be presented to the Minister/Department in a ranked order, i.e. the Panel will score applicants at interview and a list produced in order of interview score. An applicant summary will provide the Minister/Department with an objective analysis of each applicant's skills and experience, based on the information provided by each applicant during the appointment process and the Panel's assessment of that applicant.

72. The Department will operate a Guaranteed Interview Scheme (GIS) for this appointment. The GIS has been developed for applicants with disabilities or those with long term impairment or a health condition that is expected to last for at least 12 months. In these instances, provided that the applicant has demonstrated in their application form that they have met the essential criteria for the post, the applicant will be offered a guaranteed interview. You do not have to have a registered disability to apply and have your application considered under GIS. **Should you wish to be considered under the GIS scheme please complete the separate GIS Application document.**

73. Applicants whom the Panel assess as not suitable for appointment and whose names are **not** being presented to the Minister/Department will be advised by letter following interview.

74. Applicants whom the Panel assess as suitable for appointment and whose names are being presented to the Minister/Department will be advised of this by letter following interview.

75. An Access NI check is requested for the applicants the Minister/Department has selected for appointment. All documentation relating to Access NI will be destroyed by the Department once the appointment process has been completed.

76. Once the Access NI check has cleared you will be invited, by telephone, to accept the appointment. The appointment will then be formally confirmed in writing and you are required to confirm acceptance of the post and Terms of Appointment.

77. All other interviewees will be advised in writing of the outcome of their interview once the selection has been made.

78. The Minister/Department may decide to create a reserve list to cover any unforeseen vacancies that arise within 12 months following the initial appointments.

Section 6 - Probity and Conflicts of Interest

79. The Department must ensure that any individual appointed is committed to the seven principles of conduct underpinning public life and values of public service. These (Nolan) principles are: **Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership**. The successful applicant will be asked as part of their appointment to sign a declaration committing to the seven principles.

80. Attached for your information at **Annex C** is a copy of "Probity & Conflicts of Interest – Guidance for Applicants". Separately attached is a leaflet from the Commissioner for Public Appointments (NI), about "Conflicts of Interest, Integrity and Making a Complaint". These provide information on these issues including some examples to help applicants evaluate whether or not they have a real, perceived or potential conflict.

81. The Department must take account of any actual or perceived conflict of interest. Therefore, applicants in their application form must disclose information or personal connections, which, if they were to be appointed, could lead to a conflict of interest or be perceived as such. Failure to do so could lead to the appointment being terminated.

82. It is very important that all applicants provide appropriate details on their application form of any interests which might be construed as being in conflict with the appointment for which they have applied. If it appears, from the information provided on the form, that a possible conflict might exist, or arise in the future, this will be fully explored with the applicant with a view to establishing whether it is sufficiently significant to prevent the individual from carrying out the duties of the post. The Panel will do this at interview stage.

Insolvency Checks

83. The Department may also contact the Insolvency Service to check if applicants are recorded on the Disqualification of Directors or Bankruptcy registers.

Other Public Appointments

84. Departments have a duty to satisfy themselves, as far as practicable, that those they appoint to the Boards of public bodies will carry out their duties in an efficient and effective manner. This Department may therefore check with other Departments if there are any probity or performance issues associated with applicants who hold public appointments. Similar information will be provided by this Department on request about all associated Board members.

The Two Terms Rule

85. According to the CPANI Code of Practice those who have served two terms in the same position on the same Board cannot apply through open competition for a third term. If any applicant has served two terms in this position their application will be discounted at the sift stage.

Double Paying

86. Applicants who already work in the public sector need to be aware that:

- they may be ineligible for consideration for this appointment if in the Department's view there is a conflict of interest, the perception of a conflict or a potential conflict, between the appointment and their existing commitments;
- where applicable they will be asked to confirm that they have permission from their employer to take up an appointment if one is offered; and
- if they already work in the public sector they may need to be aware that no one should be paid twice from the public purse for the same period of time. As a result, applicants who already work in the public sector may not be entitled to claim remuneration for this position if the duties are undertaken during a period of time for which they are already paid by the public sector.

87. In the interests of minimising the potential for double paying, the Department reserves the right to contact your employer regarding your candidature.

Publicising Appointments

88. A Press Release will be published to announce the appointment. The Commissioner for Public Appointments also requires that the announcement about the successful applicant should contain details of their recent political activity.

Consequently, should you be appointed, you will be required to complete a political activity form. Details of any political activity, together with some of the information that you have provided in your application form will be made public in the press announcement. This applies particularly to any other public appointments you may hold, and to any significant political activity recently undertaken by you. The Press Release will include:

- Your name;
- A short description of the body to which you have been appointed;
- A brief summary of the skills and knowledge you bring to the role;
- The period of appointment;
- Any remuneration associated with the appointment;
- Details of all other current public appointments held and any related remuneration received; and
- Details of any political activity declared in the last five years.

Section 7 - Equal Opportunities Monitoring and Complaints Procedure

Equal Opportunities Monitoring Form

89. The Department is committed to providing equality of opportunity. The Department monitors the gender, ethnic origin, community background and disability of applicants to ensure that equal opportunities measures are effective in its appointments processes. Applicants are therefore asked to complete the Equal Opportunities Monitoring Form issued separately. The information is purely for monitoring purposes. It is **not** made available to the Panel and does **not** play a role in the decision-making process.

Diversity in Public Appointments

90. We value and promote diversity and are committed to equality of opportunity for all and appointments made on merit. We believe that the best boards are those that reflect the communities they serve.

91. The Department is committed to equality of opportunity and welcomes applications from all suitably qualified people irrespective of religious belief, gender, disability, ethnic origin, political opinion, age, marital status, sexual orientation or whether or not they have dependants.

92. We particularly welcome applications from women, people from ethnic minority communities, and people with disabilities who we know are under-represented in Chair and Non-Executive roles. For this competition, we would also welcome applications from men who are currently under-represented on the SHSCT Board.

Complaints Procedure

93. The Department is committed to getting this appointment process right first time. However, if you are not entirely satisfied with any aspect of our service, please tell us and we will do our best to resolve the matter. Our aim is to resolve any complaint quickly and you are invited initially to bring any concerns you may have to Public Appointments Unit. However, if you still feel dissatisfied after this approach, you may initiate a formal complaint in writing.

94. Please direct your concerns in the first instance to:

DoH Public Appointments Unit
Department of Health
Room D1
Castle Buildings, Stormont Estate
Belfast
BT4 3SQ

Email: public.appointments@health-ni.gov.uk

Telephone: Irrelevant information redacted by the USI

95. If, after the Department's Complaints procedure has been completed, you remain dissatisfied, you may also direct your concerns to:-

The Commissioner for Public Appointments for Northern Ireland (CPANI)
Annexe B
Dundonald House
Stormont Estate
Upper Newtownards Road
Belfast
BT4 3SB

Email: info@publicappointmentsni.org

Telephone: Irrelevant information redacted by the USI

Annex A

DISQUALIFICATIONS

HOUSE OF COMMONS AND NI ASSEMBLY DISQUALIFICATIONS

Under the terms of the House of Commons Disqualifications Act 1975[1], the Northern Ireland Assembly Disqualification Act 1975[2], and the European Parliamentary Elections Act 2002[3], existing MPs, MLAs and MEPs cease to hold their elected office if they take up an appointment to a public body listed in the aforementioned legislation.

A Health and Social Services trust[4] established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 is listed in the above-mentioned legislation. Therefore an individual appointed to the position of Non-Executive Chair or Non-Executive Member of the SHSCT Board will be disqualified from being an MP, MLA or MEP.

If an individual holding a public appointment decides to stand for election as an MP, MEP or MLA, it is their responsibility to check whether the public body to which they belong or the office that they hold is listed in the appropriate Disqualification Act.

If the public body to which an individual belongs or the office that they hold is listed in the Disqualification Act they must immediately notify the Department of their intention to stand for election. To avoid any disqualification issues from arising later they should resign their appointment before submitting their nomination as candidate in an election. If they have not resigned their public appointment before submitting their nomination as a candidate and are subsequently elected as an MP, MLA or MEP their election will be void.

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[1] http://www.legislation.gov.uk/ukpga/1975/24/contents

[2] https://www.legislation.gov.uk/ukpga/1975/25/contents

[3] http://www.legislation.gov.uk/ukpga/2002/24/contents

[4] Health and Social Services trusts renamed Health and Social Care trusts - see Section 1 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 http://www.legislation.gov.uk/nia/2009/1/contents

OTHER HEALTH & SOCIAL CARE BODY/ARM'S LENGTH BODY DISQUALIFICATIONS

If you are currently serving as a Non-Executive of a Health and Social Care Body or any other Arm's Length Body, there is an onus of responsibility on applicants to not only examine the disqualifications of the organisation to which they are applying, but also to be aware of any disqualifications which exist on the body to which they currently serve.

In some cases it is not possible to hold two concurrent appointments, however you should note that disqualification is from appointment to a post, not application. In the event of a relevant disqualification you may be required to resign from a current position in order to accept this post.

DISQUALIFICATION FOR APPOINTMENT TO THE SHSCT

Disqualifications apply which are specific to membership of an HSS Trust are outlined in the following extract of **The Health and Social Services Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994**

Disqualification for appointment of chairman and non-executive directors

11.- (1) Subject to regulation 12 a person shall be disqualified for appointment as the chairman or Non-Executive Director of an HSS body if -

(a) he has within the preceding five years been convicted in the United Kingdom, the Channel Islands or the Isle of Man of any offence and has had passed on him a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine; or

(b) he has been adjudged bankrupt or has made a composition or arrangement with his creditors; or

(c) he has been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body or health and social services body; or

(d) he is a person whose tenure of office as the chairperson, member or director of a health and social services body has been terminated because his appointment is not in the interests of the health and personal social services, for non-attendance at meetings or for non-disclosure of a pecuniary interest; or

(e) he is a chairperson, member, director or employee of a health and social services body; or

(f) he performs or provides primary medical services under Part VI of the Health and Personal Social Services (Northern Ireland) Order 1972, is a partner in a partnership that, or is the legal and beneficial owner of shares in a company that, provides primary medical services under Part VI of that Order, or is an employee of any of those, or is a general dental practitioner or an employee of one; or

(g) **removed – see footnote below**[5]

(h) he has had his name removed, by a direction under Schedule 11 of the Health and Personal Social Services (Northern Ireland) Order 1972, from any list prepared under Part VI of that Order and has not subsequently had his name include in such a list or a list prepared pursuant to Article 57G of that Order; or

(i) he has applied for his name to be included in a list of a Health and Social Services Board, and a direction that his name should not be included in the relevant list has been given by the Tribunal under paragraph 4 of Schedule 1 to the Health Services (Primary Care) (Northern Ireland) Order 1997, and such disqualification has not been removed following an application to the Tribunal under regulation 12 of the Tribunal Regulations (Northern Ireland) 1995

(2) For the purposes of paragraph (1)(a) the date of conviction shall be deemed to be the date on which the ordinary period allowed for making an appeal or application with respect to the conviction expires, or if such an appeal or application is made, the date on which the appeal or application is made, the date on which the appeal or application is finally disposed of or abandoned or fails by reason of it not being prosecuted.

(3) For the purposes of paragraph (1)(c) a person shall not be treated as having been in paid employment by reason only of his chairpersonship, membership or directorship of a health service body or a health and social services body.

(4) A person shall not be disqualified by paragraph (1)(e) from being the Non-Executive Director of an HSS trust referred to in paragraph 3(1)(d) of Schedule 3 to the Order * by reason of his employment with a health and social services body.

*The Health and Personal Social Services (Northern Ireland) Order 1991

Cessation of disqualification

12.- (1) Where a person is disqualified under regulation 11(1)(b) by reason of having been adjudged bankrupt -

(a) if the bankruptcy is annulled on the ground that he ought not to have been adjudged bankrupt or on the ground that his debts have been paid in full, the disqualification shall cease on the date of the annulment;

(b) if he is discharged the disqualification shall cease on the date of his discharge.

(2) Where a person is disqualified under regulation 11(1)*(b)* by reason of his having made a composition or arrangement with his creditors, if he pays his debts in full the disqualification shall cease on the date on which the payment is completed and in any other case it shall cease on the expiry of five years from the date on which the terms of the deed of composition or arrangement are fulfilled.

(3) Subject to paragraph (4), where a person is disqualified under regulation 11(1)(c) (dismissed employees) he may, after the expiry of a period of not less than two years, apply in writing to the Department to remove the disqualification and the Department may direct that the disqualification shall cease.

(4) Where the Department refuses an application to remove a disqualification no further application may be made by that person until the expiration of two years from the date of the application.

(5) Where a person is disqualified under regulation 11(1)(d) (certain chairmen and directors whose appointments have been terminated), the disqualification shall cease on the expiry of a period of two years or such longer period as the Department specifies when terminating his period of office but the Department may on application being made to it by that person, reduce the period of disqualification.

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5 Sub-paragraph (g) was omitted by Statutory Rule No 164 – Health and Social Care – The Health and Social Services Trusts (Membership and Procedure) Amendment Regulations (Northern Ireland) 2011

Annex B

GENERAL GUIDANCE

Criteria Based Selection Process

Criteria based selection is currently the most common method of making public appointments in Northern Ireland. What this means is that the onus is on you to provide evidence of workplace or personal performance which demonstrates that you can perform to the specified standard.

Under each of the criteria headings in the application form, you are required to provide specific and relevant examples of past behaviour which illustrate how you match the competences being sought. It is not just ***what*** you have done – but also ***how*** you did it.

You can use examples from your working life or personal life including any private, voluntary or community work you are, or have been, involved in.

It is not appropriate to simply list the various posts that you have held. Assumptions will not be made from the title of your post or the nature of the organisation as to the experience, qualities and skills gained.

You should structure your responses by setting a context for your examples, explain what you were trying to achieve, describe what you actually did and why, indicating your own individual contribution and outline the outcome or results.

Criteria Based Interview

If this is your first experience of a criteria based interview, bear in mind that it does not require you to:

- Talk through previous jobs or appointments from start to finish;
- Provide generalised information as to your background and experience; or
- Provide information that is not specifically relevant to the criterion the question is designed to test.

A criteria based interview does however require you to:

- Focus exclusively, in your responses, on your ability to fulfil the criteria required for effective performance in the role; and
- Provide specific examples of your experience in relation to the required criterion.

In preparation for the interview you may wish to think about having a clear structure for each of your examples, such as:

Situation:	Briefly outline the situation
Task:	What was your objective?
	What were you trying to achieve?
Action:	What did you actually do?
	What was your unique contribution?
Result:	What happened?
	What was the outcome?
	What did you learn?

The Interview Panel will ask you to provide specific examples from your past experience in relation to each of the criteria. You should therefore come to the interview prepared to discuss in detail a range of examples which illustrate your skills and abilities in each criterion area. You may draw examples from any area of your work/life experiences.

You are strongly advised to read the 'Public Appointments Guide' when preparing for interview - https://www.executiveoffice-ni.gov.uk/sites/default/files/publications/execoffice/public-appointments-guide.pdf

Annex C

PROBITY & CONFLICTS OF INTEREST
GUIDANCE FOR APPLICANTS

This guidance should be read in conjunction with the information contained in the leaflet "CPANI Guidance on Conflicts of Interest, Integrity and how to raise a complaint" which provides examples of the types of issues that may give rise to conflicts of interests.

Standards of behaviour

Ministers expect that the conduct of those they appoint to serve on the Boards of public bodies will be above reproach. Everyone who puts themselves forward for a public appointment must be able to demonstrate their commitment to the maintenance of high standards in public life.

The Seven Principles Underpinning Public Life

In 1995, the Committee on Standards in Public Life defined seven principles, which should underpin the actions of all who serve the public in any way. These are:

Selflessness - Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or other friends.

Integrity - Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity - In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability - Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness - Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty - Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership - Holders of public office should promote and support these principles by leadership and example.

As part of the selection process you will be tested on your commitment to maintaining high standards in public life with particular emphasis on probity issues and conflicts of interest.

What is a conflict of interest?

Public Appointments require the highest standards of propriety, involving impartiality, integrity and objectivity, in relation to the stewardship of public funds and the oversight and management of all related activities. This means that any private, voluntary, charitable or political interest which might be material and relevant to the work of the body concerned should be declared.

There is always the possibility for real or perceived conflicts of interest to arise. Both are a problem, as the perceived inference of a conflict may, on occasions, be as damaging as the existence of a real conflict.

No-one should use, or give the appearance of using, their public position to further their private interests. This is an area of particular importance, as it is of considerable concern to the public and receives a lot of media attention. It is important, therefore, that you consider your circumstances when applying for a public appointment and identify any potential conflicts of interest, whether real or perceived.

Surely a perceived conflict is not a problem, as long as I act impartially at all times?

The integrity of the individual is not in question here. However, it is necessary for the standing of the individual and the Board that members of the public have confidence in their independence and impartiality. Even a perceived conflict of interest on the part of a board member can be extremely damaging to the body's reputation and it is therefore essential that these are declared and explored, in the same way as an actual conflict would be. The fact that a member acted impartially may be no defence against accusations of potential bias.

What should I do if I think I have a conflict of interest?

You will find a section on conflicts of interest in the application form for you to complete. This asks you to consider and declare whether or not you have a real, or perceived, conflict. If you are unsure if your circumstances constitute a possible conflict, you should still complete this section, in order to give the Panel as much information as possible.

If I declare a conflict, does this mean I will not be considered for appointment?

No - each case is considered individually. If you are short-listed for interview, the Panel will explore with you how far the conflict might affect your ability to contribute effectively and impartially on the Board and how this might be handled, if you were to be appointed. For example, it may be possible to arrange for you to step out of meetings where an issue is discussed, in which you have an interest. However, if, following the discussion with you, the Panel believes that the conflict is too great and would call into question the probity of the Board or the appointment they can withdraw your application from the competition. The summary of the outcome of the interview process, which is put to the Ministers, will include clear written reference to any probity issues or perceived or actual conflicts of interest connected to any applicant put forward as suitable for appointment. It will include sufficient information to ensure that the Ministers are fully aware of any of these matters and can make an informed decision.

What happens if I do not declare a known conflict, which is then discovered by the Department after my appointment?

Again, each case would be considered on its merits, but the Department may take the view that by concealing a conflict of interest, you would be deemed to have breached the seven principles of conduct underpinning public life and may terminate your appointment.

What happens if I do not realise a potential conflict exists?

This situation may arise where the applicant is not familiar with the broad range of work which a body covers and therefore does not realise that a conflict might exist. In some cases, the Panel, with their wider knowledge of the body, might deduce that there is a potential conflict issue, based on the information on employment and experience provided by the applicant in the application form. They will then explore this at interview with the applicant.

What happens if a conflict of interest arises after an appointment is made?

This could arise for two main reasons. The first is that the member's circumstances may change, for example, they may change jobs and in doing so, a conflict with their work on the Board becomes apparent. The second is where a member is unfamiliar with the range of the work of the body, but after appointment, it becomes clear that a conflict exists where none had been envisaged during the appointment process.

In both cases, the issue should be discussed with the Chair of the Board and the Chief Executive of the body concerned, in consultation with the Sponsoring Department, to decide whether or not the member can continue to carry out their role in an appropriate manner and each case is considered individually.

It may be that the conflict is such that it would be impractical for the member to continue on the Board, if they would have to withdraw from a considerable amount of the body's routine business. In such cases, the member may be asked to stand down from the body.

Preeta Miller
Workforce Policy Directorate

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Upper Newtownards Road
BELFAST
BT4 3SQ

Tel: [redacted]
Email: public.appointments@health-ni.gov.uk

Issued by email only

Ms Eileen Mullan
[redacted]

Our Ref: HE1-20-33

Date: 18 November 2020

Dear Ms Mullan

APPOINTMENT OF NON-EXECUTIVE CHAIR TO THE SOUTHERN HEALTH & SOCIAL CARE TRUST

I write to confirm the Department's offer of appointment made to you as the Non-Executive Chair of the Southern Health and Social Care Trust (SHSCT).

The appointment will commence on **1 December 2020** and end on a date not later than **30 November 2024**.

The principal terms and conditions governing your appointment are set out in the attached letter of appointment and associated documents at **Annex A**. I would be grateful if you would confirm in writing your willingness to accept the appointment on these terms by completing the proforma at **Annex B** and returning it to the Department's Public Appointments Unit at the following e-mail address: public.appointments@health-ni.gov.uk.

It should be noted that the Department may give notice to terminate your appointment at any time. Please see the enclosed Minute of Appointment. Should you wish to end your appointment early, the Department will require a minimum of 3 months' notice. An annual assessment of the performance of a Non-Executive Chair will be required throughout the period of appointment.

In view of this appointment, your role as a Non-Executive Director of the Trust board will now end on **30 November 2020**. I wish to take this opportunity to thank you for the valuable contribution you have made to the operation of the SHSCT since you were first appointed to this role in February 2016.

You are required, as a condition of this appointment, to attend an induction course "Essential Skills for Board Directors" or the "On Board Training Programme for Board Members of Public Bodies in Northern Ireland" within 6 months of taking up appointment in addition to any Induction training provided by the SHSCT and you will be advised by the Chair regarding this – see http://www.cipfa.org/Events or http://www.onboard-training.co.uk for course details.

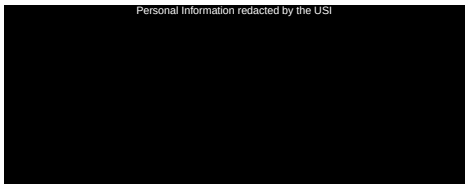
You must notify the Department's Public Appointments Unit when you have completed this course.

Please find the link to *'On Board: A Guide for Board Members of Public Bodies'.*
https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/on-board-guide-2.pdf

This guidance is an essential reference tool for all Board Directors and provides clarity on a wide range of corporate governance issues.

I hope you find your role as the Non-Executive Chair of the SHSCT interesting and fulfilling.

Yours sincerely



Preeta Miller
Workforce Policy Directorate

Enc.

Annex A

NON-EXECUTIVE CHAIR SOUTHERN HEALTH & SOCIAL CARE TRUST

LETTER OF APPOINTMENT

This letter sets out the principal terms and conditions of this Ministerial Appointment as a Non-Executive Chair of the Southern Health & Social Care Trust (SHSCT)

Name of Parties: **Department of Health**
Ms Eileen Mullan

1. Commencement and Duration of Appointment

1.1 Your appointment will commence on **1 December 2020** and will end on a date not later than **30 November 2024**.

1.2 Reappointment to the Board for a second term will not be automatic. The outgoing Non-Executive Chair may be eligible to serve a second term by applying through open public competition. Any such application would depend on the applicant having demonstrated an appropriate standard of performance during the first term of appointment including evidence of continued adherence to the seven principles of public life.

2. Title

2.1 You are appointed as a **Non-Executive Chair of the SHSCT**.

2.2 The SHSCT is one of five integrated HSC Trusts established in April 2007. The Trusts are known as the Belfast HSC Trust, the Northern HSC Trust, the Southern HSC Trust, the South Eastern HSC Trust and the Western HSC Trust. The Northern Ireland Ambulance Service Trust functions independently of these five Trusts.

2.3 The five HSC Trusts were established as statutorily separate organisations within the HSC family, responsible for the delivery of responsive and effective health and care services and for the ownership and management of hospitals and other establishments and facilities. They provide health and social care services against Ministerial/Departmental priorities, standards and targets. Services will be provided as specified in contracts with the commissioners of health and social care services, namely the HSCB.

3. Board Responsibilities

3.1 Each HSC Trust is managed directly by a board of Directors which has corporate responsibility for its operation. A board is made up of five executive Directors and seven Non-Executive Directors and a Non-Executive Chair. Non-Executive Directors and Executive Directors are full and equal members of the board.

3.2 A HSC Trust Non-Executive Chair and the Non-Executive Directors are appointed with the approval of the Minister for Health, in accordance with the Code of Practice of the Commissioner for Public Appointments for Northern Ireland.

4. Non-Executive Chair Role and Responsibilities

4.1 The Non-Executive Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

4.2 The Non-Executive Chair shall ensure that the SHSCT policies and actions support the wider strategic policies of the Minister and that the SHSCT affairs are conducted with probity.

4.3 The Non-Executive Chair has a particular leadership responsibility for:

- Formulating the Board's strategy for discharging its duties;
- Ensuring that the Board, in reaching decisions, takes proper account of guidance provided by the Minister, the sponsor department, the HSCB or the PHA;
- [redacted]uring that risk management is regularly and formally considered at Board meetings;
- Promoting the efficient, economic and effective use of staff and other resources;
- Encouraging and delivering high standards of regularity and propriety;
- Representing the views of the Board to the general public;
- Ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual Board members;
- Ensuring that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training;
- Advising the Department of the needs of the SHSCT when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise;
- Annually assessing the performance of individual Board Members;
- Ensuring the completion of the Board Governance Self-Assessment Tool on an annual basis;
- Ensuring that Board Members are made aware of the Code of Conduct for Board Members of HSC Bodies (2012) including the Nolan "seven principles of public life", and the requirement for a comprehensive and publicly available register of Board Members' interests. Communications between the Board, Ministers and the Department shall normally be through the Non-Executive Chair who shall ensure that the other Board Members are kept informed of such communications on a timely basis;
- Operating the Board and chairing all Board meetings when present. The Non-Executive Chair has certain delegated executive powers and must

comply with the terms of appointment and with the SHSCT Standing Orders; and

- Working closely with the Chief Executive and ensuring that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

4.4 This public appointment does not constitute employment. Accordingly nothing in this letter shall be construed as, or taken to create, a contract of employment between you, the SHSCT or the Department

5. Accountability and Reporting responsibility

5.1 The Non-Executive Chair of the SHSCT is Accountable to the Minister, through the Permanent Secretary of the Department of Health.

6. Time Commitment and Remuneration

6.1 The Non-Executive Chair will be expected to devote 3 days per week to the appointment. This may involve commitment both inside and outside normal working hours. The annual rate of remuneration for the Non-Executive Chair of the SHSCT is Personal Information redacted by the USI (under review).

7. Travel, subsistence and other expenses

7.1 In carrying out your role as Non-Executive Chair you are entitled to claim allowances at rates set centrally by the Department, for costs necessarily incurred on SHSCT business.

7.2 Remuneration is taxable and it is the responsibility of the SHSCT to apply PAYE deductions in respect of income tax and National Insurance, unless instructed to the contrary by the Inland Revenue. If appropriate, it will be for you to arrange exemption from National Insurance Contributions by contacting HM Revenue and Customs in Newcastle.

8. Double Paying

8.1 The Department of Finance (DoF) has issued guidance in relation to the remuneration of independent board Directors who are public sector employees. Each case will be considered individually, however, the guiding principle should be to avoid "double-paying". That is, if an individual is drawing a full-time salary from the public purse, payment should not be made twice.

9. Training (including Induction Training)

9.1 Board Directors of public bodies are expected to undergo appropriate training in corporate governance and board Directorship.

9.2 You are required, as a condition of this appointment, to attend an induction course for example "Essential Skills for Board Directors" or the "On Board Training Programme for Board Members of Public Bodies in Northern Ireland" or similar course usually within 6 months of taking up appointment, this is in addition to any Induction training provided by the SHSCT.

9.3 You must notify the Department's Public Appointments Unit of your attendance at the Induction course within the required timeframe.

9.4 The Chief Executives' Forum in Northern Ireland (NICON) provides access to training courses that provide invaluable training for newly appointed Board Members in addition to any training SHSCT may offer.

10. Performance Appraisal

10.1 As a SHSCT Non-Executive Chair your performance will be appraised on an annual basis by a Departmental Reporting Officer and a copy of the report passed to the Permanent Secretary, for countersigning.

10.2 For your appointment to continue for the remainder of your term, or for you to be considered for re-appointment at the end of your term, your performance [redacted]l report must be satisfactory. An unsatisfactory appraisal report may contribute to certain actions being taken, which could ultimately lead to termination of your appointment.

10.3 Departments have a duty to satisfy themselves, as far as is practicable, that those they appoint to the boards of public bodies will carry out their duties in an efficient and effective manner. For candidates who have held other public appointments this means that the appointing department can seek information on previous performance as a Board Member.

10.4 In the event that you apply for another public appointment, we will, on request, provide the appointing department with information relating to your performance as Chair of the Board of SHSCT.

11. Attendance

11.1 Board Members are expected to attend meetings regularly. Your appointment may be terminated if attendance becomes as erratic as to interfere with the good running of the SHSCT or its Board.

12. Termination of Appointment

12.1 Your appointment may be terminated if at any time you are considered unfit to continue in office or are incapable of performing your duties as Chair of the Board.

12.2 Should you wish to end your term early the Department will require a minimum of 3 months' notice.

12.3 In order to maintain high standards in public life, an appointment may be terminated in the event that an appointee is convicted of a criminal offence and/or where the Minister/Department believes that the appointee's conduct means that he or she is no longer a suitable person to hold office as Member of the SHSCT Board.

13. Indemnities for personal liability

13.1 The Government has indicated that a Board Member who has acted honestly and in good faith will not have to meet out of his/her own personal resources any personal civil liability which is incurred in the execution or purported execution of his/her board function, save where the person has acted recklessly.

14. Conduct

14.1 All public appointees have a duty in relation to conduct, propriety and confidentiality.

14.2 You are required to exercise care in the handling of information which you may acquire in the course of your duties and to protect from unauthorised disclosure, any documents or other information provided to you in confidence.

14.3 You will be required as a condition of your appointment to abide by the seven principles of public life and by the Code of Conduct and Code of Accountability which can be accessed via this link https://www.health-ni.gov.uk/sites/default/files/publications/health/ccabm.pdf
In addition you will be required to abide by the SHSCT Code of Conduct.

14.4 You must notify the Department if you become the subject of a police investigation or are arrested by the police.

15. Conflicts of Interest

15.1 Conflicts of interest, whether real or perceived, can be damaging to the Member, the board and the Department. If a conflict of interest arises or is identified it is essential that it is resolved as quickly as possible.

15.2 You must declare any personal or business interests, pecuniary or non-pecuniary which may, or may be perceived to, influence your judgement when performing your duties as Chair of the Board of the SHSCT. Failure to do so could lead to your appointment being withdrawn.

15.3 You are encouraged to register your own interests and the interests of close family members and persons living in the same household that appear closely related to your activities as Chair of the SHSCT. Should you be in any doubt about what to disclose it is best to err on the side of caution and disclose the information. These interests will be included in an appropriate register of interests maintained by the SHSCT and you must ensure that your entries are kept up to date.

15.4 Should an issue arise subsequent to the completion of the register of interests, which could give rise to a potential conflict of interest you must inform the Department.

15.5 If at a meeting of the Board an issue arises that could give rise to a potential conflict you should disclose your interest and withdraw from any discussion or consideration of the matter.

15.6 If a conflict of interest is identified the Department, in conjunction with the Chief Executive (where appropriate) and the individual board member will need to give careful consideration to how the problem can be resolved. In extreme situations if a conflict of interest cannot be resolved dismissal may be the most appropriate option, however due process must be followed and the principles of natural justice applied.

16. Other Appointments

16.1 You must inform the Department in advance of taking up any new appointments which may impinge on your duties.

17. Political Activity

17.1 You should not occupy paid party political posts or hold particularly sensitive positions of responsibility in a political party. Subject to the foregoing, you are free to engage in political activities provided that you are conscious of your general public responsibilities and exercise proper discretion, particularly with regard to the work of the SHSCT. Be prepared to disclose any potential conflicts of interest.

17.2 You are expected to inform the Minister/Department of any intention to accept a prominent position in any political party and to understand that your appointment to the Board of the SHSCT may be terminated if the Minister/Department feels that, in the case of you accepting such a role, the positions are incompatible.

17.3 Under the terms of the House of Commons Disqualification Act 1975 and the Northern Ireland Assembly Disqualification Act 1975, MPs and MLAs cease to hold their elected office if they take up an appointment to a public body or office listed in the aforementioned legislation.

17.4 Existing legislation puts the onus on the person standing for election to state that they are aware of the provisions of the House of Commons Disqualification Act 1975 or the Northern Ireland Assembly Disqualification Act 1975 and that, to the best of their knowledge and belief, they are not disqualified from being an MP or MLA.

17.5 Therefore, if you decide to stand for election as an MP or MLA you must ensure that the public body or office to which you belong is not listed in the House of Commons or Northern Ireland Assembly Disqualification Acts.

17.6 If the public body or office is listed in the relevant Disqualification Act you should notify the Department immediately and to avoid any disqualification issues from arising later, you should resign your appointment before submitting your nomination as a candidate in an election.

18. Bankruptcy

18.1 You may be removed from office before the end of your term of appointment if you become bankrupt or are made the subject of a Bankruptcy Restrictions Order.

19. Official Secrets Act

19.1 The provisions of the Official Secrets Act 1911 to 1989 apply to public appointees. Unauthorised disclosure of any information gained in the course of your appointment, or its use by you or others for personal gain or advancement, could result in your appointment being terminated early, or even criminal prosecution

Annex B

DECLARATION OF ACCEPTANCE OF APPOINTMENT AS NON-EXECUTIVE CHAIR OF THE SOUTHERN HEALTH & SOCIAL CARE TRUST)

MS EILEEN MULLAN

SHSCT NON-EXECUTIVE CHAIR

I am willing to accept the appointment as a Non-Executive Chair of the SHSCT commencing on **1 December 2020** on the basis of the terms and conditions set out in my letter of appointment dated **18 November 2020**.	Yes / No
I confirm that I have received a copy of the Code of Conduct and Code of Accountability (dated July 2012) and am committed to the seven principles of public life as defined by the Committee on Standards in Public Life (Nolan Principles).	Yes / No
I will confirm attendance at an Induction training course approved by the Department within 6 months of taking up appointment.	Yes / No

Name: **MS EILEEN MULLAN**

Signature: _____

Date: _____

DEPARTMENT OF HEALTH
APPOINTMENTS – PROTECT (WHEN COMPLETED)

CHAIR PERFORMANCE ASSESSMENT FORM

NAME: Eileen Mullan **PUBLIC BODY:** Southern Health and Social Care Trust

PERIOD OF ASSESSMENT: YEAR ENDING 31 MARCH 2022

DATE OF FIRST APPOINTMENT: 01ST December 2020

CURRENT APPOINTMENT EXPIRES: 30th November 2024

DEPUTY SECRETARY REVIEWING: __Jim Wilkinson

The information contained in this performance appraisal may be shared with other Government departments in line with their policy on the use of references when making public appointments.

SELF-ASSESSMENT

You should set out your key achievements against the objectives for the year including those objectives which were not met and any relevant factors which arose in the course of the year.

STRATEGIC DEVELOPMENT AND DELIVERY – Developing Strategic Direction; Responding to HPSS Policies and Priorities; Monitoring Performance.

Objective: To ensure the board sets the strategic direction of the organisation within the overall policies and priorities of the HPSS and to oversee the delivery of planned results by monitoring performance.

Process & Outcome:

I have as Chair built into the Trust Board meeting a dedicated section that focuses on strategy and over the course of this reporting period work got underway to develop a corporate plan, people framework, patient safety and quality plan.

I ensured that Board discussions take cognisance of regional plans and ministerial priorities.

One of the standing committees for the Trust is the Performance Committee and it has been bedding in during the course of this year. The Trust Board gets to see the minutes and hear from the Committee Chair on the work undertaken.

ACCOUNTABILITY AND GOVERNANCE - Probity; Corporate Responsibility; Adherence to Codes of Conduct and Accountability; Clinical Governance; Risk Management.

Objective: To have transparent, comprehensive systems of accountability set up and operating within the organisation.

Process & Outcome:

The principles of public life are central to how I work. The Trust values of working together, excellence, compassion, openness and honesty have been a significant factor in how I have steered the Trust board. As part of the broader people framework I was clear with the Board and SMT that we needed to embody these values as leadership team and show them in action from the Boardroom

I have spent a great deal of time creating psychological safety in the Boardroom and across the Board. This has over time showed that those contributing and observing the board that is a safe place and operates with openness and honesty.

Clinical and Social Care Governance has underwent a series of reviews and work to support improvements. The Urology Services Public Inquiry was announced in the autumn.

TEAMBUILDING - Leadership; Support and Development of Non-Executives; Relations with Chief Executive and Executive Team; Building an Effective Team.

Objective: To build and lead an effective, cohesive team at board level that provides a clear vision to the organisation.

Process & Outcome:

I continue to reflect on Trust Board, committee meetings and take time to ask Non Executives and Directors of their experience and indeed any room for improvement for me as Chair.

I am very clear that the Trust Board team is made up of Executive and Non-Executive with Operational Directors in attendance. My job during the year has been to get the best out of everyone and ensure that we as a Trust deliver on our functions and requirements as set to us. The CEO left the organisation in February 2022. Over the course of the period 2021/2022, the Covid pandemic was still significantly impacting service delivery. Whilst the CEO had started the work on the corporate plan and enablers, that work did not get to progress as it should in this reporting period. Responding to the pandemic was the dominant feature for the Trust, and doing so, Trust Board took every opportunity to thank and acknowledge the staff.

PUBLIC CONFIDENCE – Building constructive relationships outside the organisation; Representing the board in public; Developing networks and relationships with key stakeholders.

Objective: To manage at a strategic level the relationships and communications with a broad range of key stakeholders in order to maintain and encourage public confidence in the organisation.

Process & Outcome:

Trust Board meetings are held via zoom and this allowed members of the public, political representative, Trade Union and staff to attend and observe the meetings. I encourage those attending to ask questions on the agendas items discussed so that the CEO and SMT can answer on the day.

The previous CEO I and had started a programme of work to hold quarterly meetings with the local political parties. These had been well received.

I undertook a number of short videos to share the work of Trust Board and the decisions taken as well as to connect with our staff across the Trust.

I brought about a new Director Visit approach and template so that these visits moved from acting like an inspection to being one of listening and hearing from the staff team.

I meet with colleagues across health and social care through meetings with the Minister and the Department.

TIME COMMITMENT

Please complete the table below giving details of attendance at board/committee meetings along with the overall amount of time spent in your Chair role – please state if this is on either a weekly or a monthly basis in accordance with the terms of your appointment.

	Board meetings	**Committee meetings**
Meetings held during assessment period	**15**	**12**
Meetings attended	**15**	**12**
TOTAL TIME SPENT IN CHAIR ROLE PER WEEK/MONTH		
Estimate total time spent in the role of Chair including Board/Committee meetings (per month or per week as appropriate)	3 days per week	

Brief details of other events, activities and visits should be included in the box below.

Details of attendance at other events, activities and visits
• CEO/Chair/NED Monthly Meetings • Chair/Non-Executive Director Quarterly Meetings • Meetings with the Chief Executive • Meetings with Directors • Meetings with the Board Assurance Manager • Chairing Consultant interview panels • Children's Home Visits • Public Inquiry Training • Meeting with Chairs of HSC Trusts • Meeting with Chair of RQIA and Patient Client Council • Meetings with Department of Health Officials • Trust Board Development Day • Chief Executive's Forum Partnership in Practice • Health and Social Care Chairs Meeting with Minister of Health • Meetings with Political Representatives • Attendance at Minister of Health visits within Southern Trust • Meeting with the first cohort of Aspiring Directors • Celebration and acknowledgement events across the Trust • Meeting with Internal Audit Board Effectiveness • Leadership and Governance Conference • Meetings with Leadership Centre • Attendance at Good Governance Institute and NHS Confederation Seminars • Regional Training Maintaining High Professionals Standards • Quality Improvement and Staff Engagement • Chair's visits to Bluestone/Dorsy; Primary Mental Health Care, Lurgan; Litigation Department, Daisy Hill Hospital; Lurgan Catering Department

Notes on specific issues for the forthcoming year:
• Supporting and developing the recently appointed CEO • Stabilising Senior Management Team and in particular Executive Directors • Reducing agency spend and secure the recruitment of permanent staff to support service delivery • Building and maintaining relationships with our community, staff and political representatives • Ensuring the effective and efficient use of all Trust resources • Managing relationships within the community in regard to the interim arrangements for Emergency General Surgery and the campaign for the future of Daisy Hill Hospital • Secure the appointment of 2 Non-Executive Directors 2022 • Creation and implementation of a Partnership Agreement

PRINCIPLES OF PUBLIC LIFE

Please confirm that you have adhered to the Principles of Public Life and Codes of Conduct & Accountability. If any failures in this area have been identified, please provide details.

YES

If NO provide details.

CONFLICTS OF INTEREST

Have you taken up any other appointments, employment, etc during the year?

NO

If YES, please provide details:

If other appointments, employment, etc have been taken up, are you satisfied that no conflict of interest arises as a result?

NOT APPLICABLE

If NO, please provide details:

RE-APPOINTMENT

ONLY TO BE COMPLETED BY CHAIRS ENTERING THEIR FINAL YEAR OF APPOINTMENT

Chairs approaching the end of a first term of appointment may be offered to serve a second term. Please indicate if you would be willing to accept a second term of appointment if offered.

N/A

Deputy Secretary's comments:
(to include endorsement of re-appointment if appropriate)

I have met with the Chair to discuss this self-assessment, and I am satisfied that Eileen continues to provide Board leadership to SHSCT. Eileen has a clear focus on developing a strategic plan to guide the organisations development over the next number of years, reflecting on the significant changes that have taken place in recent years, and the significant challenges, not least response to significant issues in relation to urology, and service delivery. Eileen has established a good working relationship with the recently appointed CX, and new Executive Directors recently. She is working with other Board members to improve governance and reporting processes and set a clear strategic direction.

I consider performance to be **Effective/** (*delete as appropriate)

If performance is ineffective, has this been discussed with the member? **NA**

Provide details of any measures/action taken:-

Are you willing to endorse re-appointment for a second term? **NA**

Signed:__Jim Wilkinson Date: 22/11/2022

DEPARTMENT OF HEALTH
APPOINTMENTS – PROTECT (WHEN COMPLETED)

Chair's comments:

Thank you for these reflections and comments.

I agree with my performance assessment *(*Delete as appropriate)*

Personal Information redacted by the USI

Signed:_____ Date:_21/02/2023

Permanent Secretary's comments:

I agree with the Deputy Secretary's comments. Eileen is a diligent and focused Chair who is approachable and keen to create an enabling culture where people can give of their best.

Personal Information redacted by the USI

Signed:_____Date: 27/2/23

Department of Health
www.health-ni.gov.uk

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by Department of Health Sponsored Arms Length Bodies

Directors Workshop 13th June 2019
Trust Board 29th August 2019

Contents

Introduction

This self-assessment tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice.

The public need to be confident that ALBs are efficient and delivering high quality services. The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department rests with the ALB's board. The board is the most senior group in the ALB and provides important oversight of how public money is spent.

It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise.

Good governance best practice requires Boards to carry out a board effectiveness evaluation annually, and with independent input at least once every three years.

This checklist has been developed by reviewing various governance tools already in use across the UK and the structure and format is based primarily on Department of Health governance tools. The checklist does not impose any new governance requirements on Department of Health sponsored ALBs.

The document sets out the structure, content and process for completing and independently validating a Board Governance Self-Assessment (the self-assessment) for Arms Length Bodies of the Department of Health.

The Self-Assessment should be completed by all ALB Boards and requires them to self-assess their current Board capacity and capability supported by appropriate evidence which may then be externally validated.

Application of the Board Governance Self-Assessment
It is recommended that all Board members of ALBs familiarise themselves with the structure, content and process for completing the self-assessment.

The self-assessment process is designed to provide assurance in relation to various leading indicators of Board governance and covers 4 key stages:

1. Complete the self-assessment
2. Approval of the self-assessment by the ALB Board and sign-off by the ALB Chair;
3. Report produced; and
4. Independent verification.

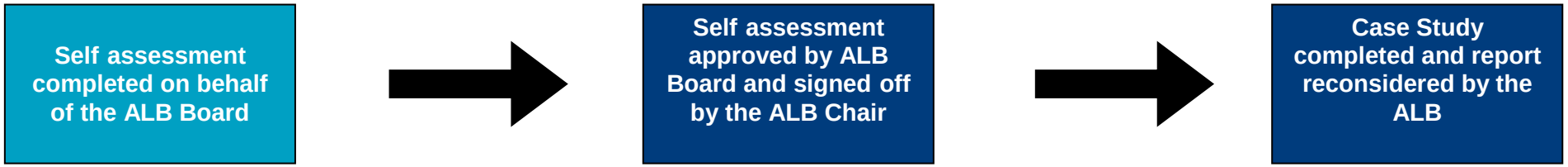
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach a consensus on the ratings. The Chair of the Board will act as moderator. A submission document is attached for the Board to record its responses and evidence, and to capture its self-assessment rating.

Refer to the scoring criteria identified on page 7 to apply self assessment ratings.

Approval of the self-assessment by ALB Board and sign off by the Chair: The ALB Board's RAG ratings should be debated and agreed at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and ultimately signed off by the ALB Chair on behalf of the Board.

Independent verification: The Board's ratings should be independently verified on average every three years. The views of the verifier should be provided in a report back to the Board. This report will include their independent view on the accuracy of the Board's ratings and where necessary, provide recommendations for improvement.

Overview



The Board Governance self-assessment is designed to provide assurance in relation to various leading indicators of effective Board governance. These indicators are:

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);

2. Board evaluation, development and learning (e.g. The Board has a development programme in place);

3. Board insight and foresight (e.g. Performance Reporting);

4. Board engagement and involvement (e.g. Communicating priorities and expectations);

5. Board impact case studies (e.g. A case study that describes how the Board has responded to a recent financial issue).

Each indicator is divided into various sections. Each section contains Board governance good practice statements and risks.

There are three steps to the completion of the Board Governance self-assessment tool.

Step 1

The Board is required to complete sections 1 to 4 of the self-assessment using the electronic Template. The Board should RAG rate each section based on the criteria outlined below. In addition, the Board should provide as much evidence and/or explanation as is required to support their rating. Evidence can be in the form of documentation that demonstrates that they comply with the good practice or Action Plans that describe how and when they will comply with the good practice. In a small number of instances, it is possible that a Board either cannot or may have decided not to adopt a particular practice. In cases like these the Board should explain why they have not adopted the practice or

cannot adopt the practice. The Board should also complete the Summary of Results template which includes identifying areas where additional training/guidance and/or assurance is required.

Step 2

In addition to the RAG rating and evidence described above, the Board is required to complete a minimum of 1 of 3 mini case studies on;

- A Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery; or
- Organisational culture change; or
- Organisational Strategy

The Board should use the electronic template provided and the case study should be kept concise and to the point. The case studies are described in further detail in the Board Impact section.

Step 3

Boards should revisit sections 1 to 4 after completing the case study. This will facilitate Boards in reconsidering if there are any additional reds flags they wish to record and allow the identification of any areas which require additional training/guidance and/or further assurance. Boards should ensure the overall summary table is updated as required.

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

- All good practices are in place unless the Board is able to reasonably explain why it is unable or has chosen not to adopt a particular good practice.
- No Red Flags identified.

Amber/ **Green** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved, there are either:
    - robust Action Plans in place that are on track to achieve good practice; or
    - the Board is able to reasonably explain why it is unable or has chosen not to adopt a good practice and is controlling the risks created by non-compliance.
- One Red Flag identified but a robust Action Plan is in place and is on track to remove the Red Flag or mitigate it.

Amber/ **Red** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved:
    - Action Plans are not in place, not robust or not on track;
    - the Board is not able to explain why it is unable or has chosen not to adopt a good practice; or
    - the Board is not controlling the risks created by non-compliance.
- Two or more Red Flags identified but robust Action Plans are in place to remove the Red Flags or mitigate them.

Red if the following applies:

- Action Plans to remove or mitigate the risk(s) presented by one or more Red Flags are either not in place, not robust or not on track

Please note: The various green flags (best practice) and red flags risks (governance risks/failures) are not exhaustive and organisations may identify other examples of best practice or risk/failure. Where Red Flags are indicated, the Board should describe the actions that are either in place to remove the Red Flags (e.g. a recruitment timetable where an ALB currently has an interim Chair) or mitigate the risk presented by the Red Flags (e.g.

where Board members are new to the organisation there is evidence of robust induction programmes in place).

The ALB Board's RAG ratings on the self assessment should be debated and agreed by the Board at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and then signed-off by the Chair on behalf of the Board.

1. Board composition and commitment

1. Board composition and commitment overview

This section focuses on Board composition and commitment, and specifically the following areas:

1. Board positions and size
2. Balance and calibre of Board members
3. Role of the Board
4. Committees of the Board
5. Board member commitment

1. Board composition and commitment

1.1 Board positions and size

Red Flag	Good Practice
1. The Chair and/or CE are currently interim or the position(s) vacant. 2. There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago). 3. The number of people who routinely attend Board meetings hampers effective discussion and decision-making.	1. The size of the Board (including voting and non-voting members of the Board) and Board committees is appropriate for the requirements of the business. All voting positions are substantively filled. 2. The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge it responsibilities. 3. It is clear who on the Board is entitled to vote. 4. The composition of the Board and Board committees accords with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders. 5. Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Standing Orders • Board Minutes • Job Descriptions • Biographical information on each member of the Board.

1. Board composition and commitment

1.2 Balance and calibre of Board members

Red Flag	Good Practice
1. There are no NEDs with a recent and relevant financial background. 2. There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector. 3. The majority of Board members are in their first Board position. 4. The majority of Board members are new to the organisation (i.e. within their first 18 months). 5. The balance in numbers of Executives and Non Executives is incorrect. 6. There are insufficient numbers of Non Executives to be able to operate committees.	1. The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan. 2. The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors. 3. The Board has had due regard under *Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without*. 4. There is at least one NED with a background specific to the business of the ALB. 5. Where appropriate, the Board includes people with relevant technical and professional expertise. 6. There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer. 7. The majority of the Board are experienced Board members. 8. Where appropriate, the Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment. 9. The Chair of the Board has previous non-executive experience. 10. At least one member of the Audit Committee has recent and relevant financial experience.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Skills audit • Biographical information on each member of the Board

1. Board composition and commitment

1.3 Role of the Board

Red Flag	Good Practice
1. The Chair looks constantly to the Chief Executive to speak or give a lead on issues. 2. The Board tends to focus on details and not on strategy and performance. 3. The Board become involved in operational areas. 4. The Board is unable to take a decision without the Chief Executive's recommendation. 5. The Board allows the Chief Executive to dictate the Agenda. 6. Regularly, one individual Board member dominates the debates or has an excessive influence on Board decision making.	1. The role and responsibilities of the Board have been clearly defined and communicated to all members. 2. Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit. 3. There is a clear understanding of the roles of Executive officers and Non Executive Board members. 4. The Board takes collective responsibility for the performance of the ALB. 5. NEDs are independent of management. 6. The Chair has a positive relationship with the Minister and sponsor Department. 7. The Board holds management to account for its performance through purposeful, challenge and scrutiny. 8. The Board operates as an effective team. 9. The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence. 10. Board members respect confidentiality and sensitive information. 11. The Board governs, Executives manage. 12. Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function. 13. The Chair is a useful source of advice and guidance for Board members on any aspect of the Board. 14. The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken. 15. The Board considers the concerns and needs of all stakeholders and actively manages it's relationships with them. 16. The Board is aware of and annually approves a scheme of delegation to its committees.

	17. The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Terms of Reference • Board minutes • Job descriptions • Scheme of Delegation • Induction programme

1. Board composition and commitment

1.4 Committees of the Board

Red Flag	Good Practice
1. The Board notes the minutes of Committee meetings and reports, instead of discussing same. 2. Committee members do not receive performance management appraisals in relation to their Committee role. 3. There are no terms of reference for the Committee. 4. Non Executives are unaware of their differing roles between the Board and Committee. 5. The Agenda for Committee meetings is changed without proper discussion and/or at the behest of the Executive team.	1. Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board. 2. Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees. 3. Schemes of delegation from the Board to the Committees are in place. 4. There are clear lines of reporting and accountability in respect of each Committee back to the Board. 5. The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle. 6. The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made. 7. The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees. 8. It is clearly documented who is responsible for reporting back to the Board.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Scheme of delegation • TOR • Board minutes • Annual Evaluation Reports

1. Board composition and commitment

1.5 Board member commitment

Red Flag	Good Practice
1. There is a record of Board and Committee meetings not being quorate. 2. There is regular non-attendance by one or more Board members at Board or Committee meetings. 3. Attendance at the Board or Committee meetings is inconsistent (i.e. the same Board members do not consistently attend meetings). 4. There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved. 5. The Board or Committee has not achieved full attendance at at least one meeting within the last 12 months.	1. Board members have a good attendance record at all formal Board and Committee meetings and at Board events. 2. The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time. 3. Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair. 4. Board meetings and Committee meetings are scheduled at least 6 months in advance.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board attendance record • Induction programme • Board member annual appraisals • Board Schedule

2. Board evaluation, development and learning

2. Board evaluation, development and learning overview

This section focuses on Board evaluation, development and learning, and specifically the following areas:

1. Effective Board-level evaluation;
2. Whole Board Development Programme;
3. Board induction, succession and contingency planning;
4. Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

Red Flag	Good Practice
1. No formal Board Governance Self-Assessment has been undertaken within the last 12 months. 2. The Board Governance Self-Assessment has not been independently evaluated within the last 3 years. 3. Where the Board has undertaken a self assessment, only the perspectives of Board members were considered and not those outside the Board (e.g. staff, etc). 4. Where the Board has undertaken a self assessment, only one evaluation method was used (e.g. only a survey of Board members was undertaken).	1. A formal Board Governance Self-Assessment has been conducted within the previous 12 months. 2. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken. 3. The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 3 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations. 4. In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective. 5. The focus of the self assessment included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum: • The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this; • How effectively meetings of the Board are chaired; • The effectiveness of challenge provided by Board members; • Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various committees; • Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session. • The quality of relationships between Board members, including the Chair and CE. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.

Examples of evidence that could be submitted to support the Board's RAG rating.	• Report on the outcomes of the most recent Board evaluation and examples of changes/ improvements made in the Board and Committees as a result of an evaluation • The Board Scheme of Delegation/ Reservation of Powers

2. Board evaluation, development and learning

2.2 Whole Board development programme

Red Flag	Good Practice
1. The Board does not currently have a Board development programme in place for both Executive and Non-Executive Board Members. 2. The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.	1. The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual self assessment and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements. 2. Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities. 3. Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues. 4. Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve: • The focus and balance of Board time; • The quality and value of the Board's contribution and added value to the delivery of the business of the ALB; • How the Board responded to any service, financial or governance failures; • Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board; • The robustness of the ALB's risk management processes; • The reliability, validity and comprehensiveness of information received by the Board. 5. Time is 'protected' for undertaking this programme and it is well attended. 6. The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.
Examples of evidence that could be submitted to support the Board's RAG rating.	• The Board Development Programme • Attendance record at the Board Development Programme

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Red Flag	Good Practice
1. Board members have not attended the "On Board" training course within 3 months of appointment. 2. There are no documented arrangements for chairing Board and committee meetings if the Chair is unavailable. 3. There are no documented arrangements for the organisation to be represented at a senior level at Board meetings if the CE is unavailable. 4. NED appointment terms are not sufficiently staggered.	1. All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB. 2. Induction for Board members is conducted on a timely basis. 3. Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation's structure, ALB values and meetings with key leaders. 4. Deputising arrangements for the Chair and CE have been formally documented. 5. The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Succession plans • Induction programmes • Standing Order

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

Red Flag	Good Practice
1. There is not a robust performance appraisal process in place at Board level that includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received. 2. Individual Board members have not received any formal training or professional development relating to their Board role. 3. Appraisals are perceived to be a 'tick box' exercise. 4. The Chair does not consider the differing roles of Board members and Committee members.	1. The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair 2. The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation. 3. There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary). 4. Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis. 5. Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level. 7. Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Performance appraisal process used by the Board • Personal Development Plans • Board member objectives • Evidence of attendance at training events and conferences • Board minutes that evidence Executive Directors contributing outside their functional role and challenging other Executive Directors.

3. Board insight and foresight

3. Board insight and foresight overview

This section focuses on Board information, and specifically the following areas:

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

Red Flag	Good Practice
1. Significant unplanned variances in performance have occurred. 2. Performance failures were brought to the Board's attention by an external party and/or not in a timely manner. 3. Finance and Quality reports are considered in isolation from one another. 4. The Board does not have an action log. 5. Key risks are not reported/escalated up to the Board.	1. The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept. 2. The Board receives a performance report which is readily understandable for all members and includes: • performance of the ALB against a range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted and explained ; • Key trends and findings are outlined and commented on ; • Future performance is projected and associated risks and mitigating measures; • Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of performance to comparable organisations is included where possible. 3. The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made. 4. The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them. 5. An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Performance Report • Board Action Log • Example Board agendas and minutes highlighting committee discussions by the Board.

3. Board insight and foresight

3.2 Efficiency and Productivity

Red Flag	Good Practice
1. The Board does not receive performance information relating to progress against efficiency and productivity plans. 2. There is no process currently in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans. 3. Efficiency plans are based on a percentage reduction across all services rather than a properly targeted assessment of need. 4. The Board does not have a Board Assurance Framework (BAF).	1. The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans. 2. The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service. 3. The Board receives information on all efficiency and productivity plans on a regular basis**.** Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated. 4. There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Efficiency and Productivity plans • Reports to the Board on the plans • Post implementation reviews

3. Board insight and foresight

3.3 Environmental and strategic focus

Red Flag	Good Practice
1. The Board does not have a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc. 2. The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB. 3. The Board does not formally review progress towards delivering its strategies.	1. The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF). 2. The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up. 3. The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan. 4. The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis. 5. The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).
Examples of evidence that could be submitted to support the Board's RAG rating.	• CE report • Evidence of the Board reviewing lessons learnt in relation to enquiries • Outcomes of an external stakeholder mapping exercise • Corporate objectives and associated milestones and how these are monitored • Board Annual programme of work • BAF • Risk register

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Red Flag	Good Practice
1. Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing. 2. Board discussions are focused on understanding the Board papers as opposed to making decisions. 3. The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting. 4. Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision. 5. The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information	1. The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time. 2. A timetable for sending out papers to members is in place and adhered to. 3. Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion). 4. Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal meetings. 5. Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through. 6. The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place. 7. The Board can provide examples of where it has explored the underlying data quality of performance measures. This ensures that the data used to rate performance is of sufficient quality. 8. The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should be collected and quality assured. 9. Board members can demonstrate that they understand the information presented to them,

	including how that information was collected and quality assured, and any limitations that this may impose. 10. Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Documented information requirements • Data quality assurance process • Evidence of challenge e.g. from Board minutes • Board meeting timetable • Process for submitting and issuing Board papers • In-month reports • Board papers • Data Quality updates

3. Board insight and foresight

3.5 Assurance and risk management

Red Flag	Good Practice
1. The Board does not receive assurance on the management of risks facing the ALB. 2. The Board has not identified its assurance requirements, or receives assurance from a limited number of sources. 3. Assurance provided to the Board is not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that have historically been problematic. 4. The Board has not reviewed the ALB's governance arrangements regularly.	1. The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board. 2. The Board has identified the assurance information they require, including assurance on the management of key risks, and how this information will be quality assured. 3. The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc 4. The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services. 5. The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate. 6. An executive member of the Board has been delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Risk management policy and procedures • Risk register • Evidence of review of risks, e.g. Board minutes • Evidence of review of governance structures, e.g. Board minutes • Board Assurance Framework (BAF) • Clinical and Social care governance policy

4. Board engagement and involvement

4. Board engagement and involvement overview

This section focuses on Board engagement and involvement, and specifically the following areas:

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

4. Board engagement and involvement

4.1 External stakeholders

The statutory duty of involvement and consultation commits ALBs to developing PPI consultation schemes. These schemes detail how the ALB will consult and involve service users in the planning and delivery of services. The statutory duty of involvement and consultation does not apply to, NISCC, NIPEC, BSO and NIFRS. However, the Department would encourage all ALBs to put appropriate and proportionate measures in place to ensure that their service delivery arrangements are informed by views of those who use their services.

Under Section 75 (NI Act 1998) all ALBs have existing obligations and commitments to consult with the public, service users and carers in the planning, delivery and monitoring of services. Under Section 49a of the Disability Discrimination Act NI (1995) ALBs have a duty to promote the involvement of disabled people in public life.

Red Flag	Good Practice
1. The development of the Business Plan has only involved the Board and a limited number of ALB staff. 2. The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc. 3. Feedback from clients is negative e.g. complaints, surveys and findings from regulatory and review reports. 4. The ALB has failed to manage adverse negative publicity effectively in relation to the services it provides in the last 12 months. 5. The Board has not overseen a system for receiving, acting on and reporting	1. Where relevant, the Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services. 2. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 3. The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan. 4. The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan.

outcomes of complaints.	5. The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide 6. The ALB has constructive and effective relationships with its key stakeholders.
Examples of evidence that could be submitted to support the Board's RAG rating.	• PPI Consultation Scheme • Complaints • Customer Survey • Regulatory and Review reports

4. Board engagement and involvement

4.2 Internal stakeholders

Red Flag	Good Practice
1. The ALBs latest staff survey results are poor. 2. There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with staff side/trade unions etc.). 3. There are significant unresolved quality issues. 4. There is a high turn over of staff. 5. Best practise is not shared within the ALB.	1. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 2. The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have been included and not included. 3. The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities. 4. The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to service delivery and the running of the ALB. 5. The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these valves will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the ALB's stated values/behaviours. 6. There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Staff Survey • Grievance and disciplinary procedures • Whistle blowing procedures • Code of conduct for staff • Internal engagement or communications strategy/ plan.

4. Board engagement and involvement

4.3 Board profile and visibility

Red Flag	Good Practice
1. With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board. 2. Attendance by Board members is poor at events/meetings that enable the Board to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions).	1. There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made. 2. There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders. 3. Board members attend and/or present at high profile events. 4. NEDs routinely meet stakeholders and service users. 5. The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board programme of events/ quality walkabouts with evidence of improvements made • Active participation at high-profile events • Evidence that Board minutes are publicly available and summary reports are provided from private Board meetings

5. Board Governance Self- Assessment Submission

Name of ALB **Southern Health and Social Care Trust**

Date of Board Meeting at which Submission was discussed

Approved by …….....(ALB Chair)

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *August 2019*

1.1 Board positions and size

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The size of the Board (including voting and non-voting members of the Board) and Board committees is appropriate for the requirements of the business. All voting positions are substantively filled.* Size of the Board is in accordance with the Southern Health and Social Services (Establishment) Order (N Ireland) 2006, Health and Social Services Trusts (Membership and Procedure) Regulations (NI) 1994. Permanent recruitment into 4 Director vacancies during 2018/19 Interim Executive Director of Nursing, Midwifery and AHP in place from January 2018. With effect from 7.3.2019 Chair position extended for 12-month period until March 2020. With effect from 29.8.2019, one NED position extended for 12-month period to August 2020. In July 2019 approval was received from Department of Health to recruit a permanent	The Trust will proceed to advertise the Executive Director of Nursing, Midwifery and AHP post on a permanent basis in 2019/20.	Approval was awaited from Department of Health in 2018/19 to advertise this post on a permanent basis.	None identified

	Executive Director of Nursing, Midwifery and AHP post. **Evidence** Board Minutes Job Descriptions Biographical information on each Board member			
GP2	*The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge its responsibilities.* **Evidence** Standing Orders and Standing Financial Instructions Management Statement/ Financial Memorandum Board Development Programme Board Assurance Manager Attendance at subject specific events	None required	Not applicable	None identified
GP3	*It is clear who on the Board is entitled to vote.* **Evidence** Addressed in Standing Orders	None required	Not applicable	None identified
GP4	*The composition of the Board and Board committees accords with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders.* **Evidence** Standing Orders	None required	Not applicable	None identified

GP5	*Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time*. **Evidence** NEDs appointments staggered – letters of appointment	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Chair and Chief Executive positions are filled. With effect from 7.3.2019, Chair position extended for 12-month period.
RF2	None identified	More than 50% of the Board has remained constant in the previous two years. Membership of Trust Board stabilised during 2018/19 with 4 permanent appointments at Director level.
RF3	None identified	There is a high attendance at Board meetings. Non attendance is by agreement with the Chair and a nominated Deputy attends in a Director's absence. Attendance at Board meetings is included in the Trust's Annual Governance Statement.

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *August 2019*

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan.* Current balance of skills deemed appropriate Allocation of NEDs to Sub Committees of the Board based on their skills, experience and knowledge **<u>Evidence</u>** Biographical information Committee membership Appraisals process	None required	Not applicable	None identified

GP2	*The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors.* Yes – good balance from public, private and voluntary sector **Evidence** Biographical information Declaration/Register of Interests	None required	Not applicable	None identified
GP3	*The Board has had due regard under Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without.* **Evidence** Equality Scheme approved by Trust Board Board Minutes S75 Annual Progress Report to Trust Board	None required	Not applicable	None identified
GP4	*There is at least one NED with a background specific to the business of the ALB.* Yes	None required	Not applicable	None identified

	Evidence Biographical information			
GP5	*Where appropriate, the Board includes people with relevant technical and professional expertise.* **Evidence** Biographical information Directors' Job Descriptions	None required	Not applicable	None identified
GP6	*There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer.* Yes there is an appropriate balance of Directors and NEDs that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer. **Evidence** Board membership	None required	Not applicable	None identified
GP7	*The majority of the Board are experienced Board members* Yes – the majority of the Board are experienced Board members. **Evidence** Biographical information	None required	Not applicable	None identified

GP8	*Where appropriate, the Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment.* Yes – the Chair of the Board has a demonstrable and recent track record of working in a large and complex organisation **Evidence** Biographical information	None required	Not applicable	None identified
GP9	*The Chair of the Board has previous non-executive experience.* Yes – the Chair has previous Non Executive experience **Evidence** Biographical information	None required	Not applicable	None identified
GP10	*At least one member of the Audit Committee has recent and relevant financial experience.* Yes – the Chair of the Audit Committee has recent and relevant financial experience **Evidence** Biographical information	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	NED Chair of Audit Committee has a recent and relevant financial background
RF2	None identified	NEDs with current or recent (within the previous 2 years) experience in the private/commercial sector
RF3	None identified	Majority of Board members are not in their first Board position
RF4	None identified	Majority of members have served on the Board > 18 months.
RF5	None identified	Balance of Directors/Non Executive Directors is correct
RF6	None identified	All Non Executive Directors in post

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *August 2019*

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The role and responsibilities of the Board have been clearly defined and communicated to all members.* **Evidence** Standing Orders Induction Programme Job Descriptions Code of Conduct and Code of Accountability Management Statement/Financial Memorandum - reviewed by the Board on an annual basis	None required	Not applicable	None identified
GP2	*Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit.* Chair ensures Board members are clear on Ministerial priorities and direction	None required	Not applicable	None identified

	Evidence Management Statement/Financial Memorandum Code of Accountability Directors Workshop agenda on Strategic Direction – 18.4.2019			
GP3	*There is a clear understanding of the roles of Executive officers and Non Executive Board members.* **Evidence** Job Descriptions Code of Conduct and Code of Accountability Management Statement/Financial Memorandum Standing Orders	None required	Not applicable	None identified
GP4	*The Board takes collective responsibility for the performance of the ALB.* **Evidence** Performance Framework Board Minutes attest to level of scrutiny and challenge applied to performance	None required	Not applicable	None identified

	Code of Conduct and Code of Accountability Management Statement/Financial Memorandum Standing Orders Reports to Trust Board – Performance, Finance, Workforce Board Assurance Framework Approval of Annual Report and Accounts			
GP5	*NEDs are independent of management.* Yes – NEDs are independent of management **Evidence** Job Descriptions Articulated in Codes of Conduct and Accountability Board Minutes to demonstrate challenge function	None required	Not applicable	None identified
GP6	*The Chair has a positive relationship with the Minister and sponsor Department.* Yes **Evidence** Minutes of Mid and Year End Accountability Review meetings	None required	Not applicable	None identified

GP7	*The Board holds management to account for its performance through purposeful, challenge and scrutiny.* **Evidence** Challenge and scrutiny function evident from Board Minutes Monthly performance and finance reports to Trust Board Scrutiny of Governance Statement, Annual Report and Accounts Trust Delivery Plan Formal Scheme of Delegation	None required	Not applicable	None identified
GP8	*The Board operates as an effective team.* **Evidence** Board meeting reflection at end of each meeting Feedback from Board Development Programme Consensus approach to decision-making evidenced in Board minutes IA Report on Board Effectiveness – satisfactory level of assurance	None identified	Not applicable	None identified

GP9	*The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence.* **Evidence** Board Minutes Robust system of identifying matters arising and follow up (action log)	None identified	Not applicable	None identified
GP10	*Board members respect confidentiality and sensitive information.* **Evidence** Trust Board confidential section for sensitive information Board Behaviours Information Governance training	None identified	Not applicable	None identified
GP11	*The Board governs, Executives manage.* Yes – The Board confirms that it governs the organisation and holds the Executive Team to account through purposeful challenge and scrutiny. **Evidence** Board Minutes and Action log	None identified	Not applicable	None identified
GP12	*Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function.* Board members contribute to Board discussions and challenge the Executive Team.	None identified	Not applicable	None identified

	Evidence Board Minutes			
GP13	*The Chair is a useful source of advice and guidance for Board members on any aspect of the Board.* Yes – Chair well informed and provides updates on actions/activities/key developments at Board meetings **Evidence** Board meeting review questionnaires Board Minutes	None identified	Not applicable	None identified
GP14	*The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken.* The Chair allows open discussion before decisions are made. Board Minutes attest to this. **Evidence** Board meeting review report evidences good Chairmanship Board Minutes	None identified	Not applicable	None identified

GP15	*The Board considers the concerns and needs of all stakeholders and actively manages its relationships with them.* **Evidence** Trust Board meetings held in public Specific meetings with interested groups PPI Consultation Scheme Consultations on Trust Strategies engage stakeholders during development	None identified	Not applicable	None identified
GP16	*The Board is aware of and annually approves a scheme of delegation to its committees*. **Evidence** Scheme of Delegation from Board to Committees approved by Board annually	None identified	Not applicable	None identified
GP17	*The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes*. Board delegated responsibility to the Audit Committee **Evidence** Annual summary report of PPEs completed on Capital and Revenue proposals > £300,000 to Audit Committee Audit Committee agenda and minutes	None identified	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Via Trust Board Minutes
RF2	None identified	Via Trust Board Minutes
RF3	None identified	Via Trust Board Minutes
RF4	None identified	Via Trust Board Minutes
RF5	None identified	Via Trust Board Minutes
RF6	None identified	Via Trust Board Minutes

1. Board composition and commitment **ALB Name** ***Southern HSC Trust*** **Date** ***August 2019***

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board.* **Evidence** Clear Terms of Reference for each Committee in place and approved by Trust Board Scheme of Delegation	None required	Not applicable	None identified
GP2	*Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees.* **Evidence** The Board recognises that it carries responsibility for the actions of its Committees. Reflected in: – **Evidence** Scheme of Delegation Terms of Reference	None required	Not applicable	None identified

GP3	*Schemes of delegation from the Board to the Committees are in place.* **Evidence** Scheme of Delegation	None required	Not applicable	None identified
GP4	*There are clear lines of reporting and accountability in respect of each Committee back to the Board.* **Evidence** Scheme of Delegation Terms of Reference Committee Minutes to Trust Board Committee Annual Reports to Trust Board Board Minutes Governance High Level Organisational Chart	None required	Not applicable	None identified
GP5	*The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle.* **Evidence** Board Assurance Framework Terms of Reference approved by Trust Board on an annual basis	None required	Not applicable	None identified

	Workplan/Schedule of Reporting in place for each Committee and agreed by Trust Board on an annual basis Trust Board Annual Cycle			
GP6	*The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made.* **Evidence** Board template completed by Committee Chairs highlighting key issues Formal report from Audit Committee Chair to Trust Board Committee Minutes Board Minutes	None required	Not applicable	None identified
GP7	*The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees.* **Evidence** Annual Evaluation undertaken and reported via Committees' Annual Reports Audit Committee self-assessment in line with NIAO guidance	None required	Not applicable	None identified

GP8	*It is clearly documented who is responsible for reporting back to the Board.* **Evidence** Responsibility of Committee Chairs as per Terms of Reference	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Meetings of Committee meetings are presented by relevant Chair and these are discussed and approved by the Board.
RF2	None identified	NED appraisals include discussion on the Sub Committees they Chair
RF3	None identified	Terms of Reference in place for all Committees
RF4	None identified	NEDs fully aware of the differing roles between the Board and Committees. NED Induction programme.
RF5	None identified	Draft agendas for Committee meetings are drafted by the Board Assurance Manager/Committee Secretary with input from Directors, as required, prior to approval by the Committee Chair

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *August 2019*

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*Board members have a good attendance record at all formal Board and Committee meetings and at Board events.* Attendance rates of Board members at Trust Board and Committee meetings has been excellent with attendance rates of 80-100% during 2018/19, with the exception of Patient and Client Experience Committee. **<u>Evidence</u>** Board attendance as evidenced in Board and Committee attendance records. These are presented to the Board for review on an annual basis as part of the Annual Reports from Committees. Board Development Programme attendance record Board and Committee Minutes Annual Performance Appraisal of NEDs identifies high attendance at events and meetings	The Chair of the Patient and Client Experience Committee has addressed the issue of attendance and will keep this under review during 2019/20	Attendance rate of 80 – 100% not achieved at Patient Client Experience (PCE) Committee meetings.	None identified

GP2	*The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time.* **Evidence** Board Behaviours Good Practice Principles for Board and Committees Reinforced by Chair at Board meetings – Board Minutes Induction Programme	None required	Not applicable	None identified
GP3	*Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair.* **Evidence** All Board members have received a copy of the Codes of Conduct and Accountability Compliance with the Codes included as part of NED annual appraisal – NED Annual Appraisal form	None required	Not applicable	None identified

GP4	*Board meetings and Committee meetings are scheduled at least 6 months in advance.* **Evidence** *Yes* - Board and Committee Schedule Board Minutes	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	No record of Board or Committee meetings not being quorate.
RF2	None identified	There is no regular non-attendance by one or more Board members at Board or Committee meetings. All non-attendance at Board meetings is reviewed by the Chair and all non-attendance at Committee meetings is reviewed by the respective Committee Chair.
RF3	None identified	Non attendance is by agreement with the Chair and a nominated relevant Deputy attends in a Director's absence.
RF4	None identified	Board members behave consistently as per Code of Conduct and Code of Accountability
RF5	None identified	Attendance at Board and Sub Committees is reviewed annually and included in the Committee's Annual Report to Trust Board. The PCE Committee Chair continues to reinforce with members the importance of full attendance.

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *August 2019*

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*A formal Board Governance Self-Assessment has been conducted within the previous 12 months.* **Evidence** Board Governance Self-Assessment was completed at Workshop on 13th June 2019 and will be presented to Trust Board at meeting in August 2019 for approval. (Note – no requirement to submit to Department of Health)	None required	Not applicable	None identified
GP2	*The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken.* **Evidence** Board Self-Assessment Action Plan in place. Updated and reviewed each year. 3 red flag areas identified in previous year's assessment have all been addressed in 2018/19 – recruitment to vacant Director	None required	Not applicable	None identified

	posts, maximising attendance at Trust Board meetings and completion of Directors' appraisals and objectives. Committee self-assessments and action plans			
GP3	*The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 3 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations.* **Evidence** Independent input required at least once every 3 years and this was included in Internal Audit report on Board Effectiveness to Board Workshop on 13th June 2019.	None required	Not applicable	None identified
GP4	*In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective.* **Evidence** Staff Surveys Top down approach adopted following outcome of Staff Survey to encourage engagement	The Board continues to utilise the information gathered from these sources as a potential indicator of board effectiveness.		

	Attendance of staff at Trust Board meetings to share examples that epitomise what Trust business is about Attendance of staff and Assistant Directors at Trust Board meetings and their perspective sought via questionnaire Perspectives of public attendees at Board meetings sought via questionnaire Leadership Walks to raise understanding/seek views/ test understanding on the front line Chair's meetings with regular attendees at Trust Board to seek their perspective on whether or not they perceive Board to be effective			
GP5	*The focus of the self assessment included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness.* **Evidence** Board Development Programme in place which includes time out for the Board to reflect on its effectiveness and focus for the future Short period of reflection by members at end of each Board meeting.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	
RF2	None identified	
RF3	None identified	
RF4	None identified	

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *August 2019*

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual self assessment and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance* arrangements. **<u>Evidence</u>** Board Development Programme 2018/19 – ongoing series of workshops on strategy, accountability, culture and effective Board reporting. Board Development Day on 15th November 2018 facilitated by The King's Fund. On Board training completed for Board members Board members Induction programme	None required	Not applicable	None identified

GP2	*Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities.* **Evidence** Management Statement reviewed by the Board on an annual basis Codes of Conduct and Accountability	None required	Not applicable	None identified
GP3	*Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues.* **Evidence** Governance arrangements – monitored by Governance Committee.	None required	Not applicable	None identified
GP4	*Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve.* **Evidence** Board Development Programme allows protected	None required	Not applicable	None identified

	time for reflection and improvement. This includes the balance of Board time, the quality and value of the Board's contribution, the effectiveness of the processes and structures that support it. As a result, recommendations and action points are agreed to ensure the ongoing development of the Board in any identified areas.			
GP5	*Time is 'protected' for undertaking this programme and it is well attended.* **Evidence** Board Development Day is scheduled one year in advance and is well attended. Attendance record	None required	Not applicable	None identified
GP6	*The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges*. Board Workshops provide time out for members to think about the Board as a whole and its training and developmental needs. Involvement of the Board in planning/strategy was an area of development identified and		Not applicable	None identified

	work in this area has commenced and will continue during 2019/20 **<u>Evidence</u>** Workshop agendas focusing on vision, strategy and culture			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Board Development Programme in place
RF2	None identified	None required

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *August 2019*

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB.* **Evidence** Induction Programme Mentor system in place for new NEDs Induction Checklist On Board programme	None required	Not applicable	None identified
GP2	*Induction for Board members is conducted on a timely basis.* **Evidence** Induction Programme	None required	Not applicable	None identified

GP3	*Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation's structure, ALB values and meetings with key leaders.* **Evidence** Induction Programme supported by Board Mentor system Individual Directorate presentations Meetings with Directorates	None required	Not applicable	None identified
GP4	*Deputising arrangements for the Chair and CE have been formally documented.* **Evidence** Appropriate deputising arrangements in place for when the Chair and Chief Executive are not available	None required	Not applicable	None identified
GP5	*The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.* **Evidence** Senior Management Team Development Programme	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	New Board members have attended the On Board training within 3 months of appointment
RF2	None identified	Documented arrangements in place for Chairing Board and Committee meetings if the Chair is unavailable.
RF3	None identified	Documented arrangements in place in respect of how the organisation is to be represented at a senior level at Board meetings if the Chief Executive is unavailable.
RF4	None identified	The Chair has raised this issue on a regular basis with the Department of Health and NED appointments are now staggered.

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *August 2019*

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair* **Evidence** Annual Performance Appraisals of NEDs completed annually by the Chair – dates scheduled for 2018/19 round	None required	Not applicable	None identified
GP2	*The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation.* **Evidence** Annual Performance Appraisals of Directors completed annually by the Chief Executive – dates scheduled for 2018/19 round One to one meetings held by the Chair with Directors in early 2019/20 to assess/evaluate their performance on the Board	None required	Not applicable	None identified

GP3	*There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary).* **Evidence** Process in place, but not yet completed for 2018/19	Note: Date awaited from Deputy Secretary's office for Chair's performance appraisal meeting for 2018/19.	Department is responsible for co-ordinating the appraisal process.	None identified
GP4	*Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis.* **Evidence** Annual Appraisal form for NEDs Directors' Performance Appraisals which address personal development needs Objectives set for Directors by Chief Executive In the case of the Chief Executive, this is undertaken by the Chair	None required	Not applicable	None identified
GP5	*Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role.* **Evidence** Assessment forms have an option for members to detail specific issues for the coming year	None required	Not applicable	None identified

GP6	*As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.* **Evidence** Board Minutes demonstrate challenge function Development of reporting to Trust Board	None required	Not applicable	None identified
GP7	*Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification*. **Evidence** All Board members subscribe to the Code of Conduct and, where appropriate, comply with the requirements of their respective professional bodies.	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Robust performance appraisal process in place.
RF2	None identified	Induction programme. Formal training and development and/or professional development is encouraged and in operation.
RF3	None identified	Time is set aside for appraisals and these are undertaken in a timely fashion for NEDs. Process to identify training needs of NEDs commences well in advance of appraisal meeting.
RF4	None identified	The Chair fully considers the differing roles of Board and Committee members.

3. Board insight and foresight ALB Name *Southern HSC Trust* Date *August 2019*

3.1 Board performance reporting

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept.* **Evidence** Board Performance Reports – Finance, Performance, Human Resources Board Minutes	None required	Not applicable	None identified
GP2	*The Board receives a performance report which is readily understandable for all members.* The Board continues to work to refine and improve performance reporting **Evidence** Monthly Board Performance Report Board Minutes	None required	Not applicable	None identified

GP3	*The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made.* **Evidence** Board Report Template outlining key issues arising from each Committee completed by Committee Chairs Board Agenda and Minutes highlighting Committee discussions	None required	Not applicable	None identified
GP4	*The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them.* **Evidence** Board Reports Board Minutes Board Assurance Framework and Corporate Risk Register	None required	Not applicable	None identified

GP5	*An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account*. **Evidence** Template in place for Board and Committee meetings where individuals and timescales are identified and progress actively monitored at subsequent meetings.	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Performance reports report significant unplanned variances and reasons for same
RF2	None identified	No performance failures were brought to the Board's attention by an external party
RF3	None identified	Finance, Performance and Quality reports considered together
RF4	None identified	Action log in place
RF5	None identified	Key risks reported/escalated to the Board as and when required

3. Board insight and foresight ALB Name *Southern HSC Trust* Date *August 2019*

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans.* **Evidence** Trust Delivery Plan includes productivity and efficiency plans Financial Plans included within Trust Delivery Plan and reported on via Finance Reports to Trust Board Monthly Performance Reports to Trust Board Minutes of Trust Board meetings and Directors' Workshop Notes on specific risks/projects Board Assurance Framework	None required	Not applicable	None identified

GP2	*The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service.* **Evidence** Community Equipment Plan CHKS 'Top 40' Financial Plan	None required	Not applicable	None identified
GP3	*The Board receives information on all efficiency and productivity plans on a regular basis. Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated.* **Evidence** Financial Plan includes efficiency and productivity plans Issues reported to Trust Board on an exception basis	None required	Not applicable	None identified
GP4	*There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.* **Evidence** Accountability Review meetings PPEs to Audit Committee Board Assurance Framework	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Board receives regular performance information relating to progress against efficiency and productivity plans
RF2	None identified	Process in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans.
RF3	None identified	Financial Planning process considers where potential savings can be made with least impact on quality of care
RF4	None identified	Board Assurance Framework which is approved by the Board on an annual basis

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3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF).* **Evidence** Chief Executive's report is a standing item on the Trust Board agenda Board Minutes Directors' Workshops Board Assurance Framework	None required	Not applicable	None identified
GP2	*The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up.* **Evidence** Board agendas and minutes.	None required	Not applicable	None identified

	Where further action/assurance is required, Trust Board remit to Governance Committee to monitor progress			
GP3	*The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan.* **Evidence** Update on progress against objectives provided at mid and year end and RAG rated	None required	Not applicable	None identified
GP4	*The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis.* **Evidence** Corporate Objectives defined in Corporate Plan 2017/18 – 2020/21 with focus on actions required to support the Trust's vision and corporate objectives. Compliance against the Corporate Plan is monitored throughout the year and reported to Trust Board. Minutes and papers for Accountability Reviews	None required	Not applicable	None identified

GP5	*The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).* **Evidence** Annual Board Cycle of Work Environmental and Strategic risks actively monitored through the Board Assurance Framework Directors Workshops for strategic planning	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Board has a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plans etc.
RF2	None identified	The Board as a programme of work in place. Workshops also regularly consider environmental and strategic risks.
RF3	None identified	The Board regularly reviews progress towards delivering its strategies.

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3.4 Quality of Board papers and timeliness of information

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time.* **Evidence** Schedule of Board and Committee meetings take account of month and year end procedures and key dates Annual Business Cycle Board meetings take place on last Thursday of the month to allow timely presentation of information	None required	Not applicable	None identified