Maximising the value of Non Executive Directors

- ✓ Trust Board and Committees
- ✓ Children's Homes
- ✓ Other Interested Areas
  - Adoption Panel (Pauline)
  - Welfare Reform (Pauline)
  - Raising Concerns (John)
  - Quality Improvement (John) – move to annual rotation across all Non Executives
  - IHRD (Eileen, Geraldine & Martin)
  - Lessons Learned (Martin) – will attend once more and come back with thoughts
  - Excellence Awards – All
  - Consultant interview panels (Chair) with Non Executives as back up
  - Young Peoples Pledge (Pauline)

- What we are stopping Non Executive involvement:
  - NEWS, M&M sub groups
  - Undergraduate/Postgraduate
  - Information Oversight Forum
  - Organ Donation Committee
  - Patient client Experience Steering Group
  - Project ECHO

- **What about these?**
  - HR – Maintaining High Professional Standards
  - Independent Panel Members for Consultant job Planning Appeals (DOH)
  - Adult Safeguarding Vulnerable Adults Lead
  - PPI Lead responsibility
  - Carers/Community Development Lead responsibility

Southern Health and Social Care Trust

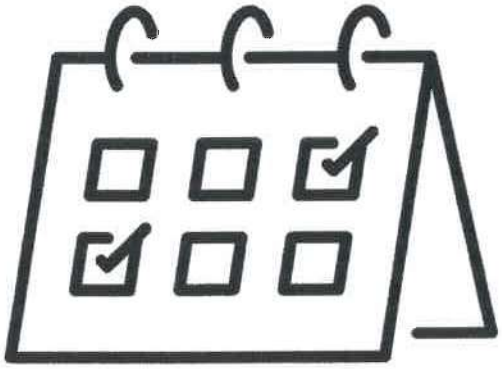
How Chair and Chief will work

- How we will work together
  - In partnership
  - No surprises
  - Office of the Chair and Chief Executive
- Communication
  - Collective Trust Board communication
  - Strategic Corporate communication (internal and external)
- Trust Board Workshops for 2021
  - Strategy, Culture and Accountability
  - Risk Appetite
  - Muckamore (Leadership and Governance)
  - Hyponatraemia (TBA)
- In partnership with the Department
  - Minister, PS, Chair and Chief
  - HSC Chairs Forum

JUNE 2023

Southern Health and Social Care Trust

Working together Excellence Openness & Honesty Compassion



A time of change

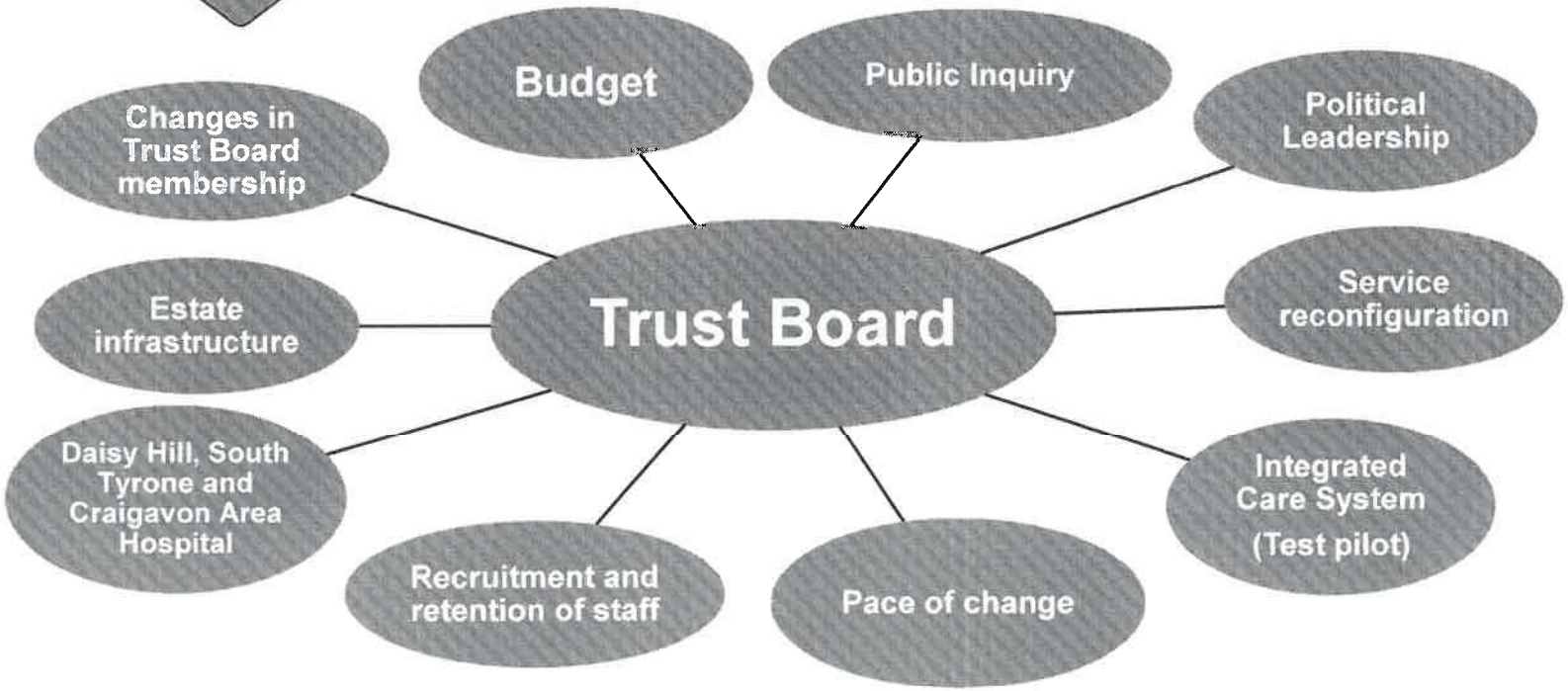
The next 18 months

TRUST BOARD

SQIE

HSC Southern Health and Social Care Trust

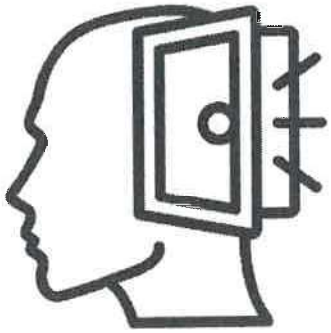
The Landscape



Southern Health and Social Care Trust

Working together Excellence Compassion

Open and Transparent



How this will be delivered

- Face to face meetings Trust Boardrooms
  - Newry, Craigavon and South Tyrone
- Public attendance in person and virtually
- Involving patients and staff
- Streaming meetings live
- Calendar of meetings (next 18 months)
- Trust website repository for Board Meetings
  - Recording and storing meetings online
  - All Board papers/pack online post meeting

Southern Health and Social Care Trust

Chair and CEO

What this looks like

- A shared vision – local/regional
- Corporate Plan 2023/24
- Where to from here? – what is the strategy
- Working in partnership
  - Importance of relationships – supportive/challenging/safe
  - Two weekly detailed 1:1 (time protected)
  - Less formal weekly touch points
- Visible leadership together
  - We come to you – wherever you are.

Southern Health and Social Care Trust

Trust Board and Committees

What this looks like

- Focus on patients and staff
- Dynamic with permission to disagree
- Psychologically safe
- The right agendas with the right papers at the right time
- Cover sheets that tell the story

Adding Value

Decision Time

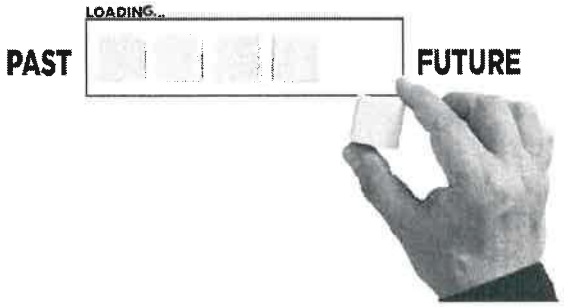
an Advanced company

Southern Health and Social Care Trust

Working together Excellence Openness & Honesty Compassion

Improving the governance

- **Corporate, clinical and social care**
- **Learning from Urology Public Inquiry**



- **New/Reprofiled Board Committees**
  - Finance and Performance
  - Audit & Risk Assurance
  - Strategic Change and Innovation
- **New Operational Steering Groups**
  - **Risk and Assurance Group**
    - Good governance
    - Standards, compliance and regulation
    - Safety and quality
- **Urology Public Inquiry**
  - Urology Lookback Review
  - Quality Assurance Steering Group
  - External Reference Group

Southern Health and Social Care Trust

Beyond the Boardroom

What this looks like

- Visible Leadership
  - Leadership Walks – NED's/Executive/Operational Directors
- Partnerships
  - Local population
  - Community & Voluntary Sector
  - Local Councils
  - Local elected representatives
  - Health and Social Care Family
- Working together
  - Minister
  - Department of Health
  - NICON, Public Chairs Forum

Southern Health and Social Care Trust

The next 18 months

- Challenges – Internally/Externally
- Important decisions to make
- Shaping organisational culture
- Embedding corporate changes at pace
- Need for agility and responsiveness
- Courage, curiosity and commitment

HSC Values

Working together

Excellence

Openness & Honesty

Compassion

SHSCT MID-YEAR ACCOUNTABILITY MEETING

Wednesday 25 January 2023, Castle Buildings

Note of Meeting

SHSCT Attendees:

Eileen Mullan **- EM**	Chair of the Board
Dr Maria O'Kane - **MOK**	Chief Executive

DOH Attendees:

Peter May – **PM**	Permanent Secretary
Jim Wilkinson - **JW**	EBM Sponsor
Carol Blee – **CB**	HSC Sponsor Branch

1. Welcome and Introduction

1.1 Following introductions, PM welcomed the return of the accountability meeting and explained the meetings' importance in context of the overall Assurance Framework. He highlighted that the upcoming move to Partnership Agreements would help to change the relationship between the Department and the Trust. MOK welcomed the move to Partnership Agreements particularly the opportunity for ongoing evaluation.

1.2 PM stated that the while the Department retained the need for accountability, it wanted to be fair in terms of its requirements. He said the Department would be happy to discuss any onerous Departmental requirements particularly those which did not add value to either party.

1.3 There was a general discussion on challenges facing the HSC system from the need to reconfigure services hospital services regionally and locally, to pressures in the primary care model. MOK said she felt there was a lot of duplication across the region, but that both senior managers and service users understood the need for change. Specifically in relation to primary care MOK highlighted challenges around

the roll out of the current MDT model. JW stated that the MDT model could be revisited and reviewed while PM agreed that this could include the grading of staff. EM suggested it was time to look at alternative ways to deliver primary care.

2 Financial Position

2.1 PM provided an overview on the current Departmental financial position, including the 3% - 5% efficiency plans, and he encouraged the Trust to focus on efficiency across the system.

2.2 PM thanked MOK for agreeing to be the Efficiency Champion on the PTEB Group looking at how waste can be reduced, and efficiency improved. There was a general discussion about off contract agency spend, including the opportunity presented by the new contracts, the need for Trusts to act collectively, and the importance of effective rostering.

2.3 PM asked EM how the Trust Board oversees Finance and Performance. EM explained that a Performance Committee was set up two years ago to ensure that performance gets close attention. She said that the committee reports to the Trust Board with any urgent issues escalated to the Chief Executive and Chair. She went on to explain that the committee delves deeply on particular issues and the Chair highlights issues via reports and action plans.

2.4 EM advised that the Trust does not have a Finance Committee, but a review of Corporate Clinical and Social Care Governance recommended that finance be built into a Board committee. The Trust plan to create a joint Finance and Performance committee with the Terms of Reference being created to focus on both. The aim is to have the Committee in place between April and June 2023. EM said the intention is this new Committee would provide the necessary scrutiny that would support performance management and efficiency.

2.5 PM asked for an update on the SHSCT financial position. MOK acknowledged that the Trust is projecting a break-even however she highlighted

that uncommissioned beds and use of agency staff particularly in relation to theatre staffing were causing pressures.

3 Performance

3.1 PM acknowledged there were areas where the Trust was performing well such as outpatient services and Echo and other areas where improvements could be made. MOK highlighted that the unlike other Trusts SHSCT had just one Cath Lab which had broken down three times in the last two years. She suggested the Trust needs an addition Cath Lab to build resilience. MOK went on to raise the need for regional waiting lists and suggested that a regional approach would help reduce lists PM also raised the issue of waiting lists and outliers and had asked the Trust to look at all patients on lists for over 5 years to make progress.

4 Ambulance Turn Around Times

4.1 PM welcomed the progress that was being made on ambulance turn around times and acknowledged the challenges in Craigavon Area Hospital.

5 Industrial Action

5.1 PM acknowledged the challenges Industrial Action would cause the Trust this week.

6 Workforce

6.1 Discussion took place on Community and District Nursing. MOK suggested that alternative thinking on the nursing model was needed. PM agreed and the need to look both at skills mix and additional pathways.

6.2 Discussion followed on Domiciliary Care and the SEHSCT Pilot. MOK acknowledge the need to monitor community provision and look at how time is being utilised PM advised Peter Toogood, Social Services Policy Group would be working on a plan to grow social care especially domiciliary care subject to funding.

EM highlighted that Southern Regional College offer Healthcare Assistant training and suggested that the FE sector could be utilised to help build the workforce. JW agreed and suggested that accredited training needed to be linked to career pathways for Domiciliary Care.

7 Estate Buildings

7.1 PM welcomed the announcement of the Daisy Hill Hospital electrical upgrade. He acknowledged the need for new build in SHSCT but highlighted that the capital budget for the next 3/4 years was very challenging, and no guarantees could be made at this time which he understood was disappointing. EM asked if capital budget could be found from other sources such as Levelling up, Peace II or private investment. She gave an example of UK new build that had been funded differently with a range of sources. PM acknowledged it would be worth exploring and he was happy to engage further on the issue.

8 Urology Inquiry

8.1 PM recognised the impact of the Inquiry on the SHSCT, and discussion took place on impact on staff. MOK said she felt staff and been open and honest to the Inquiry EM highlighted the pressure the team had been under while also doing their day jobs and welcomed the leadership shown.

8.2 MOK advised that SPPG had been asked to help and options were being worked through. JW acknowledged the challenge of having capacity in place to service the Inquiry and identifying patients who have been negatively impacted and manage normal workloads, this was a key challenge, and it was critical that the Trust develop a plan, with SPPG to manage this.

9. AOB

No further business was raised, and the meeting was brought to a close.

HSC Business Services Organisation

Southern Health & Social Care Trust

Board Effectiveness 2018/19

nqa. ISO 9001 Registered Quality Management

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Acknowledgement

Internal Audit wishes to thank management and staff at the Southern Health & Social Care Trust for their assistance and co-operation during the course of the audit engagement.

Control Log

Exit Meeting Held On:	25 March 2019 (Chair)
First Draft Issued On:	1 April 2019
Management Meeting On:	3 June 2019
Management Actions Due By:	4 April 2019
Management Actions Received:	2 September 2019
Final Report Issued On:	3 September 2019

Distribution List

Roberta Brownlee	Chair (Final report only)
Shane Devlin	Chief Executive
Sandra Judt	Board Secretary
Helen O'Neill	Director of Finance, Procurement & Estates
Alison Rutherford	Assistant Director of Finance

Introduction

In accordance with the 2018/19 annual internal audit plan, BSO Internal Audit carried out an audit of Board Effectiveness during February/March 2019. The last Internal Audit of this topic was performed during February / March 2016 when satisfactory assurance was provided.

The Board Governance 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. Good governance best practice requires Boards to carry out a board effectiveness evaluation annually and with independent input at least once every three years. The Self-Assessment was completed by the Trust during March to June 2018 and was used to self-assess the Trust Board capacity and capability supported by appropriate evidence. This assignment reviewed the results of that self-assessment.

The Trust Board has seven key functions for which they are held accountable by the Department on behalf of the Minister:

- To set the strategic direction of the organisation within the overall policies and priorities of the HPSS, define its annual and longer term objectives and agree plans to achieve them;
- To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;
- To ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;
- To appoint appraise and remunerate senior executives; and
- To ensure that there is effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
- To ensure that the HSC body has robust and effective arrangements in place for clinical and social care governance and risk management.

To ensure these functions are carried out effectively the SHSCT's governance structure is underpinned by a number of key documents including the Management Statement and Financial Memorandum and the Standing Orders (SOs), Standing Financial Instructions (SFIs), Integrated Governance Framework 2017/18 – 2020/21, Corporate and Annual Business plans. The Board, is supported by 5 Sub-Committees:

1. Governance Committee;
2. Audit Committee;
3. Remuneration Committee;
4. Endowments & Gifts Committee; and
5. Patient Client Experience Committee.

During 2018/19, a number of previously vacant or interim posts within the Executive SMT were filled on a permanent basis, and this improved stability has positively impacted the operation of the Trust Board. In addition to the board meetings, 4 board workshops have been held during the second half of 2018/19, to address the Trust vision, culture, planning etc and to help grow working relationships between the new SMT and NEDs.

Scope of Assignment

The NIAO Board effectiveness Good Practice Guide, was used as a basis on which to conduct this assignment through:

- Carrying out a survey of Non-Executive and Executive Directors;
- Using the results of the survey to interview 5 executives and non-executives.
- Attending / observing Board / Committee meetings;
- Reviewing minutes and papers of Board / Committee meetings; and
- Reviewing key strategic and operational documents.

The results of the survey were presented to the Board Workshop held on 21 February 2019.

The audit was based on the risk that the SHSCT Board may not be operating effectively.

The objectives of this audit were:

- To ensure that the Trust has appropriate processes to build / establish the Board;
- To ensure that there are appropriate arrangements in place to develop the Board;
- To ensure that there is clarity of roles, responsibilities and effective relationships among members;
- To ensure that Board meetings are conducted effectively;
- To ensure that appropriate information is received by the Board to discharge its responsibilities, including monitoring service performance and quality;
- To ensure that Board processes are effective;
- To ensure that the Board communicates effectively; and
- To ensure that the Board conducts adequate, regular assessments of its own effectiveness.

This assignment will exclude risk management, which has been the subject of a recent assignment, where satisfactory assurance has been provided

Note: We report by exception only, and where no issues and recommendations are made, the result of our work indicates that the key objectives and risks are being managed and that procedures are being adequately adhered to.

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.

Executive Summary

Internal Audit can provide Satisfactory assurance in relation to Board Effectiveness. The Trust Board is operating effectively and the recommendations in this report are aimed at enhancing an already effective Board. Satisfactory assurance has been provided on the basis that:

- The Board and its 5 Sub-committees have operated as required under their Standing Orders and respective terms of reference during 2018-19.
- From observation of the Trust Board meeting attended and review of Board minutes, there is evidence of effective challenge by Non Executive Directors.
- Papers to and minutes of Trust Board were found to be adequate.
- The survey of Executive and Non Executive Directors was largely positive (see Appendix A). The survey provided positive feedback in relation to the size of the board, engagement during board and committee meetings by both NEDs and Executives, and the skills and expertise of members. Other areas of positive feedback in the survey included: clarity of roles, effective discharge of responsibilities, objectivity of members, and the skills and experience of the Board Secretary.
- There is improved stability in the SMT membership during 2018/19 with several interim positions recruited to on a permanent basis;
- The Trust Board has conducted Board workshops in 2018/19 focusing on vision and culture.
- In line with best practice, after Board meetings there is now a short period of self-reflection by members to critically assess how well agenda items have been addressed and whether there is scope to improve future performance both individually and collectively.
- Internal Audit reviewed the Board's annual governance self–assessment which it completed in early 2018/19 and the subsequent action plan in place which had been reviewed / updated during the year by Trust Board. The 3 red flag areas identified – recruitment to vacant SMT posts, maximising attendance at Trust Board meetings and completion of directors' appraisals and objectives - have all been addressed during 2018/19. Internal Audit found the self assessment to be comprehensive and advise that the Board should incorporate the findings from this report into its new self-assessment due to be completed in early 2019/20.

There are no significant findings in this report, that impact on the assurance provided.

The key findings of the audit are:

1. Whilst no specific issues were identified with the adequacy of Performance Reporting to Board, the Trust are currently working to refine and improve their reporting. Executives and Non Executives identified a number of suggestions for improving the quality of board performance reporting including more integrated reporting across functions, focused on areas which can be actioned, and succinct reporting.
2. Board members highlighted that Board meetings are often part of a full day series of related meetings. There is an opportunity to review the Board agenda and the work of Committees to further refine and define what goes to Committee and the Board and for what purpose.
3. The main area for development that emerged from the survey of Executive and Non Executive Directors was Board Processes - specifically learning and involvement of the Board in planning/strategy. It is recognised that Trust Board are either working already or have planned work in these areas.

Other findings include:

4. There is a need to consider future proofing the Board against sudden loss of members and considering stakeholder representation (appreciating that the Trust is not in control of NED appointments). Executive Directors generally did not feel they had appropriate Board induction and annual assessment of performance on the Board. From discussions with NEDs, there is a need to review and refine HSC Board induction processes.
5. While attendance rates of NEDs and Directors at Trust Board and sub-committees has been excellent with attendance rates of 80-100%, this has not been the case for the Patient Client Experience (PCE) Committee, where average attendance rates have been 56% for directors and 60% for NEDs. Most NEDs are required to attend Governance, PCE and Audit committees. When considering their Board/Committee business, the Trust should review its committee terms of reference to assess whether it is most effectively utilising the limited time of its NEDs.
6. Internal Audit acknowledge the ongoing work of the Board Effectiveness workstream of the DoH led IHRD implementation project and the developments this workstream should bring to board effectiveness across the HSC, particularly around induction and other training.
7. Clinical Governance structures could be further developed and strengthened, as reflected in discussions with NEDs and recent Internal Audit reports.
8. During the 6 month period April to September 2018 there were 6 Leadership Walk-arounds. NEDs are expected to carry out 3 walk-around visits per year (24 in total). We are informed a further 5 visits have been conducted in October to March 2019.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Reporting Operational Performance to Trust Board	-	1	1
2.	Trust Board Meetings	-	1	-
3.	Board Processes	-	2	1
4.	Building and Developing the Board	-	2	-
5.	Attendance at Board / committees	-	2	-
6.	O'Hara and Board Effectiveness Recommendations	-	1	-
7.	Governance Structures	-	1	-
8.	Communication with Stakeholders	-	-	1

Detailed Findings and Recommendations

1 Reporting Operational Performance to Trust Board

Finding

There has been improvements in the quality of papers provided to Trust Board e.g. more succinct reports; use of trajectories to show changes in performance against OGIs; use of summary sheet to highlight key issues / points, etc. Internal Audit observed that the Trust has multi level reporting of performance against OGIs, highlighting key issues and summary data.

The Trust has expressed an intention to further develop their performance reporting to Board and in particular to explore a more integrated approach to reporting by directorate and division using integrated dashboards. This approach should address some members comments around the volume of statistical information provided and the need for summary information and appropriate analysis. Some members also highlighted the need to focus on what actions the Trust can take to improve performance.

When surveyed and through the interviews held with Executives and Non Executives, the following suggestions for improvement were made for how board performance reporting could be further improved:

- Use of comparative performance analysis with other Trusts/NHS and previous time periods within the Trust
- Development of Patient Safety Strategy with measurable outcomes and a governance assurance strategy driven by Quality Improvement
- Incorporating reporting on health of the population
- Review committee work and structure to consider what should go to Board and should go to a Committee.
- Increased use of exception reporting
- Chief Executive's report could include key risks/challenges, emerging issues, governance matters.

Implication(s)

Potential for loss of focus on key issues in performance reports, where these include too much detail / information.

Recommendation 1.1	Trust Board should consider the feedback on the current performance reporting from members, when shaping the intended reporting improvements.
Priority	2
Management Action	**ACCEPTED** Performance Committee to be established. Delegated powers and Terms of Reference approved by Trust Board on 29th August 2019. First meeting of Committee agreed for 17th October 2019
Responsible Manager	Chief Executive
Implementation Date	31st August 2019

Recommendation 1.2	It is important that NEDs are comfortable with the complexity and understanding of performance data presented to them. As current reporting arrangements are changed, NEDs should be sufficiently trained.
Priority	3
Management Action	**ACCEPTED** • Function of Performance Committee is to ensure members are appropriately trained and understand the complexity of performance data • Training needs identified will be discussed and agreed at Performance Appraisal meeting with the Chair • Once Performance Committee is up and running for six months, any further

	trained needs will be considered
Responsible Manager	Chair and Chief Executive
Implementation Date	31st March 2020

2 Trust Board Meetings

Finding

We observed that changes have been made to Trust Board agendas during 2018/19, including clarification of actions required by members against agenda items e.g. for noting, approval etc, times for each agenda item etc. We observed that agendas were appropriate and were sub-sectioned into normal business, strategic, operational performance, Board committees and Patient/Client Safety & Quality of Care, Additionally there was a Confidential Section agenda, 2 presentations by staff, and a short self assessment session at the end of the meeting.

Although Trust Board agendas were viewed as appropriate, some Board members commented that Board meetings are often part of a full day series of related meetings and commented on the potential to further refine the Board agenda. Inclusion of too many presentations, non-statutorily required items and extensive performance reporting were viewed by members as main contributors to long agendas.

Internal Audit attended the Board meeting in January 2019. An appropriate level of scrutiny and challenge was observed throughout the meeting. All members actively participated, and NEDs raised questions in a positive manner with Directors.

Implication(s)

Heavy Trust Board agendas and lengthy meetings could potentially impact on effectiveness.
Absence of guidance on how to deal with members of the public / issues at Board Meetings creates uncertainty.

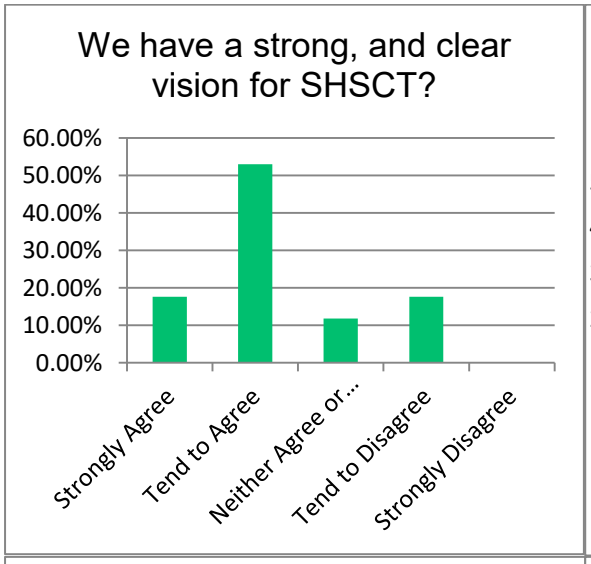
Recommendation 2.1	The Trust should review the content of Trust Board agendas to identify those items which are statutorily required and must be included and those items which are only for information / noting etc or e.g. could be better addressed through an appropriate board sub-committee. The scheduling of Board related meetings on the same day as the Board meeting should be reviewed with Board members.
Priority	2
Management Action	**ACCEPTED** New schedule of reporting approved by Trust Board on 29th August 2019
Responsible Manager	Chair and Chief Executive
Implementation Date	31st August 2019

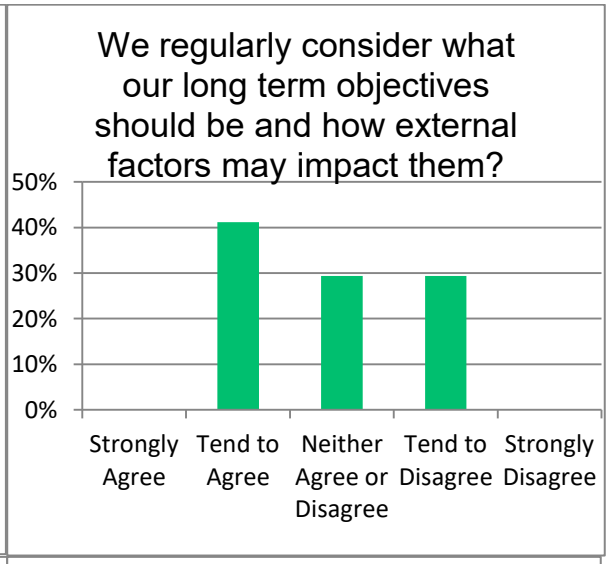
3 Board Processes

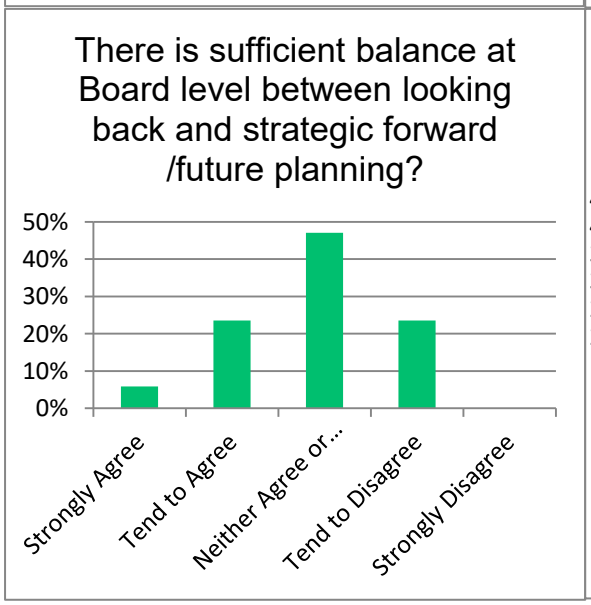
Finding

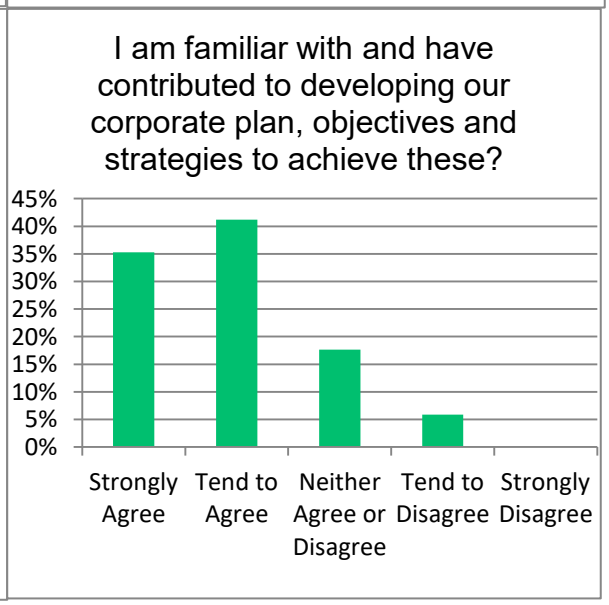
The main area for development that emerged from the survey of Executive and Non Executive Directors was Board Processes - specifically learning and involvement of the Board in planning/strategy.

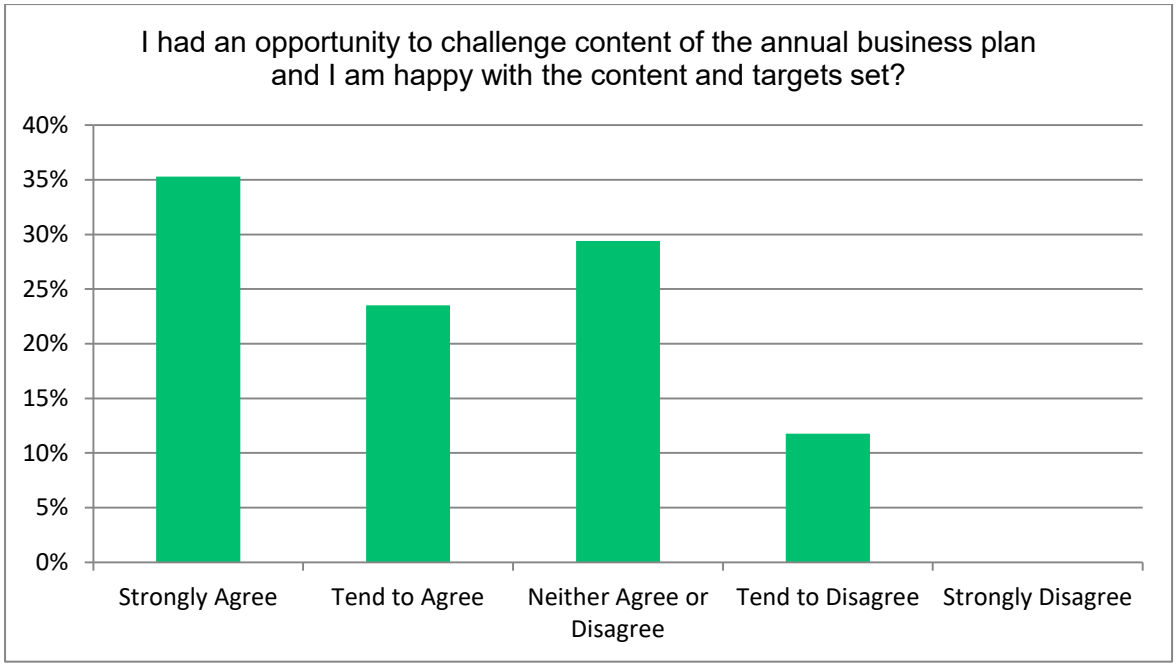
Planning/Strategy:
There were mixed views in the survey to the following questions/statement, generally around planning/strategy:





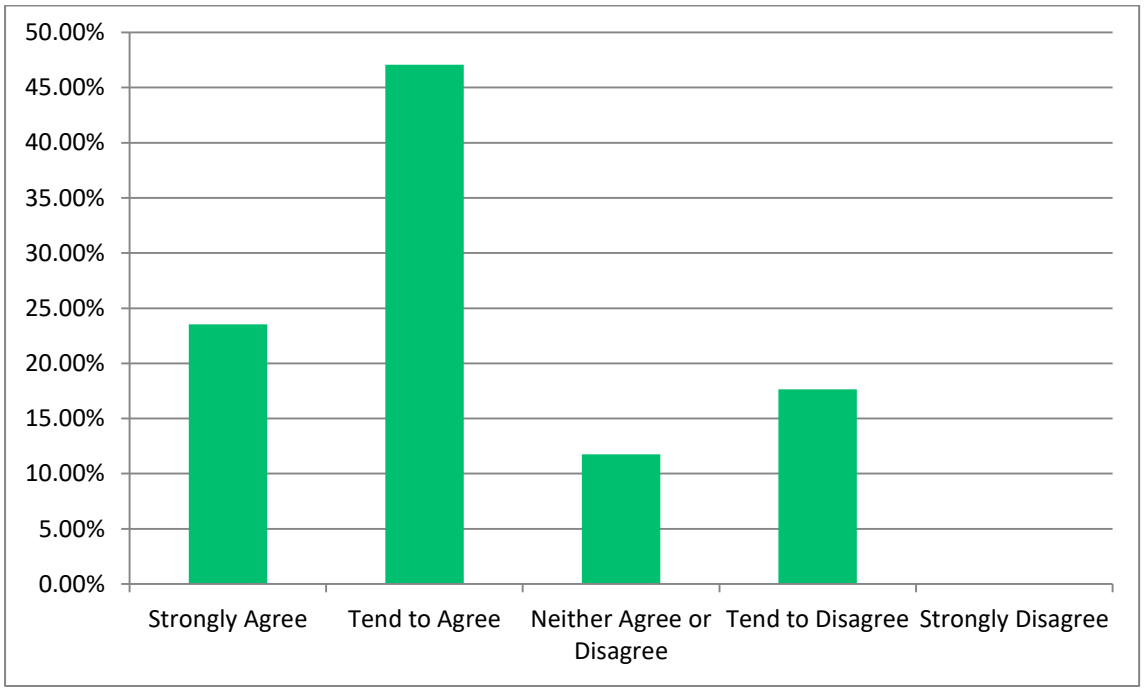






Learning:
Knowledge of other organisations and the potential to increase opportunities to work with and learn from other organisations regionally and nationally could be further developed. The survey showed 37% of respondents were neutral (31%) or negative (6%) around whether the Board has strong networks with other Trusts and support organisations. Discussion with the Chair indicated that the Trust has engaged with organisations such as the Kings Fund, and used contacts with former CEOs and Directors now working in English Trusts and Authorities to learn from their experiences.
Internal Audit appreciate this issue was recently raised at Governance Committee in December 2018 minutes and it is recognised as area for further development focussing on SAI and M&M outcomes.

Also there was mixed views in the survey of Executives and NEDS to the question 'The Board acknowledges instances where something went wrong and openly discusses how it should be addressed or missed opportunities and what should be done differently as a result?'



Implication(s)

Failure to develop a robust lessons learning culture across the Trust has potential to impact patient /client safety. Lost opportunity for joint working and shared learning with other organisations. Insufficient clarity over Trust vision and corporate plans and how these will be achieved.

Recommendation 3.1	The Board should conclude their ongoing work on the Trust vision, culture and behaviours.
Priority	2
Management Action	**ACCEPTED** Work concluded with new set of Board Behaviours agreed at Board Workshop on 18th April 2019
Responsible Manager	Chair and Chief Executive
Implementation Date	30th June 2019

Recommendation 3.2	The Trust should seek to improve Trust Board's involvement in planning and strategy. We understand this is the intended focus of the Board in their next phase of development.
Priority	2
Management Action	**ACCEPTED** Use existing workshops to focus on strategic direction. This will be the focus of the workshop on 12th December 2019
Responsible Manager	Chair and Chief Executive
Implementation Date	31st March 2020

Recommendation 3.3	The Trust should explore opportunities for strengthening networks with other Trusts and sharing of learning.
Priority	3
Management Action	**ACCEPTED** Initiated agreement with the Northern HSC Trust to bring senior teams together to explore potential for sharing of learning.
Responsible Manager	Chief Executive
Implementation Date	31st March 2020

4 Building and Developing the Board

Finding

In the survey of Executive and Non Executive Directors, 45% believed that Board membership is sufficiently diverse in terms of stakeholder representation.

22% of Executive and Non Executive Directors believe the Board is sufficiently future proofed against sudden loss of members. Internal Audit recognise that the Trust is not in control of the Non Executive Director appointment process.

Whilst NEDs were generally content with Board induction and annual performance assessment processes, Executive Directors generally did not feel they had appropriate Board induction and annual assessment of performance on the Board.

From discussions with NEDs, there is a need to review and refine HSC Board induction processes. *It is anticipated that the DoH-led IHRD implementation project will lead to improvements in current HSC Board induction processes, specifically in terms of training on statutory responsibilities and health-specific matters.*

Implication(s)

The stability and effectiveness of the Board is potentially at risk in the absence of future proofing, stakeholder diversity and suitable induction processes.

Recommendation 4.1	The Chair and Chief Executive should liaise with DoH to ensure an appropriate Chair / NED recruitment programme is introduced for the Trust, to assist in future proofing and improving stakeholder representation if possible.
Priority	2
Management Action	**ACCEPTED** The Chair and Chief Executive have and continue to liaise with the DoH, through the Accountability meeting process, to influence on this matter, most recently at meeting on 3rd July 2019.
Responsible Manager	Chair and Chief Executive
Implementation Date	31st July 2019

Recommendation 4.2	The Trust should develop its induction programme for Executive Board members and specifically include Board performance in annual Director appraisals.
Priority	2
Management Action	**ACCEPTED** Induction programme in place for all Board members. During May and June 2019, the Chair completed a series of one to one meetings with Directors to assess their performance on the Board.
Responsible Manager	Chair
Implementation Date	30th June 2019

Recommendation	See recommendation 6.1

5 Attendance at Board / Committees

Finding

While attendance rates of NEDs and Directors at Trust Board and sub-committees has been excellent with attendance rates of 80-100% during 2018/19, this has not been the case for the Patient Client Experience (PCE) Committee. Average attendance rates at the PCE Committee have been 56% for directors and 60% for NEDs as shown in the table below. The Chair of PCE Committee has raised this with committee members / Board and attendees in December 2018.

As can be seen from the table below and as per respective committee terms of reference, most NEDs are required to attend Governance, PCE and Audit committees.

	Board / Committee with Number & % Attendance (NEDs & Directors) 2018/19									
Meeting No.	Board (8 & 10)		Governance (7 & 10)		Audit (5 & 1)		E&G (3 & 3)		PCE* (5 & 6)	
	No.	%	No.	%	No.	%	No.	%	No.	%
1	7 10	87.5 100	6 9	86 90	4 2	80 100	3 3	100 100	3 4	60 67
2	7 10	87.5 100	5 9	71 90	4 1	80 100	2 3	67 100	3 3	60 50
3	8 8**	100 80	7 10	100 100	4 1	80 100	3 2	100 67	3 3	60 50
4	8 10	100 100	N/A	N/A	4 1	80 100	3 3	100 100	N/A	N/A
5	8 10	100 100			4 1	80 100	N/A	N/A		
6	7 8**	87.5 80								
7	8 10	100 100								
8	N/A	N/A								
Average	7.6 9.4	95% 94%	6 9.3	86% 93%	4 1	80% 100%	3 3	92% 92%	3 3.33	60% 56%

**PCEC also has 4 PPI representatives (service users) as members – they are not included in the table above. The average attendance of these members is 75%*
*** On these 2 occasions at Trust Board absent Directors sent another representative*
N/A – not available yet

Implication(s)

Poor attendance by Directors and NEDs at the PCE committee creates a poor impression as to how valued users views are, or alternatively whether the PCE Committee is a valued means of assurance.

Recommendation 5.1	When considering their Board/Committee business, the Trust should review its committee terms of reference to assess whether it is most effectively utilising the limited time of its NEDs.
Priority	2
Management Action	**ACCEPTED** Committee Terms of Reference reviewed and approved on an annual basis.
Responsible Manager	Chair and Chief Executive
Implementation Date	31st March 2020

Recommendation 5.2	The Trust should review the effectiveness of the Patient Client Experience Committee. The Chief Executive should re-enforce attendance at the Patient / Client Experience Committee with Directors and likewise the Chair with NEDs.
Priority	2
Management Action	**ACCEPTED** The Chair of the Patient and Client Experience Committee has addressed the issue of attendance and this will be kept under review during 2019/20
Responsible Manager	Chair and Chief Executive
Implementation Date	31st March 2020

6 Inquiry into Hyponatreamia Related Deaths (IHRD) Project

Finding

The IHRD inquiry produced a number of recommendations specifically targeted at improving board effectiveness as follows:

i. The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive board members.
ii. Trust Chairs and Non-Executive Board Members should be trained to scrutinise the the performance of Executive Directors in particular in relation to patient safety objectives.
iii. All Trust Board members should receive induction training in their statutory duty.
iv. Trusts should appoint and train Executive Directors with specific responsibility for Issues of Candour.
v. Trusts should appoint and train Executive Directors with specific responsibility for Child Healthcare.
vi. Trusts should appoint and train Executive Directors with specific responsibility for Learning from SAI related patient deaths.
vii. Effective measures should be taken to ensure the minutes of Board and Committee meetings are preserved.
viii. All Trust publications, media statements, and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated Non Executive Director.
ix. All Trust Boards should consider the findings and recommendations of this report and where appropriate amend practice and procedure.

Internal Audit acknowledge the ongoing work of the Board Effectiveness workstream of the DoH led IHRD implementation project and the developments this workstream should bring to board effectiveness across the HSC, particularly around Board Member induction and other training.

Implication(s)

Failure to address IHRD recommendations has potential to impact on patient safety and also potential for damage to public reputation of the Trust Board.

Recommendation 6.1	The Trust should continue to engage with the IHRD implementation project and work to implement the recommendations, in line with the work of the project.
Priority	2
Management Action	**ACCEPTED** IHRD implementation project is delivered through the local IHRD oversight group with progress reports to Trust Board three times per year.
Responsible Manager	Chief Executive
Implementation Date	Ongoing

7 Governance Structures

Finding

Clinical Governance structures could be further developed and strengthened, as reflected in discussions with NEDs and recent Internal Audit reports.

Implication(s)

Weaknesses in the assurance processes to Governance Committee and ultimately Trust Board.

Recommendation 7.1	The Trust should review its Clinical Governance structures, with a view to further developing and strengthening current arrangements.
Priority	2
Management Action	**ACCEPTED** Independent review of clinical and social care governance commissioned. Report to be available in October 2019.
Responsible Manager	Chief Executive
Implementation Date	31st October 2019

8 NED Leadership Walkarounds

Finding

During the 6 month period April to September 2018 there were 6 Leadership Walk-arounds and 4 of these were conducted by the Chair. NEDs are expected to carry out 3 walk-around visits per year (24 in total). We have been informed a further 5 visits have been conducted during the second half of 2018/19, although not reported yet.

Implication(s)

Reduced Board presence to staff when NED walkarounds are not completed and reduced awareness of issues 'on the ground'.

Recommendation 7.1	The process around planning and scheduling NED leadership walkarounds should be strengthened to ensure the required number are scheduled and completed.
Priority	3
Management Action	**ACCEPTED** Work underway to ensure that each NED will carry out 3 walk-around visits in 2019/20.
Responsible Manager	Chair
Implementation Date	31st March 2020

Appendix A – Results of Trust Board Survey

Board Governance and Effectiveness Survey

No	Question	*Circle / highlight as appropriate*					Comment
1	**BUILDING THE BOARD**						
1a	Are you a Director or Non-Executive Director	Director **10**			Non-Executive Director **8**		Total 18 responses
		Strongly Agree	**Tend to Agree**	**Neither Agree or Disagree**	**Tend to Disagree**	**Strongly Disagree**	
1b	The size of the Board is right in terms of the number of non-executive members, given the complexity of HSC provider environment.	33%	44%	17%	6%	0%	
1c	The work of the Board and its Committees does not overburden any individual members.	0%	65%	23%	12%	0%	
1d	The Board has an appropriate balance of professional expertise / functional skills, as well as strategic experience amongst its members.	33%	55%	6%	5%	0%	
1e	The Board has the specific skills needed for oversight of a HSC Trust.	17%	67%	5%	11%	0%	
1f	Board membership is sufficiently diverse in terms of stakeholder representation.	6%	39%	28%	22%	5%	
1g	All Board members are personally engaged and interested in the Trust's activities.	56%	33%	6%	5%	0%	
1h	Our Board is sufficiently future proofed against sudden loss of members.	0%	22%	28%	50%	0%	
2	**DEVELOPING THE BOARD**						
2a	Appropriate level of induction was available on joining the Board, including shadowing etc of previous incumbents where necessary or mentoring provided (e.g. committee chairs etc)	39%	11%	28%	22%	0%	
2b	I had an initial meeting with the chairman on appointment and was briefed on the organisation / personal induction assessment performed	72%	17%	0%	6%	5%	
2c	I receive regular updates on new developments / legislation etc in order to keep Board members' skills and knowledge up-to-date	22%	56%	11%	11%	0%	
2d	As part of my development I have visited departments in the organisation / directors & Heads of Service have presented work	65%	29%	0%	6%	0%	
2e	After a couple of months, I had a personal follow up meeting with the chair.	44%	28%	6%	17%	5%	
2f	I have an opportunity to meet informally with other board members or directors	44%	44%	6%	6%	0%	
2g	I routinely attend mandatory training and updates on new / emerging issues	39%	56%	6%	0%	0%	
2h	I have had an annual assessment of my performance on the board	50%	11%	17%	11%	11%	

No	Question	*Circle / highlight as appropriate*					Comment
3	**ROLES, RESPONSIBILITES AND RELATIONSHIPS**	**Strongly Agree**	**Tend to Agree**	**Neither Agree or Disagree**	**Tend to Disagree**	**Strongly Disagree**	
3a	There is clarity around roles of a board member, chairperson and chief executive and their respective responsibilities	50%	33%	6%	11%	0%	
3b	The Management Statement and Standing Financial Instructions (SFIs) are accurate re roles and responsibilities	39%	50%	11%	0%	0%	
3c	Our Board is underpinned by a spirit of trust and professional respect.	17%	56%	22%	5%	0%	
3d	I am happy to challenge other members views and instigate constructive debate on difficult issues	35%	59%	0%	6%	0%	
3e	I can raise concerns with the Chair and / or Chief Executive, and know they will be addressed	39%	50%	11%	0%	0%	
3f	I feel my views are valued by the Chair, Chief Executive and other Board Members	33%	50%	11%	6%	0%	
3g	The Board is always objective and collectively acts in the best interests of the organisation	47%	53%	0%	0%	0%	
3h	I always declare any conflict of interests in a timely manner.	94%	6%	0%	0%	0%	
3i	This organisation has strong leadership and appropriate culture	22%	39%	28%	11%	0%	Discussion with NEDs indicated that this largely due to Trust having 4 interim CEOs and other acting directors for approx. 3 years and this weakened leadership and culture in the Trust. However felt that now CEO and director posts substantive there was clear evidence of improvements in this.Board Workshops on culture and vision in the current year were improving this aspect.
3j	The Chief Executive values the views of the Board, and seeks our views on important decisions	39%	50%	11%	0%	0%	
3k	I am happy to contact the chair, Chief Executive or Directors outside of board meetings, if I have concerns or require further information.	61%	33%	6%	0%	0%	
3l	There is positive interaction between board members, Chief Executive and directors in meetings.	44%	44%	11%	0%	0%	
3m	Directors speak openly and engage in issues within their remit.	28%	61%	11%	0%	0%	
3n	The Board meets as often as necessary without the Chief Executive and Directors present.	19%	19%	56%	6%	0%	Exceptions are mainly Executives
3o	The Board is a strong collaborative team.	11%	61%	22%	6%	0%	

No	Question	*Circle / highlight as appropriate*					Comment
3p	The Chair effectively discharges his/her responsibilities.	56%	44%	0%	0%	0%	
4	**BOARD MEETINGS**						
4a	A dedicated Board Secretary with appropriate skills and experience is in place.	82%	12%	6%	0%	0%	
4b	Sufficient time is made available to allow the Board to discharge its collective responsibility.	23%	71%	6%	0%	0%	
4c	The agenda for Board meetings is appropriate to ensure that all relevant items are brought to the Board's attention.	12%	70%	12%	6%	0%	
4d	The Board undertakes realistic self-reflection / self-evaluation	23%	71%	6%	0%	0%	
4e	There is annual timetable for board meetings and scheduling of recurrent / 'must do' agenda items.	82%	12%	0%	6%	0%	
5	**BOARD INFORMATION**	**Strongly Agree**	**Tend to Agree**	**Neither Agree or Disagree**	**Tend to Disagree**	**Strongly Disagree**	
5a	I receive appropriate information between meetings to keep abreast of significant issues, trends or developments.	47%	29%	18%	6%	0%	
5b	I often hear significant issues for the first time on the media.	0%	6%	25%	50%	19%	
5c	Papers for Board meetings contain relevant and appropriate material and are received sufficiently in advance of the meeting.	47%	53%	0%	0%	0%	
5d	Information is available to Board members in a form and of a quality and quantity that enables the Board to discharge duties effectively.	29%	59%	12%	0%	0%	
5e	There is appropriate consideration at Board level to service quality, patient safety and client experience.	47%	35%	12%	6%	0%	
5f	There is appropriate consideration at Board level given to performance against objectives.	29%	59%	12%	0%	0%	
5g	There is appropriate consideration at Board level given to financial position.	65%	29%	6%	0%	0%	
5h	There is a sufficient balance of consideration at the Board of competing pressures of performance, financial position and quality/safety and there is appropriate integration between these three competing areas.	17%	53%	18%	6%	6%	
6	**BOARD PROCESSES**						
6a	The Board acknowledges instances where something went wrong and openly discusses how it should be addressed or missed opportunities and what should be done differently as a result.	23%	47%	12%	18%	0%	
6b	We have a strong, and clear vision for SHSCT.	17%	53%	12%	18%	0%	
6c	We regularly consider what our long term	0%	41%	29%	29%	0%	

No	Question	*Circle / highlight as appropriate*					Comment
	objectives should be and how external factors may impact them.						
6d	I am familiar with and have contributed to developing our corporate plan, objectives and strategies to achieve these	35%	41%	18%	6%	0%	
6e	There is sufficient balance at Board level between looking back and strategic forward /future planning.	6%	24%	47%	23%	0%	
6f	I had an opportunity to challenge content of the annual business plan and I am happy with the content and targets set.	35%	24%	29%	12%	0%	
6g	At board, we regularly look at what is happening across HSC / NHS / HSE	13%	31%	19%	31%	6%	
6h	The Board receives regular updates on issues impacting other Trusts both regionally and nationally.	18%	12%	35%	35%	0%	
6i	The Board sub-committee structure is clear and the Board is adequately informed of each sub-committees' activities.	71%	23%	6%	0%	0%	
		Strongly Agree	**Tend to Agree**	**Neither Agree or Disagree**	**Tend to Disagree**	**Strongly Disagree**	
6j	I know the organisational / corporate risks and these are regularly discussed at Board meetings.	59%	18%	18%	6%	0%	
6k	I am content organisational / corporate risks are identified promptly by directors and escalated to the Board.	56%	25%	19%	0%	0%	
6l	Action plans to mitigate organisational / corporate risks are promptly implemented.	29%	53%	18%	0%	0%	
6m	We have a good balance between strategic and operational issues on our agenda.	25%	30%	13%	12%	0%	
7	**COMMUNICATION**						
7a	The Board is doing a good job of communicating effectively with stakeholders including DoH, staff, health professionals, volunteers, local community officials and leaders, patients and the public generally?	29%	47%	18%	6%	0%	
7b	The Board has strong networks with other HSC Trusts and support organisations.	19%	44%	31%	6%	0%	

Describe any positive changes over the past year to the way the Board functions.

Review of performance after each meeting. Clearer papers on presentation to Board. Summary sheets much better and succinct. More of a focus on questions rather than a presentation of the papers.

Significant work on Board development & the culture of how we do business has been undertaken. Better understanding and embracing by ED on the challenge role of NEDs.

The arrival of a new permanent CEO and the completion of a recruitment exercise for Directors/SMT. Stability has arrived. The introduction of a 15 minute reflection after each Board Meeting.

Changes in both the agenda items and the way Director workshops are structured and undertaken.

More time for evaluation at end of meetings. More emphasis on culture and how we can improve.

Formal time for reflection at the end of the board meeting.

We have started a journey in relation to reflecting on the HSC core values and the associated behaviours that we need to display as Board members. Open and honest conversations have been had amongst members. However, this needs to be able to conclude in the same open manner that it has started.

More workshops and indepth analysis and space to grow relationships.

Starting to get a better balance between the acute and community services.

During my time in the Southern Trust, I have seen many improvements / changes in how the Board functions. My response to this survey reflects this. How SMT functions is inextricably linked to this.

The Board Dev Workshop in Nov 18 facilitated by the Kings Fund was useful - the Trust is on a journey - it was an opportunity to build relationships between board members and to review Board practice. The self-evaluation session at the end of Board meetings is very useful. Improvements to the Corporate Risk Register template are welcomed - these discussions take place at Governance Cttee not at Board - also the deep dive of 1 corporate risk.

We have has Board Development days which have been very useful.

Permanent CEO, permanent Director team has had a significant positive change.

Annual Board Development Day each Nov. Self Assessment of the Boards effectiveness. Learning and sharing from a recent SAI event

Suggest any areas of Board performance which could still be improved upon.

Review of the nature of items which are statutory and those which are not. Which items demand significant debate and others only for information.

greater emphasis on the experience of the patient/ service user and how we support all clinicians to achieve best care. Greater awareness of the fundamental need for QI across Trust Board, SMT eg Scil training

More time for informal discussions

Reshaping of agenda items to allow for greater discussion on corporate performance and associated issues affecting performance.

acute directorate

Driving the culture change in the organization that is needed - more time needs to be spent on this. Also redefining the vision for the Trust - need to get on with doing this.

less meaty documents to allow more focused discussion and strategic considerations.

We regularly keep this under review and any proposed changes are considered

Informal conversations around certain topics can often produce very constructive ideas. I realize however that TB is for strategic, top line conversation and there is very little time.

Perhaps we do not give sufficient time to reflect on client experience and quality / safety at Board meetings. The Board sets the strategic direction and perhaps we need to set aside time - Board Strategy Day to contribute to the corporate plan, objs and strategies. Also we could allocate some time at a workshop reviewing the annual business plan outside of the formal board meetings.

work on behaviours and culture

Large complex agendas

As the Trust is currently considering how Performance Reporting to the Trust Board could be further developed, can you provide any specific views on existing reporting and how it could be improved and / or developed.

Review of performance against definitive timescales - long term and short term performance.

As above but recognize there has been some improvement in this area.

Some comparative performances analysis from other Trusts & NHS in general might serve to escalate discussion to a more strategic level insofar as many performance issues are systemic to the NHS as a whole & reflective of the lack of investment & need for improved processes & systems.

The development of a Trust Patient safety strategy with measurable outcomes and a governance assurance strategy driven by QI should improve this.

More reporting on the health of the population instead of missed targets

See above, information presented could perhaps be benchmarked against previous years, presented in graphical formats to give a visual picture of how over time performance in many specialities has greatly reduced / underperformed/ have been facing great difficulties in achieving performance. Qualitative information could be provided to provide assurances on actions taken.

Potentially having a performance sub committee to spend time getting a deeper understanding of performance in key areas

Leave the operational Directors to account for their areas of responsibility and to offer assurances for areas requiring attention or needing higher level assurance. highlight /exception reporting rather than all areas.

Again this is regularly reviewed and refined in terms of providing quality, meaningful information.

I like the current performance reporting template. It is clear and easy to understand. I do not have any suggestions for improvement. I am happy with how it is at the moment.

I think the CE's report could be improved to consider key risks/ challenges, emerging issues, governance matters with a focus on the Trust. The HR report is very long with lots of data - my preference would be for a shorter, sharper report. I think the clinical governance framework needs to be strengthened.

There needs to be a review of committees and how they deliver in line with the key roles of accountability, strategy and culture.

Appendix B - Definition of Levels of Assurance and Priorities

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and other findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in in fulfilling their responsibilities.

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HSC Business Services Organisation

Southern Health & Social Care Trust

Board Effectiveness 2021/22

nqa. ISO 9001 Registered Quality Management

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Acknowledgement

Internal Audit wishes to thank management and staff at the Southern HSC Trust for their assistance and co-operation during the course of the audit engagement.

Control Log

Exit Meeting Held On:	14 March 2022
Working Draft Issued On:	22 February 2022
First Draft Issued On:	16 March 2022
Management Actions Due By:	**18 March 2022**
Management Actions Received:	24 March 2022
Final Report Issued On:	24 March 2022

Distribution List

Eileen Mullan	Chair
Dr Maria O'Kane	Interim Chief Executive
Sandra Judt	Board Assurance Manager
Catherine Teggart	Director of Finance, Procurement & Estates
Alison Rutherford	Assistant Director of Finance
Helen O'Hare	Acting Assistant Director of Finance

Introduction

In accordance with the 2021/22 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Board Effectiveness during December 2021 and January 2022. The last Internal Audit of this topic was performed during 2018/19 when satisfactory assurance was provided.

The Trust Board has the following key functions for which they are held accountable by the Department of Health on behalf of the Minister:

- To set the strategic direction of the organisation within the overall policies and priorities of the HPSS, define its annual and longer term objectives and agree plans to achieve them;
- To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;
- To ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;
- To appoint appraise and remunerate senior executives;
- To ensure that there is effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
- To ensure that the HSC body has robust and effective arrangements in place for clinical and social care governance and risk management.

To ensure that these functions are carried out effectively, the SHSCT's governance structure is underpinned by a number of key documents including the Management Statement and Financial Memorandum (MSFM), the Standing Orders (SOs), Standing Financial Instructions (SFIs), Corporate Plan, People Plan, Board Assurance Framework and Corporate Risk Register.

The SHSCT Board meets regularly (there were seven meetings in 2021), supplemented by Board Workshops and Development Days as required, and is supported by the following Committees:

- Audit Committee;
- Governance Committee;
- Patient Client and Experience Committee;
- Performance Committee;
- Endowments and Gifts Committee;
- Remuneration Committee.

The Board Governance 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. Department of Health (DoH) require Boards to carry out a self-assessment of effectiveness annually and to have their self-assessment ratings independently verified on average every 3 years. This audit constitutes the independent verification.

Internal Audit attended the Trust Board Meeting on 27 January 2022. In attendance were a number of public and political representatives (cross party), journalists, and various groups of staff who joined for specific agenda items. After Board Members discussed agenda items, the Chair opened the floor which provided an opportunity for active public engagement and participation. A number of the political representatives commented and asked questions. This meeting was held by zoom; this virtual format has lent itself to increased involvement from public representatives at Trust Board.

Scope of Assignment

The scope of the review was to ensure that SHSCT has an appropriate, functioning and effective Board. Internal Audit reviewed the most recent DoH Self-Assessment completed by the SHSCT Board in August/September 2021. The NIAO Board Effectiveness Good Practice Guide and the Department of Health's Self-Assessment Tool were used as a basis on which to conduct this assignment through:

- Reviewing minutes and papers of Board/ Committee meetings;
- Reviewing key strategic and operational documents;
- Surveying Board members and senior executives regularly attending Board meetings;

- Meeting with the Chief Executive, Chair and three other Non-Executive Directors (NEDs) to discuss their views on board effectiveness; and
- Attendance at a Board Meeting in January 2022 to observe how it operates.

The audit was based on the risk that the SHSCT Board may not be operating effectively.
The objectives of this audit were to ensure that:

- The Trust has appropriate processes to build / establish the Board;
- There is an effective balance between strategy, accountability and culture at Board level;
- There are appropriate arrangements in place to develop the Board;
- There is clarity of roles, responsibilities and effective relationships among members;
- Board meetings are conducted effectively;
- Appropriate information is received by the Board to discharge its responsibilities, including monitoring service performance and quality;
- Board processes are effective;
- The Board communicates effectively;
- The Board conducts adequate, regular assessments of its own effectiveness.

Note: We report by exception only, and where no issues and recommendations are made, the result of our work indicates that the key objectives and risks are being managed and that procedures are being adequately adhered to.

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.

Executive Summary

Internal Audit can provide Satisfactory assurance in relation to Board Effectiveness. Satisfactory assurance has been provided on the basis that the Trust Board and its committees are meeting regularly; and adequate papers covering the key business areas are being presented. The Board is well attended, meets as required, with papers issued on a timely basis. There is regular and appropriate consideration of key aspects of Board business including accountability, strategy and culture. Board committees are meeting regularly with updates and annual reports being presented back to Trust Board. There was evidence that the Trust responded to and addressed learning from eg the outcomes of the Independent Review into the Circumstances of Board Member Resignations in the RQIA, and the Report of the Independent Leadership and Governance Review at Muckamore Abbey Hospital as both have been the subject of Board workshops over the last year.

Internal Audit issued a survey to all Board members and Directors who attend the Board to seek their views on the effectiveness of the Board; the survey was based on the NIAO good practice guide. In addition, Internal Audit had discussions with the Chief Executive, Chair and 3 Non-Executive board members. Feedback from members was, in general, very positive. Any issues raised support the findings noted below; e.g. Board succession. *The survey results are summarised in Appendix A of this report.*

A review of Board minutes evidenced that the information currently presented to the Board in relation to accountability, strategy and culture is appropriate, both in terms of content and frequency. Additionally, review of Board minutes and attendance at the January 2022 Board Meeting evidenced discussions around key areas together with evidence of appropriate challenge / questioning when appropriate.

The Department of Health has a requirement that Arm's Length Bodies are to have their Board Self-Assessments subject to independent verification every three years. As part of this assignment, Internal Audit reviewed the most recent Board governance self-assessment and resulting action plan and found that it was in line with the outcomes of this audit as established through surveys, interviews, attendance at a Board meeting and review of records. All Board members and Directors who attend the board were involved in the completion of the self-assessment, with feedback sought at a Board Workshop in August 2021 and a paper was presented at the Board meeting on 30 September 2021. All self-assessed ratings

were deemed satisfactory and in line with all audit findings and the approach to conduct the self-assessment was robust.

There are no significant findings impacting on the assurance in this audit.

The key findings of the audit are:

1. The Trust is undergoing a significant change at a Senior Management level and is progressing the appointment of a new Chief Executive. 3 of 9 Executive/Operational Directors posts are filled on an interim/acting basis. This proportion of interim posts could impact on Board Effectiveness and governance within the organisation if it continues for a prolonged period. There is a need to develop succession planning for the Board, with two NED posts vacant and the serving NEDs terms all due to expire in 2024. 80% of NEDs who responded to our survey indicated that they disagreed that the work of the Board and its Committees does not overburden any individual members.
2. Internal Audit note that some Board Papers are lengthy and contain a significant amount of complex information. On occasions coversheets accompanying reports can be four or more pages in length, resulting in key messages not being highlighted. Some Board members stated in the survey that Board Papers were still too long and detailed and that papers needed to be condensed.
3. The Management Statement and Financial Memorandum has not been updated since September 2017. It is appreciated that this is due to be replaced with a 'Partnership Agreement'. The MSFM needs to be clearer in terms of Chief Executive reporting responsibility to Board. The MSFM at paragraph 3.6.3 refers to the Chief Executive's responsibility to advise the Board as opposed to his/her accountability to the Board. The Trust SFI's have not been reviewed since June 2018.
4. The Trust has undertaken a review of its Clinical and Social Care Governance structures however implementation of this work has been delayed due to the ongoing COVID-19 pandemic.

Other findings include:

5. One Executive Director indicated in the survey that had not had an appraisal. This was identified as an area for improvement on the Board Self-Assessment.
6. Within the Trust area there are a diverse range of socio-economic, ethnic, and religious groups. The Trust acknowledge that the diversity of Trust Board could be further developed to more appropriately reflect the diverse community it serves.
7. Induction Training could be expanded to give new members a wider understanding of the work of the Trust, particularly for new members coming with no background in health and social care.
8. Internal Audit issued a board effectiveness survey to the Chief Executive, Chairperson, NEDs, Executive Directors and the Operational Directors that attend the Board. 12 out of 15 people responded to the survey. The results were largely very positive but included some areas for further consideration:
    - 50% of respondents disagreed that the work of the Board and its Committees does not overburden any individual members.
    - 33% of respondents disagreed that the size of the Board is right in terms of the number of non-executive members, given the complexity of HSC provider environment.
    - 33% of respondents disagreed that the appropriate level of induction was available on joining the Board.
    - 25% of respondents disagreed that Board membership is sufficiently diverse in terms of stakeholder representation.
    - 17% of respondents disagreed that the Board has an appropriate balance of professional expertise / functional skills, as well as strategic experience amongst its members.
    - 17% of respondents disagreed that the Board have a strong, and clear vision for SHSCT.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Stability of the Board and Senior Team	-	2	-
2.	Trust Board Meetings and Papers	-	1	-
3.	Corporate Documents	-	1	1
4.	Development of Clinical and Social Care Governance	-	1	-
5.	Appraisals for Executive and Operational Directors	-	1	-
6.	Stakeholder Representation on Trust Board	-	-	1
7.	Induction Training	-	-	1
8.	Board Survey Results	-	-	1
	TOTAL	**-**	**6**	**4**

Detailed Findings and Recommendations

1 Stability of the Board and Senior Team

Finding

The SHSCT has 6 Non-Executive Members (1 Chair and 5 NEDs) and 5 Executive members (Chief Executive, Director of Finance, Medical Director, Director of Nursing and Director of Social Work).

The DoH is responsible for the Chair and NEDs appointments to all HSC bodies and all appointments should be time limited. At the time of the audit two out of seven NED positions were vacant. The current serving NEDs are all scheduled to end their terms of office in 2024. The resulting pressure on NEDs in post is reflected in the survey results with 4 of 5 (80%) NEDs disagreeing that the work of the Board and its Committees does not overburden any individual members.

The Trust is undergoing a significant change at a Senior Management level and is progressing the appointment of a new Chief Executive. 3 of 9 Executive/Operational Directors posts are filled on an interim/acting basis. The Trust is planning to restructure a number of director roles.

75% of survey respondents believe that the Board is not sufficiently future proofed against sudden loss of members.

Implications

The knowledge and expertise on the SHSCT Board will be reduced where a significant number of Board members leave the organisation at the same time. This could impact on the effectiveness of the Board. Interim appointments could also impact on good governance.

Recommendation 1.1	The Trust should ensure all vacant and interim Executive posts are filled on a permanent basis, as soon as possible.
Priority	2
Management Action	**ACCEPTED** Permanent Director of Mental Health and Disability appointed and commenced on 14th March 2022. Interim Director of Performance & Reform appointed, pending permanent recruitment to the role.
Responsible Manager	Chair and Director Human Resources and Organisational Development
Implementation Date	December 2022

Recommendation 1.2	The Board should continue to engage with the DoH/NI Public Appointments to develop a succession plan to ensure the staggered replacement of NEDs in line with best practice.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Chair
Implementation Date	September 2022

2 Trust Board Meetings and Papers

Finding

Although Trust Board agendas were viewed as appropriate and members stated that the Chair did keep to the timings as per the agenda. Internal Audit noted Board Papers and some Reports being presented are long and contain a significant amount of complex information. There is a standardised coversheet for Board Reports which highlights key achievements, risks and concerns on occasions these summaries can be four or more pages in length, resulting in key messages not being highlighted. Some Board members in the additional comments section of the survey stated that Board Papers were still too long and detailed and that papers needed to be condensed.

At the Board meeting in January 2022, a NED commented on the length (approx. 120 pages) of the Executive Director of Nursing, Midwifery and AHPs report NEDs and noted that the report had six different authors. The NED asked if it would be possible for the Director to consider rationalising this report and focus on key risks, challenges and governance issues. In our Performance Management audit report 2021/22, Internal Audit have also recommended review of this particular report with a view to identifying key issues.

The Trust Board Development Day in November 2021 on Risk Appetite included discussion and presentation on using risk appetite to reduce the volume of papers. This may provide the Trust with an opportunity to review the length, quantity and volume of papers being presented at each Board meeting.

Implication(s)

If Board members receive too much information, their ability to recognise the risks and fulfil their duty to question and challenge is compromised.

Recommendation 2.1	Within the confines of the statutory requirements, the Trust Board should formally define their information needs and Management should review the quality and volume of board papers presented to Board. This should include streamlining (where possible and appropriate) the volume and content of papers ensuring that key highlights and risks are included in the coversheet/summary.
Priority	2
Management Action	**ACCEPTED** All reports presented to Trust Board will be reviewed to ensure that the report cover sheet is fully completed and that achievements as well as issues/risks/challenges are being appropriately highlighted.
Responsible Manager	SMT and Board Assurance Manager
Implementation Date	June 2022

Also see recommendation 2.1in the Performance Management audit report 2021/22

3 Corporate Documents

Finding

The Management Statement and Financial Memorandum (MSFM) have not been updated since September 2017. DoH intend to replace the MSFM with a 'Partnership Agreement' between SHSCT and the DoH. The 'Partnership Agreement' will outline the overall governance framework within which SHSCT operates, including the framework through which the necessary assurances are provided to stakeholders. Roles/responsibilities of partners within the overall governance framework will also be outlined.

The MSFM is required to be tabled, at a Board meeting at least annually, the MSFM is not on the Trust Board annual cycle of reporting nor is there evidence of this having been brought to a Board meeting during 2021/22.
The MSFM needs to be clearer in terms of Chief Executive reporting responsibility to Board. The MSFM at paragraph 3.6.3 refers to the Chief Executive's responsibility to advise the Board as opposed to his accountability to the Board.

The SHSCT Standing Financial Instructions (SFIs) have not been updated since June 2018 and there is no review date recorded on the SFIs.

Implications

Potential for lack of clarity over roles and responsibilities. There is a risk that key governance documents do not reflect current and best practice.

Recommendation 3.1	The Trust Standing Financial Instructions should be reviewed and updated.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Director of Finance, Procurement and Estates
Implementation Date	March 2023

Recommendation 3.2	SHSCT should raise the need for the Partnership Agreement to be developed and agreed as soon as possible, with the DoH.
Priority	3
Management Action	**ACCEPTED**
Responsible Manager	Chair
Implementation Date	March 2023

4 Development of Clinical and Social Care Governance (CSCG)

Finding

The Trust has undertaken a review of its Clinical and Social Care Governance structures however implementation of this work has been delayed due to the ongoing COVID-19 pandemic.

Implication

Poor Clinical and Social Care Governance structures could lead to gaps in oversight by the Board.

Recommendation 4.1	The outcomes of the review of Clinical and Social Care Governance need to be actioned and fully implemented
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Medical Director and Interim Assistant Director of C&SCG
Implementation Date	November 2022

5 Appraisals for Executive and Non Executive Board Members

Finding

All NEDs had an appraisal at the end of 2021 with the new Chair. However one Executive Director indicated that they had not had an appraisal of their performance in relation to their role as a Board member. There is currently no mechanism in place within the HSC to appraise all Trust Board members and all those who attend and present to Trust Board. In addition this was identified as an area for improvement on the Board Self-Assessment.

Implication

Trust appraisal process has not been consistently applied at this most senior level.

Recommendation 5.1	The Trust should continue to work with the DoH and other Trusts regionally to ensure that there is an appraisal process developed for use within the HSC for all Executive and Non Executive Board members in relation to their role on the Board.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Chair
Implementation Date	March 2023

6 Stakeholder Representation on the Trust Board

Finding

Within the Trust area, there are a diverse range of socio-economic, ethnic, and religious groups. The Trust acknowledge that the diversity of Trust Board could be further developed to more appropriately reflect the diverse community it serves.

The Chair has suggested that a consultative forum may be a way to improve diversity of the voices heard.

Implication

Failure to ensure diversity on the Board means that it is not fully representative of the SHSCT community.

Recommendation 6.1	As per CPANI Guidance on carrying out a skills and attributes audit on a public board, the need for Board diversity should be considered in a Skills and Attributes audit in consultation with DoH, before each public appointment round.
Priority	3
Management Action	**ACCEPTED** To be carried out in advance of next public appointment process for SHSCT Board.
Responsible Manager	Chair
Implementation Date	June 2022

7 Induction Training for Board Members

Finding

There were two new Board Members in the SHSCT during 2021. All board members must complete an induction process. Internal Audit noted:

- 3 of 4 (75%) Executive Directors who responded to the survey indicated that they had not had a satisfactory board induction.
- 80% of NEDs agreed that they had a satisfactory induction. However there is a sense amongst NEDs that the induction process could be further refined.

Implication

Gaps in induction could potentially reduce the effectiveness of the Board.

Recommendation 7.1	The Trust should review induction needs of new members – both executives and non executives.
Priority	3
Management Action	**ACCEPTED**
Responsible Manager	Chair and Board Assurance Manager
Implementation Date	June 2022

8 Board Survey Results

Finding

Internal Audit issued a board effectiveness survey to the Chief Executive, Chairperson, 5 NEDs, 4 Executive Directors and 4 Operational Directors that attend the Board. The survey covered 8 specific areas including Building the Board; Developing the Board; Roles and Responsibilities and Relationships; Board meetings; Board Information; Board processes, Communication and Values. Twelve out of a potential 15 responses were received. The results were largely very positive including for example:

- 100% of respondents agreed with all five statements relating to Board Information.
- 100% of respondents agreed with all four statements relating to Values and that these are evident in how the Board conducts its business.
- 100% of respondents agreed that the Board has the specific skills needed for oversight of SHSCT.
- 100% of respondents agreed that the Board is familiar with current best practice in risk management for identifying, assessing and managing risk.
- 100% of respondents agreed that the Board is underpinned by a spirit of trust and professional respect.
- 100% of respondents agreed that they were happy to challenge other members' views and instigate constructive debate on difficult issues.
- 100% of respondents agreed that they could raise concerns with the Chair and / or Chief Executive, and know they will be addressed.
- 100% of respondents agreed that the Board is always objective and collectively acts in the best interests of the organisation
- 100% of respondents agreed that there is positive interaction between board members, Chief Executive and Directors present.
- 100% of respondents agreed that the Chair effectively discharges her responsibilities.
- 100% of respondents agreed that a dedicated Board secretary with appropriate skills and experience is in place and that Board minutes are reflective of actual discussions including contribution of individual members, decisions made, actions agreed and responsibilities allocated
- 100% of respondents to the survey agreed that all Board members are personally engaged and interested in the SHSCT's activities.
- 100% of respondents agreed that the Board acknowledges instances where something went wrong and openly discusses how it should be addressed or missed opportunities and what should be done differently as a result.
- 100% of respondents agreed that they know the organisational / corporate risks and these are regularly discussed at Board meetings.
- 100% of respondents agreed that they receive appropriate information between meetings to keep abreast of significant issues, trends or developments.

In addition to the areas highlighted in the findings above other areas for potential future consideration relate to the following:

- 50% of respondents disagreed that the work of the Board and its Committees does not overburden any individual members.
- 33% of respondents disagreed that the size of the Board is right in terms of the number of non-executive members, given the complexity of HSC provider environment.
- 33% of respondents disagreed that the appropriate level of induction was available on joining the Board, including shadowing etc. of previous incumbents where necessary or mentoring provided (e.g. committee chairs etc.)
- 25% of respondents disagreed that Board membership is sufficiently diverse in terms of stakeholder representation.
- 17% of respondents disagreed that the Board has an appropriate balance of professional expertise / functional skills, as well as strategic experience amongst its members.
- 17% of respondents disagreed that the Board have a strong, and clear vision for SHSCT.

Implication

Survey results represent an opportunity for learning/development in some aspects.

Recommendation 8.1	The Board should consider any further learning coming from the audit survey results.
Priority	3
Management Action	**ACCEPTED**
Responsible Manager	Chair and Chief Executive
Implementation Date	June 2022

Appendix A – Table of Responses to Survey

Internal Audit issued a survey to the SHSCT Board and received 12 responses – 5 from Non-Executive Members, and 7 from Executive Directors and Directors who attend the Board. A comparison between Board members results and that of the senior executive team did not identify any material differences in opinions. Combined results have been included below (please note: these figures are rounded and not all questions were answered by all those surveyed)

No.	Question	Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree
1	**BUILDING THE BOARD**					
1b	The size of the Board is right in terms of the number of non-executive members, given the complexity of HSC provider environment.	17%	42%	8%	25%	8%
1c	The work of the Board and its Committees does not overburden any individual members.	8%	42%	-	42%	8%
1d	The Board has an appropriate balance of professional expertise / functional skills, as well as strategic experience amongst its members.	8%	75%	-	17%	-
1e	The Board has the specific skills needed for oversight of SHSCT.	17%	83%	-	-	-
1f	Board membership is sufficiently diverse in terms of stakeholder representation.	8%	58%	8%	25%	-
1g	All Board members are personally engaged and interested in the SHSCT's activities.	92%	8%	-	-	-
1h	Our Board is sufficiently future proofed against sudden loss of members.	8%	8%	8%	67%	8%
2	**DEVELOPING THE BOARD**					
2a	Appropriate level of induction was available on joining the Board, including shadowing etc. of previous incumbents where necessary or mentoring provided (e.g. committee chairs etc.)	25%	33%	8%	33%	-
2b	I had an initial meeting with the chairman on appointment and was briefed on the organisation / personal induction assessment performed	36%	45%	18%	-	-
2c	I receive regular updates on new developments / legislation etc. in order to keep Board members' skills and knowledge up-to-date	50%	33%	17%	-	-
2d	As part of my development I have visited departments in the organisation / directors & Heads of Service have presented work	75%	17%	8%	-	-
2e	After a couple of months, I had a personal follow up meeting with the chair.	45%	27%	18%	9%	-
2f	I have an opportunity to meet informally with other board members or directors	67%	33%	-	-	-
2g	I routinely attend mandatory training and updates on new / emerging issues	45%	55%	-	-	-

No.	Question	Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree
2h	I have had an annual assessment of my performance on the board	50%	30%	10%	10%	-
2i	The Board understands and has agreed the organisations risk appetite	30%	40%	30%	-	-
2j	The Board is familiar with current best practice in risk management for identifying, assessing and managing risk	45%	55%	-	-	-
3	**ROLES, RESPONSIBILITES AND RELATIONSHIPS**					
3a	There is clarity around roles of a board member, chairperson and chief executive and their respective responsibilities	45%	45%	9%	-	-
3b	The Management Statement and Standing Financial Instructions (SFIs) are accurate re roles and responsibilities	45%	36%	18%	-	-
3c	Our Board is underpinned by a spirit of trust and professional respect.	82%	18%	-	-	-
3d	I am happy to challenge other members views and instigate constructive debate on difficult issues	80%	20%	-	-	-
3e	I can raise concerns with the Chair and / or Chief Executive, and know they will be addressed	73%	27%	-	-	-
3f	I feel my views are valued by the Chair, Chief Executive and other Board Members	82%	18%	-	-	-
3g	The Board is always objective and collectively acts in the best interests of the organisation	82%	18%	-	-	-
3h	This organisation has strong leadership and appropriate culture	27%	64%	9%	-	-
3i	The Chief Executive values the views of the Board, and seeks our views on important decisions	64%	36%	-	-	-
3j	I am happy to contact the chair, Chief Executive or Directors outside of board meetings, if I have concerns or require further information.	73%	27%	-	-	-
3k	There is positive interaction between board members, Chief Executive and directors in meetings.	91%	9%	-	-	-
3l	Executives speak openly and engage in issues within their remit.	73%	27%	-	-	-
3m	The Board meets as often as necessary without the Chief Executive and Directors present.	27%	36%	36%	-	-
3n	The Board is a strong collaborative team.	55%	45%	-	-	-
3o	The Chair effectively discharges his/her responsibilities.	80%	20%	-	-	-
4	**BOARD MEETINGS**					
4a	A dedicated Board Secretary with appropriate skills and experience is in place.	92%	8%	-	-	-

No.	Question	Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree
4b	Sufficient time is made available to allow the Board to discharge its collective responsibility.	50%	50%	-	-	-
4c	The agenda for Board meetings is appropriate to ensure that all relevant items are brought to the Board's attention.	58%	42%	-	-	-
4d	Board decision making is effective, and collective responsibility for taking informed and transparent decisions within its scheme of delegation is exercised	64%	36%	-	-	-
4e	Board minutes are reflective of actual discussions including contribution of individual members, decisions made, actions agreed and responsibilities allocated	75%	25%	-	-	-
4f	Potential and actual Conflicts of interest are managed effectively.	75%	25%	-	-	-
4g	The Board makes effective use of technology to conduct its business.	83%	17%	-	-	-
4h	The Board undertakes realistic self-reflection / self-evaluation	33%	58%	8%	-	-
5	**BOARD INFORMATION**					
5a	Papers for Board meetings contain relevant and appropriate material and are received sufficiently in advance of the meeting.	25%	75%	-	-	-
5b	Information is available to Board members in a form and of a quality and quantity that enables the Board to discharge duties effectively.	25%	75%	-	-	-
5c	There is appropriate consideration at Board level to service quality, patient safety and client experience.	75%	25%	-	-	-
5d	There is appropriate consideration at Board level given to financial position.	83%	17%	-	-	-
5e	There is a sufficient balance of consideration at the Board of competing pressures of performance, financial position and quality/safety and there is appropriate integration between these three competing areas.	50%	50%	-	-	-
6	**BOARD PROCESSES**					
6a	The Board acknowledges instances where something went wrong and openly discusses how it should be addressed or missed opportunities and what should be done differently as a result.	64%	36%	-	-	-
6b	We have a strong, and clear vision for SHSCT.	42%	42%	-	17%	-
6c	We regularly consider what our long term objectives should be and how external factors may impact them.	25%	67%	8%	-	-

No.	Question	Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree
6d	I am familiar with and have contributed to developing our corporate plan, objectives and strategies to achieve these	45%	55%	-	-	-
6e	There is sufficient balance at Board level between looking back and strategic forward /future planning.	45%	55%	-	-	-
6f	I had an opportunity to challenge content of the annual business plan and I am happy with the content and targets set.	55%	45%	-	-	-
6g	The Board receives regular updates on issues impacting other Trusts both regionally and nationally.	73%	18%	9%	-	-
6h	The Board committee structure is clear and the Board is adequately informed of each committees' activities.	73%	27%	-	-	-
6i	I know the organisational / corporate risks and these are regularly discussed at Board meetings.	64%	36%	-	-	-
6j	I am content organisational / corporate risks are identified promptly by directors and escalated to the Board.	64%	36%	-	-	-
6k	Action plans to mitigate organisational / corporate risks are promptly implemented.	45%	45%	9%	-	-
6l	We have a good balance between strategic and operational issues on our agenda.	55%	45%	-	-	-
7	**COMMUNICATION**					
7a	I receive appropriate information between meetings to keep abreast of significant issues, trends or developments.	73%	27%	-	-	-
7b	I often hear significant issues for the first time on the media.	0%	9%	-	82%	9%
7c	The Board is doing a good job of communicating effectively with stakeholders including DoH, staff, health professionals, volunteers, local community officials and leaders, patients and the public generally?	20%	70%	10%	-	-
7d	The Board has strong networks with other HSC organisations.	64%	27%	9%	-	-
8	**VALUES**					
8a	The Board and its committees set the tone in relation to values and adhere to these?	82%	18%	-	-	-
8b	The Trust's values are displayed in the way business is conducted and how decisions are made at the Board.	45%	55%	-	-	-
8c	Trust values and expected behaviours are embedded in our Human Resources policies, processes and practices.	55%	45%	-	-	-
8d	At Board meetings we demonstrate that we listen to the ideas and concerns of others (including key stakeholders and staff).	55%	45%	-	-	-

Appendix B - Definition of Levels of Assurance and Priorities

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and other findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in in fulfilling their responsibilities.

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MANAGEMENT STATEMENT

BETWEEN

DEPARTMENT OF HEALTH FOR NORTHERN IRELAND

&

SOUTHERN HEALTH & SOCIAL CARE TRUST

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

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

Management Statement

Southern Health & Social Care Trust

1. INTRODUCTION

1.1 This document

1.1.1 This *Management Statement* and *Financial Memorandum* (MS/FM) has been drawn up by the sponsor Department, the Department of Health, in consultation with the Southern Health & Social Care Trust (referred to in this document as SHSCT or the Trust), Southern Trust Headquarters, 68 Lurgan Road, Portadown, BT63 5QQ. The document is based on a model prepared by the Department of Finance (DoF).

1.1.2 The terms and conditions set out in the combined M*anagement Statement* and *Financial Memorandum* may be supplemented by guidelines or directions issued by the sponsor Department/Minister in respect of the exercise of any individual functions, powers and duties of the SHSCT.

1.1.3 A copy of the MS/FM for the SHSCT should be given to all newly appointed Trust Board Members, senior Trust executive staff and departmental sponsor staff on appointment. Additionally the MS/FM should be tabled for the information of Trust Board Members at least annually at a full meeting of the Board. Amendments made to the MS/FM should also be brought to the attention of the full Board on a timely basis.

1.1.4 Subject to the legislation noted below, this *Management Statement* sets out the broad framework within which the Trust will operate, in particular:

- the Trust's overall aims, objectives and targets in support of the sponsor Department's wider strategic aims and the outcomes and targets contained in the Programme for Government (PfG) and in the Commissioning Plan Direction (CPD);
- the rules and guidelines relevant to the exercise of the Trust's functions, duties and powers;
- the conditions under which any public funds are paid to the Trust; and
- how the Trust is to be held to account for its performance.

1.1.5 The associated *Financial Memorandum* sets out in greater detail certain aspects of the financial provisions which the SHSCT shall observe. However, the *Management Statement* and *Financial Memorandum* do not convey any legal powers or responsibilities.

1.1.6 The document shall be reviewed periodically by the sponsor Department in line with the reviews referred to in Section 7 below.

1.1.7 SHSCT, the sponsor Department, or the Minister, may propose amendments to this document at any time. Any such proposals by the Trust shall be considered in the light of evolving departmental policy aims, operational factors and the track record of the Trust itself. The guiding principle shall be that the extent of flexibility and freedom given to the Trust shall reflect both the quality of its internal controls to achieve performance and its operational needs. The sponsor Department shall determine what changes, if any, are to be incorporated in the document. Legislative provisions shall take precedence over any part of the document. Significant variations to the document shall be cleared with DoF Supply after consultation with the Trust, as appropriate. (The definition of "significant" will be determined by the sponsor Department in consultation with DoF).

1.1.8 The *MS/FM* is approved by DoF Supply, and signed and dated by the sponsor Department and SHSCT's Chief Executive.

1.1.9 Any question regarding the interpretation of the document shall be resolved by the sponsor Department after consultation with the SHSCT and, as necessary, with DoF Supply.

1.1.10 SHSCT should provide the documents detailed in Append 1 to the sponsor Department with the frequency described therein.

1.1.11 Copies of this document and any subsequent substantive amendments shall be placed in the Library of the Assembly. (Copies shall also be made available to members of the public on SHSCT's website).

1.2 Founding legislation: status

1.2.1 SHSCT is established by means of an Establishment Order made under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 (the 1991 Order). The Establishment Order is the Southern Health & Social Services Trust (Establishment) Order (Northern Ireland) 2006. SHSCT does not carry out its functions on behalf of the Crown.

1.3 The functions, duties and powers of SHSCT

1.3.1 SHSCT is established for the purposes specified in Article 10(1) of the 1991 Order. http://www.legislation.gov.uk/nisi/1991/194/article/10 . These include any functions of the Department with respect to administration of health and social care that the Department may direct. The Trust's general powers are listed in the Schedule to the 2006 Establishment Order -

http://www.legislation.gov.uk/nisr/2006/294/schedule/made

1.4 Classification

1.4.1 For policy/administrative purposes SHSCT is classified as a health and social care body (akin to an executive non-departmental public body).

1.4.2 For national accounts purposes SHSCT is classified to the public corporations sector.

1.4.3 References to SHSCT include, where they exist, all its subsidiaries and joint ventures that are classified to the public sector for national accounts purposes. If such a subsidiary or joint venture is created, there shall be a document setting out the arrangements between it and SHSCT.

2. AIMS, OBJECTIVES AND TARGETS

2.1 Overall aim

2.1.1 The approved overall aim for SHSCT is to improve health and social well-being outcomes, through a reduction in preventable disease and ill-health, by providing effective, high quality, equitable and efficient health and social care.

2.2 Objectives and key targets

2.2.1 The Department determines SHSCT's performance framework in light of the Department's wider strategic aims, current PfG objectives and targets and the CPD.

3. RESPONSIBILITIES AND ACCOUNTABILITY

3.1 The Minister

3.1.1 The Minister is accountable to the NI Assembly for the activities and performance of SHSCT.

His/her responsibilities include:

- keeping the Assembly informed about the Trust's performance, as part of the HSC system;
- carrying out responsibilities specified in the founding legislation including appointments to the Trust Board (including its Chairman) and laying of the annual report and accounts before the Assembly; and

- approving the remuneration scheme for Non-Executive Board members and setting the annual pay settlement each year under these arrangements.

3.2 The Accounting Officer of the sponsor Department

3.2.1 The Permanent Secretary, as the sponsor Department's principal Accounting Officer (the 'Departmental Accounting Officer'), is responsible for the overall organisation, management and staffing of the sponsor Department and for ensuring that there is a high standard of financial management in the Department as a whole. The Departmental Accounting Officer is accountable to the Assembly for the issue of any grant-in-aid (GIA) to the SHSCT. The Departmental Accounting Officer designates the Chief Executive of the SHSCT as its Accounting Officer, and may withdraw the Accounting Officer designation if he/she believes that the incumbent is no longer suitable for the role.

3.2.2 In particular, the Departmental Accounting Officer of the sponsor Department shall ensure that:

- SHSCT's strategic aim(s) and objectives support the sponsor Department's wider strategic aims, current PfG objectives and targets and the CPD;

- the financial and other management controls applied by the sponsor Department to SHSCT are appropriate and sufficient to safeguard public funds and for ensuring that the Trust's compliance with those controls is effectively monitored ("public funds" include not only any funds granted to the Trust by the Assembly but also any other funds falling within the stewardship of the Trust);

- the internal controls applied by SHSCT conform to the requirements of regularity, propriety and good financial management; and

- any GIA to SHSCT is within the ambit and the amount of the Request for Resources and that Assembly authority has been sought and given.

3.2.3 The Departmental Accounting Officer is also responsible for ensuring that arrangements are in place to:

- continuously monitor SHSCT's activities to measure progress against approved targets, standards and actions, and to assess compliance with safety and quality, governance, risk management and other relevant requirements placed on the organisation;

- address significant problems in the Trust, making such interventions as he/she judges necessary to address such problems;

- periodically carry out an assessment of the risks both to the Department's and the Trust's objectives and activities;
- inform the Trust of relevant Government policy in a timely manner; and
- bring concerns about the activities of the Trust to the full SHSCT Board, requiring explanations and assurances that appropriate action has been taken.

3.2.4 The responsibilities of a Departmental Accounting Officer are set out in more detail in Chapter 3 of Managing Public Money Northern Ireland (MPMNI).

3.3 The DoH Executive Board Member, the sponsor team and Finance Directorate

3.3.1 Sponsorship of SHSCT is the responsibility of DoH as a whole. The Department has allocated an Executive Board Member (EBM) Sponsor to each Arms Length Body (ALB). The EBM Sponsor has primary responsibility for overseeing sponsorship of the ALB. In particular the EBM supports the Permanent Secretary in ensuring sponsorship is applied systematically; provides an assurance that a proportionate approach to assurance and accountability is in place; manages the ALB's business planning process; and ensures that significant governance, risk management or internal control issues are escalated within the Department. The EBM sponsor also undertakes end-year appraisals for ALB Chairs and participates in ground-clearing and accountability meetings as required.

3.3.2 HSC Sponsorship Branch is the sponsor team for the SHSCT. The sponsor team, in consultation as necessary with the Departmental Accounting Officer, is the primary source of advice to the Minister on the discharge of his/her responsibilities in respect of the SHSCT, and, subject to paragraph3.3 4, is the primary point of contact for the Trust in dealing with the sponsor Department. The sponsoring team carries out its duties under the management of the EBM.

3.3.3 The sponsor Department shall advise the Minister on an appropriate framework of objectives and targets for SHSCT in the light of the Department's wider strategic aims, current PfG objectives and targets and the CPD.

3.3.4 On financial matters, the primary point of Departmental contact for the Trust is the Department's Finance Directorate. The Directorate supports the Departmental Accounting Officer on his / her responsibilities towards the Trust regarding accounting arrangements, budgetary control and other financial matters, including procurement. In doing so, Finance Directorate shall liaise as appropriate with the sponsor team.

3.4 The SHSCT Board

3.4.1 Non Executive Board Members are appointed by the Minister following an open and transparent public appointment competition carried out in line with the Code of Practice issued by the Commissioner for Public Appointments NI. The Trust Board comprises a Non-Executive Chair and seven Non-Executive Members. The Non-Executive Members include 6 Lay Members and a Lay Member with Financial experience. Appointments are normally for a four year term and are restricted to 2 terms. Notwithstanding the length of individual appointment terms, the maximum period in post must not exceed 10 years. Appointments are made in line with appropriate legislation; Health and Social Services Trusts (Membership and Procedure) Regulations (NI) 1994.

3.4.2 The SHSCT Board has corporate responsibility for ensuring that SHSCT fulfils 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. To this end, and in pursuit of its wider corporate responsibilities, SHSCT Board shall:

- establish the overall strategic direction of the Trust within the policy and resources framework determined by the sponsor Minister and Department;

- constructively challenge the Trust's executive team in their planning, target setting and delivery of performance;

- ensure that the sponsor Department (through the Health & Social Care Board (HSCB)) is kept informed of any changes which are likely to impact on the strategic direction of the Trust or on the attainability of its targets, and determine the steps needed to deal with such changes;

- ensure that any statutory or administrative requirements for the use of public funds are complied with; that the Trust Board operates within the limits of its statutory authority and any delegated authority agreed with the sponsor Department, and in accordance with any other conditions relating to the use of public funds; and that, in reaching decisions, the Trust Board takes into account all relevant guidance issued by DoF and the sponsor Department;

- ensure that the Trust Board receives and reviews regular financial information concerning the management of the Trust; is informed in a timely manner about any concerns about the activities of the Trust; and provides positive assurance to the sponsor Department that appropriate action has been taken on such concerns;

- demonstrate high standards of corporate governance at all times, including using the independent Audit Committee, (see paragraph 4.7) to help the Trust Board to address the key financial and other risks facing the Trust; and

- in accordance with the latest Departmental guidance, appoint a Chief Executive to the SHSCT and, in consultation with the sponsor Department, set performance objectives and remuneration terms linked to these objectives for the Chief Executive, which give due weight to the proper management and use of public monies.

3.4.3 Individual Trust Board Members shall act in accordance with their wider responsibilities as Members of the Board – namely to:

- comply at all times with the Code of Conduct and Accountability (see paragraph 3.5.5) that is adopted by SHSCT and with the rules and guidance relating to the use of public funds and to conflicts of interest;

- not misuse information gained in the course of their public service for personal gain or for political profit, nor seek to use the opportunity of public service to promote their private interests or those of connected persons or organisations; and to declare publicly and to the Trust Board any private interests that may be perceived to conflict with their public duties;

- comply with the Trust Board's rules on the acceptance of gifts and hospitality, and of business appointments; and

- act in good faith and in the best interests of the Trust.

3.4.4 The Trust Board shall provide the sponsor Department with access to all Trust Board meeting minutes. These should be provided to the sponsor team in draft form at the same time as they are circulated to Board Members. The Trust shall provide final agreed minutes to the sponsor team in a timely way

3.5 The Chairman of the SHSCT

3.5.1 The Chairman is appointed by the Minister following an open and transparent public appointment competition as outlined in paragraph 3.4.1. Appointments are made in line with appropriate legislation; Health and Social Services Trusts (Membership and Procedure) Regulations (NI) 1994 http://www.legislation.gov.uk/nisr/1994/63/pdfs/nisr_19940063_en.pdf

3.5.2 The Chairman is accountable to the Minister of the sponsor Department. The Chairman shall ensure that SHSCT's policies and actions support the wider strategic policies of the Minister; and that the Trust's affairs are conducted with probity. The Chairman shares with other Trust Board members the corporate responsibilities set out in paragraph 3.4.2, and in particular for ensuring that the Trust fulfils the aims and objectives set by the sponsor Department and approved by the Minister.

3.5.3 The Chairman has a particular leadership responsibility on the following matters:

- formulating the Trust Board's strategy for discharging its duties;
- ensuring that the Trust Board, in reaching decisions, takes proper account of guidance provided by the Minister, the sponsor Department, the HSCB or the PHA;
- 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 Trust Board to the general public;
- ensuring that risk management is considered regularly and formally at Board meetings; and
- ensuring that the Trust 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. Meetings must be open to the public, the public should be advised in advance of meetings through the press or other media such as the Trust's website and the minutes must be placed on the Trust's website after formal approval.

3.5.4 The Chairman shall also:

- ensure that all members of the Trust 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, including on the financial management and reporting requirements of public sector bodies and on any differences which may exist between private and public sector practice;
- advise the Department of the needs of SHSCT when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise; and

- assess the performance of individual Trust Board Members. Trust Board Members will be subject to ongoing performance appraisal, with a formal assessment being completed in consultation with Trust Committee Chairs as appropriate by the Chair of the Board at the end of each year and prior to any proposed re - appointment or extension of the term of appointment of individual members taking place. Members will be made aware that they are being appraised, the standards against which they will be appraised, and will have an opportunity to contribute to and view their report. The Chair of the Board will also be appraised on an annual basis by the Departmental EBM.

- ensure the completion of the Board Governance Self Assessment Tool on an annual basis. Assurance will be provided through the mid-year assurance statement that the tool is being completed, actions are being addressed and that any exception issues will be raised with the Department.

3.5.5 The Chairman shall also ensure that Trust Board Members are made aware of the Code of Conduct for Board Members of HSC Bodies (2012) which reflects the Cabinet Office's *Code of Practice for Board Members of Public Bodies*, (FD (DFP) 03/06), including the Nolan "seven principles of public life", and also including a requirement for a comprehensive and publicly available register of Trust Board Members' interests.

3.5.6 Communications between the Board, the Minister and the Department shall normally be through the Chairman. The Chairman shall ensure that the other Trust Board Members are kept informed of such communications on a timely basis.

3.6 The Chief Executive's role as Accounting Officer

3.6.1 The Chief Executive of SHSCT is designated as the Trust's Accounting Officer by the Departmental Accounting Officer of the sponsor Department.

3.6.2 The Accounting Officer of SHSCT is personally responsible for safeguarding the public funds for which he/she has charge; for ensuring propriety and regularity in the handling of those public funds; and for the day-to-day operations and management of the Trust. The Chief Executive should aim to attend the training course 'An Introduction for Accounting Officers' within 3 months of appointment.

3.6.3 As Accounting Officer, the Chief Executive shall exercise the following responsibilities in particular:

on planning and monitoring -

- establish, with approval of the sponsor Department, as appropriate, the SHSCT's corporate and business plans in support of the Department's wider strategic aims and current PfG objectives and targets;

- inform the HSCB and the sponsor Department as appropriate of the Trust's progress in helping to achieve the Department's policy objectives and in demonstrating how resources are being used to achieve those objectives;

- ensure that timely forecasts and monitoring information on performance and finance are provided to the HSCB and the sponsor Department as appropriate, including prompt notification if overspends or underspends are likely and that corrective action is taken;

- that any significant problems, whether financial or otherwise, and whether detected by internal audit or by other means, are notified to the HSCB or the sponsor Department as appropriate in a timely fashion;

on advising the Board -

- advise the Trust Board on the discharge of its responsibilities as set out in this document, in the founding legislation and in any other relevant instructions and guidance that may be issued from time to time by DoF or the sponsor Department;

- advise the Trust Board on SHSCT's performance compared with its aims and objectives;

- ensure that financial considerations are taken fully into account by the Trust Board at all stages in reaching and executing its decisions, and that standard financial appraisal techniques are followed appropriately;

- take action in line with Section 3.8 of MPMNI if the Trust Board, or its Chairman, is contemplating a course of action involving a transaction which the Chief Executive considers would infringe the requirements of propriety or regularity, or does not represent prudent or economical administration, efficiency or effectiveness;

on managing risk and resources –

- ensure that a system of risk management is maintained to inform decisions on financial and operational planning and to assist in achieving objectives and targets;

- ensure that an effective system of programme and project management and contract management is maintained;

- ensure compliance with the Northern Ireland Public Procurement Policy;

- ensure that all public funds made available to SHSCT, including any income or other receipts, are used for the purpose intended by the Assembly, and that such monies, together with the Trust's assets, equipment and staff, are used economically, efficiently and effectively;

- ensure that adequate internal management and financial controls are maintained by SHSCT, including effective measures against fraud and theft;

- maintain a comprehensive system of internal delegated authorities that are notified to all staff, together with a system for regularly reviewing compliance with these delegations;

- ensure that effective personnel management policies are maintained;

on accounting for SHSCT's activities –

- sign the accounts and be responsible for ensuring that proper records are kept relating to the accounts and that the accounts are properly prepared and presented in accordance with any directions issued by the Minister, the sponsor Department, or DoF;

- sign a Statement of Accounting Officer's responsibilities, for inclusion in the annual report and accounts;

- sign a Governance Statement regarding SHSCT's system of internal control, for inclusion in the annual report and accounts, which details significant internal control divergences;

- sign a mid-year assurance statement on the condition of the Trust's system of internal control which details significant internal control divergences;

- ensure that effective procedures for handling complaints about SHSCT are established and made widely known within the Trust;

- act in accordance with the terms of this document and with the instructions and relevant guidance in *MPMNI* and other instructions and guidance issued from time to time by the sponsor Department and DoF - in particular, Chapter 3 of MPMNI and the Treasury document *Regularity and Propriety and Value for Money* (a copy of which the Chief Executive shall receive on appointment). Section IX of the *Financial Memorandum* refers to other key guidance;

- give evidence, normally with the Accounting Officer of the sponsor Department, if summoned before the Public Accounts Committee on the use and stewardship of public funds by SHSCT;

- ensure that an Equality Scheme is in place, reviewed and equality impact assessed as required by the Equality Commission and The Executive Office;

- ensure that Lifetime Opportunities is taken into account;

- ensure that the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 are complied with;

- report on compliance with controls assurance and quality standards to the sponsor Department;
- ensure that a business continuity plan is developed and maintained;
- ensure that copies of adverse inspection reports are shared with the relevant policy lead in the Department;
- ensure full compliance with the requirements of relevant statutes, court rulings and departmental directions; and
- ensure that a policy on acceptance and provision of Gifts and Hospitality is in place, which sets out the principles and requirements under which gifts and hospitality can be received and in turn when such offers can be made.

3.7 The Chief Executive's role as Consolidation Officer

3.7.1 For the purposes of Whole of Government Accounts, the Chief Executive of SHSCT is normally appointed by DoF as the Trust's Consolidation Officer.

3.7.2 As the Trust's Consolidation Officer, the Chief Executive shall be personally responsible for preparing the consolidation information, which sets out the financial results and position of the SHSCT; for arranging for its audit; and for sending the information and the audit report to the Principal Consolidation Officer nominated by DoF.

3.7.3 As Consolidation Officer, the Chief Executive shall comply with the requirements of the SHSCT Consolidation Officer Letter of Appointment as issued by DoF and shall, in particular:

- ensure that the Trust has in place and maintains sets of accounting records that will provide the necessary information for the consolidation process; and

- prepare the consolidation information (including the relevant accounting and disclosure requirements and all relevant consolidation adjustments) in accordance with the consolidation instructions and directions ["Dear Consolidation Officer" (DCO) and "Dear Consolidation Manager" (DCM) letters] issued by DoF on the form, manner and timetable for the delivery of such information.

3.8 Delegation of duties

3.8.1 The Chief Executive may delegate the day-to-day administration of his/her Accounting Officer and Consolidation Officer responsibilities to other employees in SHSCT. However, he/she shall not assign absolutely to any other person any of the responsibilities set out in this document.

3.9 The Chief Executive's role as Principal Officer for Ombudsman cases

3.9.1 The Chief Executive of SHSCT is the Principal Officer for handling cases involving the Northern Ireland Commissioner for Complaints. As Principal Officer, he/she shall inform the Permanent Secretary of the sponsor Department of any complaints about the Trust accepted by the Ombudsman for investigation, and about the Trust's proposed response to any subsequent recommendations from the Ombudsman.

3.10 Consulting customers

3.10.1 SHSCT will work in partnership with its stakeholders and customers, patients, other service users and carers to deliver the services/programmes for which it has responsibility, to agreed standards. It will consult regularly, within the parameters of the Trust's Consultation Scheme, to develop a clear understanding of citizens' needs and expectations of its services, and to seek feedback from both stakeholders and customers, patients, other service users and carers and will work to deliver a modern, accessible service.

3.10.2 SHSCT shall comply with the duties and requirements relating to the duty to co-operate with the Patient and Client Council, public involvement and consultation schemes in Sections 18, 19 and 20 of the Health and Social Care (Reform) Act (Northern-Ireland) 2009 - http://www.legislation.gov.uk/nia/2009/1/pdfs/nia_20090001_en.pdf .

4. PLANNING, BUDGETING AND CONTROL

4.1 The corporate plan

4.1.1 The term corporate plan refers to the Trust's four year plan which sets out the strategic issues the Trust will deal with in that period. Consistent with the timetable for the NI Executive's Budget process reviews, SHSCT shall submit to the sponsor team a draft of its corporate plan normally covering the four years ahead. The Trust shall have agreed with the sponsor Department the issues to be addressed in the plan and the timetable for its preparation. A draft of the corporate plan should be provided to the sponsor team by 31st January in the year preceding the first year of the plan.

4.1.2 DoF reserves the right to see and agree SHSCT's corporate plan.

4.1.3 The plan shall reflect the Trust's statutory duties and, within those duties, the priorities set from time to time by the Minister. In particular, the plan shall demonstrate how the Trust contributes to the achievement of the Department's strategic aims, PfG objectives and targets and the CPD. The plan may also refer to the financial environment within which the Trust is operating.

4.1.4 The corporate plan shall set out:

- SHSCT's key objectives and associated key performance targets for the forward years, its strategy for achieving those objectives and an estimate of performance in the current year;
- alternative scenarios to take account of factors which may significantly affect the execution of the plan, but which cannot be accurately forecast;
- a forecast of expenditure and income, taking account of guidance on resource assumptions and policies provided by the sponsor Department at the beginning of the planning round. These forecasts should represent the Trust's best estimate of all its available income, not just any grant or GIA; and
- other matters as agreed between the sponsor Department and the Trust – for example - statement of purpose of organisation as per legislation, strategic aims, performance in preceding

corporate plan period, governance and accountability arrangements, links with PfG, wider ministerial/departmental priorities and the CPD.

4.1.5 The main elements of the plan, including the key performance targets, shall be agreed between the sponsor Department and SHSCT in the light of the sponsor Department's decisions on policy and resources taken in the context of the Executive's wider policy and spending priorities and decisions.

4.1.6 In line with paragraph 4.1.1 the corporate plan should be submitted to the sponsor Department for approval.

4.2 The Trust Delivery Plan

4.2.1 The first year of the corporate plan, amplified as necessary, shall provide the basis of the Trust Delivery Plan (TDP) for the relevant forthcoming year. The Trust and the HSCB should agree on a timeframe for submission and agreement of the TDP, which shall include key targets and milestones for the year immediately ahead and shall be linked to budgeting information, so that resources allocated to achieve specific objectives can readily be identified by the sponsor Department.

4.2.2 The TDP should include reference to Specific, Measurable, Attainable, Realistic and Time-bound objectives that:

- support the delivery of PfG Commitments;
- support the delivery of Departmental policy and strategy;
- deliver on the functions etc. specified in SHSCT's founding legislation setting out the purposes for which the Trust was created and the functions/services it is to deliver;
- address known areas of underperformance, the findings of inquiries etc.; and
- respond to particular events, serious adverse incidents and near misses; and support the training and development of staff.

4.2.3 DoF reserves the right to ask to see and agree SHSCT's TDP.

4.2.4 The TDP is for formal approval by the HSCB.

4.3 Publication of plans

4.3.1 The corporate plan and the TDP shall be published by the Trust and made available on its website. A summary version shall be made available to staff.

4.4 Reporting performance to the sponsor Department

4.4.1 SHSCT shall operate management information and accounting systems which enable it to review in a timely and effective manner its financial and non-financial performance against the budgets and targets set out in its agreed corporate plan and TDP.

4.4.2 The Trust shall take the initiative in informing the HSCB and the sponsor Department of changes in external conditions which make the achievement of objectives more or less difficult, or which may require a change to the budget or objectives as set out in the corporate plan or TDP.

4.4.3 The Trust's performance against the CPD's objectives and targets shall be reported to the Department on a monthly basis, through formal reporting arrangements with the HSCB and the PHA. Performance will be reviewed formally twice yearly through the formal accountability review process by officials of the sponsor Department. The Minister may meet the Trust Board as appropriate to discuss the Trust's performance, its current and future activities, and any policy developments relevant to those activities.

4.4.4 The Sponsor Department may, at its discretion, request evidence of progress against key objectives at any time.

4.4.5 Senior Departmental officials will hold biannual Ground Clearing meetings with SHSCT. The purpose of these meetings is to discuss the Trust's overall performance, its current and future activities, any policy developments relevant to those activities, safety and quality, financial performance, corporate control/risk management performance, and other issues as determined by the Department. Issues identified at the Ground Clearing meeting which cannot be resolved at the meeting or through other avenues will be escalated for discussion to the Accounting Officer Accountability meeting with the Chair and Chief Executive of the SHSCT.

4.4.6 The SHSCT's performance against key targets shall be reported in its annual report and accounts [see Section 5.1 below].

4.5 Budgeting procedures

4.5.1 SHSCT's budgeting procedures are set out in the *Financial Memorandum* at Appendix 2 to this Management Statement.

4.6 Internal audit

4.6.1 SHSCT shall establish and maintain arrangements for internal audit in accordance with the Public Sector Internal Audit Standards (PSIAS).

4.6.2 The sponsor Department shall:-

- have input to SHSCT planned internal audit coverage;
- agree arrangements for the receipt of audit reports, assignment reports, the Head of Internal Audit's annual report and opinion etc;
- agree arrangements for the completion of Internal and External Assessments of the Trust's internal audit function against PSIAS including advising that the sponsor Department reserves a right of access to carry out its own independent reviews of internal audit in SHSCT; and
- have the right of access to all documents prepared by the Trust's internal auditor, including where the service is contracted out. Where the SHSCT's audit service is contracted out the Trust should stipulate this requirement when tendering for the services.

4.6.3 SHSCT shall consult the Business Services Organisation (BSO) to ensure that the latter is satisfied with the competence and qualifications of the Head of Internal Audit and that the requirements for approving the appointment are in accordance with Public Sector Internal Audit Standards (PSIAS) and relevant DoF guidance.

4.6.4 The sponsor Department will review the Trust's terms of reference for internal audit service provision. The Trust shall notify the sponsor Department of any subsequent changes to internal audit's terms of reference.

4.6.5 The sponsor team will have an annual meeting with SHSCT's internal audit to discuss the Trust's audit plan and strategy.

4.7 Audit Committee

4.7.1 SHSCT shall set up an independent Audit Committee as a committee of its Board, in accordance with current Cabinet Office Guidance and in line with the Audit and Risk Assurance Committee Handbook

4.7.2 The audit committee's meeting agendas and minutes shall be forwarded as soon as possible to the sponsorship team. Audit Committee papers should be provided to the sponsor team for the purposes of paragraph 4.7.5.

4.7.3 The Audit Committee should complete the National Audit Office Checklist on an annual basis. Assurance on completion of the checklist will be provided through the mid-year assurance statement. Any exception issues should be reported to the Department.

4.7.4 The sponsor team will review SHSCT's Audit Committee terms of reference. The Trust shall notify the sponsor Department of any subsequent changes to the Audit Committee's terms of reference.

4.7.5 The sponsor team will attend at least one Trust Audit Committee meeting per year as an observer and will not participate in any Audit Committee discussion.

4.8 Fraud

4.8.1 SHSCT shall report immediately to the Counter Fraud and Probity Services (CFPS) within the BSO all frauds (proven or suspected), including attempted fraud. CFPS shall then report the frauds immediately to the Sponsor Department, DoF and the Comptroller & Auditor General. In addition the Trust shall forward to CFPS the annual fraud return, commissioned by DoF, on fraud and theft suffered by the Trust.

4.8.2 SHSCT must have an Anti Fraud Policy and Fraud Response Plan in place. These should be reviewed at least every 5 years and sent to CFPS for review. The Trust shall notify the sponsor Department of any subsequent changes to the policy or response plan.

4.9 Additional departmental access to SHSCT

4.9.1 In addition to the right of access referred to in paragraph 4.6.2 above, the sponsor Department shall have a right of access to all SHSCT's records and personnel for purposes such as sponsorship audits and operational investigations (See also paragraphs 3.4.4 and 4.7.2 access to Board and Audit Committee minutes).

5. EXTERNAL ACCOUNTABILITY

5.1 The annual report and accounts

5.1.1 After the end of each financial year SHSCT shall publish as a single document an annual report of its activities together with its audited annual accounts. The report shall also cover the activities of any corporate bodies under the control of the Trust. A draft of the report shall be submitted to the sponsor Department in line with the timescale set by the Department before the proposed publication date although it is expected that the Department and the Trust will have had extensive pre-publication discussion on the content of the report prior to formal submission to the Department.

5.1.2 The report and accounts shall comply with the most recent version of the Government Financial Reporting Manual (FReM) issued by DoF. The accounts shall be prepared in accordance with any relevant statutes and the specific Accounts Direction issued by the sponsor Department.

5.1.3 The report and accounts shall outline SHSCT's main activities and performance during the previous financial year and set out in summary form its forward plans. Information on performance against key financial targets shall be included in the notes to the accounts, and shall therefore be within the scope of the audit.

5.1.4 The report and accounts shall be laid before the Assembly and made available, in accordance with the guidance on the procedures for presenting and laying the combined annual report and accounts as prescribed in the relevant Finance Director (FD) letter issued by DoF.

5.1.5 Due to the potential accounting and budgetary implications, any changes to accounting policies or significant estimation techniques underpinning the preparation of annual accounts requires the prior written approval of Finance Directorate in the sponsor Department.

5.2 External audit

5.2.1 The C&AG audits SHSCT's annual accounts and passes the accounts to Finance Directorate in the sponsor Department who shall lay them before the Assembly. For the purpose of audit the C&AG has a statutory right of access to relevant documents as provided for in Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003.

5.2.2 The C&AG will liaise with SHSCT on the arrangements for completing the audit of its accounts. This will either be undertaken by staff of the NIAO or a private sector firm appointed by the C&AG to undertake the audit on his behalf. The final decision on how such audits will be undertaken rests with the C&AG, who retains overall responsibility for the audit.

5.2.3 The C&AG has agreed to share with the sponsor Department relevant information identified during the audit process, including the report to those charged with governance, at the end of the audit. This shall apply, in particular, to issues which impact on the Department's responsibilities in relation to financial systems within SHSCT. The C&AG will also consider, where asked, providing Departments and other relevant bodies with reports which Departments may request at the commencement of the audit and which are compatible with the independent auditor's role.

5.3 VFM examinations

5.3.1 The C&AG may carry out examinations into the economy, efficiency and effectiveness with which SHSCT has used its resources in discharging its functions. For the purpose of these examinations the C&AG has statutory access to documents as provided for under Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003. Where making payment of a grant, or drawing up a contract, SHSCT should ensure that it includes a clause which makes the grant or contract conditional upon the recipient or contractor providing access to the C&AG in relation to documents relevant to the transaction. Where subcontractors are likely to be involved, it should also be made clear that the requirements extend to them.

6. STAFF MANAGEMENT

6.1 General

6.1.1 The decision to create or fill a Director or Assistant Director position within SHSCT is subject to approval by the Permanent Secretary of the Department of Health. This position will be kept under review by the Department. Similarly, no change to the remuneration of Senior Executives can be made without prior approval by the Permanent Secretary of the Department. Any request for approval in connection with this paragraph should be addressed to the Departmental Director of Workforce Policy.

6.1.2 Within the arrangements approved by the Minister and DoF, SHSCT shall have responsibility for the recruitment, retention and motivation of its staff. To this end the Trust shall ensure that:

- its rules for the recruitment and management of staff create an inclusive culture in which diversity is fully valued; where appointment and advancement is based on merit; and where there is no discrimination on grounds of gender, marital status, domestic circumstances, sexual orientation, race, colour, ethnic or national origin, religion, disability, community background or age;

- the level and structure of its staffing, including grading and numbers of staff, are appropriate to its functions and the requirements of efficiency, effectiveness and economy;

- the performance of its staff at all levels is satisfactorily appraised and the Trust's performance measurement systems are reviewed from time to time;
- its staff are encouraged to acquire the appropriate professional, management and other expertise necessary to achieve the Trust's objectives;
- proper consultation with staff takes place on key issues affecting them;
- adequate grievance and disciplinary procedures are in place;
- whistle blowing procedures consistent with the Public Interest (Northern Ireland) Order 2003 are in place; and
- a code of conduct for staff is in place based on Annex 5A of Public Bodies: A Guide for NI Departments (available at www.afmdni.gov.uk).

7. REVIEWING THE ROLE OF SHSCT

7.1 The role of SHSCT may be reviewed at the discretion of the sponsor Department, particularly to align with the outcomes of the strategic transformation agenda. Chapter 9 of the Public Bodies: a Guide for Northern Ireland Departments refers.

SIGNED ON BEHALF OF THE DEPARTMENT OF HEALTH

Personal Information redacted by the USI

PERMANENT SECRETARY

DATE: 13/12/17

SIGNED ON BEHALF OF SHSCT

Personal Information redacted by the USI

CHIEF EXECUTIVE

DATE: 26/9/17

Appendix 1

1. Documentary requirements

Documentation to be sent to the Sponsor Branch (except where elsewhere is specified, in which case cc to Sponsor Branch)

Monthly (or as the occasion arises)

- Board meeting agenda and draft minutes for each meeting as and when issued to Board members, and when requested, specific papers prepared for Board meetings
- Audit Committee agenda and papers (including draft minutes for each meeting as and when issued to Committee members
- Monthly financial monitoring returns, to Finance Directorate in the Department

Bi-annual

- Corporate Risk Register every six months
- DAC returns, to Finance Directorate in the Department

Annually

- Annual Governance Statement
- Mid-year Assurance Statement (by end-October)
- Annual report on Compliance with Controls Assurance Standards, to Governance Unit in the Department
- Annual Internal Audit work-plan
- Internal Audit Progress Report
- Annual Fraud return, to Finance Directorate in the Department

- The Head of Internal Audit's Annual Mid Year Assurance statements
- Register of Board members' interests
- Reports to Those Charged with Governance provided by NIAO to the Department's Permanent Secretary
- The annual report, with the draft submitted to the Department two weeks before the publication date (*separate timetable for the annual accounts, Governance Statement etc, set by Finance Directorate*)
- The Assurance Framework

Once and then when revised

- Code of Conduct for Board members, to Workforce Policy Directorate in the Department
- Audit Committee Terms of Reference
- Complaints procedure
- Anti-Fraud Policy
- Fraud Response Plan
- Whistle-blowing procedures
- Grievance and Disciplinary procedures
- Gifts & Hospitality Policy
- Equality scheme
- Publication scheme
- Consultation Scheme
- Business Continuity Plan

As specified

- Corporate Plan for approval

Once

- Adverse inspection reports by external bodies (e.g. RQIA, MHRA) to relevant policy leads in the Department.
- Internal Audit reports with less than satisfactory assurance.

Southern Health and Social Care Trust

Quality Care - for you, with you

Trust Board Membership

2010 – 2021

Chair and Non Executive Directors

Role and Name	From	To
Mr R Alexander Non-Executive Director	August 2011	December 2014
Mrs D Blakely Non-Executive Director	April 2007	December 2015
Mrs R Brownlee Non-Executive Director Chair	April 2007 March 2011	March 2011 November 2020
Ms G Donaghy Non-Executive Director	January 2017	Present
Mr E Graham Non-Executive Director	April 2007	December 2016
Mrs H Kelly* Non-Executive Director	April 2007	December 2015
Mr A Joynes Non-Executive Director	April 2007	August 2011
Mrs P Leeson Non-Executive Director	January 2017	Present
Mrs E Mahood Non-Executive Director	April 2007	December 2016
Mrs H McCartan Non-Executive Director	February 2016	Present
Mr McDonald Non-Executive Director	January 2017	Present
Ms E Mullan Non-Executive Director Chair	February 2016 December 2020	November 2020 Present
Dr R Mullan Non-Executive Director	April 2007	December 2016
Mrs S Rooney Non-Executive Director	August 2011	August 2020
Mr J Wilkinson Non-Executive Director	February 2016	Present

*deceased

Chief Executive and Directors

Role and Name	From	To
Chief Executive		
- Mrs Mairead McAlinden	November 2010 (having held this role in an acting position since September 2009)	March 2015
- Mrs Paula Clarke (Deputy) (Acting)	January 2015 April 2015	March 2015 March 2016
- Mr Francis Rice (Interim)	April 2016	March 2018
- Mr Stephen McNally (Acting Interim)	January 2017 & November 2017	July 2017 March 2018
- Mr Shane Devlin	March 2018	February 14th 2022
- **Dr Maria O'Kane**	February 14th 2022	Present
Deputy Chief Executives		
- Mrs Heather Trouton	June 2023	Present
- Ms Catherine Teggart	June 2023	Present
Director of Mental Health & Disability Services		
- Mr Francis Rice *(also Executive Director of Nursing & AHPs)*	April 2007	March 2016

- Mr Miceal Crilly (Acting)	January 2013	April 2015
- Mr Bryce McMurray (Acting) *(also Interim Executive Director of Nursing & AHPs)*	May 2016 October 2017	December 2017 December 2017
- Mrs Carmel Harney (Acting)	January 2018	December 2018
- Mr Barney McNeany	January 2019	March 2021
- Dr Maria O'Kane (Acting)	March 2021	February 14th 2022
- Mrs Heather Trouton (Interim)	February 14th 2022	March 2022
- Ms Jan McGall	March 2022	Present
Director of Human Resources and Organisational Development		
- Mr Kieran Donaghy - Mrs Vivienne Toal	April 2007 September 2016	August 2016 Present
Director of Finance & Procurement		
- Mr S McNally	January 2011 (having held this role in an acting position since September 2009)	January 2017
- Ms Helen O'Neill	July 2017 September 2018 (having held this role in an acting position since January 2017)	November 2017 July 2021
- Ms Catherine Teggart	September 2021	Present
Director of Children & Young Peoples Services/Executive Director of Social Work Mr Paul Morgan	March 2011 (having held this role in an acting position since December 2009)	September 2021
Mr Colm McCafferty (Interim)	September 2021	Present
Director of Acute Services		
- Joy Youart	April 2008	30 November 2009
- Dr Gillian Rankin	1 December 2009	March 2013
- Mrs Debbie Burns (Acting)	March 2013	August 2015
- Mrs Esther Gishkori	August 2015	April 2020

- Mrs Anita Carroll (Acting)	July 2018	September 2018
- Mrs Melanie McClements	October 2020 (having held this role in an interim positon since June 2019)	July/August 2022
- Mrs Trudy Reid (Interim Director of Surgery and Elective Care, Cancer & Clinical Services & Integrated Maternity & Women's Health)	July/August 2022	January 1st 2023
- Mrs Cathrine Reid (Interim Director of Unscheduled Care)	July/August 2022	January 1st 2023
- Mrs Cathrine Reid (Director of Surgery and Clinical Services)	January 1 2023	Present
- Mrs Trudy Reid (Director of Medicine and Unscheduled Care)	January 1 2023	Present
Director of Performance and Reform		
- Mrs Paula Clarke	March 2011 (having held this role in an acting positon since September 2009)	March 2015
- Mrs A Magwood	February 2017 (having held this role in an acting positon since March 2015)	March 2022
- Mrs Lesley Leeman (Interim)	March 2022	June 2023
- Ms Elaine Wilson	June 2023	Present
Director of Older People and Primary Care Services (now Adult Community Service)		
- Mrs A McVeigh	March 2011 (having held this role in an interim position since December 2009)	October 2017
(also Executive Director of Nursing & AHPs)	April 2016	October 2017 June 2019

- Mrs Melanie McClements - Mr Brian Beattie (previously Interim until October 2022)	September 2018 (having held this role in an interim positon since October 2017) June 2019	 Present
Medical Director - Dr Patrick Loughran - Dr John Simpson - Dr Richard Wright - Dr Ahmed Khan (Interim) - Dr Maria O'Kane - Dr Aisling Diamond (Interim) - Dr Damian Gormley (Interim) - Dr Damian Scullion (Interim) - Dr Stephen Austin	 April 2007 June 2011 July 2015 April 2018 December 2018 May 2022 July 2022 September 2022 November 2022	 July 2011 August 2015 August 2018 December 2018 April 2022 July 2022 September 2022 November 2022 Present
Director of Nursing, Midwifery and AHPs Mrs Heather Trouton	November 2019 (having held this role in an interim positon since January 2018)	Present

Version September 2011

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

FRAMEWORK DOCUMENT

Index

1. Introduction

2. Structures, Roles and Statutory Responsibilities

3. Setting the Agenda

4. Commissioning

5. Personal and Public Involvement

6. Holding the System to Account

7. Conclusion

1. INTRODUCTION

1.1. The Department has produced this Framework Document to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department.

Background

1.2. The reform of the health and social care system in Northern Ireland has its origins in the Review of Public Administration (RPA) which was initiated by the Northern Ireland Executive in June 2002. The purpose of RPA was to review Northern Ireland's system of public administration with a view to putting in place a modern, citizen-centred, accountable and high quality system of public administration.

1.3. The need to reform the health and social care system at the earliest possible opportunity was widely supported. The new design is more streamlined and accountable and aimed at maximising resources for front-line services and ensuring that people have access to high quality health and social care. Another key feature is that public health and wellbeing is put firmly at the centre of the new system, with a greater emphasis on prevention and support for vulnerable people to live independently in the community for as long as possible.

1.4. The Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the Reform Act") provides the legislative framework within which the new health and social care structures operates. It sets out the high level functions of the various health and social care bodies. It also provides the parameters within which each body must operate, and describes the necessary governance and accountability arrangements to support the

effective delivery of health and social care in Northern Ireland.

Framework Document

1.5. The Health and Social Care (Reform) Act (NI) 2009, Section 5(1), requires the Department of Health, Social Services & Public Safety ('the Department') to produce a 'Framework Document' setting out, in relation to each health and social care body:

i the main priorities and objectives of the body in carrying out its functions and the process by which it is to determine further priorities and objectives;

ii the matters for which the body is responsible;

iii the manner in which the body is to discharge its functions and conduct its working relationship with the Department and with any other body specified in the document; and

iv the arrangements for providing the Department with information to enable it to carry out its functions in relation to the monitoring and holding to account of HSC bodies.

1.6. Section 1 (5) of the Reform Act defines "health and social care bodies" as:

i Regional Health and Social Care Board (known as Health and Social Care Board);

ii Regional Agency for Public Health and Social Well-being (known as Public Health Agency);

iii Regional Business Services Organisation (known as Business Services Organisation);

iv HSC Trusts;

v Special Agencies (i.e. Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency and Northern Ireland Guardian ad Litem Agency);

vi Patient and Client Council; and

vii Regulation and Quality Improvement Authority

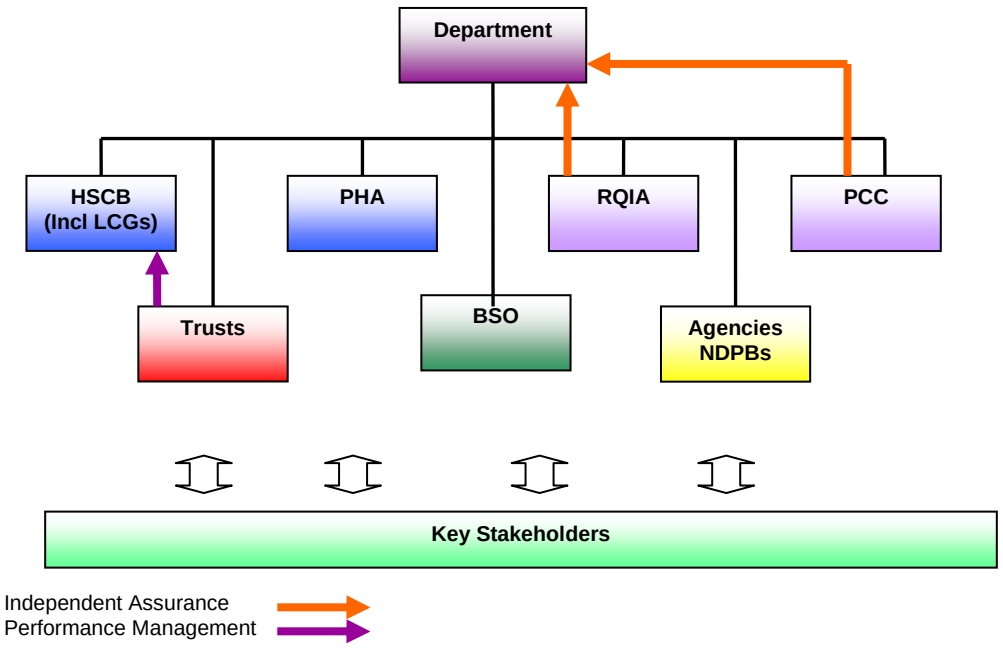
1.7. The focus of the Framework Document is the health and social care system in Northern Ireland and, although not covered by the Reform Act, the Northern Ireland Practice and Education Council and the Northern Ireland Social Care Council are included in the document for completeness. The Northern Ireland Fire and Rescue Service is outside the scope of the Framework Document.

1.8. All of the HSC bodies referred to above remain ultimately accountable to the Department for the discharge of the functions set out in their founding legislation. The changes introduced by the Reform Act augment, but do not detract from, that fundamental accountability.

1.9. Independent family practitioners also play a significant role in the delivery of health and social care. Health and social care objectives can only be achieved with the engagement of a high quality primary care sector that is accessible, accountable and focused on the needs of patients, clients and carers.

2. STRUCTURES, ROLES AND STATUTORY RESPONSIBILITIES

2.1. This section outlines the roles, responsibilities and relationships between the Department and health and social care (HSC) bodies. The diagram below shows the structure of the health and social care system.



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)

Department of Health, Social Services & Public Safety

2.2. Section 2 of the Reform Act places on the Department a general duty to promote an integrated system of:

i health care designed to secure improvement:

- in the physical and mental health of people in Northern Ireland, and
- in the prevention, diagnosis and treatment of illness; and

ii social care designed to secure improvement in the social well-being of people in Northern Ireland.

2.3. 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) 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, to the Assembly for the manner in which this duty is performed.

2.4. 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 DFP guidance *Managing Public Money Northern Ireland* and are reflected in each body's management statement/financial memorandum (MSFM), in the letter appointing its chief executive as accounting officer for the body, and in the letters appointing its chair and other non-executive board members. The functioning of the bodies covered by this Framework Document is to be viewed in the context of, and without prejudice to, the Department's overriding authority and overall accountability.

Health & Social Care Board

2.5. The HSCB, which is established as the Regional Health & Social Care Board, under Section 7(1) of the Health & Social Care (Reform) Act

(Northern Ireland) 2009, has a range of functions that can be summarised under three broad headings.

2.6. **Commissioning** – this is the process of securing the provision of health and social care and other related interventions that is organised around a "commissioning cycle" from assessment of need, strategic planning, priority setting and resource acquisition, to addressing need by agreeing with providers the delivery of appropriate services, monitoring delivery to ensure that it meets established safety and quality standards, and evaluating the impact and feeding back into a new baseline position in terms of how needs have changed. The discharge of this function and the HSCB's relationship with the PHA are set out in sections three and four.

2.7. **Performance management and service improvement** – this is a process of developing a culture of continuous improvement in the interests of patients, clients and carers by monitoring health and social care performance against relevant objectives, targets and standards, promptly and effectively addressing poor performance through appropriate interventions, service development and, where necessary, the application of sanctions and identifying and promulgating best practice. Working with the PHA, the HSCB has an important role to play in providing professional leadership to the HSC.

2.8. **Resource management** – this is a process of ensuring the best possible use of the resources of the health and social care system, both in terms of quality accessible services for users and value for money for the taxpayer.

2.9. The HSCB is required by the Reform Act to establish five committees, known as Local Commissioning Groups (LCGs), each focusing on the planning and resourcing of health and social care services to meet the needs of its local population. LCGs are co-terminus with the five HSC Trusts.

Public Health Agency

2.10. The PHA, which is established as the Regional Agency for Public Health & Social Well-being under Section 12(1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009 incorporates and builds on the work previously carried out by the Health Promotion Agency, the former Health and Social Services Boards and the Research and Development Office of the former Central Services Agency. Its primary functions can be summarised under three broad headings.

2.11. **Improvement in health and social well-being** – with the aim of influencing wider service commissioning, securing the provision of specific programmes and supporting research and development initiatives designed to secure the improvement of the health and social well-being of, and reduce health inequalities between, people in Northern Ireland;

2.12. **Health protection** – with the aim of protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being, including dangers arising on environmental or public health grounds or arising out of emergencies;

2.13. **Service development** – working with the HSCB with the aim of providing professional input to the commissioning of health and social care services that meet established safety and quality standards and support innovation. Working with the HSCB, the PHA has an important role to play in providing professional leadership to the HSC.

2.14. In exercise of these functions, the PHA also has a general responsibility for promoting improved partnership between the HSC sector and local government, other public sector organisations and the voluntary and community sectors to bring about improvements in public health and social well-being and for anticipating the new opportunities offered by

community planning.

Health and Social Care Trusts

2.15. HSC Trusts, which are established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991, are the main providers of health and social care services to the public, as commissioned by the HSCB. There are now six HSC Trusts operating in Northern Ireland:

- Belfast Health and Social Care Trust (covering local council areas of Belfast and Castlereagh);
- South Eastern Health and Social Care Trust (covering local council areas of Newtownards, Down, North Down and Lisburn);
- Northern Health and Social Care Trust (covering local council areas of Coleraine, Moyle, Larne, Antrim, Carrickfergus, Newtownabbey, Ballymoney, Ballymena, Magherafelt and Cookstown);
- Southern Health and Social Care Trust (covering local council areas of Dungannon, Armagh, Craigavon, Banbridge and Newry and Mourne);
- Western Health and Social Care Trust (covering local council areas of Derry, Limavady, Strabane, Omagh, and Fermanagh)
- Northern Ireland Ambulance Service Trust (covering all of Northern Ireland)

2.16. The six HSC Trusts are established to provide goods and services for the purposes of health and social care and, with the exception of the Ambulance Trust, 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).

2.17. Section 21 of the Reform Act 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.

Business Services Organisation

2.18. The BSO, which is established as the Regional Business Services Organisation under Section 14 (1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, contributes to health and social care in Northern Ireland by taking responsibility for the provision of a range of business support and specialist professional services to other health and social care bodies, as directed by the Department in accordance with Section 15 of the Reform Act.

2.19. The BSO incorporates the majority of services previously provided by Central Services Agency. The BSO, however, provides a broader range of support functions for the health and social care service, bringing together services which are common to bodies or persons engaged in providing health or social care. These include: administrative support, advice and assistance; financial services; human resource, personnel and corporate services; training; estates; information technology and

information management; procurement of goods and services; legal services; internal audit and fraud prevention. Such support services may be provided directly by the BSO or through a third party.

Patient and Client Council

2.20. The PCC, which is established under Section 16 (1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, is a regional body supported by five local offices operating within the same geographical areas covered by the five HSC Trusts and LCGs. The overarching objective of the PCC is to provide a powerful, independent voice for patients, clients, carers, and communities on health and social care issues through the exercise of the following functions:

- to represent the interests of the public by engaging with the public to obtain their views on services and engaging with Health and Social Care (HSC) organisations to ensure that the needs and expectations of the public are addressed in the planning, commissioning and delivery of health and social care services;
- to promote the involvement of patients, clients, carers and the public in the design, planning, commissioning and delivery of health and social care;
- to provide assistance to individuals making or intending to make a complaint relating to health and social care; and
- to promote the provision of advice and information to the public by the HSC about the design, commissioning and delivery of health and social care services.

Regulation and Quality Improvement Authority (RQIA)

2.21. The RQIA was established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. Although accountable to the Department, it is an independent health and social care regulatory body, whose functions

include:

i Keeping the Department informed about the provision, availability and quality of health and social care services;

ii Promoting improvement in the quality of health and social care services by, for example, disseminating advice on good practice and standards;

iii Reviewing and reporting on clinical and social care governance in the HSC - the RQIA also undertakes a programme of planned thematic and governance reviews across a range of subject areas, reporting to the Department and the Health and Social Care and making recommendations to take account of good practice and service improvements. Such reviews may be instigated by RQIA or commissioned by the Department;

iv Regulating (registering and inspecting) a wide range of health and social care services. Inspections are based on a new set of minimum care standards which ensures that both the public and service providers know what quality of services is expected. Establishments and agencies regulated by the RQIA include nursing and residential care homes; children's homes; independent hospitals; clinics; nursing agencies; day care settings for adults; residential family centres; adult placement agencies and voluntary adoption agencies. The Reform Act also transferred the functions of the former Mental Health Commission to the RQIA with effect from 1 April 2009. The RQIA now has a specific responsibility for keeping under review the care and treatment of patients and clients with a mental disorder or learning disability.

2.22. The RQIA is also the enforcement authority under the Ionising Radiation and Medical Exposure (Amendment) Regulations (N.I.) 2010 [IRMER] and is one of the four designated National Preventive Mechanisms under the United Nations Optional Protocol for the Convention against Torture [OPCAT] with a responsibility to visit individuals in places of detention and to prevent inhumane or degrading treatment. RQIA also conducts a rolling programme of hygiene inspections in HSC hospitals.

2.23. The Department can ask the RQIA to provide advice, reports or information on such matters relating to the provision of services or the exercise of its functions as may be specified in the Department's request. The RQIA may also advise the Department about any changes which it considers should be made in the standards set by the Department.

Special Agencies

2.24. Special Agencies are established under the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 to provide specific functions on behalf of the Department.

2.26. **Northern Ireland Blood Transfusion Service (NIBTS)** - The NIBTS is responsible for the collection, testing and distribution of blood donations each year. The main aim of the NIBTS is to fully supply the needs of all hospitals and clinical units in Northern Ireland with safe and effective blood, blood products and other related services. The discharge of this function includes a commitment to the care and welfare of blood donors.

2.27. **Northern Ireland Medical and Dental Training Agency (NIMDTA)** – The NIMDTA was established to ensure that doctors and dentists are effectively trained to provide the highest standards of patient care. The NIMDTA is responsible for funding, managing and supporting postgraduate medical and dental education. It provides a wide range of functions in the organisation, development and quality assurance of postgraduate medical and dental education and in the delivery and quality assurance of continuing professional development for general, medical and dental practitioners.

2.28. **Northern Ireland Guardian ad Litem Agency (NIGALA)** – The NIGALA is responsible for maintaining a register of Guardians ad Litem who are independent officers of the court experienced in working with

children and families. Under the Children (NI) Order 1995, a Guardian ad Litem is appointed to safeguard the interests of children who are subject to family and adoption court proceedings and to ensure that their feelings and wishes are made clear to the court. The NIGALA also has a pivotal role in ensuring that the Children (Northern Ireland) Order is implemented as intended. The provision of an effective and efficient Guardian ad Litem Service is vital if the Children Order is to operate satisfactorily. It occupies a similar role under the Adoption (Northern Ireland) Order 1987 in that it brings an independence and objectivity to the task of safeguarding the interests of the child.

Non Departmental Public Bodies (NDPBs)

2.29. **The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) -** The NIPEC was established under the Health and Personal Social Services Act (Northern Ireland) 2002 as a non-departmental public body to support the development of nurses and midwives by promoting high standards of practice, education and professional development. The NIPEC also provides advice and guidance on best practice and matters relating to nursing and midwifery.

2.30. **The Northern Ireland Social Care Council (NISCC)** - The NISCC was established under the Health and Personal Social Services Act (Northern Ireland) 2001 as a non-departmental public body to protect the public, specifically those who use social care services, and to promote confidence and competence in the social care workforce. It achieves this aim by registering and regulating the social care workforce, setting and monitoring the standards for professional social work training and promoting training within the broader social care workforce.

Summary of working relationships

2.31. In common with all Arms Length Bodies (ALBs), on issues of

governance and assurance, all the HSC bodies are directly accountable to the Department. Detailed accountability arrangements are set out in section 6 of this Framework Document.

2.32. Article 67 of the Health and Personal Social Services (Northern Ireland) Order 1972 as amended by the Health and Social Care (Reform) Act (Northern Ireland) 2009 provides that "In exercising their respective functions, health and social care bodies, district councils, Education and Library Boards and the Northern Ireland Housing Executive shall co-operate with one another in order to secure and advance the health and social welfare of Northern Ireland."

2.33. Under the Reform Act, the Department has an overall duty to promote an integrated system of health and social care designed to improve the health and social well-being of the people in Northern Ireland. All health and social care bodies must work closely and co-operatively with the Department, with each other and with organisations outside the Department, in the manner best calculated to further that overall duty. Whilst this general duty of co-operation is paramount, there are a number of specific areas where co-operative working needs to be highlighted and these are dealt with in the following paragraphs.

2.34. The Department sets the strategic context for the commissioning of health and social care services through a Commissioning Direction to the HSCB. It may also direct the HSCB as to the performance indicators it should employ in improving the performance of HSC Trusts.

The Health and Social Care Board and the Public Health Agency

2.35. Under Section 8 of the Reform Act, the HSCB is required to produce an annual commissioning plan in response to the Commissioning Direction, in full consultation and agreement with the PHA. The form and content of the commissioning plan is directed by the Department in accordance with Section 8 of the Reform Act. This requirement is at the core of the

key working relationship that translates the strategic objectives, priorities and standards set by the Department into a range of high quality, accessible health and social care services and general improvement in public health and wellbeing. In practice, the employees of the HSCB and PHA work in fully integrated teams to support the commissioning process at local and regional levels.

2.36. Developing, securing approval for and implementing the annual commissioning plan and associated Service and Budget Agreements with providers is the responsibility of the HSCB. The HSCB is, however, statutorily required to have regard to advice and information provided by the PHA and cannot publish the plan unless it has been approved by the PHA. In the unlikely event that the HSCB and the PHA cannot agree on the commissioning plan, the matter is referred to the Department for resolution. The HSCB and the PHA must also work together in a fully integrated way to support providers to improve performance and deliver desired outcomes.

2.37. Given the Department's retained responsibilities in areas such as human resources and estate management, strategic planning for health and social services must take place in a spirit of co-operation between the Department, the HSCB, the PHA and other HSC stakeholders, notwithstanding the formal accountability arrangements described elsewhere in this Framework Document.

Health and Social Care Board and HSC Trusts

2.38. Trusts must provide services in response to the commissioning plan, and must meet the standards and targets set by the Minister. Service and Budget Agreements (SBAs) are the administrative vehicle for demonstrating that these obligations will be met. SBAs are established between the HSCB and Trusts setting out the services to be provided and linking volumes and outcomes to cost.

2.39. Working with the PHA as appropriate, the HSCB is responsible for managing and monitoring the achievement by Trusts of agreed objectives and targets, including financial breakeven. At the same time, the HSCB and PHA also work together closely in supporting Trusts to improve performance and achieve the desired outcomes.

2.40. Section 10 of the Reform Act gives the HSCB power, subject to the approval of the Department, to give guidance or direction to a Trust on carrying out a Trust function. Before giving direction, the HSCB is required to consult with the Trust concerned except when the urgency of the matter may preclude consultation. The HSCB must not however give any direction or guidance to a Trust that is inconsistent with this Framework Document or inconsistent with any other direction or guidance already given to the Trust by the Department.

Health and Social Care Board and Family Practitioner Services

2.41. Primary care in general and family practitioner services (FPS) in particular are central to the health and social care system. Family practitioners and those who work with them in extended primary care teams act as the first point of contact and as a gateway to a wider variety of services across the HSC. The HSCB has a key role to play in managing contracts with family practitioners, not only in terms of pay and performance monitoring but also in terms of quality improvement, adherence to standards and delivery of departmental policy. The HSCB is accountable to the Department for the proper management of FPS budgets.

Business Services Organisation and the Wider HSC

2.42. The role of BSO is to provide support services on behalf of HSC bodies as directed by the Department. The relationships between the BSO and HSC bodies are governed by the development of SLAs between the BSO and the relevant organisation setting out the range, quantity, quality

and costs of the services to be provided. These SLAs will develop in accordance with the phased expansion of the range of services provided by the BSO.

Patient and Client Council and Wider HSC

2.43. In addition to the overall requirement on HSC bodies to co-operate with each other to secure and advance the health and social welfare of Northern Ireland, Section 18 of the Reform Act places a specific duty on certain HSC bodies, as defined in the Act, to co-operate with the PCC in the exercise of its functions. This means that HSC bodies must consult the PCC on matters relevant to the latter's functions and must furnish the PCC with the information necessary for the discharge of its functions. Furthermore, HSC bodies must have regard to advice provided by the PCC about best methods and practices for consulting and involving the public in health and social care matters.

2.44. The PCC's relationship with the other HSC bodies is therefore characterised by, on the one hand, its independence from these bodies in representing the interests and promoting the involvement of the public in health and social care and, on the other, the need to engage with the wider HSC in a positive and constructive manner to ensure that it is able to efficiently and effectively discharge its statutory functions on behalf of patients, clients and carers. It also has considerable influence over the manner in which consultations are conducted by the HSC.

2.45. The PCC's functions do not include a duty to consult on behalf of the HSC. Each HSC body is required to put in place its own arrangements for engagement and consultation.

Regulation and Quality Improvement Authority, the Department and Wider HSC

2.46. The RQIA's relationship with the Department and other HSC bodies is

driven by its independent role in keeping the Department informed about the availability and quality of services, drawing on its regulatory functions, and its wider statutory responsibility to encourage improvement in the quality of services. HSC bodies look to the RQIA for independent validation of their internal arrangements for clinical and social care governance. Examples of RQIA's work in this respect can be seen within its rolling programme of special and thematic reviews within the HSC. The RQIA must also work closely with HSC Trusts in the discharge of its functions relating to regulation of independent sector providers, particularly in terms of safeguarding the interests of vulnerable people.

Special Agencies and the Department

2.47. Special Agencies carry out a range of discrete functions as set out above. Their primary relationship is with the Department, on behalf of which they discharge their functions. The services they deliver are largely in support of the wider health and social care system and they must therefore develop appropriate working relationships with other health and social care bodies.

The Northern Ireland Practice and Education Council, the Department and the HSC

2.48. The NIPEC's primary relationship is with the Department on behalf of which it discharges its functions. NIPEC also works closely with key stakeholders in the HSC system to support registered nurses, midwives and specialist community public health nurses to provide a safe and effective nursing and midwifery service to the population of Northern Ireland.

The Northern Ireland Social Care Council (NISCC), the Department and the Wider HSC

2.49. The NISCC's primary relationship is with the Department, on behalf of which it discharges its functions. The NISCC provides a framework for commissioners and providers to promote consistency in standards of conduct and practice throughout the social care system. The NISCC also works closely with its registrants and other key stakeholders to achieve its aims of raising the quality of social care practice.

3. SETTING THE AGENDA

Establishing the Priorities

3.1. In terms of setting the strategic agenda for the Health and Social Care system, Section 2 of the Reform Act requires the Department to:

i develop policies to secure the improvement of the health and social wellbeing of, and to reduce health inequalities between, people in Northern Ireland;

ii determine priorities and objectives for the provision of health and social care;

iii allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way;

iv set standards for the provision of health and social care;

v formulate the general policy and principles by reference to which particular functions are to be exercised.

3.2. The Department sets the strategic vision and priorities for Health and Social Care. The strategic vision provides an overarching direction of travel for the HSC that reflects already well-established policies and strategies. The strategic vision underpins the Department's contribution to budget process and Programme for Government (PfG) and, flowing from this, provides the context for the development of an annual Commissioning Direction, Priorities for Action (PfA), Commissioning Plan and Trust Delivery Plans (TDPs).

3.3. The Programme for Government (PfG) and a framework of Public Service Agreements (PSAs) express the Executive's strategic aims and

policies in measurable objectives and targets.

3.4. The Department publishes annually Priorities for Action (PfA), which translates the PfG and other ministerial priorities into an achievable and challenging agenda for Health and Social Care.

3.5. The Department sets out the Minister's instructions to the commissioners in the annual Commissioning Direction under Section 8 (3) of the Reform Act. This reflects the priorities in the PfA as revised annually, and the relevant standards and obligations that apply every year. Hence this makes clear the framework within which the HSCB (including its LCGs) and the PHA commission health and social care.

3.6. Every year the HSCB is responsible for producing a commissioning plan in full consultation and with the approval of the PHA. The plan must outline how they plan to deliver on the key priorities standards or targets set in PfA. This plan provides the framework for each HSC Trust to develop its annual Trust Delivery Plan (TDP) detailing the Trust's response to the annual commissioning priorities and targets set out in the commissioning plan.

Allocating the resources

3.7. Section 2 of the Reform Act requires the Department to allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way.

3.8. Resources available to the Northern Ireland Block are largely determined at the outcome of the HM Treasury Spending Review on the basis of the population based Barnett formula. This sets the overall Departmental Expenditure Limit (DEL) for Northern Ireland. The funding levels are normally set for three or more financial years and may be reviewed every two years or so. Within the constraints of the NI DEL, gross spending power available to the Executive can be increased, currently

through revenue generated from the Regional Rate and borrowing power within the Reinvestment and Reform Initiative. Within the overall Block limits set by Treasury (i.e the NI DEL), the NI Executive establishes, in the light of local priorities, the three or four year resource allocations for all NI Departments, which cover both current expenditure and capital investment. The PfG specifies the Executive's plans and priorities for the years covered by the relevant budget period, while a separate Investment Strategy establishes capital priorities over a 10-year period.

3.9. It is the Department's responsibility to secure, as part of the Budget process, resources that enable the health and social care system to satisfy the population's need for high quality, accessible services.

3.10. In allocating current expenditure to HSC bodies, the Department must strike a balance between facilitating full and timely deployment of resources to the frontline and the need to ensure that appropriate control of funds is retained centrally by the Department. The aim is to channel the maximum resources to the point of service delivery at the earliest possible stage, with appropriate controls in place to ensure that they are deployed in accordance with Government priorities.

3.11. A Capitation Formula informs the Department (and, in turn, the HSCB) as to the most fair and equitable allocation of revenue funding for LCG areas. It does this by taking into account the number of people living within an area, with suitable adjustments relating to the age, sex and additional needs (largely due to deprivation) of the populations in question. The HSCB is required annually to provide the Department with an assessment of equity gaps, including the potential for re-distribution of resources across LCG populations and to demonstrate that resources have in fact benefited the populations for which they were intended. Allocation of capital expenditure to HSC Trusts is managed by the Department, with input from commissioners on the associated current expenditure funding required. The capital allocation and reporting process in described in more detail later in this section.

Funding the Health and Social Care Board and the Public Health Agency

3.12. The HSCB is responsible and accountable for commissioning of services, resource allocation and performance management, whilst the primary objective of PHA is to protect and improve the health and social well-being of the Northern Ireland population.

3.13. Section 8 of the Reform Act requires the HSCB, in respect of each financial year, to prepare and publish a commissioning plan in full consultation with and approved by the PHA. Each organisation holds the administrative and programme resources appropriate to their respective roles and responsibilities. Where such resources are deployed outside the context of the commissioning plan, the HSCB and the PHA submit, for Departmental approval, separate business plans in respect of those resources.

3.14. The following principles apply in relation to the funding arrangements for the HSCB and the PHA:

i Each of the bodies receives the bulk of its funding directly from the Department and each organisation remains separately accountable for all of the funds allocated to it;

ii In accordance with the detailed commissioning arrangements set out in section four, the funds allocated to the HSCB are:

- Committed to secure the provision of health and social care services for local populations from the six HSC Trusts, Family Health Services and other providers, consistent with the approved Commissioning Plan; and
- used for staffing, goods and services associated with the discharge of its functions;

iii The PHA directly funds initiatives related to its core roles of health improvement, screening or health protection activity, partnership working with local government, staffing and goods and services. Plans for use of the PHA's funding are incorporated within the Commissioning Plan, developed by the HSCB in consultation with and the agreement of the PHA. Similarly, services commissioned by the PHA from HSC Trusts and independent practitioners are reflected the Commissioning Plan as appropriate. Whilst the payment of funds for these services is administered by the HSCB on behalf of the PHA through the Service and Budget Agreements with HSC Trusts, the PHA remains accountable to the Department for the deployment of the resources. In the case of services commissioned from Family Health Service contractors, such as GPs, the HSCB takes primary responsibility for contract management, taking input from the PHA as appropriate.

Funding the Patient and Client Council

3.15. The Department directly meets the operating costs of the Patient and Client Council (PCC) to ensure that it operates independently from the service. The PCC produces, for Departmental approval, an annual business plan demonstrating how these resources will be used.

Funding the Business Services Organisation

3.16. Funding for the Business Services Organisation's (BSO) operating costs will flow through Service and Budget Agreements (SBAs) with its customers, the other HSC bodies. The SBAs determine the range, quality and costs of services to be provided. Movement towards the position of the BSO as an organisation fully financed from its service agreements with customers is being staged over a transitional period from April 2009.

3.17. The Health and Social Care (Reform) Act requires BSO to ensure that the arrangements which it puts in place for securing support services for its customers are the most economic, efficient and effective way of providing such services. It is required to have these arrangements approved by the Department before they are put in place. The Department approves the BSO's annual corporate business plan.

Funding Health and Social Care Trusts

3.18. HSC Trusts access funds by means of Service and Budget Agreements (SBAs) with their commissioners. Trusts are required to submit annual delivery plans (TDPs) to the HSCB for approval. TDPs must address both the content of the agreed SBAs with commissioners and the wider range of other corporate responsibilities. The HSCB provides assurance to the Department about the service and financial viability of TDPs.

Funding the Regulation and Quality Improvement Authority

3.19. The RQIA is funded directly by the Department on the basis of the priorities and objectives set out in its annual business plan and 3- year corporate strategy, which are approved by the Department. RQIA generates the balance of income through statutory fee charges for regulation of establishments and agencies.

Funding the Northern Ireland Guardian ad Litem Agency

3.20. NIGALA is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department.

Funding the Northern Ireland Medical and Dental Training Agency

3.21. NIMDTA is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is

approved by the Department.

Funding the Northern Ireland Blood Transfusion Service

3.22. Resources are allocated initially to the HSCB and are then channelled to Trusts through their Service and Budget Agreements (SBAs). NIBTS accesses the funds through the SBAs it has with Trusts for its services.

Funding the Northern Ireland Practice and Education Council

3.23. The NIPEC is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department.

Funding the Northern Ireland Social Care Council

3.24. The NISCC is funded substantially by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department. It also receives income from registration fees, Skills for Care and Development and in respect of student placements in the criminal justice sector (funded by the Department of Justice).

The Capital Allocation and Reporting Process

3.25. The strategic capital planning function, together with responsibility for overseeing procurement and performance management of capital programme delivery, rests with the Department. The Investment Strategy for Northern Ireland (ISNI), managed by the Strategic Investment Board (SIB) in conjunction with OFMDFM provides an indicative 10-year funding envelope for the Department. The Department contributes to the development of the ISNI, which is approved by the NI Executive.

3.26. Resources available to the Northern Ireland are largely determined at the outcome of the HM Treasury Spending Review on the basis of the population based Barnett formula. The NI Executive establishes, on the basis of its own priorities, the spending plans for all NI departments. In parallel, the Executive's infrastructure plans are set out in a separate 10-year Investment Strategy for Northern Ireland. The current Strategy covers the period 2008-2018.

3.27. To inform ministerial decisions on capital allocation, the Department conducts a biennial Capital Priorities Review, with input from a Policy Infrastructure Forum comprising representatives from the Department, the HSCB and the PHA. A 10-year rolling capital plan is produced as the output of these regular reviews.

3.28. The HSCB and the PHA are responsible for identifying and quantifying the services required to meet assessed needs and for commissioner endorsement of the associated current expenditure costs subject to considerations of affordability.

3.29. The Trusts and the HSCB (for ICT), are responsible for preparing and obtaining approval for business cases for the capital requirements needed to deliver the service. These business cases must have commissioner support before approval.

3.30. The Department has overall responsibility for the capital investment programme and also acts as a Centre of Specialist Expertise (COSE) and a Centre of Procurement Expertise (COPE) for capital infrastructure and undertakes a performance management role in relation to the estate.

3.31. The HSCB, taking account of professional advice from the PHA, is responsible for confirming the appropriate models of care to deliver health and social care across Northern Ireland and the associated indicative infrastructure requirements.

3.32. BSO is the responsible Centre of Procurement Expertise for the procurement of services, supplies and IT equipment.

4. COMMISSIONING

Introduction

4.1. The purpose of HSC commissioning is to improve and protect the health and social well-being of the people of Northern Ireland and reduce differences in access to good health and quality of life. Commissioning aims to achieve a progressive improvement in services through investment based on evidence of effectiveness, compliance with quality and efficiency standards and a focus on addressing the determinants of poor health and wellbeing. The involvement of patients, clients, carers and communities and engagement with other partners has a central role in the commissioning process.

4.2. The Department sets the policy and legislative context for health and social care in Northern Ireland. It also determines the standards and targets by which quality, access and outcomes should be measured and provides the strategic direction for the health and social care professions. The commissioning process, which includes resource and performance management and is led by the HSCB, translates the agenda set by the Department into a comprehensive, integrated commissioning plan for health and social care services. Commissioning must maintain a strong focus on identifying and prioritising the needs of patients, clients, carers and communities. In doing so, it is the driver for continuous service improvement and provides assurance that resources are delivering the maximum benefits for users and taxpayers alike. In management terms, the separation of commissioners and providers is designed to promote a patient and client-centred system.

The Commissioning Cycle

4.3. Commissioning includes the following activities:

i Assessing the health and social well-being needs of groups,

populations and communities of interest;

ii Prioritising needs within available resources;

iii Building the capacity of the population to improve their own health and social well-being by partnership working on the determinants of health and social well-being in local areas;

iv Engag ing with patients/clients/carers/families and other key stakeholders and service providers at local level in planning health and social care services to meet current and emerging needs;

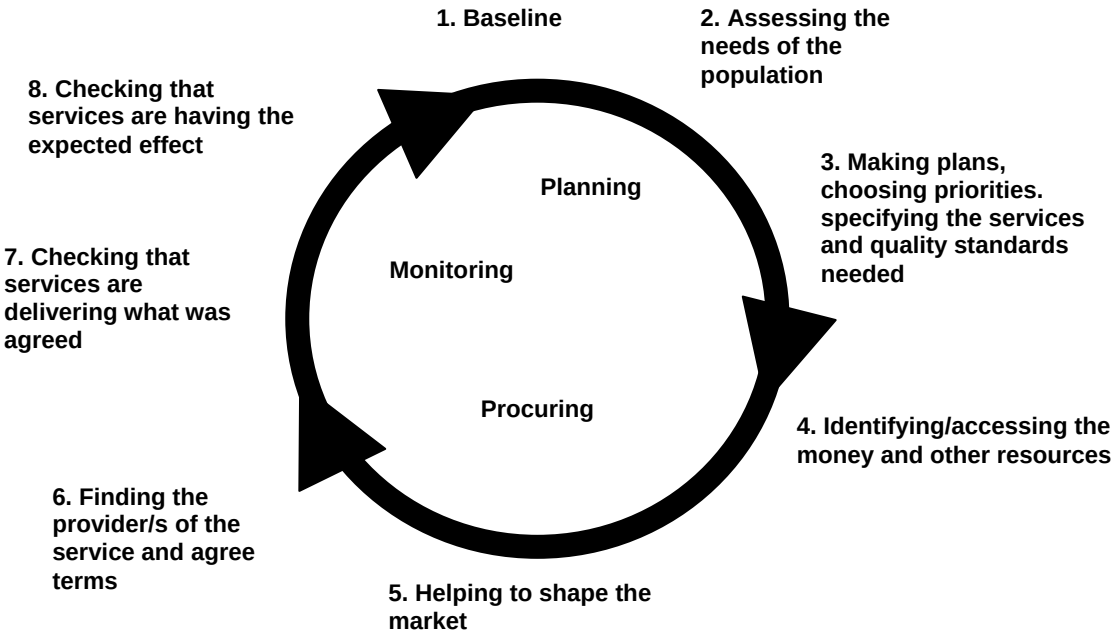
v Securing, through Service and Budget Agreements, the delivery of value for money services that meet standards and service frameworks for safe, effective, high quality care;

vi Safeguarding the vulnerable; and

vii Using investment, performance management and other initiatives to develop and reform services.

4.4. In the context of the integrated health and social care system in Northern Ireland, commissioning should be seen as an 'end to end' process. It organises activities around a commissioning cycle that moves through from assessing needs, strategic planning, priority setting, securing resources to address needs, agreeing with providers the delivery of appropriate services, monitoring that delivery, evaluating impact and feeding back that assessment into the new baseline position in terms of how needs have changed. Throughout the cycle, the HSCB and its LCGs engage with stakeholders, including service providers, at regional and local level.

4.5. Commissioners will facilitate a more integrated provider system by managing the interfaces between providers (statutory, independent and voluntary), developing provider networks and acting as 'guardians' of the care pathway.



The Commissioning Plan Direction

4.6. In exercising the powers conferred on it by Section 8 (3) of the Reform Act, the Department sets out the Minister's instructions to commissioners in an annual commissioning plan direction. The commissioning plan direction sets the framework within which the HSCB (including its LCGs) and the PHA commission health and social care.

The Commissioning Plan

4.7. Section 8 of the Reform Act requires the HSCB, in respect of each financial year, to prepare and publish a commissioning plan in full consultation with and approved by the PHA. The commissioning direction specifies the form and content of the commissioning plan in terms of the services to be commissioned and the resources to be deployed. The plan may not be published unless approved by the PHA. In the unlikely event of failure to agree the commissioning plan, the matter is referred to the Department for resolution.

Local Commissioning

4.8. The reformed system of commissioning introduced from 1 April 2009 established five geographically based Local Commissioning Groups (LCGs) that are co-terminus with the boundaries of the five Health and Social Care Trusts. The status of LCGs as committees of the HSCB is established in primary legislation.

4.9. LCGs have a lead role in the strategic commissioning process, in particular, having helped to shape strategic thinking, to apply it locally on behalf of their populations. They have responsibility for assessing health and social care needs in their areas, planning to meet current and emerging needs and securing the delivery of a comprehensive range of services to meet the needs of their populations. They have full delegated authority to discharge these responsibilities, including a significant ability to direct resources. The capitation formula identifies funds for the populations of each LCG area, and the HSCB is accountable for ensuring that they are used for that purpose. LCGs identify local priorities taking account of the views of patients, clients, carers, wider communities and service providers. They forge partnerships and involve a range of stakeholders in designing and reshaping services to better meet the needs of their local communities. The resources for each LCG population may be used to secure services for that population from any appropriate provider.

4.10. For the most part, the HSCB's Commissioning Plan reflects the decisions and recommendations of the LCGs in relation to the use of the capitation-based shares of the budget for their populations at local level. However, it is recognised that some services, by virtue of their specialist nature, restricted volume or statutory accountability, must be commissioned collaboratively on a regional basis, and hence the LCGs' decisions and recommendation will include contributions to the commissioning of regional services. The HSCB is responsible for establishing appropriate mechanisms for this process, which will ensure

that fair shares from the capitation-based budgets are committed to regionally commissioned services.

4.11. As committees of the HSCB, LCGs work within strategic priorities set by the Department, the HSCB, regional policy frameworks, available resources and performance targets. Section 9 (4) of the Reform Act requires LCGs to work in collaboration with the PHA and have due regard to any advice or information provided by it. To ensure a joint approach to commissioning, LCGs are supported by fully integrated, locally based, multi-disciplinary commissioning support teams made up of staff from the PHA and HSCB. Professional staff from both the HSCB and PHA are included in the membership of LCGs.

4.12. Each year the HSCB determines, in consultation with LCGs, the range of services to be commissioned locally and regionally and identifies the budgets from which such services are to be commissioned. LCGs prepare local commissioning plans, in keeping with the priorities and objectives of the HSCB. LCG commissioning plans are incorporated within the overall commissioning plan, which must be approved by the HSCB and the PHA.

Link between Commissioning and Performance Management

4.13. Monitoring performance of providers against the agreements they make in relation to service delivery is a key part of the commissioning cycle, and commissioners continue to ensure that this role remains core to how they work with providers. The HSCB and PHA must maintain appropriate monitoring arrangements in respect of provider performance in relation to agreed objectives, targets, quality and contract volumes.

4.14. The HSCB incorporating its LCGs must have appropriate monitoring arrangements to confirm that commissioned services are delivered, to benchmark comparative performance, and to ensure that quality outcomes, including positive user experience, are delivered.

4.15. Providers must have appropriate monitoring arrangements to ensure that they are meeting the requirements of commissioners and performing efficiently, effectively and economically.

4.16. The Department maintains appropriate monitoring arrangements in relation to the HSCB and the PHA to ensure that resources are used to best effect in the achievement of agreed strategic objectives and targets.

4.17. The HSCB and PHA also work together closely in supporting providers, through professional leadership and management collaboration, to improve performance and achieve desired outcomes. The HSCB is the lead organisation for supporting providers in relation to the delivery of a wide range of health and social care services and outcomes, with support provided by PHA professional staff. PHA is the lead organisation for supporting providers in the areas of health improvement, screening and health protection, with support provided by the performance, commissioning, finance, primary and social care staff of the HSCB.

Procurement by HSC Trusts

4.18. At the present time, it is not practical or desirable for the HSCB to contract directly with the full range of providers involved in the HSC system. The services involved are numerous, diverse, need to be provided flexibly and often need to be arranged at short notice, to meet the needs of individuals. Therefore a wide range of services commissioned by the HSCB are sub-contracted by Trusts to independent sector providers.

5 PERSONAL AND PUBLIC INVOLVEMENT

5.1 Patients, clients, carers and communities must be put at the centre of decision making in health and social care. This means that they must be properly involved in the planning, delivery and evaluation of their services. HSC bodies are accountable to people and communities for the quality, accessibility and responsiveness of the services they plan and provide.

5.2 Section 19 of the Reform Act places a statutory requirement on each organisation involved in the commissioning and delivery of health and social care to provide information about the services for which it is responsible; to gather information about care needs and the efficacy of care; and to support people in accessing that care and maintaining their own health and wellbeing.

5.3 This statutory requirement extends to the development of a consultation scheme, which must set out how the organisation involves and consults with patients, clients, carers and the Patient Client Council (PCC) about the health and social care for which it is responsible. Consultation schemes must be submitted to the Department for approval. The Department may approve a consultation scheme, with or without amendments, after consulting with the PCC.

5.4 Section 20 of the Reform Act specifies the form that consultation schemes should take, but this is supplemented by detailed policy guidelines for the HSC on personal and public involvement and the development and approval of consultation schemes.

Roles in Personal and Public Involvement (PPI)

5.5 In respect of Personal and Public Involvement (PPI), the Reform Act places a specific responsibility on the PCC to promote best practice in

involvement and in the provision of information about health and social care services. HSC bodies are required by the Reform Act to co-operate fully with the PCC in the discharge of these statutory responsibilities. The Department may consult the PCC in respect of specific consultation schemes before approving them.

5.6 The Department sets the policy and standards for Personal and Public Involvement (PPI). Working through the HSCB, the PHA has responsibility for ensuring that Trusts meet their PPI statutory and policy responsibilities and leading the implementation of policy on PPI across the HSC. A PPI Forum, chaired by the PHA and involving representatives from all HSC organisations, has been established for that purpose. This in no way detracts from the individual statutory responsibilities of organisations with regard to PPI.

5.7 The HSCB is responsible for ensuring that its LCGs establish arrangements for effective PPI which will allow the views of stakeholders to inform the development of commissioning plans. The HSCB should also ensure that Family Practitioner Services are meeting the requirements laid down in Departmental guidance on PPI.

5.8 HSC Trusts are responsible for establishing individual organisational governance arrangements, and for implementing their PPI consultation schemes, to meet their statutory duty of involvement, as well as any requirements laid down in Departmental guidance on PPI.

5.9 Special agencies also have responsibilities in respect of PPI. The NI Blood Transfusion Service (NIBTS), the NI Guardian Ad Litem Agency (NIGALA) and the NI Medical and Dental Training Agency (NIMDTA) should establish arrangements to ensure they meet their statutory duty of involvement and any requirements laid down in Departmental guidance. Each of these three special agencies will be accountable directly to the Department for the discharge of these functions.

5.10 The PCC will undertake research and conduct investigations into the most effective methods and practices for involving the public and provide advice on these to HSC organisations. The PCC also has an important challenge role for those HSC bodies prescribed in the Reform Act in respect of PPI, and will accordingly be expected to comment upon and scrutinise the actions and decisions of these bodies as they relate to PPI.

5.11 RQIA will continue to provide independent assurance to the Minister, via the Department, of the effectiveness of PPI structures in HSC organisations by continuing to monitor these as part of its programme of review of clinical and social care governance arrangements against the Quality Standards.

6 HOLDING THE SYSTEM TO ACCOUNT

Introduction

6.1. Ultimate accountability for the exercise of proper control of financial, corporate and clinical and social care governance in the HSC system rests with the Department and the Minister. Within a system of such magnitude and complexity, assurance about the rigour of control mechanisms can only be derived from the development and operation of robust systems and processes at all levels of decision making.

Performance and Assurance Dimensions

6.2. This section of the Framework Document describes the various lines of accountability and how they are exercised at different levels within the HSC system. The key performance and assurance roles and responsibilities are encompassed in the four dimensions of:

i Corporate Control – the arrangements by which the individual HSC bodies direct and control their functions and relate to stakeholders;

ii Safety and Quality – the arrangements for ensuring that health and social care services are safe and effective and meet patients' and clients' needs, including appropriate involvement;

iii Finance – the arrangements for ensuring the financial stability of the HSC system, for ensuring value for money and for ensuring that allocated resources are deployed fully in achievement of agreed outcomes in compliance with the requirements of the public expenditure control framework;

iv Operational Performance and Service Improvement – the arrangements for ensuring the delivery of Departmental targets and required service improvements.

Key Principles

6.3. The requirements in relation to performance and assurance roles may differ from body to body but some key principles underpin the overall approach to holding the HSC system to account:

i the Department has ultimate accountability for the effective functioning of the HSC across the four dimensions;

ii the Department will provide clear guidance across each of the four dimensions, specifying outputs and outcomes that are appropriate, affordable and achievable. This guidance will be developed with the involvement of the HSC bodies, consistent with their roles and responsibilities;

iii each HSC body is locally accountable for its organisational performance across the four dimensions and for ensuring that appropriate assurance arrangements are in place. This obligation rests wholly with the body's board of directors. It is the responsibility of boards to manage local performance and to manage emerging issues in the first instance;

iv the standard assurance arrangements and associated information streams within individual HSC organisations will, as far as possible, be used to meet the assurance requirements of the HSCB and PHA, and those of the Department, subject to such additional independent verification as may be deemed necessary;

v the Department, and in turn the HSCB and PHA (where they have a performance and assurance role in relation to one or more of the other bodies), will maintain a relationship with other HSC bodies based on openness and the sharing of information, adopting an informal, supportive approach to clarify and resolve issues as they

arise, and thereby minimising the need for formal intervention.

Corporate Control Dimension

6.4. Corporate control encompasses the policies, procedures, practices and internal structures which are designed to give assurance that the HSC body is fulfilling its essential obligations as a public body. Most of the requirements reflect those in place across the public sector, but a few have been instituted for reasons peculiar to the field of health and social care – notably the statutory duty of quality created by Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003. In addition to that obligation, the controls relate to: the existence of appropriate board roles, structures and capacity; corporate and business planning arrangements; risk management and internal controls; and monitoring and assurance of those processes.

6.5. All HSC bodies shall:

i adhere to the terms of the Accounting Officer appointment letter issued by the Department. This letter specifies the governance responsibilities and duties which the body owes to the Departmental Accounting Officer;

ii comply, in full, with the control framework requirements set out in the Management Statement/Financial Memorandum issued by the Department, in a form agreed by the Department of Finance and Personnel;

iii submit to the Department an annual Statement on Internal Control, signed by the Accounting Officer of the body, covering the range of issues in the standard form prescribed by the Department of Finance and Personnel, augmented by the additional health and social care-specific requirements set by the Department;

iv submit to the Department a mid-year assurance statement on control issues covering the same areas as the annual Statement on Internal Control;

v report as required on compliance with controls assurance and quality standards set by the Department including compliance with the Department's requirements for implementation of a risk management strategy and evidence that guidance on an assurance framework is being followed;

vi ensure that the appointment processes carried out by the body are demonstrably independent and free from external conflicts of interest;

vii adopt an Assurance Framework to strengthen board-level control and assurance in general, the Statement on Internal Control, and the mid-year assurance statement;

viii operate a board-approved scheme of delegated decision-making within the body based on systems of good practice updated by the Department;

ix ensure compliance with accepted or prescribed standards of public administration set by the Department – for example, in relation to equality of opportunity, equality legislation, complaints, etc;

x ensure compliance with the checklist of actions required of sponsor branches in the Department in obtaining assurance from their respective body's covering: roles and responsibilities; business planning and risk management; governance; and internal audit;

xi ensure compliance with procurement policy securing value for money, economically advantageous outcomes, equality of opportunity, sustainable development, etc., in accordance with the

policy framework set by the Executive and the Department of Finance and Personnel, key performance indicators set by the Department, the procurement strategy led by Regional Procurement Group (supported by BSO) and procurement under the Department's Infrastructure Strategy;

xii ensure that an Internal Audit function within each body operates to HM Treasury standards, including the requirement for external assessments, adhering to the professional qualifications, conduct and remit set out by the Department, and giving a comprehensive professional opinion from the chief internal auditor on the adequacy and effectiveness of the body's system of internal control;

xiii ensure implementation of agreed Northern Ireland Audit Office and Public Accounts Committee recommendations; and

xiv comply with the NI Executive's pay policy for the HSC e.g. arrangements for senior executive pay.

6.6. Compliance with the requirements at (i) – (x) are the subject of ongoing monitoring by the Department, and issues for resolution are resolved at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department.

6.7. In relation to the requirement at (xi) the Regional Procurement Group, supported by BSO, as a centre of procurement expertise, promotes and oversees implementation of the overall procurement strategy and monitors compliance with procurement policy, while the Department secures assurance on adherence to policy rules and achievement of key performance indicators. All capital infrastructure is procured in conjunction with the centre of procurement expertise within the Department.

6.8. Adherence to the requirement at with (xii) is subject to ad hoc scrutiny by

the Department's Head of Internal Audit, with issues resolved at bi-annual accountability reviews or through ad hoc action if deemed appropriate by the Department.

6.9. Compliance with (xiii) is the subject of ongoing monitoring by the Department (or HSCB or PHA as determined by the Department), with issues for resolution will be resolved at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department. Progress in relation to the recommendations is reported by the Department to the Northern Ireland Audit Office, Public Accounts Committee and the Department of Finance and Personnel.

6.10. Compliance at (xiv) is monitored by the Department, with issues for resolution addressed at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department.

Safety and Quality Dimension

6.11. Safety and quality covers a broad agenda, overlapping with many areas of operational performance and, to some extent, with financial performance and corporate control. It also applies to all programmes of care, including health improvement and health protection, and to infrastructure. This section describes assurance arrangements for specified elements of safety and quality, in particular, the arrangements for ensuring that HSC services are:

i safe - doing no harm to patients or clients and provided in an environment that is safe and clean;

ii effective - achieving agreed clinical and social care outcomes, which reflect high quality care and treatment and have a proven impact on health and wellbeing, especially prevention of poor health and wellbeing;

iii personalised - centred on the needs of individual patients clients and carers through their involvement in planning, delivery and evaluation.

6.12. Assurance to the Department and the Minister about the safety and quality of services is provided from a number of different sources. Each health and social body has clearly defined roles and responsibilities in this regard, which are summarised below.

6.13. The HSCB, working with the PHA on (i) to (viii) and (xii) below, is responsible for monitoring and reporting to the Department on:

i Compliance with Priorities for Action safety and quality requirements at least quarterly e.g. quality improvement plans;

ii Implementation of the RQIA and other independent safety and quality review recommendations in accordance with agreed plans;

iii Implementation of National Institute for Health and Clinical Excellence (NICE) technology appraisals endorsed by the Department;

iv Application by Trusts of lessons from adverse incidents and near misses (including those to be recorded on the PHA-managed RAIL system) and communicating, acting upon and reporting action taken in relation to safety information issued through the Northern Ireland Adverse Incident Centre Safety Alert Broadcast System (SABS);

v Evidence of provider-initiated action to improve safety and quality;

vi Family Practitioner Services' compliance with accepted standards e.g. clinical and social care governance arrangements, evidence of quality improvement, professional regulation and training and

development etc;

vii Trusts' compliance with accepted standards e.g. professional regulation and training and development (excluding those covered in para 6.14 (i) below);

viii Independent sector contracts related to waiting lists initiatives regarding for example conformity with clinical and social care governance arrangements and their performance on specified quality measures;

ix Independent sector contracts related to the provision of social care, regarding compliance with clinical and social care governance arrangements and specific quality standards;

x Implementation of statutory functions under agreed Schemes of Delegation;

xi Trust compliance with accepted standards for social care professionals e.g. professional regulation and training and development; and

xii Safety and quality aspects of HSCB contracts with independent sector providers.

6.14. The PHA is responsible for monitoring and reporting to the Department on:

i Trust compliance with accepted standards for medical, nursing and allied health professionals e.g. professional regulation and training and development; and

ii Compliance with statutory midwifery supervision requirements;

iii The identification and effective promulgation of learning from investigation of adverse incidents through the Regional Adverse Incident and Learning (RAIL) system and support for the development of quality improvement plans; and

iv Safety and quality aspects of PHA contracts with independent sector providers.

6.15. Joint Commissioning Teams led by the HSCB or PHA, as appropriate, are responsible for monitoring:

i Implementation of Service Frameworks;

ii Implementation of mandatory policy or guidance issued by the Department, which are not subject to formal performance arrangements, e.g. pandemic 'flu plans, quality of screening programmes, etc

iii Compliance with safety and quality and clinical and social care governance requirements specified by the commissioners of HSC services.

6.16. Trusts are responsible for monitoring independent sector contracts for health and social care to ensure compliance with relevant Departmental, HSCB or Trust guidance, including clinical and social care governance, relevant quality standards and arrangements to duly safeguard children and vulnerable adults.

6.17. The HSCB, working with the PHA, is responsible for monitoring Trust compliance with policies, standards and specific targets for the patient and client environment and support services including laundry and linen, catering, cleaning, portering and car parking.

6.18. The Department is responsible for monitoring:

i Compliance with policy, legislation and standards in respect of reusable medical devices;

ii Compliance with policy, legislation, standards and guidance in respect of the safe operation of life-critical healthcare-specific systems and processes.

6.19. In addition to assurance processes outlined above, the RQIA has an overall responsibility to encourage continuous improvement in the quality of health and social care across the public and independent health and social care sectors, against standards set by the Department, and to provide independent assurance on the quality of that care. When asked to do so by the Department it provides advice, reports or information on such matters relating to the provision of services or the exercise of its functions as may be specified in the Department's request. It may also, at any time, advise the Department on any changes which it thinks should be made in the minimum standards set by the Department. RQIA also undertakes a programme of planned thematic and governance reviews across a range of subject areas, examining services provided, and highlighting areas of good practice, and making recommendations for improvement and reporting lessons learned to the Department and the wider HSC. Such reviews may be conducted as part of RQIA's ongoing independent assessment of quality, safety and availability of HSC services or may be commissioned by the Department.

Finance Dimension

6.20. Appropriate financial accountability mechanisms are necessary to:

i Ensure that the optimum resources are secured from the Executive for health and social care;

ii Ensure the resources allocated by Minister/Department deliver the agreed outcomes and represent value for money;

iii Deliver and maintain financial stability, through effective operation of the financial accountability of Trusts via the HSCB to the Department;

iv Ensure that the commissioners can be assured that financing of services is managed on the agreed and approved basis set by the HSCB, its LCGs and the PHA;

v Facilitate the delivery of economic, effective and efficient services by rewarding planned activity that maximises effectiveness and quality and minimises cost; and

vi Facilitate the development of innovative and effective models of care.

6.21. All financial resources delegated by the Department to HSC bodies remain subject to the same standards of probity and accountability irrespective of where day-to-day management and control is vested.

6.22. All organisations are ultimately accountable to the Department for the achievement of overall financial balance. The Department monitors on a monthly basis the break-even performance of each organisation and, exceptionally, bids for unanticipated and inescapable in-year pressures. The HSCB monitors the performance and financial breakeven of Trusts, measuring against Service and Budget Agreements and delivery of service targets, reporting on its monitoring to the Department;

6.23. To guard against over-spending and minimise under-spending, the Department undertakes monthly monitoring of the overall HSC (and Departmental) financial position, reporting the evolving position to the Department of Finance and Personnel. The Department is also responsible for the strategic capital planning process and oversight of procurement and programme management, taking action where slippage or potential overspends become apparent. HSC Trusts are required to report on capital expenditure on a monthly basis and detailed liaison on projects is undertaken through quarterly Strategic Investment Group meetings.

6.24. The Department undertakes monitoring of the efficiency savings obligations contained in the Executive's Budget settlement. Each HSC body is required to provide such information in order to satisfy itself, and the Executive, that the conditions attached to the efficiencies are being met.

6.25. Trust Financial Returns and Strategic Resource Framework-related data, which provide essential information on expenditure on HSC services and contain cost comparisons across providers, continue to be produced under Departmental guidance. Responsibility for collation, analysis etc lies with HSCB.

6.26. The Department is responsible for keeping the counter-fraud strategy under review, and for the development and issuing of related guidance. It also approves publication of the annual fraud report and addresses performance issues relating to the counter-fraud assurance arrangements in each HSC body. It is for the BSO to maintain and provide to the Department all monitoring information that it, DFP or the NIAO may require. Each HSC body is required to comply with prescribed fraud prevention, fraud reporting, fraud investigation and other operational counter-fraud processes, availing itself of BSO support as appropriate.

6.27. The Department, informed by Department of Finance and Personnel, is the focal point for developing and cascading financial guidance, circulars and memoranda. This includes the specification of statutory and other reporting requirements.

Operational Performance and Service Improvement

6.28. Performance management and service improvement arrangements are those that are necessary to ensure the achievement of Government and ministerial objectives, standards and targets.

6.29. Section 8 of the Reform Act requires that the HSCB exercise its functions with the aim of improving the performance of HSC Trusts, by reference to such indicators as the Department may direct. In determining responsibilities for performance management and service improvement, the overriding principle is that, unless there is good reason to the contrary, as in the case of capital expenditure, estate management and Human Resources, all such functions should be undertaken by the HSCB because: this is a core function of the HSCB; it minimises the lines of accountability for providers; it maximises the 'breadth of sight' for the HSCB, allowing it to adopt a holistic view of performance taking account of all relevant factors.

6.30. Possible exceptions to this principle are areas for which the HSCB does not have lead responsibility, or where there is likely to be significant formal interaction with other Government departments, e.g. joint responsibility for the delivery of Public Service Agreement (PSA) targets (in which case the Department would take the lead on behalf of the HSC sector).

6.31. The HSCB is in the lead for monitoring and supporting providers in relation to the delivery of a wide range of HSC services and outcomes, with support from PHA professional staff. The PHA is in the lead for monitoring and supporting providers in the areas of health improvement, screening and health protection, with relevant support provided by the HSCB. The organisations are, therefore to establish and maintain a number of joint programme teams, consisting of relevant staff from each organisation.

6.32. In relation to the monitoring of provider performance, the resolution of any performance issues is a matter for the HSCB, in close co-operation with the PHA, escalating to the Department only if required.

6.33. With the approval of the Department, the HSCB and the PHA (where

appropriate) produce detailed practical definitions for the application of targets. They also put in place arrangements to: monitor progress against targets, assess risks to achievement; hold regular performance meetings with providers; and escalate risks as appropriate. The HSCB reports on this process to the Department to enable it to maintain an overview of performance in these areas. The HSCB also resolves performance issues, escalating to the Department only where such resolution cannot be achieved. Capital, estate management and human resource targets are performance managed by Department.

6.34. The HSCB is responsible for the collection of all routine information from HSC Trusts for performance monitoring or statistical publication purposes at agreed intervals and to agreed standards, and for providing this to the Department. This will minimise the potential for duplication and establish a clear, single channel for submission and validation of information

6.35. In pursuit of service improvements in their respective areas of responsibility, the HSCB and the PHA must:

i identify evidenced-based good practice and develop an annual programme of action;

ii take account of patient, client and carer experience, including lessons learnt from complaints;

iii lead regional reform programmes, issuing guidance and specifying required actions;

iv provide training and support;

v review Trust action plans;

vi provide support to individual providers to address specific issues

and manage provider-provider interfaces;

vii review implementation of reforms and make available any reports on progress;

viii make regular reports to the Department, as required, on their activities in this field.

6.36. Regarding Public Service Agreement targets, the Department is responsible for their development and agreement, and for reporting progress against them to the Office of the First Minister and Deputy First Minister and the Department of Finance and Personnel.

6.37. The Department sets HSC productivity and other HR-related targets and reports to Office of the First Minister and Deputy First Minister and the Department of Finance and Personnel on progress towards their achievement. The HSCB is responsible for the regular ongoing monitoring of progress by providers, addressing issues of under-performance where they arise, escalating to the Department only where necessary;

6.38. The European Working Time Directive has put in place compliance arrangements, for which the Department sets targets for the medical workforce. The HSCB monitors progress, addresses issues of under-performance and reports to Department on compliance and progress. It is for the HSCB to resolve any compliance etc issues, escalating matters to the Department's attention only where necessary.

6.39. The Department is responsible for setting targets and monitoring HSC Trust performance in relation to the level of compliance with policy, legislation, standards and guidance in respect of the management of the HSC estate. HSC Trusts are accountable for the practical application of such guidance etc, for the effective management of the associated operational risks, and for providing appropriate assurance as to the

discharge of these responsibilities. The Department has in place an appropriate review process to allow Trusts to report to the Department on a regular basis as to their overall management of the HSC estate.

Independent Challenge

6.40. In considering how the HSC system is held to account, special mention should be made of the Regulation and Quality Improvement Authority and the Patient and Client Council, both of which have a particular role to play. They each provide an independent perspective on the performance of the HSC system, one which validates and challenges the system's own performance management arrangements.

6.41. The RQIA focuses on the quality and safety of services, using statutory and other standards agreed by the Department to benchmark not only the services but also the governance frameworks within which they are provided. PCC focuses on the interests of patients, clients and carers in HSC services. This goes beyond a straightforward information or advocacy role; it includes working with HSC bodies to promote the active involvement of patients, clients, carers and communities in the design, delivery and evaluation of services. The RQIA and the PCC also have the power to look into specific aspects of health and social care and report their findings publicly to the Department.

6.42. Both of these organisations provide important independent assurance to the wider public about the quality, efficacy and accessibility of health and social care services and the extent to which they are focused on user needs.

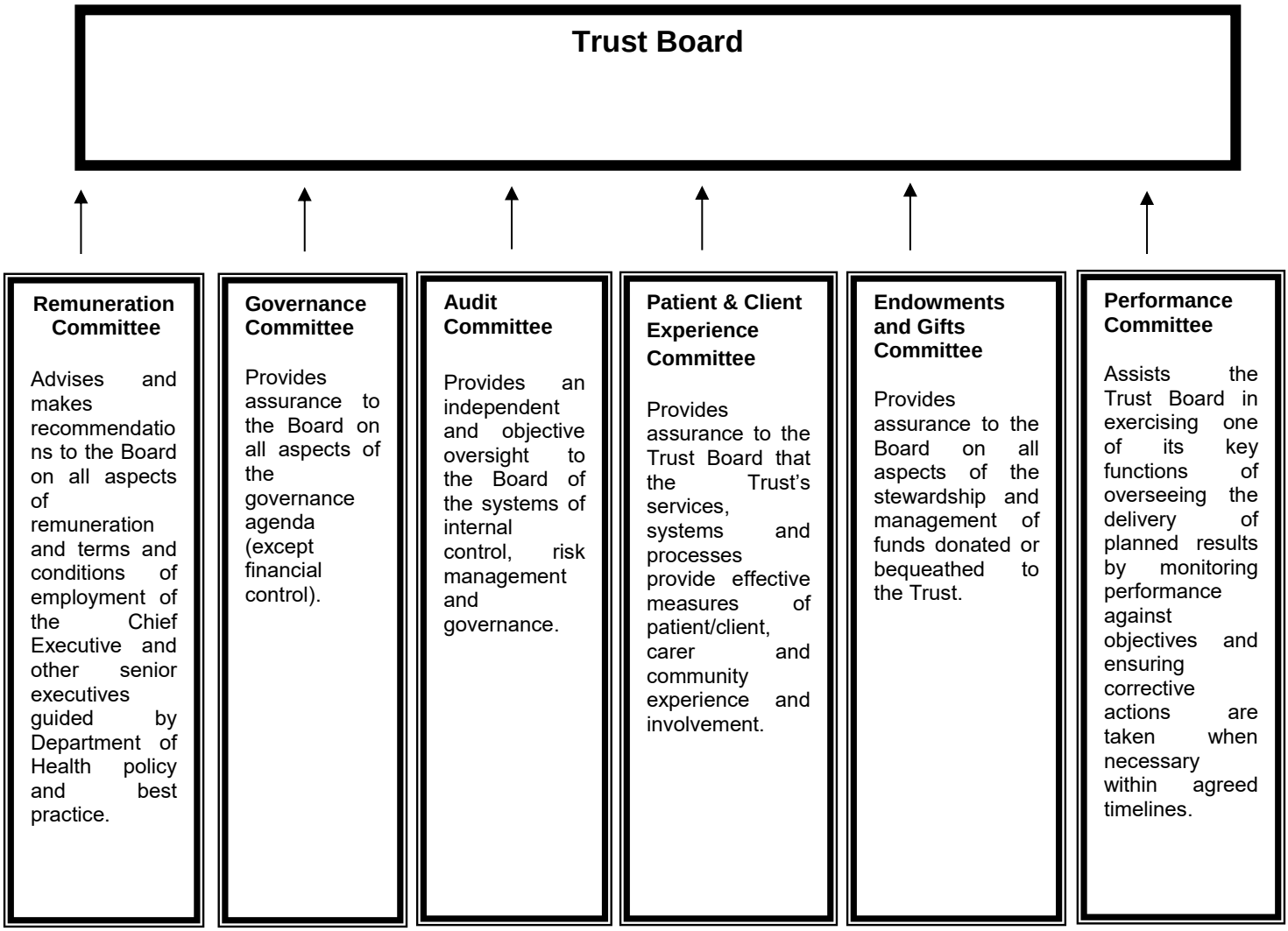
7 Conclusio n

7.1 This Framework Document is a summary of the structures, functions and processes that underpin the planning, delivery and evaluation of health and social care services in Northern Ireland. It will be kept under continuous review in the light of emerging policy and legislation.

7.2 If you have any enquiries about the content of the Framework Document, please contact:

Office of Permanent Secretary
DHSSPS
Personal Information redacted by the USI

High Level Governance Structure



As outlined above, assurance is provided through the Committee structure to Trust Board. The Senior Management Team is represented on each Committee and provides information to support decision-making and effective operation of the Trust at all levels.

Within the governance structure, there are sub-committees and groups; each with delegated responsibility. The reporting and accountability mechanisms are described in the Integrated Governance Framework.

Southern Health and Social Care Trust

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TRUST BOARD
SCHEME OF DELEGATION TO COMMITTEES

January 2022

DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
AUDIT COMMITTEE	**The Committee will:** 1. Advise the Board on internal and external audit services. 2. Oversee the maintenance of an effective system of integrated governance, risk management and internal control. 3. Review the adequacy of all risk and control related disclosure statements, in particular the Mid-Year Assurance Statement and the Governance Statement, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board. 4. Review the adequacy of the policies for ensuring compliance with relevant regularity, legal and code of conduct requirements, including consideration of revised versions of the Trust's Standing Orders and Standing Financial Instructions. 5. Review the annual schedule of losses and compensation payments and making recommendations to the Board regarding their approval. 6. Review and approval of the policies and procedures for all work related to bribery, fraud and corruption as required by the Counter Fraud and Probity Service at the Business Services Organisation . 7. Review the Trust's Annual Report and the audited Financial Statements prior to submission to the Board. 8. Receive the annual report to those charged with governance from the external auditor and agreement of proposed action. 9. Review and approval of the Internal Audit Strategy, operational plan and more detailed programme of work, ensuring this is consistent with the audit needs of the organisation. 10. Review the findings of other significant assurance functions, both internal and external to the organisation.

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	11. Review, on an annual basis, Post Project Evaluations completed on projects with a capital/revenue value in excess of £300,000. 12. Review and approval of Trust Procurement Strategy 13. Review the Trust Procurement Board Annual Report 14. Review, on an annual basis, all approved Direct Award Contracts (DACs) 15. Receive regular updates in relation to fraud cases under investigation 16. Complete National Audit Office checklist on an annual basis and develop an action plan. 17. Receive Value for Money reports from C&AG.
REMUNERATION AND TERMS OF SERVICE COMMITTEE	**The Committee will:** 1. Advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives, including all aspects of salary and arrangements for termination of employment and other contractual terms 2. Ensure decisions to create or fill Director or Assistant Director positions have been approved by the Permanent Secretary and no change to the remuneration of Senior Executives is made without prior approval of the Permanent Secretary 3. Ensure robust objectives, performance measures and evaluation processes are in place within the Trust in respect of Senior Executives 4. Make recommendations to the Board on succession planning and on the remuneration, allowances and terms of service of the Chief Executive and on the advice of the Chief Executive, other Senior Executives to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff. 5. The Committee shall report its recommendations to the Board for approval.

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
GOVERNANCE COMMITTEE	**The Committee will:** 1. Review the structures in place to support the effective implementation and continued development of integrated governance across the Trust. 2. Assess the 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. 3. Consider principal risks and significant gaps in controls or assurances and ensure these are appropriately escalated to Trust Board. 4. Evaluate sources of independent and objective assurance as to robustness of key processes across all areas of governance. 5. Review the adequacy of all governance and risk management and control related disclosure Statements (in particular the Governance Statement). 6. Make recommendations to the Board recognising that financial governance is primarily dealt with by the Audit Committee. 7. Receive minutes from the Trust's Mid Year and End Year Ground Clearing meetings with the Department of Health.
ENDOWMENTS AND GIFTS COMMITTEE	**The Committee will:** 1. Oversee the administration, including banking arrangements, of Endowment and Gift (E&G) Funds, their investment and disbursement. 2. Satisfy itself that E&G Funds are managed in line with the Trust's Standing Financial Instructions, Departmental guidance and legislation. 3. Ratify the creation of a new fund by the Director of Finance where funds and/or other assets are received and where the wishes of the donor cannot be accommodated within the scope of an existing fund.

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	4. Make recommendations on the potential for rationalisation of funds within statutory guidelines. 5. Ensure that assets in ownership of, or used by the E&G fund will be maintained with the Trust's general estate and inventory of assets. 6. Ensure that funds are not unduly or unnecessarily accumulated. 7. Ensure that a Trustees report is produced as part of the production of annual accounts for Endowments & Gifts. 8. Ensure expenditure from E&G funds is subject to appropriate value for money considerations, including proper procurement procedures where applicable. 9. Ensure that annual accounts are prepared in accordance with Department of Health guidelines and submitted to the Trust Board with agreed timescales. 10. Authorise appropriate policies and procedures in relation to E&G Funds.
PATIENT AND CLIENT EXPERIENCE COMMITTEE	**The Committee will** 1. Provide assurance to the Trust Board that the Trust's services, systems and processes provide effective measures of patient, client and carer experience involvement. 2. Identify gaps and areas of opportunity for development to ensure continuous, positive improvement to the patient, client and carer experience. 3. Ensure that patient, client and carer experience improvement initiatives are in place to address identified shortcomings and that these are monitored. 4. Review and analyse trends emerging from users' feedback on their experience of care. Reviews and analysis of trends will focus on themes, service areas and professional matters.

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	5. Assess the evidence that effective learning and improvement is occurring in relation to the user and carer experience. 6. Receive assurances of the quality and breadth of the training and development provided to staff to deal appropriately with patients and clients. 7. Review progress of the Trust's Quality Improvement Strategy in relation to the patient, client and user experience. 8. Review progress of the Carers Action Plan. 9. Receive assurances on the development of the Trust's approach to learning from the patient, client and carer experience. 10. Make recommendations to the Trust Board for consideration.
PERFORMANCE COMMITTEE	**The Committee will** 1. Oversee 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. 2. Ensure there is sufficient independent and objective assurance as to the robustness of key processes across all areas of performance. 3. Identify risks and gaps in control and assurance and seek assurance that risks are mitigated and being managed effectively. 4. 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. 5. Review the monitoring information in sufficient detail to advise the Trust Board, with confidence, concerning the performance of the Trust.

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	6. Receive reports on significant performance improvement initiatives within the Trust and review progress. 7. 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. 8. Ensure recommendations considered appropriate by the Committee are made to the Trust Board. 9. Review the findings of other significant assurance functions, both Internal and external to the organisation, and consider the implications for the performance of the organisation. These will include, but will not be limited to any reviews by Department of Health, commissioned bodies or professional bodies with responsibility for the performance of staff or functions.

Southern Health and Social Care Trust

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LEADERSHIP WALK AROUNDS

Summary Report for Period
1st October 2019 – 31st March 2020

Introduction

As part of the ongoing 'Board to Ward' governance assurance process within the Southern Trust, a framework for leadership 'walk arounds' has been developed and implemented since July 2011.

Leadership walk arounds are a direct process of engagement with staff where Board members step outside the Boardroom to see and assess at first hand the experience of patients and the issues of staff. They provide an informal method for Board members to talk with front line staff about issues in the organisation by asking a series of structured questions. Sample questions to ask are provided in a guidance tool and focus on:-

- What works well/doesn't work well
- Challenges faced
- Ideas for improvement
- Commendations/Complaints
- User engagement
- Team meetings/Staffing issues
- Training and Supervision
- Audits
- Incident reporting
- Risks
- Infection prevention and control

A report is completed within 14 days of each visit and shared with the Chair, as well as the person(s) who conducted/assisted in the walk round. Issues identified (if any) are escalated to the Chief Executive who in turn addresses them with the relevant Director. A response to the issues raised is required within a three week timeframe. Assurance is then provided back to the Chair by either explaining the issue or assurance that remedial action has been taken to address concerns. This process also enables Board members to offer appreciation and encouragement where performance is excellent.

Completed reports are held in the Chair's office and summary information will be routinely provided to the Senior Management Team and on a six-monthly basis to the Governance Committee.

The expectation is that the Non-Executive Directors complete 3 walk arounds each year in addition to their statutory visits to Children's Homes.

Period October 2019 – March 2020

Table 1 provides a summary of the leadership walk arounds undertaken during the period October 2019 – March 2020. During this period a total of 11 leadership walk arounds were undertaken.

Table 1: Leadership Walk arounds undertaken during October 2019 – March 2020

Date	Name	Visit to
October 2019	Mrs Roberta Brownlee, Chair	Portadown, Lurgan and Banbridge Integrated Care Team
	Mrs Hilary McCartan, Non Executive Director	Pharmacy Aseptic Suite, Craigavon Area Hospital
November 2019	Mrs Roberta Brownlee, Chair	Lung Function Department and Sleep Service, Craigavon Area Hospital
	Mrs Pauline Leeson, Non Executive Director	Silverwood Ward, Bluestone Unit
	Ms Geraldine Donaghy, Non Executive Director	Dysphagia Support Team Transformation Programme
January 2020	Mrs Roberta Brownlee, Chair	Catering Department, Daisy Hill Hospital*
	Mrs Siobhan Rooney, Non Executive Director	Dorsy Unit, Bluestone
February 2020	Mrs Roberta Brownlee, Chair	Blossom Children and Young People's Centre, Craigavon Area Hospital
	Ms Eileen Mullan, Non Executive Director	Glanree House, Newry
	Ms Eileen Mullan, Non Executive Director	Sterile Services Department, Daisy Hill Hospital*

Date	Name	Visit to
March 2020	Mrs Hilary McCartan, Non Executive Director	Portadown Family Intervention Team

*No Key Issues

Issues raised

Please see Appendix 1.

Appendix 1

Southern Health and Social Care Trust

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LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Mrs Roberta Brownlee
Visit To:	Portadown, Lurgan and Banbridge ICT (Portadown HCC)
Date and time of visit:	14 Oct 2019 14.00-16.30 pm
Accompanied By:	Caroline Rice, Helena McLean

Key Issues:

1. Twilight Nurse (7-11 pm) does not have a FOB to access the carpark at OOH's in CAH, where they are based for the duration of their shift. This results in either staff paying for their parking in order to be close to base, or using free parking which can be some distance from the base, leaving them feeling vulnerable as lone workers at this late hour.
2. Twilight shift at present does not have an on call line management rota for staff to communicate with, should they have any issues. This has been escalated and currently awaiting a decision based on costing.
3. At weekends and Bank holidays a specific mobile is held by the District Nurse in charge. This is a basic Nokia phone and does not receive emails. If this was a smart phone / mobile device it would negate the need for the nurse to enter the building alone at 8 am to check emails, potentially from twilight shift the previous night relating to patient care.
4. Equipment – regarding timeframe for delivery and collection. The biggest impact to District Nursing is delay in delivery of hospital beds. For families a delay in collection can go on for many weeks despite numerous communications between Community Equipment stores and DN Staff. Families have reported this can be very distressing especially after a bereavement. This has been escalated and was discussed at the most recent Community Equipment Meeting.

Appendix 1

Director's Response: (Key Issues highlighted have been themed as follows):

Twilight Period: (Key Issues 1&2 - Concerns regarding FOB access to the carpark at OOHs and access to Senior staff during on-call periods).

Arrangements have been put in place to provide Twilight Nurses with access to:

- the OOHs carpark to ensure staff can park close to the OOHs base and
- Senior Nursing staff during the OOHs period for consultation, if required.

District Nursing Telephone: (Key Issue 3 - simple mobile versus smart phone)
Arrangements have been put in place to replace the ordinary District Nursing mobile with a smartphone.

Community Equipment Collection: (Key Issue 4)
Additional staff capacity has been deployed to reduce the waiting times for the receipt of equipment, as well as for the collection of equipment no longer required.

Additional Comment by Director:
The Trust will continue to work with commissioners in an attempt to secure additional resources to facilitate the introduction of "Normative" staffing levels, as expected by the regional District Nursing Framework. When implemented, this will resolve many of the concerns raised by staff in respect of staff and caseload capacity. Additional staff resources will support the implementation of new operational hours. This approach has been identified as being a central requirement to the successful implementation of the new Multi-Disciplinary Teams in Primary Care. This initiative is being rolled-out incrementally across the region and currently funds have been identified to facilitate implementation in the Newry, Mourne and Banbridge GP Federation area.

Appendix 1

Southern Health and Social Care Trust

Quality Care - for you, with you

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Hilary McCartan
Visit To:	Pharmacy Aseptic Suite – Craigavon Area Hospital
Date and time of visit:	15th October 2019 at 11.00am
Accompanied By:	Dr Tracey Boyce, Director of Pharmaceutical Services

Key Issues:

- Staff capacity issues in light of increasing demand – patient numbers increasing c6% year on year.
- Increasing complexity of products prepared by staff for chemotherapy preparation.

Director's Response:

- In relation to the staff capacity issues, we will pursue the outstanding service impact funds due from HSCB. Now that the HSCB service impact assessment process has been reinstated, this should not happen in the future.

Appendix 1

Southern Health and Social Care Trust

Quality Care - for you, with you

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	Lung Function Department, CAH
Date and time of visit:	7/11/2019 3-4 pm
Accompanied By:	Rhonda Green/ Eimear Hughes (input from all staff into report)

Key Issues:

- There are no Band 7s in the Department – presently there are Band 7s working in STH and DHH. The Lab at CAH is the main central lab which supports 6 Consultants and a specialist staff grade and carries out specialist tests not done in the other labs.
- Lack of communication within the Department
- Poor amenities for patients on CAH site
- Poor layout of department

Director's Response:

Staffing Issues

- There is 8A funding available currently carrying out work regionally with HSCB regarding Respiratory Investigation Workforce and clearly defined criteria for 8A posts.
- The band 7's in STH are currently only work 1 day per week
- The band 7 on DHH has just been upgraded as part of AFC and has rotated to work on the CAH site
- Staff in Lung Function lab in CAH have submitted review of Job descriptions regarding Band 6 to Band 7.
- Recently appointed Band 7 has commenced monthly meetings and developed clear communication plan with staff.

Director's Response continued:

Estates issues

- The CAH estates work has been escalated and the plan was that lung function moved to paediatric outpatient area as interim to allow Ambulatory Unit to be refurbished but unfortunately that did not happen
- Estates colleagues involved in design of new unit which required 5 separate rooms , Storage area, waiting area and Decontamination area.
- The sleep services were to be separately accommodated.
- Sleep Services were allocated two rooms in Paediatric outpatients area but returned as felt this area was too noisy.
- We have tried to source other areas on the CAH site or off site

Booking of Patients

A Quality Improvement project was carried out by one of the respiratory Clinical Physiologists which demonstrated

1. Patients attending Respiratory outpatients clinics were sent to the lung function department for investigations ordered by Medical Team. Unfortunately there were long delays on clinics days so not all investigations could be carried out (as indicated in this report on the same day) so patients are having to return.
2. CAH site undertake same day testing as Clinic but patients are returning whilst DHH site patients have test completed prior to their clinic appointment. This assists in more timely diagnosis.
3. Having the investigations carried out prior to clinic is the goal to be achieved. Difficult for CAH staff to accept this new change.
4. We have moved to all booking of respiratory investigations onto CVIS (Tom Cat) were we can clearly identify waiting times, activity carried out.
5. IT department are working with us to install system were all respiratory investigation outcomes are uploaded onto NIECR. This will reduce having to print out results and it will allow results to be made available to referrer in timely manner. This work was to start in April 2020 after funding was secured.

Regarding ARTP Accreditation

Aspects required to even apply for accreditation are

- Staffing – All BSE accredited. Two staff are not.
- Accommodation specific requirements
- The System for ordering, reporting and validation of results

All of the above we are working through to address.

Appendix 1

Southern Health and Social Care Trust

Quality Care - for you, with you

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	Sleep Service, Craigavon Area Hospital
Date and time of visit:	7/11/2019 3 – 4pm
Accompanied By:	Rhonda Green/Eimear Hughes (input from all staff into report)

Key Issues:

- Sleep Service/Lung Function Dept – accommodation/layout of room not ideal. Lung Function patients are being tested behind a curtain. Test can be overheard by other staff, patients in the department and also relatives in the waiting room.
- Inadequate sinks for hand washing and equipment sterilisation

Director's Response:

Staffing

We secured 1wte for Sleep services and we have recently recruited to the post and staff member commenced.

Head of Services involved in demand and capacity for Sleep Services regionally and this work will involve the following:

- Number of staff in post
- Time allocated for each appointment.
- Establishing a SABA for Sleep Services

Successful in recruiting agency to cover maternity leave. This member of staff would be keen to secure permanent post if funding available.

Clinical Physiology staff difficult to secure as numbers trained per year in NI small.

Band 7 upgraded has rotated to CAH site and has commenced regular meetings with staff

Director's Response continued:

Estates issues

- Sleep Services require the following accommodation 2 out patient rooms, Waiting area, Storage area and decontamination area. This has been escalated to estates service
- The sleep service does not have to be housed on CAH site. We have sourced other accommodation. They are listed for Dungannnon Care and Treatment centre
- We have agreed area on the DHH site and staff are willing to rotate to this area.

Equipment and activity

- Regional Contract awarded and we have experienced difficulties with Company
- We have met with company to highlight our concerns
- We have established a group with CP staff, HOS and finance to review contract as CPAP is being rented not bought.
- We have established that all patients are logged on PAS and Staff are currently reviewing compliance of patients with CPAP
- We have reviewed clinical review process for patients.

Appendix 1

Southern Health and Social Care Trust

Quality Care - for you, with you

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Pauline Leeson
Visit To:	Silverwood Ward, Bluestone Unit
Date and time of visit:	7 November 2019
Accompanied By:	William Delaney – Patient Flow Coordinator

Key Issues:

- Need for clarity on interface with safeguarding team re procedures which are proper and proportionate
- Senior and Middle Managers need to be supported to continue change in culture
- Staffing issues need to be kept under review.

Director's Response:

The leadership walks by Non Executive Directors and other senior staff are very much welcomed, with a further walk scheduled for January 2020. It is very reassuring that new appointments to Bluestone are highlighted as having resulted in improved team working, better communications, more supportive to staff, and improved safety, governance and accountability. However, the requirement for succession planning, KPI's, safeguarding etc are included within the improvement action plan for the Unit, against which progress is monitored through the Director's Oversight Group. The lack of availability of a Registered workforce remains and will continue to be a significant challenge and risk going forward to the delivery of safe and effective care. The recognition of the committed and dedicated staff within the Unit is good to hear and will mean a lot to the staff.

Appendix 1

Southern Health and Social Care Trust

Quality Care - for you, with you

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Geraldine Donaghy
Visit To:	Dysphagia Support Team Transformation Programme
Date and time of visit:	Thursday 7th Nov 2019
Accompanied By:	Carmel Harney, Louise Campbell, Arlene Watt and Louise Pollard

Key Issues:

TRF Programme Funding was for 1 year only.
Recurring investment to secure the sustainability of the significant system wide work undertaken to date is urgently needed.

Director's Response:

The Dysphagia Support Team was established under the TRF Programme following the "Regional Thematic Review of Choking". This project was presented to SMT TRF Workshop on 27th Nov 2019 and was received very positively in terms of the need for this to be a permanently invested in as an expert service to offer advices, consultation bespoke support to core services and to the Independent, Voluntary and Community Sectors. Negotiation with the Trust and DoH, HSCB and PHA will be required to achieve successful investment.

Appendix 1

Southern Health and Social Care Trust

Quality Care - for you, with you

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Siobhan Rooney, Non Executive Director
Visit To:	Dorsy Unit
Date and time of visit:	2pm 20/01/2020
Accompanied By:	Lynn Woolsey; Sister Geraldine Dinsmore. Also spoke with William Delaney Lead Nurse and Ciara Lavery Head of Service meeting at time of visit

Key Issues:

- Unit operating with 9 beds only as 1 patient requiring 2 rooms and 2:1 supervision due to challenging complexity of needs
- Of the 9 patients in Dorsey Unit:

  1 admitted - 2014
  1 admitted - 2016
  2 admitted - 2017
  4 admitted - 2019
  1 admitted - 2020

  2 other patients admitted Oct and November 2019 respectfully are nursed as outlyers in Bluestone (note this is a short term assessment and treatment unit)
- Heavy reliance on bank and agency staff
- Staff in post 27 WTE reported Telford exercise 2 years ago stated 38 WTE required
- Atmosphere and ward management much improved since last visit in 2014
- Profile of patients in the unit highly challenging and complex needs, some admitted because community placements have broken down
- Delayed discharges due to complexity and waits for appropriate community packages having an impact on the Unit performance as a short tern assessment and treatment Unit
- All staff now have personal alarms

Sister Dinsmore must be commended for her dedication, management and positive developments of both staff and services within the Unit, Her interactions with both staff and patients observed during my visit evidenced the relationships and respect that is afforded her in her leadership role.

Director's Response:
The Leadership Walk conducted was very much welcomed by staff within the Unit, both in terms of a member of Trust Board taking the time to visit to see first-hand the service being delivered, as well as the opportunity for feedback and learning this affords.

It was particularly valuable for staff to have achievements recognised, which included a recognition of the improved atmosphere and good leadership, as well as the provision of a car for patient outings and the appointment of an Activity Worker.

Response to Issues Highlighted
These have been grouped to facilitate a more comprehensible response.

1. Staffing
   "Heavy reliance on bank and agency staff", "Staff in post 27 WTE reported Telford exercise 2 years ago stated 38 WTE required" and "Like to see an increase in male staff".

   The service is in agreement with the concerns expressed regarding the noted reliance on bank and agency staff. This is due to a variety of factors, not least a global shortage of Registered Nurses. In order to safely care for the people in Dorsy and meet their assessed need, bank and agency staff are required to maintain a safe nurse staffing level. In addition, the majority of patients in Dorsy are complex and highly challenging individuals who require high levels of nursing care and interventions.

   The FSL noted for the Unit is historic and is not sufficient for the level of acuity in the ward. An IPT is in development which will detail the workforce required to deliver the service moving forwards. In addition, regional work has commenced to specify safe nurse staffing levels for LD, as part of the Delivering Care Policy Framework led by the CNO.

   There are several work streams in progress - regional Trust and local – to address the workforce issues. These include the attracting men into nursing regional campaign, the development of a Trust Nursing and Midwifery Workforce Plan and commencing support staff on the new Open University Pre-Registration Learning Disability programme.

Director's Response continued:

Recruitment is ongoing with a successful RN recruitment day in November 2019, and the recruitment day for Band 3 Nursing Assistants scheduled for March 2020 (postponed due to Covid-19) attracted 168 applications for Bluestone and Dorsy.

2. Acuity and Patient Flow

"Profile of patients in the unit highly challenging and complex needs, some admitted because community placements have broken down", "Delayed discharges due to complexity and waits for appropriate community packages having an impact on the Unit performance as a short tern assessment and treatment Unit" and "Like to see an improvement in discharge and patient flow systems".

The service is in agreement with the analysis re patient flow. Due to the lack of suitable, alternative accommodation and the appropriately skilled workforce required, the length of stay for some patients has greatly exceeded that which one would expect in an acute assessment and treatment unit.

This issue is not specific to Dorsy, and has been widely reported across other LD facilities. The Trust is fully involved in the regional review of LD services to develop a new model of care.

Governance oversight has been strengthened, with a recent audit completed on restrictive practice and seclusion. The findings from this audit will be presented at the next Dorsy Governance and operational meetings. The Trust is also participating in the regional DoH group to set the policy direction re restrictive practice and seclusion for NI.

The national Patient Safety Thermometer has also been implemented in the Unit, which benchmarks Dorsy with other similar Units across the UK. Data to date evidences that the safety of service users is on a par with the rest of the UK.

Director's Response continued:

3. General

We have commenced accreditation with the Royal College of Psychiatrists. The Quality Network for LD is a standards-based quality network through which accreditation is achieved through a process of standards-based self- and peer-review, engaging staff and service users. We are in Year 1, with the full process taking 3 years to complete. Dorsy has hosted a successful first peer review visit, and QI work was positively commented upon, confirmation made of our commitment to a quality environment for our service users and carers and real praise for our activities diary for service users were highlighted.

Following the invited review by the Royal College of Psychiatrists, a Directors Oversight Group was established, with a number of work streams identified with the aim of improvement. These work streams are led by an Assistant Director or Clinical Director and are centred on the following themes: culture, workforce, quality, technology and a miscellaneous category.

The Directorate Collective Leadership Team are actively involved and regularly undertake formal and informal walk arounds to speak directly with staff. Café style conversations have been facilitated and a culture questionnaire completed, with issues identified being actioned. Overall the staff feedback is they now feel very much supported. Mirroring the Directorate Leadership Team, a Collective Leadership Team for Bluestone and Dorsy has been established.

The introduction of an on-call rota for the Directorate, the implementation of Health Roster, the enhancement to the senior team in the Unit and the introduction of more structured and formalised Ward Manger meetings, have combined to contribute to the improvements noted for the Unit.

Appendix 1

Southern Health and Social Care Trust

Quality Care - for you, with you

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	Blossom Children and Young People's Centre
Date and time of visit:	7th February 2020 - 9.30 am-12.30 pm
Accompanied By:	Bernie McGibbon, Head of Acute Paediatrics

Key Issues:

- When speaking to HoS/Lead Nurse and other staff – concerns were expressed at the support/timeliness of how HR matters are attended to – this should be fully explored
- The comments made by the Lead Physiotherapist 'C' on how patient flow/acute directorate should be further explored. How important solutions could help/support physiotherapy/bed management
- Urgent concerns raised (by Sister) how surgical team interacts for young people under 16 years of age and gave recent example that has been escalated – follow-up for actions

Director's Response:

HR Matters: There are ongoing challenges for the ward manager in relation to ensuring safe staffing levels. It is acknowledged that there was a period when there was a delay in HR dealing with attendance management issues and getting staff to 'Attendance Management Panels'. There may also have been a delay in responding to HR related issues due to a change in staffing within HR. However with replacement staff now established the situation has improved and HR is more responsive to supporting managers with ongoing issues.

Director's Response continued:

Physiotherapy Service: The Head of Service met with Lead Paediatric Physiotherapist. The Lead Paediatric Physiotherapist explained that her feedback was in relation to the whole hospital system where new processes could be developed to improve the outcome for the patient and the service; reducing hospitalization, freeing up beds in the non-acute hospitals and improving the mobility of the patient/client. Currently the physiotherapy service is only able to deliver on urgent work and has reduced capacity for rehabilitation work in the acute hospital setting. With a relatively small amount of additional investment this could be turned around with the physiotherapy service extending hours across the full 7 day week. This would increase capacity to address demand in the Emergency Department and urgent / rehabilitation work leading to earlier hospital discharge. This would also enable physiotherapists working in the acute hospital wards to have protected time for training and quality improvement. The Lead Physiotherapist is reviewing workforce plans to improve outcomes physiotherapy patients but in the longer term workforce planning will require additional places on university undergraduate physiotherapist degree courses and additional investment of staffing and skill mix.

Specifically in relation to Paediatric Services there is a recognised gap in funding for the provision of Paediatric Physiotherapy given an incremental year on year level of demand. The CYPS Directorate is preparing a proposal for the Strategic Investment Committee to seek funding for an additional Band 7 Paediatric Physiotherapist for Blossom CYP Centre.

Surgical Interface – All Trusts bar the Belfast Trust have increased Acute Paediatric age range to include referrals for children and young people up to their 16th birthday. Unfortunately this has led to RBHSC having a different age limit for accepting transfers from the District General Hospitals. This causes difficulty for Pediatricians and Surgeons as the RBHSC as Tertiary Centre has not increased their age limit beyond 14th birthday and in some specialties their 13th birthday. During the Covid 19 pandemic the RBHSC has increased this age limit up to a child/ young person's 16th birthday so this may positively move forward regional consistency in respect of age range. Within the Surgical Team there is a range of experience in working with children and the IHRD Inquiry on hyponatraemia has also caused concern for surgeons. There is significant interface work going on between Paediatrics and Surgical colleagues to improve processes and a Principles Paper has been developed to focus on timely and responsive management of surgical patients with Paediatric support when requested/required.

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Southern Health and Social Care Trust

Quality Care - for you, with you

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Eileen Mullan
Visit To:	Glanree House, Needham Close, 37 Patrick Street, Newry, BT35 8EB
Date and time of visit:	Monday 24th February 2020 11:30am
Accompanied By:	Geraldine Rushe Head of Service

Key Issues:

- High sickness levels
- Rolling recruitment continues
- High number of medication incidents
- Need for additional named manager and medication manager

Director's Response:

High Sickness Levels

There are a number of reasons there are currently high sickness levels in Glanree. These include: 3x staff who lost close family members ([redacted]). Two staff have undergone complex surgery and incurred associated complications following their surgery resulting in extended time off work. Two other staff are off on work related stress; one due to an assault by a tenant and another due to a HR process. A whistleblowing safeguarding investigation October 2017 to June 2019 has contributed to low staff morale in the unit which is likely to have compounded sickness levels. All sickness/absence is managed according to Trust policy and procedure with staff referred to Occupational Health and a return to work interview completed once returned to work. The manager and head of service are working with staff to improve morale.

Rolling recruitment
The recruitment strategy for Supported Living includes cyclic recruitment for band 3 support worker roles. Once an advertisement closes, if all posts are not filled another advertisement goes out again for a further 3 weeks. This requires a significant commitment from managers but it is necessary to ensure we have a sustainable work force into the future reducing reliance on banking staff to fill gaps and to ensure succession planning and filling of vacant posts. In 2019 a recruitment video was co-produced with staff and tenants. This was shared on social media to highlight the role of the support worker and to promote working in a Supported Living environment. This campaign has generated a lot of interest in support worker roles, however, challenges remain in getting people into posts. Reasons for recruitment delays include BSO recruitment processes, shift patterns not being family friendly and being declined by successful applicants. Some units have tenants with more challenging behaviours and staff vacancies in these facilities tend to have a higher turnover of staff.

High number of medication incidents
Internal monitoring reporting and datix indicate a high number of medication incidents related to the administration of medication. All staff attend medicine management training, undergo competency assessments and identified band 5 staff transcribe medications. Each manager/assistant manager runs a report from datix to highlight medication issues which is then shared at each facilities staff team meetings. Supported Living services aim to reduce datix incidents by 5% in the next 6 months.

Medicine Management Nurse
It is recognised there are low numbers of nurse registrants working in Supported Living; less than 10 across eight schemes Trust wide. The Head of Service is currently considering a proposal to recruit 1WTE band 5 dedicated medicine management nurse for Supported Living to take forward a Quality service improvement with a view to promote improved governance in this area and reduce the number of medication errors. This person would be a dedicated resource assisting with competency assessments, training, transcribing assessments and audits, and undertaking medication action plans with staff. Recruitment of this post is subject to funding approval.

Another named Manager
This reference was regarding the recent challenges with the existing management structure in light of assistant & registered manager sickness absence and the impact of this on the whole service. A business case has been developed and is with finance for costing.

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Southern Health and Social Care Trust

Quality Care - for you, with you

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Hilary McCartan
Visit To:	Portadown Family Intervention Team (Children's Services)
Date and time of visit:	5th March 2020 at 9.45am
Accompanied By:	Gina Hall - Team Manager Ciaran Eastwood - Head of Service

Key Issues:

- Difficulties in recruiting and retaining social work staff - soon to embark on 4th recruitment round since May19.
- Practicalities of working with BME families and engaging with these families through interpreters.

Director's Response:

No current vacancies in the team including band 4. There are no unallocated cases and there is capacity to manage volume of child protection/LAC work. There is an accessible interpreting service and staff are given capacity in their work load to work with families where English is not their first language. The team also has a senior social work practitioner.

This is an experienced team who is committed to their work and has a supportive team environment.

Stinson, Emma M

From: Leeson, Pauline [redacted]
Sent: 11 March 2022 16:15
To: Mullan, Eileen; McDonald, Martin; Donaghy, Geraldine; McCartan, Hilary; Wilkinson, John
Cc: OKane, Maria; McClements, Melanie
Subject: Stroke Services - Sentinel Stroke National Audit (SSNAP)

Eileen. We had a presentation from Dr McCormick at Performance Committee yesterday on SSNAP and I wanted to raise my deepest concern at what we heard. Dr McCormick came to Governance Committee in 2019 when there were plans for a regional strategy, restructuring and investment. I would encourage everyone to read his presentation. Despite the deep professional and personal commitment of him and his team, there is now a marked deterioration in the service. It will be detailed in Committee report and my Chair's report. It appears that he has done everything that was expected of him in terms of reconfiguring services at CAH and DHH but the SSNAP quarterly audit performance in CAH in particular is far below what I would deem as acceptable. Nursing, therapy and rehab goals are also all below recommended guidelines. I understand that his staff were redeployed to ICT during the pandemic and there have also been pressures on AHPs but the deterioration in this service is unacceptable. My overwhelming feeling was of a dedicated clinician and his team who had been quietly working away trying to do their best with little support from us as a Trust. Melanie McClements has picked this up and drawn up an action plan which is very helpful. She has even put in posts at risk to help. I feel strongly that we should be keeping a close eye on this service and on Dr McCormick and his team, giving Stroke Services more priority as part of Rebuild, actively looking for investment and providing support to staff who are at risk , in my opinion, of burnout. We have a duty of care to our staff and an obligation to maintain and improve services for our population. This concern is not a reflection on any of our staff but I would want an assurance going forward that this service and its action plan is prioritised and I have requested that it comes back to Performance Committee in 9 months for an update. Happy to discuss further. I don't think that it would be helpful to bounce this issue around other committees or Trust Board. It seems clear enough that we need to implement Melanie's action plan and reassure Dr McCormick that we care as part of our Trust values. Pauline

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of Virtual Chief Executive update meeting with Non Executive Directors held on Monday, 13th June 2022 @ 10.30 a.m.

Present: Eileen Mullan (Chair of meeting)
Dr Maria O'Kane
Geraldine Donaghy
Hilary McCartan

In attendance: Sandra Judt (Notes)

ITEM	NOTE	ACTION
1	**APOLOGIES** Pauline Leeson; Martin McDonald; John Wilkinson	
2	**DECLARATION OF INTERESTS** There were no interests to declare.	
3	**NOTES OF PREVIOUS MEETING** The notes of the previous meeting held on 9th May 2022 were agreed as an accurate record.	
4	**MATTERS ARISING** • **Early Alerts** The Chief Executive spoke of the impact on the system due to the scope of discovery under the S21 notice responses. Ms Donaghy raised the question she asked at the previous meeting when the Cardiology Early Alert was discussed as to whether there was a pathway for early alerts and stated that progress updates on actions, lessons learned from early alerts would be useful as an assurance for Non Executive Directors. Dr O'Kane stated that a progress update on lessons learned in the Trust, including early alerts, was being discussed at SMT the following day. She undertook to bring a report to Trust Board on the Cardiology early alert once the investigation has concluded.	

	The Chair welcomed a summary report on early alerts to Governance Committee. ***Action: Dr O'Kane*** • **SMT Restructuring** Dr O'Kane spoke to a paper which outlines the final plans for changes to the senior management structure. She advised that the new structure must allow for an improvement in safety through good governance and ultimately ensure that the Trust is focused on care delivery. Given the pending retirement of the existing Director of Acute Services in Summer 2022, it is planned to issue an expression of interest for 2 interim posts:- 1. Interim Director of Surgery & Elective, Integrated Maternity and Women's Health, Cancer & Clinical Services 2. Interim Director of Medicine and Unscheduled Care Services She reported that the Medical Director and the Director of Performance and Reform posts have been publicly advertised. Mrs McCartan asked about the rationale for the transfer of functional support services to the Directorate of Nursing, Midwifery and AHPs. The Chief Executive stated that functional support services in the other Trusts either sits in the Acute Directorate or under the Director of Nursing. Services such as catering, domestic, laundry etc. are services that add to the patient experience hence why the proposal to transfer them under the Director of Nursing, Midwifery and AHPs. Currently 11 direct reports to Chief Executive. Mrs McCartan raised the Executive Director of Social Work/Social care and the expanding professional responsibilities under this role. She welcomed the further consideration regarding the role, function and remit of the Executive Director of Social Work.	***Dr O'Kane***

	A Deputy Chief Executive was raised. Mrs Donaghy highlighted the importance of any Deputy Chief Executive/Chief Operating Officer job role having clear roles and responsibilities to avoid duplication. The Chief Executive stated that her aim was to have posts recruited to by Autumn 2022.	
5	**CURRENT PRESSURES** Dr O'Kane provided an update as follows:- **<u>Children's Services Pressures</u>** The Chief Executive advised of a meeting the previous week between Trust Chief Executives and the Department of Health in relation to Children's Services pressures. Each Trust has been asked to produce a plan on how to address. The lack of available social workers to recruit into the service was raised and Dr O'Kane stated that the Trust was actively working to recruit social work students during the Summer. **<u>Covid-19</u>** Dr O'Kane advised that it is anticipated that there will be another surge July/August 2022. **<u>Statutory Public Inquiry into Urology Services</u>** Dr O'Kane spoke of the significant demand on the Trust to respond to the Public Inquiry particularly the S21 notices. **<u>The Firs</u>** The Chief Executive advised that the owner of the facility will be retiring on 24th June 2022 and thus the services provided by her business will no longer be operational. There are no confirmed interested parties / potential buyers for The Firs. There has been significant local elected representative and family lobbying, along with local newspaper coverage of this issue and coverage on the televised Nolan show in recent weeks.	

	The Chief Executive informed members that the Trust clinical staff are working intensively with 4 of the 5 remaining families to identify suitable alternative placements prior to the home closure on 24th June 2022. There are plans in place for each of the residents. There is one individual and family who are not engaging with relocation planning, although having assessed this individual's current needs, the Trust is satisfied that these assessed needs can be met in an alternative available placement within the Trust area. A progress update will be provided at the Trust Board confidential meeting on 23rd June 2022.	***Dr O'Kane***
6.	**CLINICAL AND SOCIAL CARE GOVERNANCE ROUND-UP** As agreed at the previous meeting, the Chief Executive provided members with the most recent clinical and social care governance round-up report. She informed members of a recent discovery that a [redacted] had performed a procedure, allegedly without obtaining full consent of the patient. The doctor is now subject to MHPS processes and the GMC have been notified. Litigation cases in relation to Urology were raised. Dr O'Kane stated that there were 18 open cases identified at present, but it was anticipated that this number will increase as the Urology Public Inquiry progresses.	
7.	**UPDATE ON STROKE SERVICES – SSNAP AUDIT** Dr O'Kane advised that SMT had agreed to implement a plan to address areas of concern which includes going at risk to recruit some posts. Mrs McCartan asked if there were other areas of concern that required additional investment. Dr O'Kane spoke of her concern about overcrowding in ED, particularly the number of over 85 year olds on trollies. The Trust is working on improving where it can.	
8.	**ANY OTHER BUSINESS** **i) Irish News article re offensive footage on social media** Dr O'Kane referred to the investigations into claims that Trust employees were linked to recent offensive footage on social media. She stated that the issue was being handled sensitively	

	and a letter is being sent to both families to offer the Trust's sincere apologies. HR process is underway. **ii)** Irrelevant information redacted by the USI Dr O'Kane advised of an allegation involving a staff members' handling of a service user in Irrelevant information redacted by the USI which was well below the standard expected by the Trust. This matter is being investigated under the Joint Protocol with the PSNI.	

The meeting concluded at 11.30 a.m.

Southern Health and Social Care Trust

Quality care – for you, with you

PERFORMANCE COMMITTEE COVER SHEET

Meeting Date	Performance Committee Thursday 9 March 2022		
Agenda item	External Assurance Stroke Services – Sentinel Stroke National Audit Programme (SSNAP)		
Accountable Director	Melanie McClements Director of Acute Services		
Report Author	Name	Dr Michael McCormick Consultant Physician Anne McVey Assistant Director of Medicine and Unscheduled Care	
	Contact details	Personal Information redacted by the USI	
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	
	v	Being a great place to work – supporting, developing and valuing our staff	
	☐	Working in partnership	

WORKING TOGETHER · EXCELLENCE · COMPASSION · OPENNESS & HONESTY	*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.details how it impacts on the people we serve.*

1. Detailed summary of paper contents:

Background and Context

- The Trust has 19 dedicated acute stroke beds on CAH site, including x 1 protected bed for Thrombolysis administration and x 1 bed for stroke assessment. DHH has a 30 bedded unit encompassing acute stroke and stroke rehabilitation patients alongside older peoples beds
- The Trust undertook local consultation in 2014 in respect of configuration of stroke services. The preferred outcome was a centralised model to support improvement of stroke services with acute beds centralised in CAH and rehabilitation beds at DHH. The infrastructure and investment required to deliver on the preferred model has not been actualised.
- A subsequent regional public consultation on stroke services in 2019, focused on the delivery of hyper-acute stroke services; CAH was identified as a hyper-acute site in all the options presented. The outcome of the report was delayed and is as yet not concluded.

Purpose

- Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme based in the School of Life Course and Population Sciences at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland.
- The Southern Trust participates and utilises information from SSNAP to inform its Stroke Quality Improvement group.
- This report is to provide information to the Performance Committee to provide assurance that a range of mechanisms are in place and new improvement opportunities identified in respect of arrangements to manage and improve Stroke Services throughout the Trust.

Performance

- SSNAP quarterly audit performance in CAH has been banded level 'D' and DHH banded level 'C' in the quarter July – September 2021.
- Comparative Trust analysis is detailed in Table 1 below

Table 1

Trust	BHSCT			NHSCT			NHSCT			SEHSCT			SHSCT			SHSCT			WHSCT			WHSCT		
Team	Royal Victoria Hospital			Antrim Area Hospital			Causeway Hospital			Ulster Hospital			Craigavon Area Hospital			Daisy Hill			Altnagelvin			South West Acute		
Reporting period	Apr - Jun 2021	Jul - Sep 2021		Apr - Jun 2021	Jul - Sep 2021		Apr - Jun 2021	Jul - Sep 2021		Apr - Jun 2021	Jul - Sept 2021		Apr - Jun 2021	Jul-Sep 2021		Apr - Jun 2021	Jul-Sep 2021		Apr - Jun 2021	Jul-Sep 2021		Apr - Jun 2021	Jul-Sep 2021	
SSNAP level	A	A	↔	B	B	↔	B	D	↓	C	C	↔	D	D	↔	B	C	↓	D	D	↔	A	A	↔
SSNAP score	92.0	91.0	↓	74.0	70	↓	72.0	58	↓	63.0	66.0	↑	56.0	54.0	↓	71.0	62.0	↓	56.0	58.0	↑	90.0	83.0	↓
1) Scanning	A	A	↔	A	B	↓	B	C	↓	B	B	↔	A	B	↓	A	C	↓	B	A	↑	A	A	↔
2) Stroke unit	D	D	↔	E	E	↔	E	E	↔	E	E	↔	E	E	↔	E	E	↔	E	E	↔	B	C	↓
3) Thrombolysis	A	A	↔	D	C	↑	C	D	↓	C	C	↔	C	D	↓	C	E	↓	D	C	↑	A	A	↔
4) Specialist Assessments	A	B	↓	A	A	↔	B	C	↓	D	D	↔	D	D	↔	C	D	↓	D	C	↑	A	A	↔
5) Occupational therapy	A	A	↔	A	B	↓	A	C	↓	A	A	↔	C	C	↔	A	A	↔	B	C	↓	A	B	↓
6) Physiotherapy	A	A	↔	B	B	↔	C	B	↑	D	C	↑	D	D	↔	B	B	↔	D	D	↓	B	C	↓
7) Speech and Language therapy	A	A	↔	B	C	↓	A	B	↓	C	B	↑	E	E	↔	D	D	↔	B	D	↑	A	C	↓
8) MDT working	A	A	↔	C	D	↓	C	E	↓	D	D	↔	E	E	↔	C	C	↔	E	E	↓	B	B	↔
9) Standards by discharge	B	B	↔	A	A	↔	A	A	↔	A	A	↔	B	A	↑	A	A	↔	A	B	↑	B	A	↑
10) Discharge processes	A	A	↔	C	C	↔	C	C	↔	B	B	↔	A	A	↔	A	A	↔	C	C	↔	B	B	↔

2. Areas of improvement / achievement:

- The Trust has a Stroke Improvement Group which meets regularly and reviews SSNAP data .
- A Stroke service improvement lead is in place but was seconded to ICU during the pandemic and has now returned to post with an aim of focussing on key areas for improved performance.
- A Quality Improvement Project (QIP) has commenced on stroke identification in the Emergency Department and targeting ward of first admission.
- A new consultant has been appointed to the Craigavon Area Hospital and has stroke dedicated sessions.
- A need for an increase in stroke Allied Health Professional capacity has been identified and an investment proposal has been developed
- The Trust is currently exploring options to reconfigure and improve stroke services within the existing infrastructure to create a centre of frailty and stroke services – this will require investment from the Trusts general capital and commissioner commitment to revenue support.
- There is close collaborative working with non-acute colleagues in the management of early and support discharged for stroke patients and these arrangements are well established.

3. Areas of concern/risk/challenge:

Key areas of concern relate to

- Bed pressures on the CAH site present challenges in maintaining the protected assessment bed and access to the dedicated stroke beds
- Overcrowding in Emergency Department, impacts on triage and the patients journey time which is critical in this time-sensitive condition
- Providing stroke services across four different hospital sites dilutes staff within an already under-resourced service meaning performance across all areas remains below the standards required.
- In order to care appropriately for stroke patients the Trust needs to protect bed capacity to provide the necessary acute care and rehabilitation requirement. The current model where stroke patients are cared for on 4 different hospital sites does not facilitated focused 7 day therapy and smooth transition to Early Supported Discharge (ESD)
- The challenging current financial climate and impact on the ability to secure capital and revenue investment to effect the reconfiguration in services required to achieve improvement;
- The Stroke workforce for Nursing and Allied Health Professionals is inadequate and falls well below recommended guidelines. The Trust needs to commit to improving the Nursing and AHP workforce with agreed assessment and input to patients at weekends. Access to Speech and Language Therapy at weekends is needed with access to dedicated swallow review. Nursing numbers are poor resulting in concerns surrounding safe delivery of thrombolysis 24/7.
- SSNAP data should drive performance and act as a surrogate of medical care across all disciplines within the trust. Whilst Stroke services remain a priority improvement area for the Trust change has not progressed at pace.
- Reference to a Centre for Stroke and Frailty is a suggested long term model to facilitate consolidation but there is a need for change now.

4. Impact: Indicate if this impacts with any of the following and how:	
Corporate Risk Register	
Board Assurance Framework	
Equality and Human Rights	

Southern Health and Social Care Trust

Quality care – for you, with you

SMT paper on Stroke Service Services & Workforce Concerns

Introduction and cause of concern raised

There has been significant clinical and operational concern raised with regard to increased patient safety risk and poorer outcomes for patients, predominantly relating to lack of skilled staff to treat and care for Stroke patients (nursing, physiotherapy, occupational health, speech & language therapy). Access to appropriate levels of therapeutic intervention is well below expected standards and lack of SALT (timely swallow assessment) is causing nutritional impact. Availability of trained stroke nurses is concerning. There was a presentation by the Stroke Lead Clinician @ Performance Committee in March 2022 and the need for investment was supported and other improvement work acknowledged.

Background and Context

- There are 14 funded acute stroke beds on CAH site and 5 medical beds = 19 beds in 2 South Stroke, including x 1 protected bed for Thrombolysis administration and x 1 bed for stroke assessment.
- DHH has a 30 bedded unit encompassing 8 acute stroke and 22 general/stroke rehabilitation patients alongside older people's beds.
- The Teams provide 24hour cover, 7 days per week for Acute Stroke and lysis. In DHH the lysed patients go to HDU for 24 hrs.
- The Trust undertook local consultation in 2014 in respect of configuration of stroke services. The preferred outcome was a centralised model to support improvement of stroke services with acute beds centralised in CAH and rehabilitation beds at DHH. The infrastructure and investment required to deliver on the preferred model has not been actualised.
- A subsequent regional public consultation on stroke services in 2019, focused on the delivery of hyper-acute stroke services; CAH was identified as a hyper-acute site in all the options presented. The outcome of the report was delayed and is as yet not concluded.
- Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme based in the School of Life Course and Population Sciences at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland.
- The Southern Trust participates and utilises information from SSNAP to inform its Stroke Quality Improvement group.
- SSNAP quarterly audit performance in CAH has been banded level 'D' and DHH banded level 'C' in the quarter July – September 2021 (latest regional benchmarked). Remains unchanged in Dec 21.
- Comparative Trust analysis is detailed in Table 1 below

Trust	BHSCT			NHSCT			NHSCT			SEHSCT			SHSCT			SHSCT			WHSCT			WHSCT		
Team	Royal Victoria Hospital			Antrim Area Hospital			Causeway Hospital			Ulster Hospital			Craigavon Area Hospital			Daisy Hill			Altnagelvin			South West Acute		
Reporting period	Apr - Jun 2021	Jul - Sep 2021		Apr - Jun 2021	Jul - Sep 2021		Apr - Jun 2021	Jul - Sep 2021		Apr - Jun 2021	Jul - Sept 2021		Apr - Jun 2021	Jul-Sep 2021		Apr - Jun 2021	Jul-Sep 2021		Apr - Jun 2021	Jul-Sep 2021		Apr - Jun 2021	Jul-Sep 2021	
SSNAP level	A	A	↔	B	B	↔	B	D	↓	C	C	↔	D	D	↔	B	C	↓	D	D	↔	A	A	↔
SSNAP score	92.0	91.0	↓	74.0	70	↓	72.0	58	↓	63.0	66.0	↑	56.0	54.0	↓	71.0	62.0	↓	56.0	58.0	↑	90.0	83.0	↓
1) Scanning	A	A	↔	A	B	↓	B	C	↓	B	B	↔	A	B	↓	A	C	↓	B	A	↑	A	A	↔
2) Stroke unit	D	D	↔	E	E	↔	E	E	↔	E	E	↔	E	E	↔	E	E	↔	E	E	↔	B	C	↓
3) Thrombolysis	A	A	↔	D	C	↑	C	D	↓	C	C	↔	C	D	↓	C	E	↓	D	C	↑	A	A	↔
4) Specialist Assessments	A	B	↓	A	A	↔	B	C	↓	D	D	↔	D	D	↔	C	D	↓	D	C	↑	A	A	↔
5) Occupational therapy	A	A	↔	A	B	↓	A	C	↓	A	A	↔	C	C	↔	A	A	↔	B	C	↓	A	B	↓
6) Physiotherapy	A	A	↔	B	B	↔	C	B	↑	D	C	↑	D	D	↔	B	B	↔	D	D	↓	B	C	↓
7) Speech and Language therapy	A	A	↔	B	C	↓	A	B	↓	C	B	↑	E	E	↔	D	D	↔	B	D	↑	A	C	↓
8) MDT working	A	A	↔	C	D	↓	C	E	↓	D	D	↔	E	E	↔	C	C	↔	E	E	↓	B	B	↔
9) Standards by discharge	B	B	↔	A	A	↔	A	A	↔	A	A	↔	B	A	↑	A	A	↔	A	B	↑	B	A	↑
10) Discharge processes	A	A	↔	C	C	↔	C	C	↔	B	B	↔	A	A	↔	A	A	↔	C	C	↔	B	B	↔

Table 1

Areas of improvement / achievement:

- The Trust has a Stroke Improvement Group which meets regularly and reviews SSNAP data.
- A Stroke service improvement lead is back in place (seconded to ICU during the pandemic) with an aim of focusing on key areas for improved performance.
- A Quality Improvement Project (QIP) has commenced on stroke identification in the Emergency Department and targeting ward of first admission.
- A need for an increase in stroke Allied Health Professional capacity has been identified and an investment proposal has been developed.
- The Trust is currently exploring options to reconfigure and improve stroke services within the existing infrastructure to create a centre of frailty and stroke services – this will require investment from the Trusts general capital and commissioner commitment to revenue support. (Ramone proposal for Centre of Excellence for Older People)
- There is close collaborative working with non-acute colleagues in the management of early and support discharged for stroke patients and these arrangements are well established.

1. Areas of concern/risk/challenge:

Key areas of concern relate to

- Bed pressures on the CAH site present challenges in maintaining the protected assessment bed and access to the dedicated stroke beds
- Overcrowding in Emergency Department, impacts on triage and the patients journey time which is critical in this time-sensitive condition
- Providing stroke services across four different hospital sites dilutes staff within an already under-resourced service meaning performance across all areas remains below the standards required.
- The current model where stroke patients are cared for on 4 different hospital sites does not facilitate focused 7 day therapy and smooth transition to Early Supported Discharge (ESD)
- The Stroke workforce for Nursing and Allied Health Professionals is inadequate and falls well below recommended guidelines. **The Trust needs to commit to improving the Nursing and AHP workforce with agreed assessment and input to patients at**

weekends. Access to Speech and Language Therapy at weekends is needed with access to dedicated swallow review.

- **Nursing numbers are poor** resulting in concerns surrounding safe delivery of stroke care and thrombolysis 24/7.
- Centre for Stroke and Frailty is a suggested long term model to facilitate consolidation but there is a need for change now.

Risks

- Inability to provide stroke Lysis cover 24/7 without appropriate **Nurse Stroke Trained availability**. Only have 6.38WTE available Nurses to cover Stroke Lysis on CAH (including 1 Agency)
- Current lysis cover gaps have been covered by the Clinical Coordinators at Night. This service is currently under pressure and is no longer able to guarantee provision of same.
- Inability to provide 1:1 Nursing at ward level post lysis and for those receiving Blood Pressure management infusions
- Inability to release Nurse to accompany patients to RVH for Thrombectomy. Non recurrent funding Thrombectomy in DHH 1 wte to support transfers, No current funding for the CAH site
- Inability to meet national SSNAP standards
- Risk of unmet clinical need due to high level clinical acuity
- Increase in vacancy rate due to current pressure with workforce (retention and recruitment)
- Dependency on Bank and Agency putting further pressure on the financial overspend
- Specialist Stroke Nurse availability 0.86WTE for CAH which is **lower comparatively than the region** and 1 wte in DHH
- A lack of AHPs at ward level is putting increased the demand on both Nursing and Medical Team to conduct their assessment of clinical need.

Projected Nurse Staffing levels for 2 South from July 2022

STAFFING TOTALS				
2 South Stroke	**FSL**	**ACTUAL**	**AVAILABLE**	**Skill Mix**
BAND 7	0.5	1	1	
BAND 6	3.86	2	1	EOI for 2WTE
BAND 5	16.21	13.09	11.31	Includes 2.86WTE Newly Qualified / International Nurses and 1.61WTE Block booking Not included - 2WTE Pending Pin (Sept 2022 - currently working Band 3) **Total Stroke Trained Nurses 6.38WTE**
BAND 3/2	6.68	7.95	4.95	Inc. 3.88 BBB
TOTALS	**27.75**	**24.04**	**18.26**	
Band 7 – Stroke Specialist Nurses	**1**	**0.85**	**0.85**	

Actions	
Band	**Actions**
BAND 7	Agreed to increase to increase from 0.5 to 1WTE to support clinical activity at ward level
BAND 6	1WTE converted into Educator Facilitator Role (due to OH requirement and service need) 2WTE EOI out to add
BAND 5	All E-Reqs complete – unsuccessful recruitment Attempts to recruit BBB/BBA ongoing Outreach to previous stroke staff which has been unsuccessful Currently upskilling of all staff on both Stroke and Medical side for Stroke Lysis
BAND 3/2	All E-Reqs complete Link with Bank and HR to backfill positions

Immediate need to increase trained Stroke Nurses

Approval sought for additional nurse posts:
DHH
Increase Band 5 to deliver Lysis (currently HDU) - stroke nurse skill set needs built and assist retention (5.6 wte)
+Nurse Specialist 6/7 x1
+ Educator Facilitator Part Time B6

CAH
Funding for Nurse Specialist B6/7 x1 (backfill for Ed Facilitator role)
+ Thrombectomy nurse B5
+ Additional **trained** b5/6 stroke nurses to reduce bank and agency dependency

STROKE GAP ANALYSIS – ACUTE AHP – PT/OT/SLT HIGHLIGHTED

RESPONSIVE 7 DAY SERVICE - 17 BEDS (BASED ON CAH CURRENT FUNDED STAFFING FOR 18 BEDS)						
Professional Group	**Current Staffing Qualified**	**Current Staffing Support**	**Recommended staffing level (as per RCP)**		**Deficit Qualified**	**Deficit Support**
			Qualified	Support		
Physio CAH	1.18	0.3	5.95	2.38	4.77	2.08
OT CAH	0.87	0.12	4.76	1.19	3.89	0.85
SLT CAH	0.65	0	2.38	0	1.73	0
Dietetics CAH	0.09	0	0.68	0.68	0.59	0.68
Orthoptics	0	0	0.68	0	0.34	0
Podiatry	0	0	0.24	0	0	0
TOTAL	2.79	0.42	14.69	4.25	11.32	3.61

PROPOSED IMMEDIATE ACTIONS:

- Release of the at-risk posts through finance. In addition to requested OT/PT the approval of **0.4SLT B6** would allow recruitment of 1wte from existing waiting list now – 0.4 of which I could ring-fence to stroke.
- Ring-fence existing staff complement and at risk posts to stroke provision only – knock on impact elsewhere in acute
- A combined stroke approach should be progressed as the way forward - Immediate request for weekend cover (1 morning) for stroke to Trust wide stroke staff – PT/OT/SLT as additional hrs/overtime
- Weekend provision with a combined staffing model e.g. shared SALT Saturday
- Explore the potential for all SALT's with swallowing assessment competency to become part of a rota – similar to Respiratory Physio model
- Recognising that workforce pool is limited, consideration may need to be given to the approval of prioritisation of these posts Trust wide in conjunction with professional HOS. Due to overall small numbers of staff, decisions may need to be made as to where are the priority areas for that resource to be placed NAH/ESD/Acute
- Finalisation of Acute stroke IPT and submission for urgent consideration by - priority to establish a phased approach to 7 day working (not reliant on additional hrs)

PERFORMANCE COMMITTEE MEETING

10/03/22

Dr Michael McCormick

SSNAP
(Sentinel Stroke National Audit Programme)

- **Clinical Audit**
  - Continuous
  - All stroke admissions
  - Standards of care against KPI
  - Quarterly report (bench marking)

- **Organisational Audit**
  - SNAP shot (2012,2014,2016,2019,2021)
  - Workforce (Numbers/Training), Bed compliment
  - Organisational structures (Feedback/Accountability)

Clinical Audit

Trust	BHSCT			NHSCT			NHSCT			SEHSCT			SHSCT			SHSCT			WHSCT			WHSCT		
Team	Royal Victoria Hospital			Antrim Area Hospital			Causeway Hospital			Ulster Hospital			Craigavon Area Hospital			Daisy Hill			Altnagelvin			South West Acute		
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SSNAP score	92.0	91.0	↓	74.0	70	↓	72.0	58	↓	63.0	66.0	↑	56.0	54.0	↓	71.0	62.0	↓	56.0	58.0	↑	90.0	83.0	↓
1) Scanning	A	A	↔	A	B	↓	B	C	↓	B	B	↔	A	B	↓	A	C	↓	B	A	↑	A	A	↔
2) Stroke unit	D	D	↔	E	E	↔	E	E	↔	E	E	↔	E	E	↔	E	E	↔	E	E	↔	B	C	↓
3) Thrombolysis	A	A	↔	D	C	↑	C	D	↓	C	C	↔	C	D	↓	C	E	↓	D	C	↑	A	A	↔
4) Specialist Assessments	A	B	↓	A	A	↔	B	C	↓	D	D	↔	D	D	↔	C	D	↓	D	C	↑	A	A	↔
5) Occupational therapy	A	A	↔	A	B	↓	A	C	↓	A	A	↔	C	C	↔	A	A	↔	B	C	↓	A	B	↓
6) Physiotherapy	A	A	↔	B	B	↔	C	B	↑	D	C	↑	D	D	↔	B	B	↔	D	D	↓	B	C	↓
7) Speech and Language therapy	A	A	↔	B	C	↓	A	B	↓	C	B	↑	E	E	↔	D	D	↔	B	D	↑	A	C	↓
8) MDT working	A	A	↔	C	D	↓	C	E	↓	D	D	↔	E	E	↔	C	C	↔	E	E	↓	B	B	↔
9) Standards by discharge	B	B	↔	A	A	↔	A	A	↔	A	A	↔	B	A	↑	A	A	↔	A	B	↑	B	A	↑
10) Discharge processes	A	A	↔	C	C	↔	C	C	↔	B	B	↔	A	A	↔	A	A	↔	C	C	↔	B	B	↔

Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

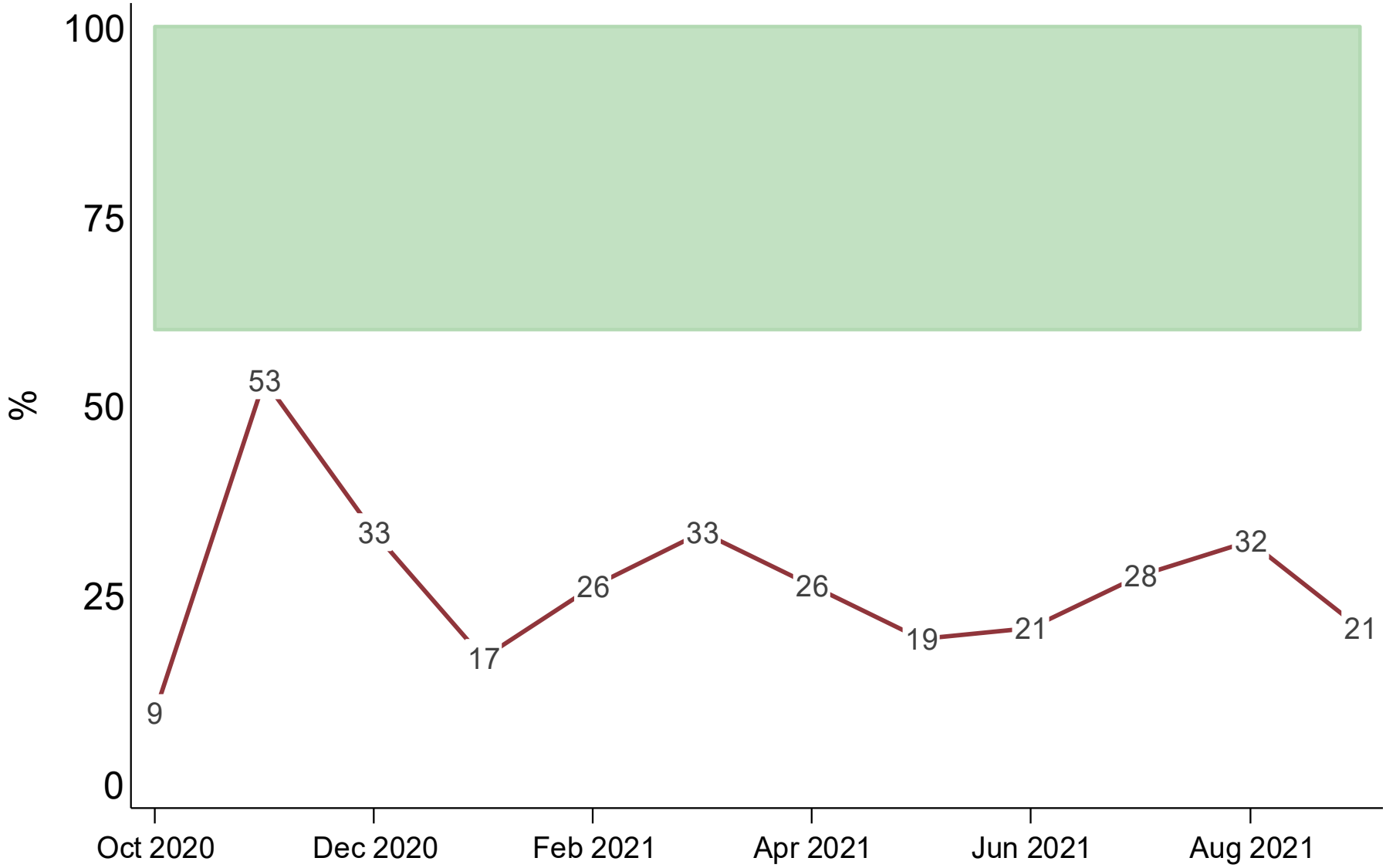
National Audit Assurance Report Template

		Jan – June 2019			Apr – June 2021		
		CAH	DHH	UK	CAH	DHH	UK
1	Admission to stroke unit within 4hours:	57.8%	52%	56.3%	30.7% Declined by 27.1%	20.6% Declined by 31.4%	51.5 %

		CAH	DHH	UK	CAH	DHH	UK
2	Applicable patients have a swallow screen within 4hours:	75%	78%	75%	66.4% Declined by 8.6%	48.7% Declined by 29.3%	74.4%

		CAH	DHH	UK	CAH	DHH	UK
3	Applicable patients assessed by a nurse and one therapist within 24 hours and all relevant therapists within 72 hours and rehab goals within 5 days.	28.2 %	25%	64.3%	22.7% Declined by 5.5%	68.4% Improved by 43.4%	63. 4%

Nursing, therapy and rehab goals within time limits



Source: SSNAP Jul-Sep 2021
Patient-centred results at team level for Key Indicator 8.8A

Team 139

Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

Short term Solutions

- Workforce investment
- Prioritise Stroke
  - Discharges, COVID, Orthopaedics
- Stroke assessment at weekends
  - Pooled resource (OPPC/Acute)
  - OT Competencies/SALT input
  - Not just ESD/DHH
- Consolidation
  - One ward, identified cohort of patients
  - ESD/CST interface

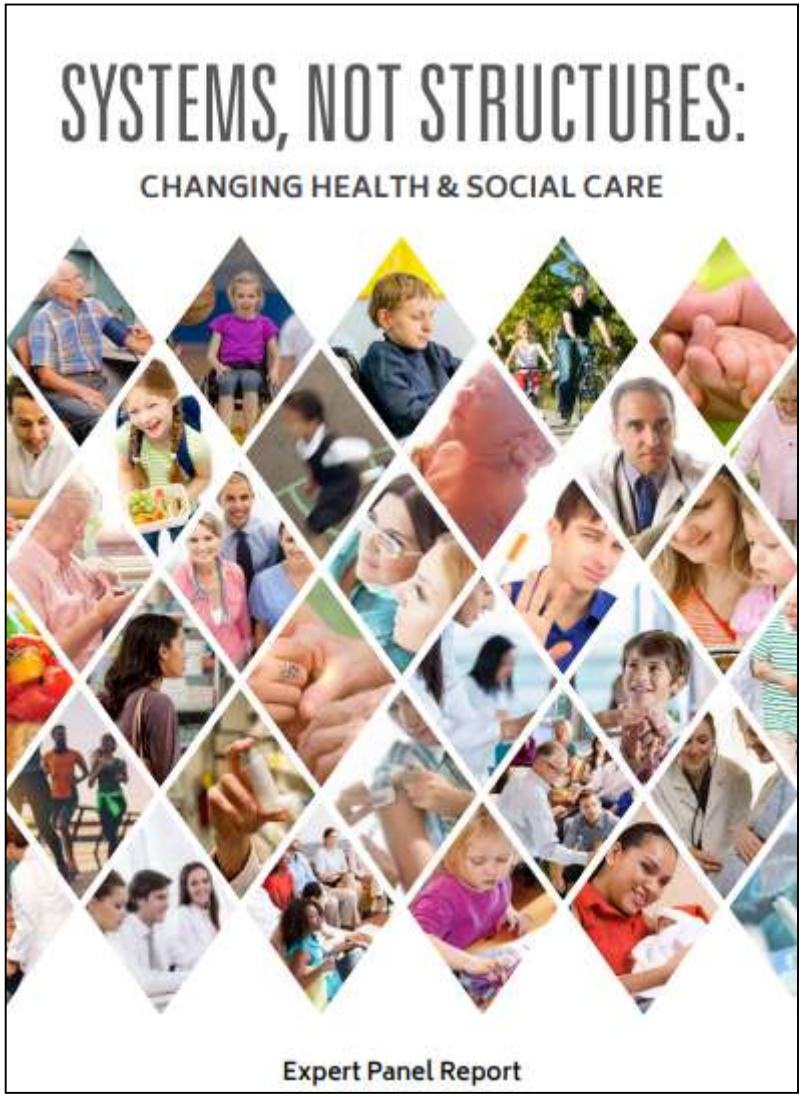
B. Trust Level – Stroke Services in the Southern Trust

In 2014, following public consultation, a decision was taken to create a single specialist stroke inpatient unit within the Southern Health and Social Care Trust, at Craigavon Area Hospital. The Trust is proposing to provide a consistent and specialist service 24/7 in one centre rather than spreading the specialist team of staff across four sites. Daisy Hill Hospital will continue to provide ongoing rehabilitation and support through community stroke teams working to a regionally agreed care model.

The proposals are consistent with clinical evidence which shows that patients are 25% more likely to survive or recover from stroke if treated in a specialised centre. Other benefits will include:

- High quality medical care
- Improved levels of Stroke Care in line with National Audit (SSNAP) recommendations – appropriate staffing levels to allow early assessment, observation and early rehabilitation input.
- The highest quality medical care in hospital (more concentrated levels of specialist medical, nursing and AHP care).
- Patients being admitted to a Stroke Unit as a ward of first admission. Latest medical evidence demonstrates that where patients are treated in specialist stroke units they achieve best outcomes.
- Better rehabilitation outcomes - a specialised service which will bring community and hospital based staff together as an integrated team providing care to Stroke patients. This will provide more focused care and continuity of service provision throughout the patient's pathway.

Reduced length of stay in hospital - more focused community based rehabilitation to allow Stroke patients to be discharged from hospital earlier and recover at home.



Organisational Audit (key indicators)

- **Key Indicator 1: Minimum establishment of band 6 and band 7 nurses per 10 beds**
  - (Criterion: Sum of band 6 and 7 (WTE) nurses per 10 stroke unit beds is equal to/above **2.375 per 10 beds** for ALL stroke beds.)
- **Key Indicator 2: Presence of a clinical psychologist (qualified)**
  - (Criterion: Presence of at least one (WTE) qualified clinical psychologist per 30 stroke unit beds)
- **Key Indicator 3: Out of hours presence of stroke specialist nurse**
  - (Criterion: Met if there is out of hours presence of a stroke specialist nurse to undertake assessments of suspected stroke patients in ED)
- **Key Indicator 4: Minimum number of nurses on duty at 10am weekends**
  - (Criterion: Met if have 3.0 nurses per 10 type 1 and 3 beds (average number of nurses on duty on type 1 and type 3 beds)
- **Key Indicator 5: At least two types of therapy available 7 days a week**
  - (Criterion: Met if 7-day working for at least two types of qualified therapy. Includes occupational therapy, physiotherapy and speech and language therapy)
- **Key Indicator 6: Stroke team receives a pre-alert for suspected stroke patients**
  - (Criterion: Met if a pre-alert is received for all types of strokes and if the call is made to Stroke Specialist Nurse, Stroke Consultant on call or Stroke Junior Doctor)
- **Key Indicator 7: Access to a specialist (stroke/neurological specific) early supported discharge (ESD) team**
  - (Criterion: Met if they have access to at least one stroke stroke/neurology specific early supported discharge multidisciplinary team AND at least 66% of patients have access to at least one of the teams if needed)
- **Key Indicator 8: Formal survey undertaken seeking patient/carer views on stroke services**
  - (Criterion: Met if at least one a year)
- **Key Indicator 9: First line of brain imaging for TIA patients is MRI**
  - (Criterion: Met if MRI is first line brain imaging for suspected TIA AND investigations are completed within in 2 days (Next weekday, the next day, the same day (5 days a week) or the same day (7 days a week))
- **Key Indicator 10: Management level that takes responsibility for audit results**
  - (Criterion: Met if Executive on the Board, Non-executive on the Board, or Chairman of Clinical Governance takes responsibility for the follow-up of stroke audit results)

Acute Organisational Audit

	Score	1	2	3	4	5	6	7	8	9	10
Belfast trust											
RVH	4	X		X				X	X		
Northern trust											
Antrim	4	X		X						X	X
Causeway	2									X	X
South-Eastern Trust											
Ulster	3							X	X		X
Western Trust											
Altnagelvin	5	X			X			X	X	X	
SWAH	3				X			X	X		
Southern Trust											
Craigavon	2							X		X	
Daisy Hill	1							X			

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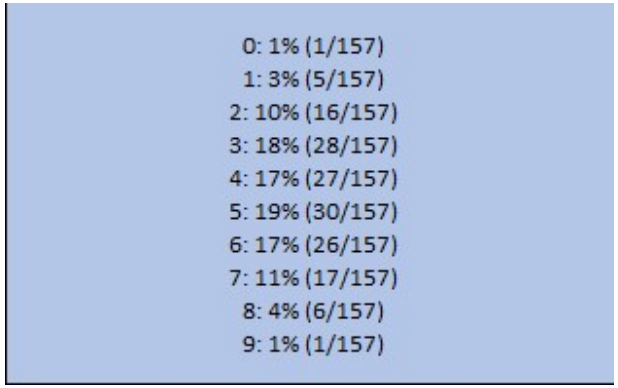


Benchmarking

- Action Plan
  - Survey (no excuse)
  - Management level that takes responsibility for results and recommendations
  - Resources (stroke specialist nurses)

- Why collect data?
  - Going backwards (2012-2022)
  - Indicator of medical care
  - Accountability

Summary

- Clinical and Organisational Audit
- Poor Performance consistently
  - Patient care is inadequate
  - Workforce deficiencies
- New ward/infrastructure will take time
- Need to consolidate now
  - Stroke needs to be a priority
    - Weekend hierarchy
  - Can we target improved SSNAP scores (external marker) for better quality care

SSNAP Quarterly Report January 2022 – March 2022 (scored from A- E Nationally)

CAH SSNAP Result – Level D (previously D)

Areas Improved	No Change	Deteriorated
Scanning (A)	Admitted to SU within 4 hours (E)	OT (D)
Specialist Assessments (C)	Thrombolysis (C)	
Standards by Discharge (A)	Physio (D)	
	SALT (D)	
	MDT working (E)	
	Discharge Processes (A)	

DHH SSNAP Result – Level B (previously B)

Areas Improved	No Change	Deteriorated
Scanning (A)	Admitted to SU within 4 hours (E)	SALT (D)
Specialist Assessments (B)	Thrombolysis (C)	
	OT (A)	
	Physio (B)	
	MDT working (C)	
	Standards by Discharge (A)	
	Discharge Processes (A)	

		National	CAH	DHH	Target to obtain Level A
Scanning	Scanning within 1 hour	54.9%	**A** 56.4%	**A** 56.8%	48% scanned within 1 hour (median scan time < 60 mins)
	Scanning within 12 hours	95.3%	93.6%	100%	95% scanned within 12 hours
Stroke Unit	Patients admitted directly to the Stroke unit (SU) within 4 hours	38.3%	**E** 16.7%	**E** 13%	90% admitted within 4 hours (median to stroke unit < 2 hours)
	Patients that spend at least 90% of their stay in SU	73.8%	52.9%	50%	
Thrombolysis	Percentage of stroke patients given thrombolysis	10.3%	**C** 7.7%	**C** 10.8%	15% of patients lysed (NI)
	Percentage of patients Thrombolysed within 1 hour of clock start	61.2% Median DTN 52 mins	100% Median DTN 30 mins	75% Median DTN 59 mins	55% within 1 hour plus clock start to Lysis < 40 minutes
Specialist Assessments	Patients assessed by stroke consultant within 24 hours	82.9%	**C** 85.9%	**B** 83.8%	95% assessed within 24 hours
	Patients assessed by a nurse trained in stroke management within 24 hours of clock start	89.5%	87.2%	97.3%	95% assessed within 24 hours
	Applicable patients given swallow screen within 4 hours	71.2%	67.7%	71.4%	85% screened within 4 hours
	Applicable patients given formal swallow assessment within 72 hours	72.2%	88.1%	93.8%	85% assessed within 72 hours
Occupational Therapy	Percentage of patients requiring OT	82.2%	**D** 80.3%	**A** 82.9%	80% reported as requiring OT
	Median number of minutes per day on which OT is received	38.8	40	35.8	Median number of minutes greater than 32

Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

		National	CAH	DHH	Target to obtain Level A
	Median % of days as an inpatient on which OT is received	60.6%	37.7%	72.2%	Median % of days greater than 70%
	45 minutes of therapy 5 out of 7 days for 80% of patients	75.1%	47%	83.3%	80% of minutes of therapy delivered
Physiotherapy	Percentage of patients requiring Physiotherapy	83.5%	**D** 65.8%	**B** 82.9%	85% reported as requiring Physio
	Median number of minutes per day on which Physio is received	35	33.3	35.5	Median number of minutes greater than 32
	Median % of days as an inpatient on which Physio is received	68.3%	55.3%	69.4%	Median % of days greater than 75%
	45 minutes of therapy 5 out of 7 days for 80% of patients	73.1%	44.4%	74.8%	90% of minutes of therapy delivered
SALT	Percentage of patients requiring SALT	51.2%	**D** 36.8%	**D** 36.6%	50% reported as requiring SALT
	Median number of minutes per day on which SALT is received	32.2	31	34	Median number of minutes greater than 32
	Median % of days as an inpatient on which SALT is received	48.2%	56.3%	46.9%	Median % of days greater than 70%
	45 minutes of therapy 5 out of 7 days for 80% of patients	49.4%	40%	36.3%	90% of minutes of therapy delivered
MDT working	Applicable patients assessed by OT within 72 hours	90.4% (22:17hr)	**E** 66.2% (44:11hr)	**C** 100% (22:06hr)	90% assessed by OT within 72 hours (median clock start to OT less than 12 hours)
	Applicable patients assessed by Physio within 72 hours	93.4% (21:45hr)	76.4% (36:47hr)	97.3% (22:24hr)	90% assessed by Physio within 72 hours (median clock start to Physio less than 12 hours)

		National	CAH	DHH	Target to obtain Level A
	Applicable patients assessed by SALT within 72 hours	87.9% (23:30hr)	60% (45:12hr)	78.9% (24:10hr)	90% assessed by SALT within 72 hours (median clock start to SALT less than 12 hours)
	Applicable patients with goals set within 5 days	91.1%	88.9%	91.4%	80% goals set within 5 days
	Applicable patients assessed by a nurse and one therapist within 24 hours and all relevant therapists within 72 hours and rehab goals within 5 days	58.9%	17.7%	42.9%	60% applicable patients assessed by a nurse and one therapist within 24 hours and all relevant therapists within 72 hours and rehab goals within 5 days
Standards of Discharge	Applicable patients screened for nutrition and seen by a dietician	75.8%	**A** 100%	**A** 100%	95% of applicable patients screened
	Applicable patients who have a continence plan drawn up within 3 weeks of clock start	93.8%	100%	100%	95% of applicable patients
	Applicable patients who have had a mood and cognition screen by discharge	92.8%	96%	88%	95% of applicable patients
Discharge Processes	Applicable patients receiving joint health and social care plan by discharge	92.7%	**A** 100%	**A** 100%	90% of applicable patients
	Patients treated by stroke Early Supported Discharge team	47.3%	100%	100%	40% of applicable patients
	Patients in AF discharged on anticoagulants or plan to start on anticoagulants	98.1%	100%	100%	95% of applicable patients
	Patients discharged with a named point of contact for post discharge	97%	100%	100%	95% of applicable patients

Southern Health and Social Care Trust

Minutes of a Virtual Trust Board meeting held on Thursday, 27th October 2022 at 10.30 a.m.

PRESENT

Ms E Mullan, Chair
Dr M O'Kane, Chief Executive *(items 1-15 only)*
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr C McCafferty, Interim Director of Children and Young People's Services /Executive Director of Social Work *(items 1-15 only)*
Ms C Teggart, Director of Finance, Procurement and Estates *(Item 18 onwards)*
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals
Dr D Gormley, Deputy Medical Director *(for Dr Scullion)*

IN ATTENDANCE

Mr B Beattie, Interim Director of Older People and Primary Care
Mrs L Leeman, Interim Director of Performance and Reform
Ms C Teggart, Director of Finance, Procurement and Estates
Ms R O'Hare, Assistant Director of Disability Services *(for Jan McGall)*
Mrs C Reid, Interim Director of Medicine and Unscheduled Care
Mrs T Reid, Interim Director of Surgery & Elective Care, Cancer & Clinical Services & Integrated Maternity & Women's Health
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs P Tally, Assistant Director, Quality Improvement *(Item 16 only)*
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary *(Minutes)*

APOLOGIES

Ms J McGall, Director of Mental Health and Disability Services
Dr D Scullion, Interim Medical Director

1. CHAIR'S WELCOME

The Chair welcomed everyone to the virtual meeting including Dr D Gormley, Deputy Medical Director Governance Safety & Quality Improvement and Ms R O'Hare, Assistant Director of Disability Services deputising for Dr Scullion and Ms J McGall respectively. The Chair particularly welcomed five members of Trust staff from the Nursing, Midwifery and Allied Health Professionals (AHPs) and Functional Support Services Directorate and stated that she would appreciate their feedback in terms of what they will learn at today's meeting and how they take this learning back to their colleagues. Regular public attendees were also welcomed to the meeting.

The Chair reminded everyone regarding some aspects of virtual meeting etiquette and the business of the meeting proceeded.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. CHAIR'S REMARKS

The Chair acknowledged the challenges facing the HSC system in the winter months ahead and alluded to the associated impact on staff. She put on record her appreciation to the workforce for their ongoing support to ensure safe, quality services are delivered to the Southern Trust population on a daily basis.

4. CHIEF EXECUTIVE UPDATE

The Chief Executive provided a comprehensive update on a number of current issues.

Ms Donaghy welcomed the announcement that Daisy Hill Hospital (DHH) will be an Elective Overnight Stay Centre and asked if there was a timeframe attached to the elective surgery plan. Ms Donaghy also asked if the required workforce, particularly medical, would be in place. In responding, the Chief Executive advised no definitive timeframe has been set and the Trust's surgical team will now be engaging with colleagues regionally to develop these plans...In relation to staffing, Dr O'Kane envisaged surgical cover would be undertaken internally, with additional support coming from the region. She went on to advise that a

limiting factor is the availability of theatre nurses, however this announcement will provide a huge opportunity for this cohort of staff to avail of training and development opportunities and become part of the team at DHH. She acknowledged a full complement of staff was not yet in place, however, the Trust plan to promote the opportunities available widely, in order to attract staff ito work at DHH.

Ms Kimmins MLA, SF stated she had met recently with the Chief Executive on a number of matters including delayed discharges and advised that other elected representatives and herself would continue to engage with local constituents to make them more aware of the issues.. Ms Kimmins also welcomed the announcement by the Minister on the elective surgery hub and stated it would provide staff and the public with confidence in the future of DHH. The Chief Executive reiterated that the Trust looked forward to enhancing its elective surgical capacity and it was an opportunity to showcase DHH at its best. In relation to emergency general surgery, Dr O'Kane explained the rationale for the changes the Trust has implemented through the current contingency model of Emergency General Surgery provision to ensure good outcomes for patients.

5. MINUTES OF MEETING HELD ON 29TH SEPTEMBER 2022

The minutes of the meeting held on 29th September 2022 were agreed as an accurate record.

The Board approved the minutes of the meeting held on 29th September 2022.

6. MATTERS ARISING

Members noted the progress updates from the relevant Directors to issues raised at the previous meeting. In relation to the reinstatement of the Young People's Pledge, Mr McCafferty confirmed young people will participate at the Trust Board meeting in March 2023 and again in May 2023 and with support by key staff will present on specific areas of interest/concern. Services will include Care experienced young people, Autism and CAMHS.

STRATEGY

7. UPDATE ON STROKE SERVICES

At the outset, Mrs C Reid advised the paper was a further update from the document presented to the Performance Committee in March 2022 on Sentinel Stroke National Audit Programme (SSNAP). She advised the update also sets out further opportunities and the challenges being faced by the service.

Members considered Appendix 1, which demonstrates a regional SSNAP comparative position and were pleased to note that CAH site has improved its performance to a level 'C' and DHH maintained level 'B'. The improvement on CAH site is largely attributed to progress in Thrombolysis, Occupational Therapy and Physiotherapy, the latter two of which have improved as a result of the appointment of additional AHP staffing.

Mrs C Reid advised on a number of areas for improvement/achievement including a new project structure established to drive service improvement within Stroke and Frailty services and members noted the detail on Acute AHP staffing. Further investment is required to support improvements in performance and patient outcomes and discussions are ongoing with the SPPG regarding the need for additional recurrent investment. In relation to the proposed reconfiguration of the Ramone building to provide an extension to accommodate 12 stroke beds, Mrs C Reid advised the project has had to be scaled back, providing only 6 beds in 2022/23 due to the significant market price increases and construction workforce availability. The Trust plan to bid for further capital funding in subsequent years to enable the project to be achieved in full. Mrs C Reid assured members the Trust continues to be committed to the long term vision and strategic priority of building and improving stroke services for the local population.

Members welcomed the detail on two Quality Improvement (QI) projects, i) ED to Stroke unit in less than 4 hours and ii) 'Door In Door Out (DIDO) for potential Thrombectomy patients.

At this point, Mrs C Reid updated members on a range of challenges impacting stroke services including, bed pressures on both acute and non-acute sites making it difficult to maintain protected assessment beds and access to the dedicated stroke beds. Furthermore, winter pressures and unscheduled emergency presentations continue to impact on time

sensitive presentations for stroke. Workforce, along with patient flow and infrastructure issues also present daily concerns.

Mrs Leeson welcomed the improvement in performance at CAH since the last update due to appointing posts at risk in the absence of recurring revenue funding. She welcomed the speed by which the improvement has been made and added that the Trust must continue to advocate for investment to improve Trust infrastructure. Mrs Leeson stated she looked forward to a further update to the Performance Committee in due course.

Mr McDonald said he was assured by the positive changes the Trust has made and the clear action plan in place. Whilst no regional way forward for Stroke Services has been agreed, he welcomed the changes the Trust has implemented within its own control. Mrs Leeman updated members on a meeting with the SPPG and reported that whilst no commitment for funding has been made, there was an openness to look at Trust proposals again and if necessary take appropriate steps to keep a safe and progressive service.

Mr Wilkinson asked if the Trust has a fully operational stroke service in DHH at present. He went on to state that keeping in mind the width of the Trust catchment area, it was important that stroke beds are maintained and developed if required to ensure patients get the necessary treatment in a timely manner. In responding, Mrs C Reid confirmed the Trust has a Stroke Service at DHH with one protected bed. She advised the preferred model going forward would be a dedicated centre of excellence for Stroke Services at CAH site with thrombosis being delivered at DHH. The Trust continues to work hard to protect the bed for stroke patients at DHH whilst recognising the significant pressures across the whole system.

Ms Donaghy highlighted DHH performance was ahead of CAH in relation to the 4 hour timeframe. She also raised 'Door In Door Out' (DIDO) for potential Thrombectomy patients and asked if the Trust was working with NIAS to achieve the 60 minute target. In responding, Mrs C Reid stated she was unsure as to why DHH out performed CAH in relation to the 4 hour timeframe, however this would continue to be monitored. In terms of working with NIAS, she stated it was important to note the current pressures on ambulances waiting at EDs and the number responding to the community. She added that moving forward, a whole system approach was required to ensure improvement and scoping ways of working better with NIAS.

Mr Beattie advised work continues to improve stroke services and ambulate patients earlier in order to help prevent admissions. Mr Beattie pointed out it was not about just creating more bed capacity but creating more options and other approaches. He reminded members the Trust has a vision for improved services within Acute but also within non Acute and the Community settings and numerous services are working together to support stroke patients including, community stroke teams and early supported discharge teams. Dr O'Kane provided reassurance that the number of patients requiring transfer to the Royal for treatment is small. She stated a whole system approach was required to ensure timely discharge and improve outcomes for stroke patients.

In conclusion, the Chair thanked Mrs C Reid for her clear and concise report, demonstrating the improvements achieved. She stated further progress updates would be provided to the Performance Committee and noted an update report including further improvements would be provided to Trust Board at a future meeting.

Action – Mrs C Reid

ACCOUNTABILITY

8i. FINANCIAL PERFORMANCE REPORT (ST1118/22)

Ms Teggart presented the Finance Report for approval, for the 6 months ending 30th September 2022 in which the Trust reported a deficit of £3.3m. She reminded members that in the last reporting period the Trust had projected a deficit of £8m, however through consultation with the Strategic Planning and Performance Group (SPPG), additional funding particularly in relation to Covid has been confirmed. This is expected to offset the £8m pressures in 2022/23 financial year leaving the Trust in a breakeven position at year-end. However, Ms Teggart emphasised the anticipated break-even position is also predicated on current out-turn and if expenditure increases above anticipated levels, this would impact on the Trust's ability to break-even.

At this point, Ms Teggart stated it was important to note the Trust was closely monitoring a number of risks and uncertainties, including the impact of the cost of living as well as inflationary increases across a number of areas. She advised the Trust's projected energy costs will rise to £16.8m from prior year figures of £9.7m, however she assured

members additional funding has been committed by the DoH, albeit concern remains that energy costs will continue to climb over the winter months. Members also noted the risk to community focus schemes as a result of the DoH withdrawing funding for no more silos in a number of key areas. Ms Teggart went on to refer to the Minister's target imposed on Trusts to reduce off-contract agency spend and the Southern Trust's share of £2.5m in year. She advised that work is progressing internally through the Workforce Stabilisation Group and members were updated on a range of areas identified to help achieve this target; however, Ms Teggart added it will be difficult to fully achieve this in the absence of the new regional procurement process for agency staff which is expected later in the year.

Members noted the current position in terms of payroll, goods and services and prompt payment performance. In conclusion, Ms Teggart advised that the year to date spend at month 6 for the capital budget is £5.2m. She reported that it is anticipated that the Trust's Capital Resource Limit (CRL) will be spent in full by year-end.

At this point, Mrs McCartan asked what the quantum of funds equated to in relation to the DoH retracted funding for 'no more silos'. Ms Teggart stated that the overall impact for the first 6 months of the financial year would be in the region of £300k and added the Trust would not be in a position to cover this under its current allocation. The SPPG are looking at other funding options/alternatives. Mrs McCartan referred to the annual standard pay uplift and asked if funding was guaranteed from the DoH. Ms Teggart advised this area was outside normal funding allocations and considered by the DoH on an overall regional basis. In relation to the increasing energy costs, Mr McDonald asked if the DoH was expected to put any special funding arrangements in place. In responding, Ms Teggart advised an extra £10m has been made available this year, however it is a concerning issue which is being monitored closely. She added that in the long term there was a need to capitalise on sustainability and explore savings through the use of renewable energy to ensure the organisation was less reliant on recurrent funding. Ms Teggart assured members the Trust is continually looking at ways to reduce energy costs and advised that work was progressing to roll out the installation of solar panels on a number of smaller buildings across the Trust estate in due course. Mr McDonald acknowledged the huge task ahead.

In conclusion, the Chair referred to the £2.5m target to reduce off contract agency spend and asked if the Trust was able to convert

temporary posts to permanent in light of the associated challenges with non-recurrent/recurrent funding. Ms Teggart advised this work will form part of the Trust's financial strategy going forward.

The Board approved the Financial Performance Report (ST1118/22)

8ii. FINANCIAL STRATEGY UPDATE (ST1119/22)

Ms Teggart presented an update paper to the Draft Budget paper presented to Trust Board in March 2022 and the update on Financial Strategy paper presented to Trust Board in June 2022.

At the outset, Ms Teggart reminded members that in June 2022, the Trust Board was provided with the best estimate of the year-end forecast position, which showed a projected deficit of £16.3m. However, after further discussions with SPPG to attempt to secure additional sources of funding and as further reported to Trust Board in September, it is anticipated that the revised Trust deficit for 2022/23 will be in the region of £8m. Subsequently, ongoing discussion with SPPG, along with confirmation of Covid funding for the remainder of the financial year and formalisation of the balance of indicative allocations for the Trust, it is now anticipated that the Trust will achieve a break-even position by year-end. Ms Teggart stated it was important to note that whilst the Trust has potentially received funding this year to achieve a break-even position, this funding is not recurrent. She took time to outline for members the main risks which could influence the achievement of a break even position and emphasised the Trust must therefore continue to contain costs and avoid service growth or investment without confirmed recurrent funding or appropriate assurances from the DoH. She emphasised it was imperative to continue reinforcing the need for robust financial discipline across all teams. Ms Teggart stated this work will assist the Trust as it develops a financial sustainability review.

Mrs McCartan welcomed as helpful, the detail on the movement in financial deficit from June to October 2022 and suggested it would also be useful to include in future reporting, baseline RRL figures and the additional allocations received to arrive at £870m. Ms Teggart agreed to consider Mrs McCartan's suggestion further.

Mr McDonald referred to the current political situation in Northern Ireland and the absence of a Health Minister and agreed budget. He

asked if the DoH through the Permanent Secretary would now be in a position to allocate a budget. In responding, Ms Teggart advised that the Permanent Secretary for Health has indicated overall pressures of £650m this year. She stated the DoH have allocated out as much as is within their gift to allow Trusts to begin budget planning. Ms Teggart confirmed the Trust had received written confirmation of their share of funding allocation for the financial year 2022/23. In concluding discussion, the Chief Executive alluded to the impact the current financial instability was having on the Trust's ability to plan effectively.

The Board approved the Financial Strategy Update (ST1119/22)

8iii. FINANCIAL SUSTAINABILITY GROUP TERMS OF REFERENCE (ST1120/22)

Ms Teggart explained the paper sets out the terms of reference for the Financial Sustainability and Productivity Review 2022-23, commencing October 2022 with completion by 31 March 2023. Members noted the purpose of the review in light of the extremely difficult financial position moving forward into the financial year 2023/24. Ms Teggart stated it was important the Trust has a clear understanding on how and where the Organisation is spending its budget for maximum productivity. She advised the Permanent Secretary for Health has clearly indicated that moving forward Trust budgets will be reduced to pre covid levels and he has made a request that growth is capped and costs contained. Moving forward, Ms Teggart stated the Trust must reallocate and prioritise current resources to areas of most need.

Ms Teggart advised the DoH would be seeking proposals from Trusts on how to balance deficits over a 3-year budget period as part of the HSC Recovery and Sustainability Plan. She reiterated it was important the Trust assured itself funding was being utilised prudently and areas of most need are prioritised. In light of this, Ms Teggart advised the Trust was working to prepare a Financial Sustainability Strategy for Trust Board approval by March 2023, outlining recommendations on improving financial sustainability and productivity within the Trust.

In conclusion, the Chair welcomed the exercise as a real time opportunity to gather intelligence, which will, despite the challenges, allow Trust Management to make informed decisions moving forward for the betterment of the Southern population. The Chair advised interim updates would be provided to Trust Board along the review.

Members approved the Financial Sustainability Group Terms of Reference (ST1120/22)

9. DRAFT MID-YEAR ASSURANCE STATEMENT (ST1121/22)

Ms Teggart presented the draft Mid-Year Assurance Statement for retrospective approval. Members noted the document had been reviewed in detail by the Audit Committee on 13th October 2022. On behalf of the Audit Committee, Mrs McCartan welcomed the comprehensive statement, which reflected the day-to-day challenges facing the Trust and the Chief Executive's assessment that it accurately reflects the system of internal governance as at 30 September 2022.

The Board approved the Draft Mid-Year Assurance Statement (ST1121/22)

10. EXECUTIVE DIRECTOR OF SOCIAL WORK REPORT

Mr McCafferty presented the Executive Director of Social Work report for assurance. He stated that despite ongoing challenges, the profession as a whole, continues to be highly compliant with core Delegated Statutory Functions. Members were updated on the establishment of cross Directorate social work governance interface meetings, the purpose of which will be to strengthen existing professional governance arrangements and provide assurance to Trust Board. Mr McCafferty outlined the areas of focus, including compliance with supervision standards, monitoring vacancies, and staff training and development.

Members welcomed improvement in areas including the implementation of the Mental Capacity Act (MCA), with Phase 1 DoLS complete and. Phase 2 legacy DoLS in learning disability services progressing well. Supports for Looked After Children (LAC) has seen enhanced educational support leading to improved educational outcomes for LAC. Mr McCafferty also referred to ongoing collaborative multidisciplinary working in terms of Domestic Abuse.

Members noted the high levels of vacancies in social work, particularly within Children's Services, which in turn impacts capacity. As a consequence of substantive social work vacancies, there are high numbers of unallocated cases within Children's Services, however Mr McCafferty reassured members that all children on the Child Protection Register and LAC have an allocated Social Worker. Members also noted

the current challenges within the Older People's Directorate in relation to retention of social work and social care staff given the demands of the job roles.

In conclusion, Mr McCafferty referred to the ongoing Independent Review of Children's Social Care Services led by Professor Ray Jones and the Interim findings, which recommend the establishment of an ALB responsible for children's services subject to an options appraisal. He stated it was important to acknowledge and commend staff for their continued commitment to provide safe, high quality care despite the ongoing challenges.

Mrs McCartan welcomed the strengthening of accountability and governance arrangements detailed within the report. She also highlighted page 14, the introduction of the new Adult Protection Bill, NI and suggested it would be beneficial to have a short presentation at a future Trust Board meeting on the Trust's Adult Protection Quality Improvement Pilot. Mr McCafferty suggested that with the Chair's agreement he would include Adult Safeguarding in his next reporting cycle and include service updates. The Chair agreed to the suggested approach.

Action – Mr McCafferty

In light of the challenges outlined within the report, Mr Wilkinson asked if the Trust had any recent data available on staff morale, in order to get a feel for staff experiences at work. Whilst Mr McCafferty had no specific data to hand, he assured members that follow up on staff exiting the service is in place. Despite the demands, staff remain committed to their roles however in light of constant pressures he recorded concern in regards to the long-term impact. In terms of leadership visibility, Mr McCafferty assured members that he engages very regularly with the workforce including facilitating meetings with social work staff from across the Directorates. Whilst Mr Wilkinson welcomed this, he suggested using a proforma specifically looking at the health of staff across the Social Work division would be helpful by way of assisting to measure morale. Mr McCafferty said he would consider this further with the assistance of the Workforce Development Team. The Chair referred to the recently launched 'People Framework' and its priority on 'Wellbeing' to which Mrs Toal emphasised the importance of services using this to inform their own Directorate plans. Mrs Toal suggested a survey of Social Work and Social Care staff could be pursued in terms of

scoping data around staff wellbeing to ascertain staff morale levels within this service area. She agreed to explore this further with Mr McCafferty.

Action – Mrs Toal / Mr McCafferty

Ms Donaghy referred to the challenges in terms of the availability of domiciliary care home packages and care home provision and asked, in light of the Minister's recent statement on trying to reduce agency workers, what reliance does the sector have on agency staff and if this was seen as another area of developing concern. Mr McCafferty stated that reliance on agency staff within social work is minimum, however Mr Beattie stated that Independent Sector (IS) Domiciliary Care and IS Care home providers have communicated to the Trust both the lack of access to staff and the expense of staff through agency costs is very challenging.

The Chair concluded the item by thanking Mr McCafferty for the assurances provided through his report.

11. FINAL REPORT TO THOSE CHARGED WITH GOVERNANCE

Ms Teggart presented the final report for information purposes and advised there were no substantial changes from the draft position reported to the Audit Committee in May 2022. Audit Committee members discussed the final report at their meeting held on 13th October 2022. The Chief Executive stated she was content with the auditor's year-end assessment.

12. PATIENT & CLIENT EXPERIENCE COMMITTEE

- **Committee Chair Report from 15th September 2022**
  Mr Wilkinson presented his Committee Chair Report from the meeting held on 15th September 2022.

- **Minutes of meeting held on 16th June 2022**
  Mr Wilkinson presented the minutes of the Patient & Client Experience Committee meeting for information purposes.

- **Committee Annual Report 2021/22 (ST1122/22)**
  Mr Wilkinson presented the Committee Annual Report 2021/22 for approval.

The Board approved the Patient and Client Experience Committee Annual Report 2021/22 (ST1122/22)

13. PERFORMANCE COMMITTEE

- **Committee Chair Report from 22nd September 2022**
  Mrs Leeson presented her Committee Chair Report from the meeting held on 22nd September 2022 and highlighted in particular an emerging issue, namely workforce challenge in health visiting. She also welcomed the informative presentation delivered on nurse to bed ratios.

- **Minutes of meeting held on 19th May 2022**
  Mrs Leeson presented the minutes of the Performance Committee meeting for information purposes.

- **Committee Annual Report 2021/22 (ST1123/22)**
  Mrs Leeson presented the Committee Annual Report 2021/22 for approval.

  The Board approved the Performance Committee Annual Report 2021/22 (ST1123/22)

- **Revised Terms of Reference (ST1124/22)**
  Mrs Leeson presented the Committee Terms of Reference for approval.

  The Board approved the Committee Terms of Reference (ST1124/22)

14. ENDOWMENTS & GIFTS COMMITTEE

- **Committee Chair Report from 3rd October 2022**
  Ms Donaghy presented her Committee Chair Report from the meeting held on 3rd October 2022 and referenced the ongoing work in regards to progressing increasing spending activity in 3 keys areas, namely, historical funds, current funds and the Staff Support Fund. Fund Managers of the four Directorate wide funds have updated the Committee on progress against their 2022/2023 spending proposals and whilst movement was disappointing in some instances, the challenges were recognised.

- **Minutes of meeting held on 14th June 2022**
  Ms Donaghy presented the minutes of the Endowments & Gifts Committee meeting for information purposes.

- **Committee Work Programme 2023 (ST1125/22)**
  Ms Donaghy presented the Committee Work Programme 2023 for approval.

  The Board approved the Committee Work Programme 2023 (ST1125/22)

15. AUDIT COMMITTEE

- **Committee Chair Report from 13th October 2022**
  Mrs McCartan presented her Committee Chair Report from the meeting held on 13th October 2022 and pointed out 6 final reports were presented by Internal Audit, the outcome of which is reflected within the IA mid-year assurance statement. A comprehensive update from the Fraud Liaison Officer (FLO) was provided including a completed self-assessment checklist from the NIAO best practice guide to Fraud risks, which the committee very much welcomed. A representative from the DoH sponsor branch attended the meeting in line with good practice procedures.

- **Minutes of meetings held on 5th May 2022 and 14th June 2022**
  Mrs McCartan presented the above named minutes of Audit Committee meetings for information purposes.

- **Committee Work Programme 2023 (ST1126/22)**
  Mrs McCartan presented the Committee Work Programme 2023 for approval.

  The Board approved the Committee Work Programme 2023 (ST1126/22)

  At this point, members were advised that Mr Martin McDonald, Non-Executive Director, would take up the Chairmanship of the Trust Governance Committee as of the 1 December 2022.

  At this point, the Chair advised that the Director of Children and Young People's Services/Executive Director of Social Work and herself were required to attend another meeting and Ms Donaghy, Non-Executive Director would chair the remaining agenda items.

CULTURE

16. TRUST ANNUAL QUALITY REPORT (ST1127/22)

Mrs Paula Tally was welcomed to the meeting to present the Trust's Annual Quality Report for approval. At the outset, members noted the document is published in response to the DoH's Quality 2020 Strategy. Mrs Tally began her presentation by pointing out the report provides an overview of the 2021/22 year with respect to how the Trust performed against a range of core indicators of quality and includes some examples of improvements led by staff. She reported on this under five themes:-

- **Transforming the Culture**
  Members noted how this was being progressed through various mechanisms including, Collective Leadership, Patient Client Experience training and Care Opinion stories
- **Strengthening the Workforce**
  Mrs Tally alluded to the importance of acknowledging and celebrating staff achievements along with the vital role training, supervision/coaching/mentoring and leadership programmes play in strengthening the workforce.
- **Measuring Improvement**
  Mrs Tally considered with members some of the key data sets used by the Trust as safety measures across areas including medicines management, Venous Thromboembolism (VTE) compliance and Falls. She pointed out the Southern Trust remains the only Trust without a dedicated Falls co-ordinator.
- **Raising the Standards**
  Members were presented with detail on how the Trust continues the work of raising the standards of the care it delivers. Mrs Tally presented data demonstrating patients seen or admitted to ED within 4 hours as well as those who waited over 12 hours. Mrs Tally alluded to the valuable work undertaken through C&SCG Research as well as the Trust Research Office and both Regional and National Audits.
- **Integrating the Care**
  Members noted the work underway to integrate pathways of care for individuals along with how the Trust makes better use of multidisciplinary team working and shares opportunities for learning and development.

Mrs Tally concluded her presentation by emphasising the report showcases an array of examples which have taken place throughout the 2021/22 year demonstrating how the Trust continues to work towards the delivery of safe, high quality compassionate care for all those who use our services.

Members welcomed the report and the opportunity to celebrate staff achievements. In particular Mr Wilkinson commended the Trust's relentless pursuit of excellence through continuous improvement exercises which feed through to the Patient & Client Experience Committee. He recorded appreciation for the work led by the Trust Quality Improvement (QI) Team. Mrs Leeman stated that whilst the report was cumbersome and the content mandated, the Trust continues to influence regionally, working towards alignment with its new enabling strategies into the future. Mrs Tally advised the Annual Quality Improvement Event has been rescheduled to February 2023.

The Board approved the Trust Annual Quality Report 2021/22 (ST1127/21)

17. APPLICATION OF TRUST SEAL (ST1128/22)

Ms Teggart sought approval for the Application of the Trust Seal to contract documentation as outlined in members' papers.

The Board approved the Application of the Trust Seal (ST1128/22)

18. CHAIR AND CHIEF EXECUTIVE'S BUSINESS AND VISITS INCLUDING NON-EXECUTIVE DIRECTORS' BUSINESS AND VISITS

On behalf of the Chair, Ms Donaghy drew members' attention to the written report detailing events the Trust Chair and Chief Executive had attended since the previous meeting, together with details of some good news stories and innovative work across the Trust. A list of Non-Executive Directors' business and visits was also noted.

19. ANY OTHER BUSINESS

Ms Donaghy asked the Executive Directors of Medicine, Social Work, Nursing and Finance if there were any other issues relating to their

professional roles they wished to bring to the Board's attention. There were none noted.

In concluding, Ms Donaghy recorded thanks to everyone for their participation and advised the next meeting would take place on Thursday, 26th January 2023 at 10.00 a.m.

The meeting concluded at 1.20 p.m.

SIGNED: _____ **DATED:** _____

Southern Health and Social Care Trust

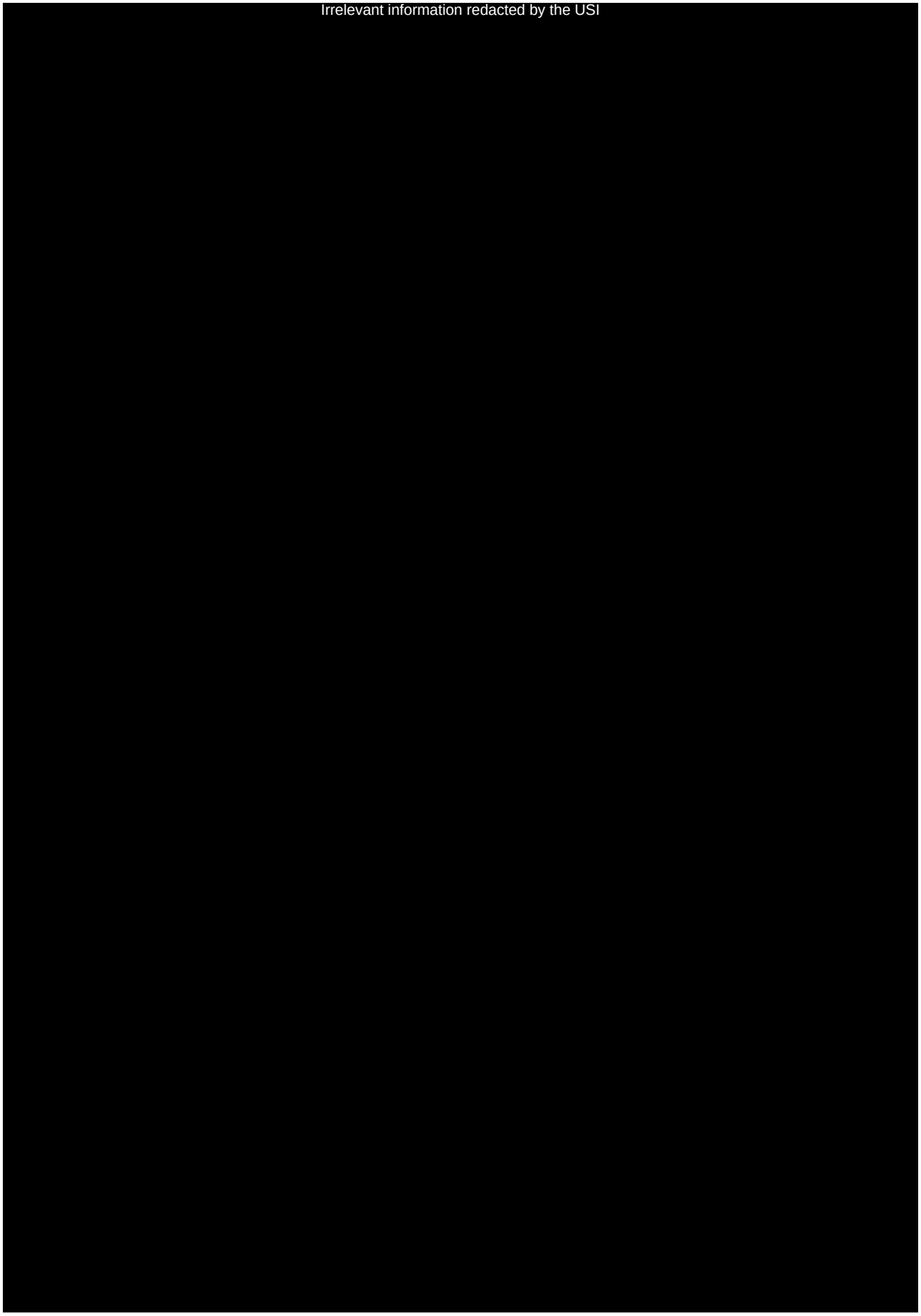
Quality care – for you, with you

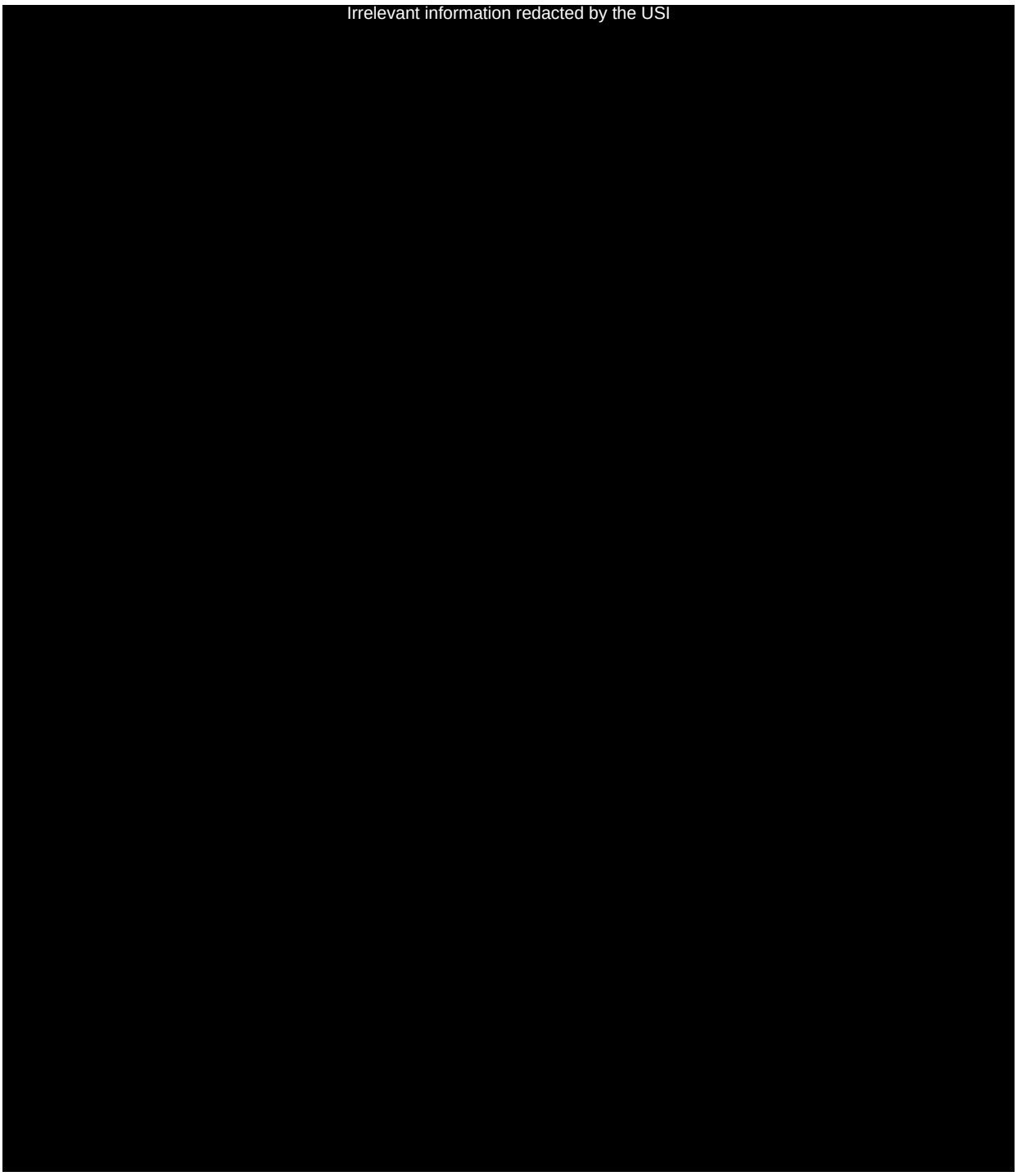
TRUST BOARD COVER SHEET

Meeting Date	30th September 2021	
Agenda item	4(iii) SAI Personal Information redacted by the USI	
Accountable Directors	Mrs V Toal – Director of HROD Mrs A Magwood – Director of Performance & Reform Dr M O'Kane – Interim Director of Mental Health & Disability	
Report Author	Name	Mrs Vivienne Toal
	Contact details	Personal Information redacted by the USI
This paper sits within the Trust Board role of: **Culture**		
This paper is presented for: **Information**		

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

WORKING TOGETHER EXCELLENCE COMPASSION OPENNESS & HONESTY	*This report cover sheet has been prepared by the Accountable Director.* *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

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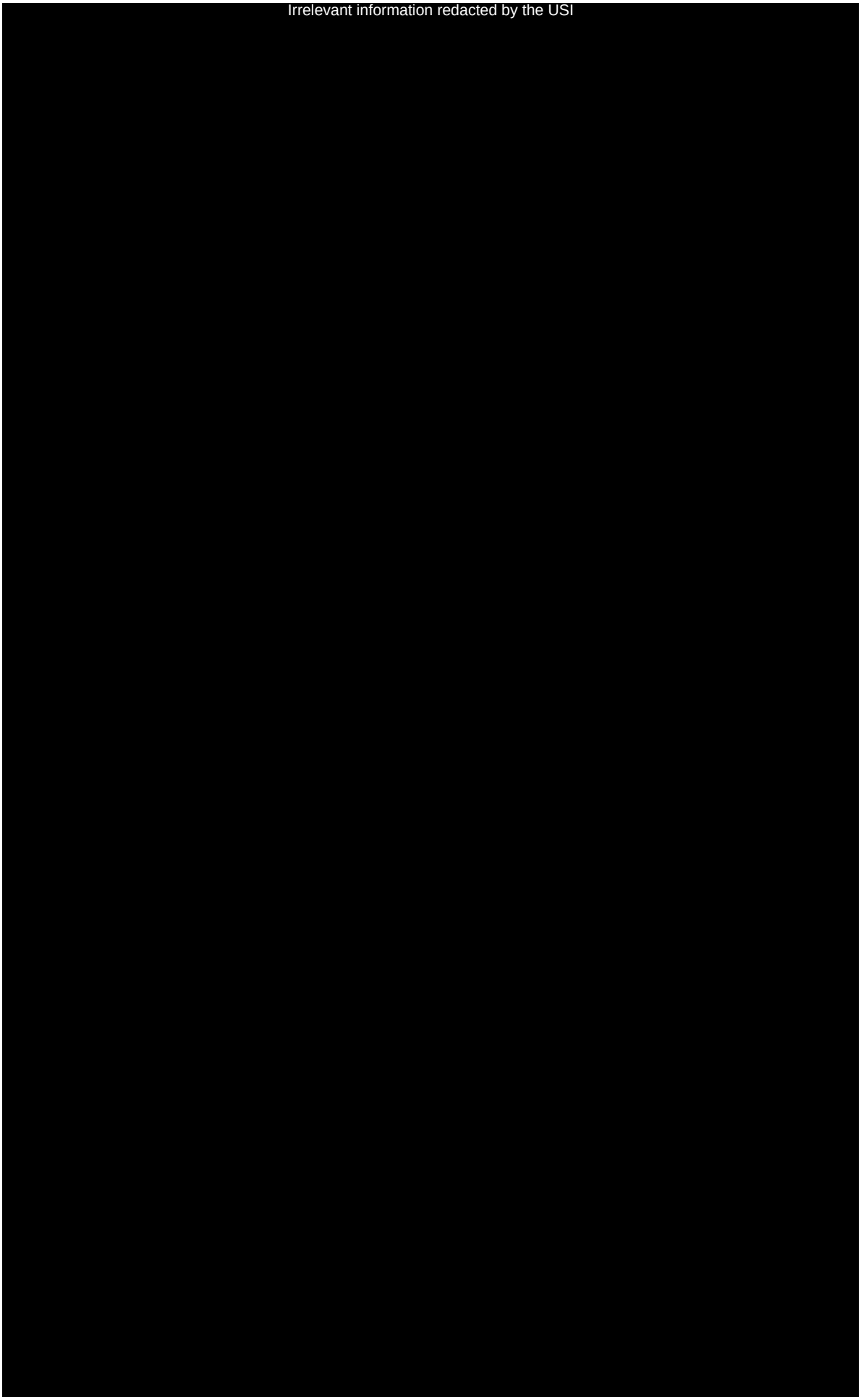
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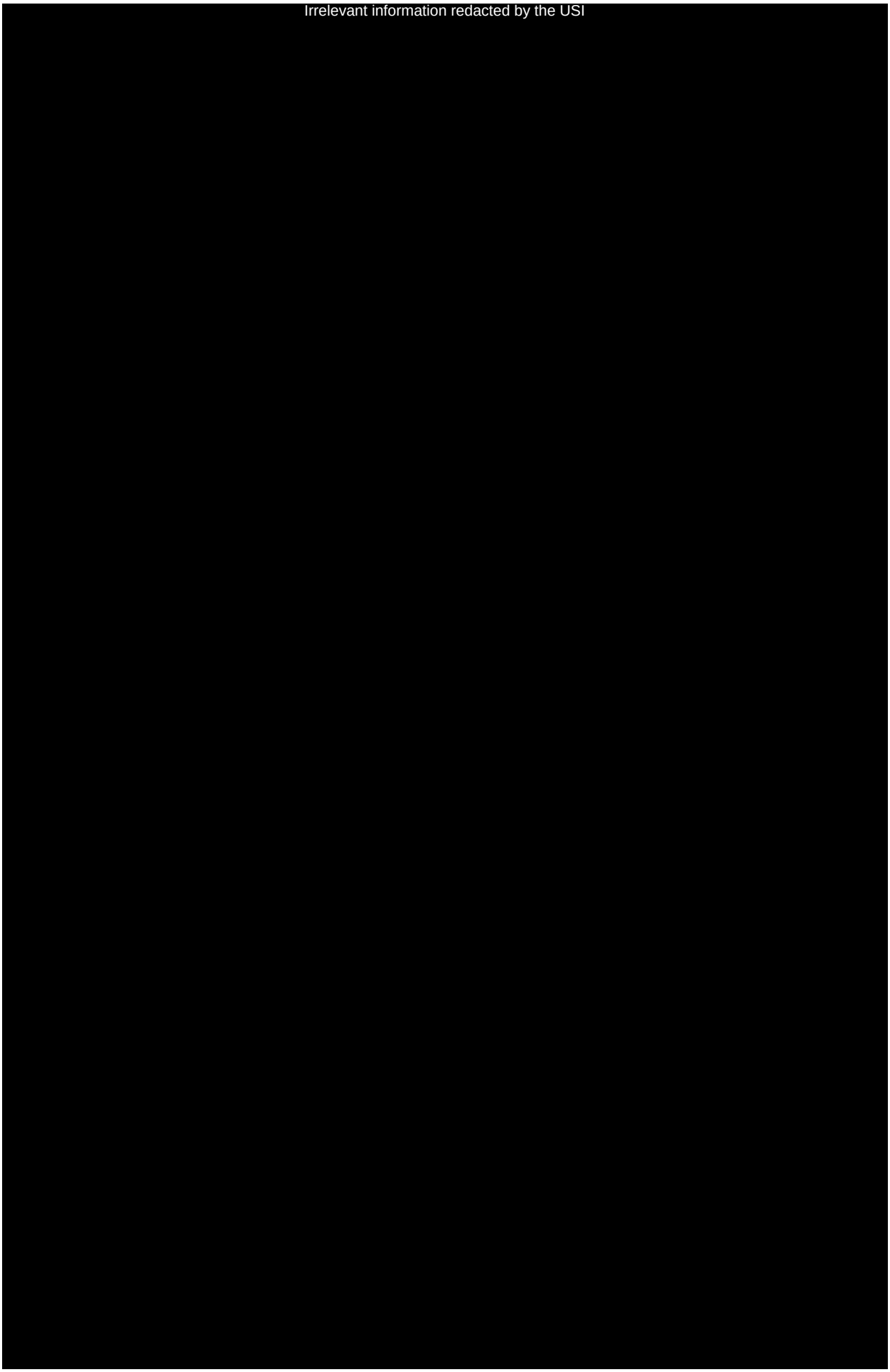
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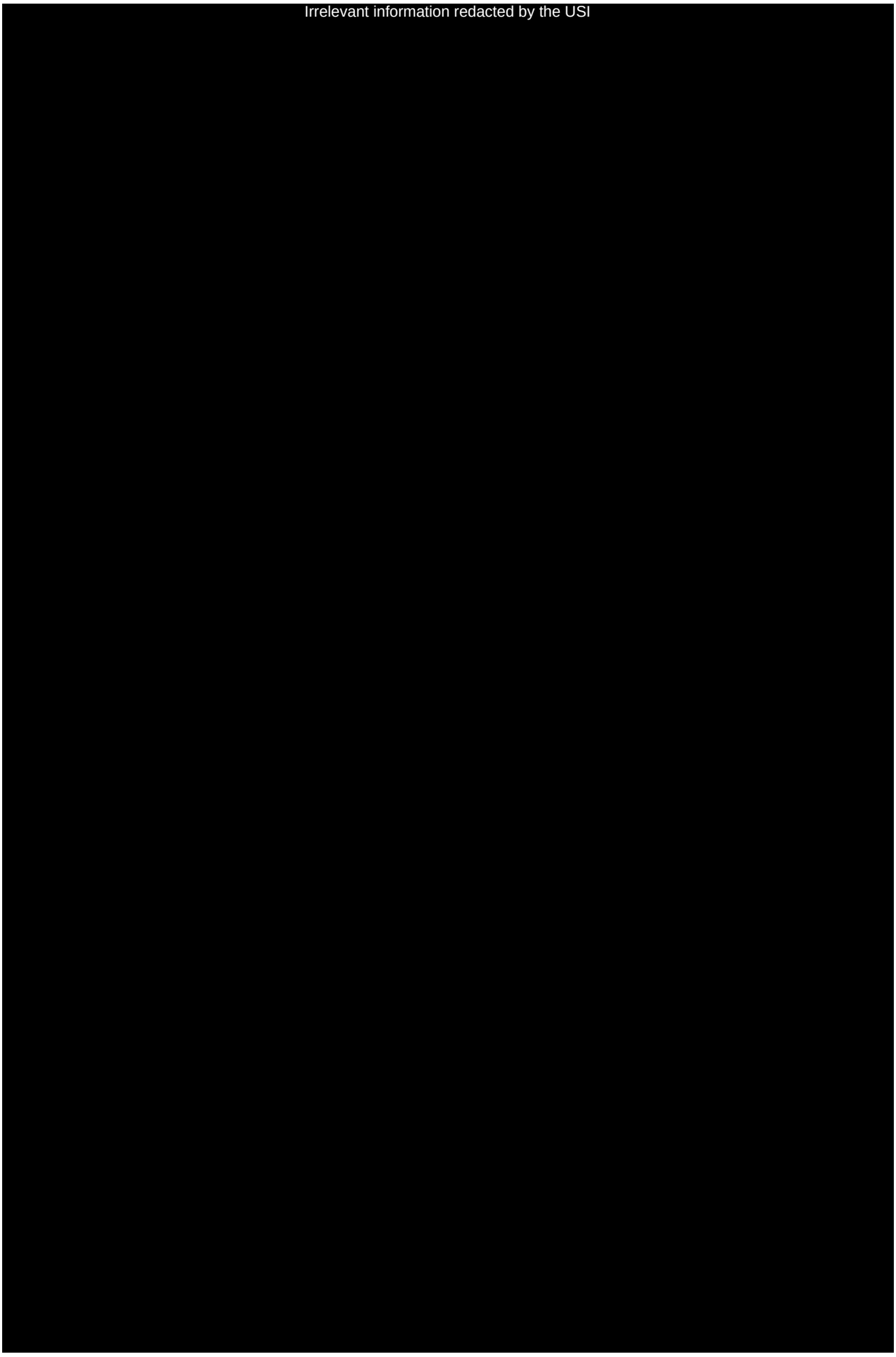
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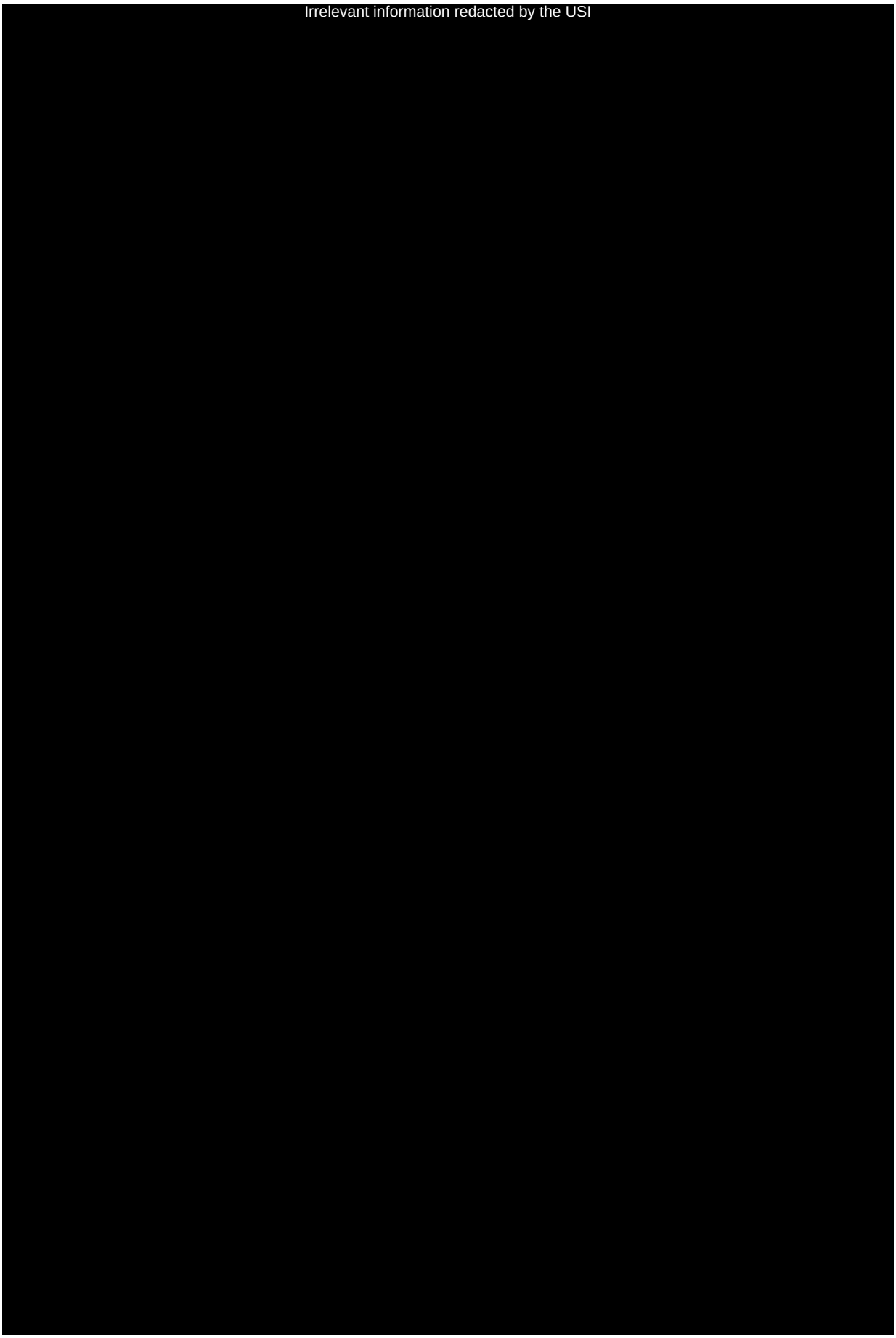
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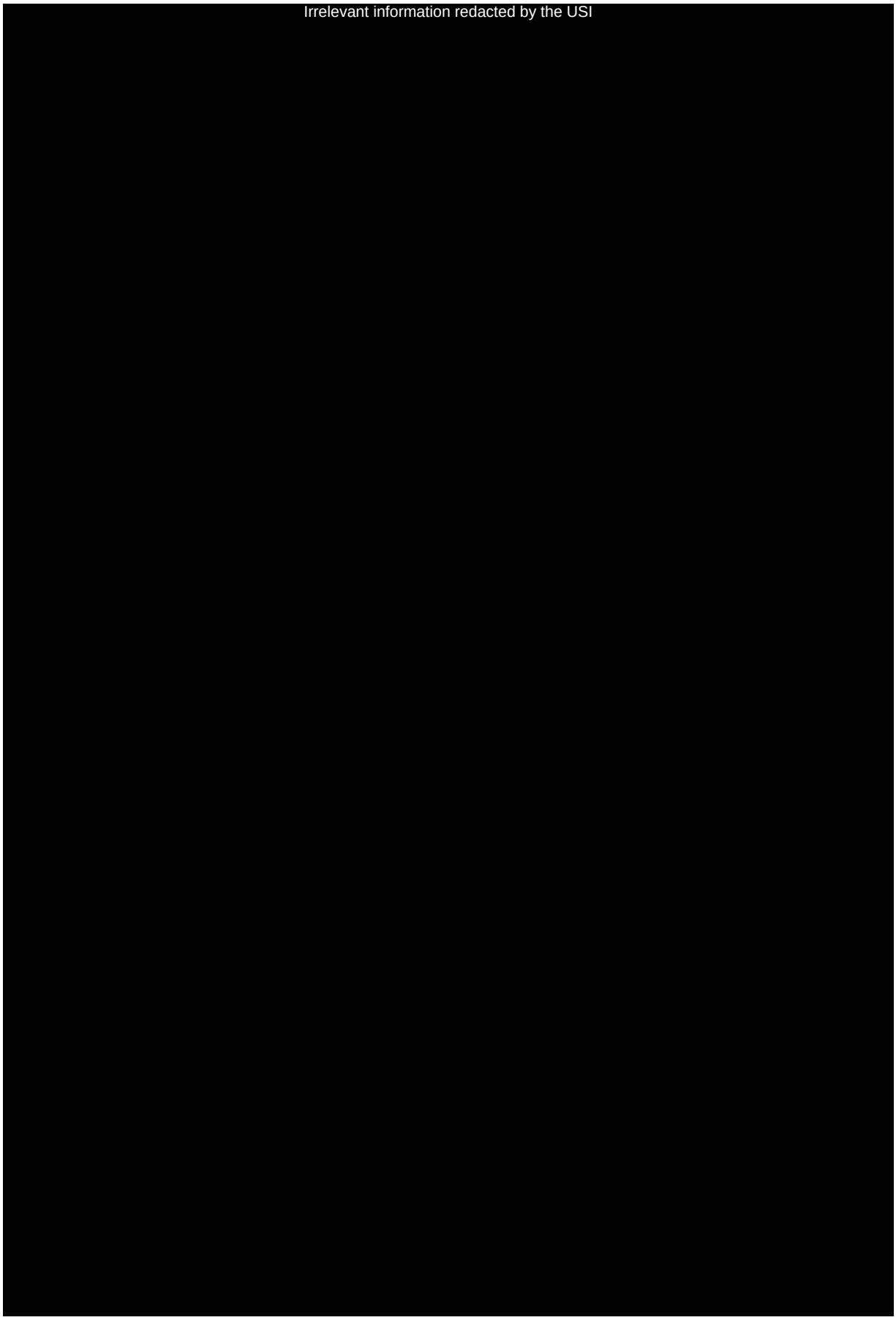
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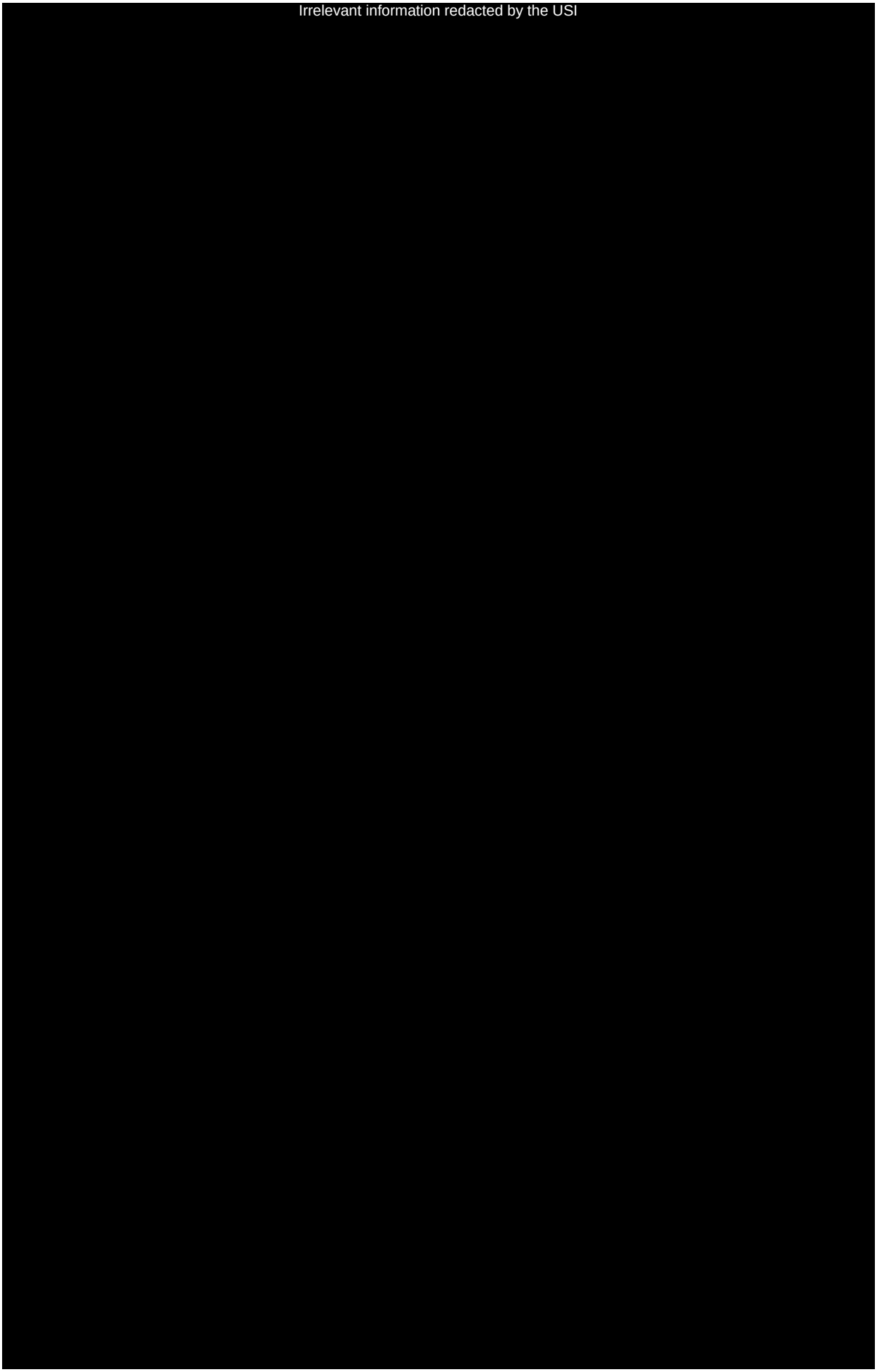
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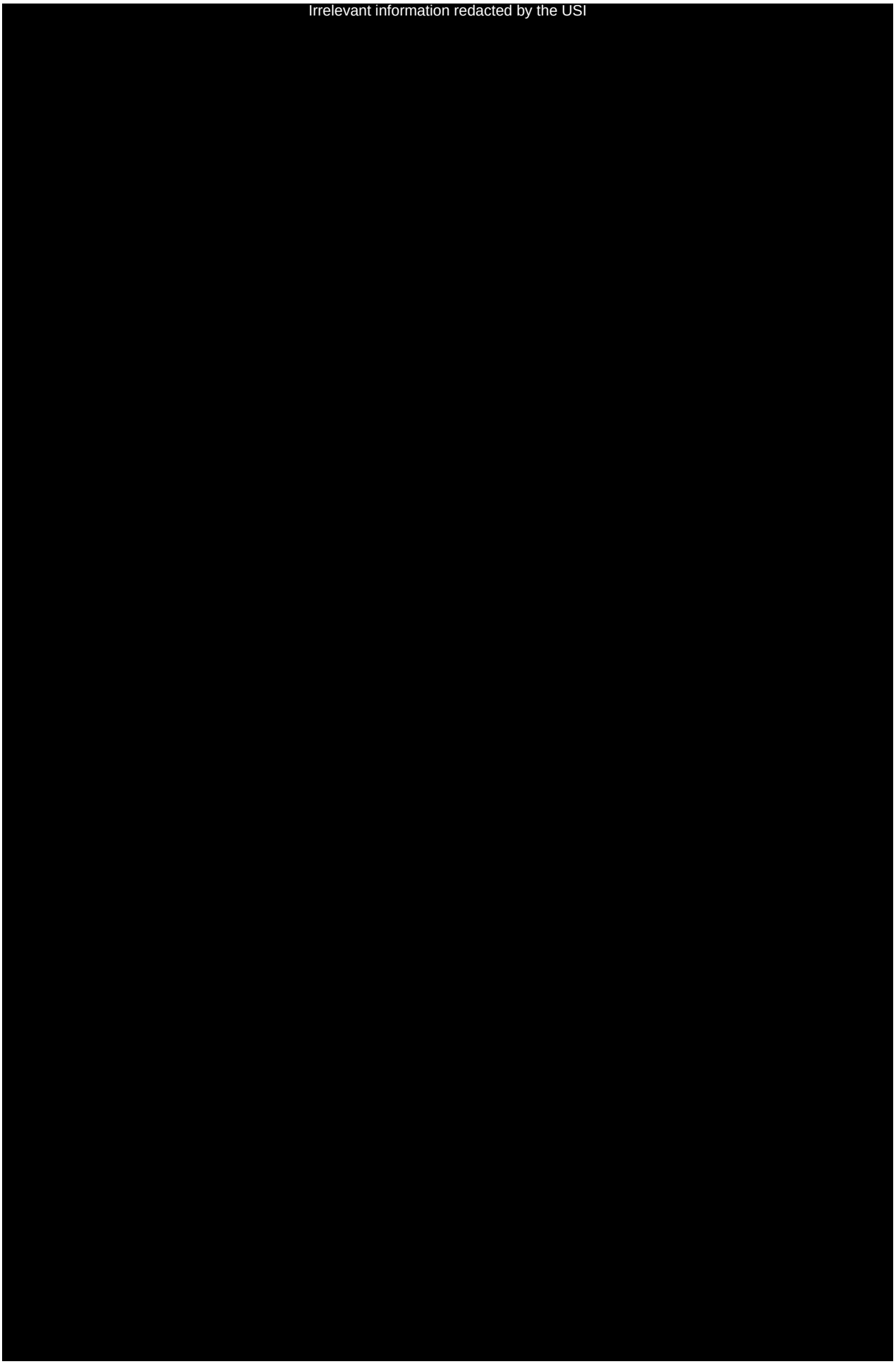
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SAI [redacted]

ACTION PLAN

SAI Report Recommendation	Actions Required to meet recommendation	Person(s) Responsible for Actions	Start Date	End Date	Status/ Evidence of Completion
9.1 The current redeployment policy was not designed to operate in the circumstances in which [redacted] found herself. *A separate provision within this policy could be developed under Conflict, Bullying and Harassment procedures.* Consideration should be given to a different approach when there is evidence of conflict, harassment and/or bullying, which would enable urgent redeployment of staff to another location. This consideration must also involve the use of supernumerary posts in other departments and the replacement of Agency workers by Trust staff	• HR will develop a new re-assignment policy and procedure to take account of all situations when a staff member may require a re-assigned role due to matters of health and well-being, attendance, conduct, capability or conflict. The existing redeployment policy and procedure will remain in situ for organisational change. • Additional training will be implemented for HROD staff managing matters of conflict, bullying and harassment. • Formal monthly case management oversight meetings of all informal and formal conflict, bullying and harassment cases will be implemented within HROD	Director of Human Resources and Organisational Development	June 2021 July 2021 June 2021	August 2021 Sept 2021 On-going	
9.2 The HR Business Continuity Plan should be reviewed to assess whether there is a need for a more nuanced approach to the categorisation of investigations. If there is evidence of mental health issues which have the potential to end in harm to an employee they	• HROD Business Continuity Plan to be updated in respect of prioritisation of ER cases	Director of Human Resources and Organisational Development	July 2021	Sept 2021	

could be provided at a higher level category. That is not to say that this case would have been so prioritised, as no-one could have anticipated the eventual outcome.					
9.3 Consideration should be given to the creation of an urgent pathway into Occupational Health for people with mental health issues and who are experiencing difficulty in the workplace.	• Consultant Clinical Psychologist for Occupational Health & Wellbeing has been recruited – due to commence in Sept / Oct 2021. Part time locum cover has been secured in interim. Management referrals / self -referrals will be triaged on receipt to Occ Health.	Director of Human Resources and Organisational Development	June 2021	Ongoing	
9.4 The Trust should ensure that if an employee withdraws a grievance or complaint until Conflict Bullying and Harassment policy on more than one occasion, an immediate formal investigation should commence.	• Formal monitoring of withdrawn complaints will be managed through the formal ER case oversight meetings on a monthly basis. Each case will be considered on its merits to determine if an immediate formal investigation should commence. The decision to initiate a formal investigation will be taken by the Head of Employee Relations or the Deputy Director – HR Services	Director of Human Resources and Organisational Development	June 2021	Ongoing	
9.5 Managers would not know that incoming employees may have a medical history unless a 'reasonable adjustment' is required.	• A key priority for Workplace Health & Wellbeing Steering Group will be Mental Health during	Director of Human Resources and Organisational Development	July 2021	Ongoing through-out 2021/22	

SAI [redacted]

ACTION PLAN

This was not the case for [redacted] and therefore this left manager A and later manager B at a disadvantage in understanding [redacted] predicament. Some employers in HSC are commencing a process of training managers in recognising some of the early symptoms of mental health issues in the workplace and developing some mental health first aid skills. The Trust should consider piloting some of this work if it has not already done so.	2021/22 in the Workplace – guided by actions identified in the Equality Commission Mental Health Charter. • Training for managers – to be commissioned through Recovery College • Awareness raising training for employees to be sourced				
9.6 The mental health staff involved have identified that the specific documentation in [redacted] Mental Health Assessment, Risk Assessment and Recovery Care Plans had not been updated within the expected time frames in recent years. There is a recognised need to make improvements in terms of their note-keeping and the SHSCT should ensure this is achieved and evidenced in their respective Appraisals.	• 4-6 weekly clinical supervision for staff with Team Leaders, which includes review of note keeping, including risk assessments (supervision structure attached) • Staff reminded of their professional and employment responsibilities with regards to clinical note keeping – reinforced at team meetings • A service improvement project was carried out to improve record keeping. Team Leaders use Qlikview to complete weekly assessment audits of caseloads and have set up	Director of Mental Health & Disability / Assistant Director of Mental Health Services / Associate Medical Director	Ongoing Ongoing January 2021	Ongoing Ongoing March 2021	

	a spreadsheet on the sharepoint where they record the results of the assessment audit, this includes assessments risk assessments and care plans. Issues are then addressed with staff in supervision.				
9.7 There does not seem to be a routine mechanism in the relationship between consultant, the team leader and key workers (in this case a CPN) whereby the weekly multidisciplinary meeting flags up the need for a case discussion when an outpatient appointment is delayed or routine care is interrupted by any other disruption of normal business. MH systems of care should be designed to maintain business continuity. The Trust must improve its performance in this area with particular reference to the team leader's role, in conjunction with the consultant, in actively managing the caseload as a whole as well as the individual caseloads of key workers.	Consultant out-patient lists need to be shared with the team leader. Patients who have delayed review appointments **must** be discussed by the consultant for prioritisation and identifying any actions which will then be taken to the weekly multi-disciplinary team meeting. This is to ensure that here is on-going contact with the patient. The patient **must** also be provided with details of crisis contacts should they need input whilst awaiting the review appointment. This **must** include all patients including those who do not have a key worker.	Director of Mental Health & Disability / Assistant Director of Mental Health Services / Associate Medical Director			
9.8 An employee's GP/MH team would not normally be made aware of an occupational health assessment unless the occupational health doctor's concerns had reached a threshold whereby the person's health or safety was at serious risk. However, in light of this case it would be advisable for the	• Joint meeting between mental health services and occupational health to discuss and explore any potential for greater information sharing mechanisms between the two services.	Director of Mental Health & Disability / Assistant Director of Mental Health Services / Associate Medical Director	June 2021		

SAI [redacted]

ACTION PLAN

Trust's occupational health service and mental health service together to explore mechanisms whereby, with the employee's permission, information could be shared by occupational health in advance of such a threshold being reached.					

HSC Business Services Organisation

Southern Health & Social Care Trust

Review of Mr A's Compliance with Relevant Authorities/Guidance in terms of his Private Work 2020/21

nqa ISO 9001 Registered Quality Management

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Acknowledgement

Internal Audit wishes to thank management and staff at the Southern Health and Social Care Trust for their assistance and co-operation during the course of the assignment.

Control Log

Working Draft Issued to Inform Exit Meeting: 28 April 2021
Exit Meeting Held On: 29 April 2021
First Draft Issued On: 30 April 2021
Management Actions Received:
Final Report Issued On:

Distribution List

Shane Devlin	Chief Executive
Helen O'Neill	Director of Finance, Procurement & Estates
Dr Maria O'Kane	Medical Director
Melanie McClements	Director of Acute Services

Introduction

In November 2020, at the request of the Urology Assurance Group, the SHSCT Chief Executive requested a review of Mr A's patients transferring into SHSCT as HSC patients. In addition, the review will consider any Trust involvement with the Craigavon Urological Research & Education organisation.

Terms of Reference

The audit focused primarily on Mr A's change of status private patient's work during the period 1 January 2019 to 30 June 2020 in order to:

1. Establish the extent of SHSCT awareness of Mr A's private work, through the job plan process and their private patient identification and management processes.
2. Establish the extent to which Mr A's private work interacted with HSC services and facilities.
3. To identify all of Mr A's patients that changed status (private/NHS) and check that there is evidence that relevant guidance/authorities have been adhered to. This will include providing assurance that:
    - The appropriate Change of Status paperwork has been completed and authorised and that this is supported by an assessment, by the consultant, of the patient's clinical priority for treatment as a Health Service patient.
    - For all private work identified above, the patient joined the HSC waiting list at the same point as if their consultation had taken place as an NHS patient.
    - The Consultant fulfilled all obligations with regard to recording and identifying private activity.
    - Where private work was conducted on HSC premises, ensure the patient has been invoiced for relevant costs.

Internal Audit also considered whether the Trust has any involvement with CURE - Craigavon Urological Research & Education, to understand if there was a flow of money into the Trust and to check, as much as is possible from review of Trust records and engagement with Trust staff, whether any Directors/staff benefited from the operation of the company.

Limitation of Scope: Internal Audit would caution that the analysis conducted is largely based on the data provided by the Trust. Internal Audit did not walk through each individual patient's journey on their patient file and therefore the analysis may not be fully complete.

Executive Summary

Internal Audit has identified issues with Mr A's compliance with relevant guidance around private practice. Significant issues with the timing, completion and approval of change of status paperwork were identified when patients transferred from private to NHS care. Occasions were also found when patients that had been seen privately, were treated more quickly that than the Trust standard waiting times.

Significant issues were also found around the Trust's management and monitoring of compliance with private patient guidance in particular the change of status process and their ability to monitor that patients transferring from private to NHS care, are treated in an equitable manner. The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue.

In total in the review period, 5 of Mr A's private patients were identified as having been treated at the Trust without/prior to receipt of a change of status form. A further 8 patients were potentially private when they were seen in the Trust (excluding those cases that the Trust believe are poor administration rather than private work). 5 patients switched status more than once (from NHS-private-NHS). 6 change of status patients were seen ahead of Trust waiting times. A further 2 patients were added to PAS retrospectively effectively being placed on the waiting list ahead of where they should have been placed.

In addition to private practice issues, there are also patient safety matters identified in the report primarily around performance of Pre Operative Assessments.

The findings of the review are summarised as:

Trust Processes and Awareness of Mr A's Private Work

Trust Knowledge of Mr A's Private Work

1. The Trust were aware that Mr A holds a private outpatient clinic at his home. It is unclear what happened these private outpatients if they required diagnostics and/or inpatient/daycase procedures. The Trust does not appear to have explored or challenged the potential interaction with the Trust in the scenario where private outpatients may require diagnostics/procedures etc. There is learning for the Trust in this matter in terms of considering circumstances when a Consultant conducts private outpatients work only.

Job Planning & Payment

2. In line with job planning guidance and Consultant terms and conditions, a job plan review should take place annually. The most recent job plan available for Mr A is an unsigned job plan, dated 1 April 2018.
3. There is a query over the accuracy of APA payments to Mr A. As per HRPTS during the period January 2014 to July 2020, Mr A was paid for 2 Additional PAs. This does not agree to the various unsigned job plans available which show a range of APAs (from 1.275 to 2.5) for this period.

The Trust's Change of Status Process

4. The Trust's Change of Status form for when a private patient transfers to NHS treatment, has limited monitoring or control value. The Change of Status activity is not effectively approved by the Medical Director or reviewed by the Trust Clinical/Directorate Management. The Change of Status form itself and the Change of Status process require strengthening.
5. The Trust is not compliant with the regional guidance issued in 2018 which requires all Change of Status patients to be identified with a 'PTN' code on PAS.
6. The Trust does not have a process in place to ensure all change of status patients have been identified for monitoring purposes and to ensure that the process for changing status is effectively controlled and documented, as an assurance that the delivery of service is equitable.

Identification of Private Work

7. Laboratories, Radiology and Pharmacy are reliant on Consultants highlighting any private activity. There is a risk therefore that private activity in these departments may not be identified.
8. There is insufficient control over prescriptions pads to prevent the use of Trust prescription pads for private work.

Mr A's Change of Status Patient Activity

Approved Effective Change of Status Date

9. Contrary to Trust written procedure, the date the patient is added to PAS as an NHS patient is the effective date as per the Change of Status form, not the date the Change of Status form was approved by Medical Director.

Change of Status Patients who had Diagnostic (Radiology) Tests

10. In 10 out of the 21 Change of Status cases during the period from January 2019 to June 2020, the patient was referred for 1 or more imaging tests. In 3 of these 10 cases, the patient had the imaging tests in the Trust prior to changing status to NHS ie whilst still private patients. A further 5 out of the 10 patients had diagnostic requests made on the same date as the effective change of status date and the same date the patient was last seen privately. Given that these 5 Change of Status forms are unlikely to have been submitted and approved by the Medical Director on the same day as the patients' private appointments, these patients should potentially have been treated by the Trust as private patients.
11. 3 (including 1 of the 3 patients found to be private) out of the 10 patients were seen sooner than the Trust waiting time for the diagnostic/imaging test.

Patients who changed Status and had Inpatient/Daycase Procedure

12. Out of the 13 Change of Status cases transferred into the NHS for an inpatient/day procedure, 5 had their procedure during the review period (ie up to June 2020). The Trust Consultant Urologist assisting Internal Audit in this review considered that 2 of the 5 patients were not seen in line with the Trust waiting list time. These cases were not Urgent/red flag procedures (as categorised on PAS) and were seen significantly sooner than other patients on the waiting lists.

Retrospective Entry to PAS

13. Two change of status forms had been added retrospectively to PAS. Most significantly, one of these patients was added to the waiting list from September 2018 but this was not actually added to PAS in May 2020. At December 2020 this Change of Status had not been approved by Medical Director.

Protected Reviews

14. The Trust does not monitor the use of protected review appointments and there is a risk that private patients or Change of Status patients could potentially be seen quicker in a protected review appointment slot.
15. Internal Audit identified 1 case where a routine outpatient was seen in a protected review slot, 15 days after being added to the waiting list and therefore seen ahead of NHS patients with the same clinical priority.

Multiple Switches in Status

16. Contrary to guidance, in 5 of the 21 cases where a change of status form had been completed, the patient moved between NHS to Private to NHS for the same referral.

Analysis of Mr A Activity Data

Pre-Operative Assessments (POAs)

17. In 86 (25%) of the 351 procedures conducted by Mr A during the period January 2019 to June 2020 which required a Pre-Operative Assessment, a POA was not completed.
18. Upon further analysis, 1 of these 86 cases related to a private patient who was subsequently treated in the NHS. No Change of Status form had been completed.
19. 95% of the POAs completed on Mr A patients during the review period were completed less than 3 weeks before admission for surgery. The Trust requires POAs to be competed at least 3 weeks before (and up to 13 weeks before) admission for surgery,
20. The lack of POA or the short time scales between the completion of a POA and the date of admission for surgery is a potential indicator that a patient may have been seen privately and then had their procedure in the NHS.

Elective Surgery With No Outpatient Appointment

21. Out of a sample of records where a patient had surgery but there was no evidence on PAS of an outpatient appointment, we found:
    - 1 patient changed from NHS to private and back to NHS status in one day, with no Change of Status forms. This is a blatant breach of proper process and is an example whereby a significant advantage has been gained in terms of speed of treatment, by paying privately for an outpatient appointment. In the absence of an approved Change of Status form, this is arguably a private patient having a procedure using trust facilities and staffing.
    - In 2 cases, there was no outcome letter completed for the procedure potentially indicating that the patient may have transferred back to the private sector for review. *It should be noted that the Trust believe that these are poor administration issues rather than private patients.*

Elective Surgery with an Outpatient Appointment

22. Out of a sample of 29 patients who had an elective procedure and an outpatient appointment in the period under review, 4 occasions were found where the patient may potentially have been a private patient. In one case the patient was a retired Consultant and in another case the patient was a close relative of a GP. *It should be noted that the Trust believe that one of these cases associated with non completion of an outcome letter is poor administration rather than a private patient.*

Other Observations

23. Other issues have been noted by Internal Audit around the audit trail when ordering scans on NIPACS (Sectra); changes being made to the referral date on PAS (which should not be changed); registrations for episodes of care on PAS that remain open rather than being closed; and use and monitoring of electronic sign off on NIECR.

Extent of Trust Involvement with CURE

24. CURE - Craigavon Urological Research & Education – is an independent entity, separate from the Trust. Whilst a number of Trust staff sit on the CURE Committee, these roles are independent from their role in the Trust. From discussion with Trust Management and Trust staff involved with CURE, there is no indication of any flow of money into the Trust or Trust involvement in fund raising in recent years. Internal Audit understands from the Committee members that Trust staff may apply to CURE for funding and if granted, a cheque will be written from CURE to the applicant. Trust procedures do not provide guidance in respect of staff involvement in independent organisations with a potentially perceived affiliation to the Trust by their nature.
    Internal Audit did not have access to CURE financial records as part of this review and therefore do not have visibility over any payments made by CURE to Trust staff.

Detailed Findings Of The Review

1. TRUST'S AWARENESS OF MR A'S PRIVATE WORK AND MANAGEMENT OF COMPLIANCE WITH PRIVATE PATIENT GUIDANCE

1.1 Job Plan Document

The Consultant Job Planning - Standards of Best Practice (November 2003) and Consultant Terms and Conditions of Service (Northern Ireland) 2004 states that a job plan review should take place annually. A similar requirement is contained in the Medical and Dental terms and conditions 2008.

Internal Audit requested a copy of Mr A's job plan for the period 1 January 2019 to 30 June 2020. In line with the annual job plan review schedule, there should be 2 job plans to cover this period. There is no signed off job plan held by the Trust for the period 1 April 2011 to 30 June 2020. The most recent job plan available for Mr A is an unsigned job plan, dated 1 April 2018 and there is no end date recorded. This document is not signed by Mr A or his Clinical Director.

The most recent job planning meeting appears to have been held in November 2018. Regular, annual job plan meetings have not been held.

1.2 Trust Knowledge of Mr A's Private Practice

"A Code Of Conduct For Private Practice - Recommended Standards Of Practice For HPSS Consultants (An Agreement between the BMA(NI) Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland) (November 2003)" requires that Consultants declare any private practice and as part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work.

Trust procedures "Trust Guidance on Paying/Private Patients – 2018 states:
In section 2.2 "Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser"
In Section 5.1 "While Medical Consultant staff have the right to undertake Private Practice within the Terms and Conditions of the Consultant Contract (2004) as agreed within their annual job plan review, it is the responsibility of Consultants, prior to the provision of any diagnostic tests or treatment to:

- *ensure that their private patients are identified and notified to the Paying Patients Officer.*
- *ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.*
- *ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, hospital charges.*
- *Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.*

Although there is no private work identified in Mr A's most recent job plan, the Trust were aware that Mr A conducted private work outside the Trust:

- Mr A submitted a Trust "Declaration of Private Practice" in February 2018. In this declaration form, Mr A advised that he did not complete private practice within the Trust, however he did

treat private patients outside of the Trust. The declaration form is not sufficiently clear to clarify the type of private practice undertaken (ie outpatient/daycases/inpatients). On the Declaration Mr A did not confirm that he had read and understood the Trusts Guidance on Paying/Private patients. He did declare that he understood that any private patient work whether undertaken inside or outside of the Trust must be included in his job plan. *The Trust Declaration of Private Practice process should be conducted every year. A declaration therefore should have been made by Mr A in 2019 however this was not submitted to the Trust and the annual declaration process was not conducted in 2020 due to COVID-19.*

- The most recent appraisal completed for Mr A was in 2018. Internal Audit do not require access to this appraisal document, however the Trust have confirmed that Mr A declared that he conducted a private outpatient clinic at his home.

In the event that a private outpatient seen at Mr A's home clinic required diagnostics including blood tests or a daycase/inpatient procedure, it is unclear how this private activity was administered and whether or not such work entered the Trust either as private or NHS work. This issue is considered further in sections 2 and 3 of this report.

The Trust does not appear to have explored or challenged the potential interaction with the Trust in the scenario where private outpatients may require diagnostics/procedures etc. There is learning for the Trust in this matter in terms of considering circumstances when a Consultant conducts private outpatient work only.

1.3 Reconciliation of Job Plan to Payroll

Internal Audit reviewed HRPTS to ascertain what Mr A was paid. From 1 January 2014 to 17 July 2020 payment details were as follows:-

- 10 PAs – (full time contract – *agrees to most recent job plan*)
- 2 Additional PAs (APAs)
- 5% Category A on call from 12/05/2014 to 17/07/2020 *(agrees to operational rota)*
- Step 2 clinical excellence award *(awarded for the remainder of consultants career by the Trust's Local Clinical Excellence Award Committee in April 2009, with effective date from April 2008.)*

There is a query over the accuracy of APA payments to Mr A. As per HRPTS during the period January 2014 to July 2020, Mr A was paid for 2 Additional PAs (additional to full time PAs). This does not agree to the various unsigned job plans available for this period which record a range of APAs (2.5, 1.275 and 1.733) throughout this period.

1.4 Change of Status Process

The "Management of Private Practice in Health Service Hospitals in Northern Ireland: A Handbook – November 2007" requires that patients changing status from Private to NHS must have a Change of Status form completed by the consultant. The form must also detail the clinical priority for treatment as a health service patient. The Trust should be able to clearly identify these patients for monitoring purposes. It is important that the process of changing patient status is effectively controlled and documented as an assurance that the delivery of service is equitable.

The Trust Guidance on Paying/Private Patients procedures require Consultants to complete a Change of Status form when a private patient transfers to NHS treatment. However, effectively this form has limited monitoring or control value because:

1. The form is signed by the Consultant and stamped as approved by the Medical Directors office. It is not possible to establish who applied this stamp or the date it was applied. The change of status forms are filed in the cash offices at Craigavon Area Hospital/Daisy Hill Hospital and no

action or reporting takes place within the Trust. The Change of Status activity is not effectively approved by the Medical Director or reviewed by the Trust Clinical/Directorate Management.

2. The form contains no detail of the reason for the change of status.
3. The date the patient changes status to NHS is recorded on PAS as the effective date as per the Change of Status form, not the date the Change of Status form was approved by the Medical Director. This appears contrary to Trust Guidance on Paying/Private Patients procedures which state *"It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."* The Change of Status form is confusing this matter, by including an effective date of change of status rather than, an approved date. The form does not clearly state that the approval date will be the date of transfer to NHS from private status.
4. There are no dates applied to the change of status form by either the Paying Patient Officer on receipt of the form or by the Medical Director's Office on approval of the form. Therefore Internal Audit were unable to establish whether the Change of Status forms were approved prior to the patient receiving an appointment/treatment, potentially impacting on income that may have been due to the Trust.

Prior to 11 September 2018 when the regional PAS Technical Guidance approved a code (PTN) to identify private patients transferring to NHS status, the Patient Administration System (PAS) did not require a change of status to be recorded on the system. The change of status may have been entered in a free text field which is not a mandatory field. The Southern HSC Trust has not yet implemented the regional code 'PTN' for patients transferring from private practice to NHS. A PAS report cannot therefore be run showing all change of status patients.

The Trust does not have a process in place to ensure all change of status patients have been identified for monitoring purposes and to ensure that the process for changing status is effectively controlled and documented, as an assurance that the delivery of service is equitable.

1.5 Private Patient Identification Processes

In line with the "Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007)" Consultants have a contractual obligation to cooperate in recording all private outpatient and day patient attendances, treatments and procedures. The patient's records and referral forms etc should always be suitably marked. Records kept in departments away from the main outpatient area (e.g. x-ray, pathology and physiotherapy) should identify private patients.

Internal Audit met with senior staff in Laboratories, Radiology and Pharmacy to discuss the processes in these departments for the identification and management of private patients. All three departments are reliant on Consultants highlighting any private activity. There is a risk therefore that private activity in these departments may not be identified.

Pharmacy:

When a consultant prescribes medication to a private/NHS patient at an outpatient clinic, there are 2 different prescription pads used:-

- Prescription which can be written and given to the patient to take to the hospital pharmacy for dispensing. These are numbered but there is no control over the issue of the prescription pads. These are in quadruplicate – White copy –to GP, yellow copy to Pharmacy, Blue copy community nursing and pink copy patient notes.
- Prescription letter which the patient must take to their GP and the GP writes a prescription for dispensing at the community pharmacist.

There are inadequate controls surrounding the issue and use of prescription pads. Pads are held in consulting rooms and may be used by multiple consultants who apply their own name labels to the scripts.

If a patient takes the script to the Trust pharmacy for dispensing, the pharmacy have no mechanism to identify whether the patient is private or has come from a NHS outpatient appointment. Similar to the rest of private practice, the Trust are reliant on the Consultant declaring activity as private and in this case, writing the prescription advising that the patient is private so that pharmacy can ensure that the cost of the medications are invoiced.

Internal Audit discussed 6 sampled cases with Pharmacy to identify if any of these patients had received medication while still private patients. No issues were identified.

Laboratory Services:

The Head of Laboratory Services advised that within the Trust they are reliant on the Consultant/doctor who completes the laboratory request ticking a box to identify a private patient. There is no other mechanism to identify private patients.

Laboratory results are put on NIECR and there is nothing to identify private tests unless the consultant has declared this on the lab request.

Diagnostic Services:

The Head of Acute Information in conjunction with the NIPACS Manager confirmed referrals received for scans etc are all completed on the same referral form and there is no mechanism to identify private or change of status patients on the system. Consultants order scans etc directly themselves on the NIPACS (Sectra) system.

As per Section 2 of this report, radiology activity was identified that should potentially have been declared and treated as private.

Recommendations Specific to Review of Mr A's Practice:

Recommendation 1.1	The Trust should review Mr As job plan and actual APAs worked in order to ascertain if overpayments have occurred, and seek recompense if required.
Management Action	ACEPTED
Responsible Manager	Medical Director and Director of Acute Services
Implementation Date	October 2021

General Recommendations Regarding Trust Process:

Internal Audit completed an audit in 2019/20 (finalised in October 2020 following delay in obtaining Management Response to the report due to COVID-19) and provided limited assurance in relation to Management of Private Medical Practice (including patient change of status processes). A number of the recommendations included in the 2019/20 report have been restated throughout this report.

Recommendation 1.2	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report and as per the 'Code of Conduct for Private Practice - recommended standards of practice for HPSS consultants (November 2003)', the Trust must ensure that: • All consultants have an annual job planning review. • All consultants completing private practice declare any private practice and as part of the annual job planning process, consultants should

	disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of HPSS work and out of hours cover. • As part of the job planning process, the Trust should consider total working hours across HSC and private practice. Job plans should be signed and dated by the consultant and their Clinical Director.
Management Action	**ACCEPTED**
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	Februaury 2022

Recommendation 1.3	The Trust should strengthen their management arrangements in scenarios where a Consultant declares that they conduct private outpatient work only, specifically where the work is carried out outside the NHS including premises not regulated by RQIA. The following specific measures are suggested: • Assurances should be sought as to how associated diagnostics/subsequent required treatment are managed. • Medical Director approval should be introduced in the event that Consultants conduct outpatient work privately. • Trust monitoring processes should be alert to ensuring Change of Status patients are placed on the waiting list based on clinical priority. • The Trust "Declaration of Private Practice" form should be amended to clearly identify the type of private practice undertaken (ie outpatient/daycases/inpatients). Trust management should review these declaration as and triangulate the information with appraisals and job plans.
Management Action	ACCEPTED
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	February 2022

Recommendation 1.4	The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue. The Trust should review and strengthen management of private patient procedures. As part of this process the new procedures should be shared with all relevant trust staff and roles and responsibilities should be reiterated where required. Specifically consulants must be reminded of their responsibility to ensure that all private work and change of status patients are declared. Consideration should be given as to how Radiology, Laboratories and Pharmacy can strengthen their processes, scrutiny and challenge of service requests that could potentially originate from the private sector.

Management Action	ACCEPTED
Responsible Manager	Assistant Director Systems Assurance,
Implementation Date	February 2022

Recommendation 1.5	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, Consultants should be instructed to complete the required declaration in relation to Private practice for the current year.
Management Action	**ACCEPTED**
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	October 2021

Recommendation 1.6	The Change of Status process should be strengthened. Specifically: • The Change of Status form currently in use within the Trust for patients transferring from Private Practice to NHS must be reviewed and updated to include all relevant information including clear documentation of the reason for change. The effective date of change of status should be amended to the approved date for change of status and it should be clear on the form that the effective date of change will be the date that the form is approved by the agreed appropriate senior clinical and operational leads. The agreed appropriate senior clinical and operational leads should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the by the agreed appropriate senior clinical and operational leads. *Previously reported in 2019/20* • The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form, namely until the form is approved, the patient will remain private and may be liable for charges. *Previously reported in 2019/20*
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Recommendation 1.7	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, the Trust should develop a process to monitor change of status patients and to ensure that the process for changing status is effectively controlled and documented as an assurance that the delivery of service is equitable.

	The Trust should implement the regional PAS code for patients transferring from private to NHS and develop a mandatory requirement to indicate changes of status on PAS. A printout from PAS should then be regularly reviewed and reconciled to Change of Status forms received.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance, Assistant Director Functional Support Services
Implementation Date	February 2022

Recommendation 1.8	The Trust should increase controls over prescription pads held in consulting rooms. These should be maintained as controlled stationery.
Management Action	**ACCEPTED**
Responsible Manager	Director of Pharmacy
Implementation Date	February 2022

2 REVIEW OF MR A's COMPLIANCE WITH RELEVANT PRIVATE PRACTICE GUIDANCE/AUTHORITIES – CHANGE OF STATUS PATIENTS

2.1 Change of Status Activity During the Period January 2019 to June 2020

The "Management of Private Practice in Health Service Hospitals in Northern Ireland: A Handbook – November 2007" requires that patients changing status from Private to NHS must have a Change of Status form completed by the consultant. The form must also detail the clinical priority for treatment as a health service patient. The Trust should be able to clearly identify these patients for monitoring purposes. It is important that the process of changing patient status is effectively controlled and documented as an assurance that the delivery of service is equitable.

The Trust's procedures and Change of Status form states "It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."

Internal Audit requested all of Mr A's patient Change of Status forms for the period January 2019 to June 2020, from the cash office at Daisy Hill Hospital. Internal Audit were provided with the database which recorded 21 Change of Status Patients.

Internal Audit requested and reviewed the 21 Change of Status forms completed by Mr A from January 2019 to June 2020 and noted the following issues:

- 16 Change of Status forms had the Medical Director stamp on them as evidence of approval but it is not possible to establish who applied this stamp or the date it was applied.
- 4 Change of Status forms were still with the Medical Director at the 7 December 2020 awaiting approval. The dates that these patients transferred to NHS as per the change of status forms ranged from 2 - 14 months earlier than December 2020. Internal Audit were unable to establish when the forms were received in the Medical Directors Office.
- 1 Change of status form had been physically signed by the Medical Director, approximately 10 weeks after the effective Change of Status date.

2.2 Management of Patients Transferring from Private to NHS, Joining the HSC waiting list

Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) states:

"A change of status from private to Health Service must be accompanied by an assessment, by the appropriate consultant, of the patient's clinical priority for treatment as a Health Service patient. It is important that any private patient who wishes to become a Health Service patient should gain no advantage over other Health Service patients by so doing."

"No patient should proceed –except in emergencies – to an investigation or treatment in a Health Service hospital until some mechanism has been applied which makes their status clear. Whichever system is introduced it must be capable of identifying the patient's status at every stage."

Internal Audit reviewed PAS data (provided by the Trust) for the 21 patients who changed status from private practice to NHS during the audit period January 2019 to June 2020. 13 of the 21 Change of Status forms related to day case or inpatient referrals and the remaining 8 forms were for outpatient appointments.

A range of issues were found in respect of Mr A's practice and administration of these 21 Change of Status cases (as outline below). However the issues also demonstrate the inadequacies in Trust monitoring processes around Change of Status patients and the limited control in the current process. The following issues were identified on review of the Change of Status forms:

Approved Effective Change of Status Date

The date the patient is added to PAS as an NHS patient is the effective date as per the Change of Status form, not the date the Change of Status form was approved by Medical Director. *This is contrary to Trust's procedures and Change of Status form which state "It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."*

On all 21 Change of Status forms, the effective date of transfer to NHS was the same as the date the patient was last seen privately.

Change of Status Patients who had Diagnostic (Radiology) Tests

In 10 of the 21 change of status cases, the patient had been referred for a diagnostic test (radiology) in the period 1 January 2019 to 30 June 2020:

- In 3 of the 10 cases, the diagnostic work was performed prior to the date of change of status. This diagnostic work was performed at a time when there was no referral on PAS for the patient ie whilst they were still a private patient.
  - One patient had a change of status date of 31/08/2019 – this patient had 2 imaging tests requested and performed in June 2019 whilst still private.
  - One patient had a Change of Status date of 09/11/2019 - this patient had 3 imaging tests requested and performed in June 2019 whilst still private.
  - One patient had a change of status date 09/11/2019 and had 1 imaging test requested in June 2019 with the test performed in July 2019 whilst still private.
- 5 of the 10 diagnostic tests were requested on the same date as the effective change of status date and the same date the patient was last seen privately (according to the Change of Status Form). Given that these Change of Status forms are unlikely to have been submitted and approved by the Medical Director on the same day as the patients' private appointments, these patients should potentially have been treated by the Trust as private patients.
- 2 of the 10 Change of Status patients had an exam/diagnostic test requested after the effective date on the Change of Status form (1 was 3 weeks, 1 was 4 months). However given the weaknesses in the Change of Status process, it is unclear if this NHS test was performed after the change of status was approved.

3 (including 1 of the 3 patients found to be private) out of the 10 patients were seen sooner than the Trust waiting time for the diagnostic/imaging test:-

- 1 of the 3 patients identified as private (above) was seen within 6 weeks against a waiting list of 21-32 weeks (at least 15 weeks earlier than Trust waiting time). This patient was seen in South Tyrone Hospital.
- For 1 patient the Trust waiting time for the imaging was 16-20 weeks and the patient had their imaging test within 5 weeks of request (at least 11 weeks earlier than Trust waiting time).
- For 1 patient the Trust waiting time was 5-10 weeks and the patient had their imaging test within 3 weeks of request (at least 2 weeks earlier than Trust waiting time).

Patients who changed Status and had Inpatient/Daycase Procedure

Out of the 13 Change of Status cases transferred into the NHS for an inpatient/day procedure, 5 had subsequently had their procedure. The other 8 patients, whilst added to waiting list, had not had their procedure as at June 2020.

Internal Audit in conjunction with Senior Trust staff reviewed the patient journeys of the 5 cases who have had their inpatient/daycase procedures. All 5 cases were classed as URGENT on PAS per the report received by Internal Audit.

As part of this audit review, a Trust Urology Consultant considered the waiting times for treatment in the context of the clinical priority and Trust standard waiting times. The Consultant advised that:

- 3 cases were in line with Patient Target List (PTL) waiting times/ for the procedure for the relevant clinical priority.
- 2 of the 5 patients were not seen in line with the Trust waiting list time. The Trust Consultant Urologist assisting Internal Audit in this review considered that these cases were not Urgent/red flag procedures and were seen significantly sooner than other patients on the waiting lists:
  - Patient 1 - the time between being added to waiting list and the procedure taking place was 23 days (approx. 3 weeks). The PTL waiting times for the same procedure for Mr A patients at this time were between 15 weeks and 217 weeks so we can conclude this Change of Status patient was seen much quicker than other patients waiting on the same procedure.
  - Patient 2 - the time between being added to the waiting list and the procedure taking place was 12 days. The Consultant Urologist advised that given the symptoms, this patient was seen much quicker than other patients requiring the same procedure at that time.

Retrospective Entry to PAS
Through review of change of status patients on PAS, it was noted that two change of status forms had been added retrospectively to PAS:

- One patient was added to the waiting list from 09/09/2018 but this was not actually added to PAS until 12/05/2020. At December 2020 this Change of Status had not been approved by Medical Director.
- One patient had a Change of Status on 11/10/2019 however the patient was not added to PAS by the consultant secretary until 01/02/2020, 4 months after the Change of Status.

See section 6 for related registration issue.

2.3 Protected Reviews

Internal Audit understand from the Trust that most Consultants retain a number of protected review appointments at each of their outpatient clinics. These slots should be for patients that the Consultant needs to see urgently (for example cancer patients) however there is no documented Trust procedure around the use of protected review clinic slots. The Trust does not monitor the use of protected review appointments and there is a risk that private patients or Change of Status patients could potentially be seen quicker in a protected review appointment slot.

Internal Audit were advised that the central booking team at the Trust are responsible for booking new and review outpatient appointments. However Mr A's secretary was responsible for booking Mr A's Protected Review appointments.

Internal Audit have not specifically tested Protected Review bookings however we identified 1 case where a routine outpatient was seen in a protected review slot, 15 days after being added to the waiting list. Internal Audit queried this case with the Trust and the Consultant Urologist agreed that the protected review appointment had not been used for the correct purpose and therefore the patient would have been seen ahead of NHS patients with the same clinical priority.

2.4 Capturing and Invoicing of Private work Conducted on HSC Premises

In line with the "Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007)" Consultants have a contractual obligation to cooperate in recording all private outpatient and day patient attendances, treatments and procedures. The patient's records and referral forms etc should always be suitably marked. Records kept in departments away from the main outpatient area (e.g. x-ray, pathology and physiotherapy) should identify private patients.

As per Trust procedures no private activity was declared to the Cash Office in Daisy Hill Hospital during the audit period by Mr A and no invoices have been raised for private treatment – both indicating that Mr A did not perform private work on HSC premises.

However, as outlined above, upon review of the 21 Change of Status Forms, Internal Audit noted cases whereby Mr A's Private Patients had received treatment in the NHS while still being a private patient.

Furthermore as described below, there are examples of patients seemingly switching several times between private and NHS and potentially receiving private treatment on the NHS, without declaration or charging. As per the *NHS A Code of Conduct for Private practice and* The Trust Change of Status Form – *"Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private practice"*

In 5 of the 21 cases where a change of status form had been completed, the patient moved between NHS to Private to NHS for the same referral.

- In one case the patient had been under the care of another urology consultant within the Trust around the time of seeing Mr A privately.
- In one case from the review of PAS it was determined that the patient has seen a number of urology consultants and had been NHS and moved to Private and then subsequently transferred back to NHS.
- One patient had been seeing another Urology Consultant in 2018 and was called for a follow up outpatient appointment in July 2018 but didn't attend. It would appear that this patient then attended Mr A privately who completed a Change of Status form with an effective date of 17/08/2019.
- One patient had been under the care of the Trust at 31/01/2019 and was due for review at the end of 2019. This appointment was delayed and it would appear that this patient then attended Mr A privately who completed a Change of Status form with an effective date of 15/02/2020 and added the patient to the waiting list.
- One patient who had been added to the Elective waiting list for a procedure on 09/11/2019 (effective date of Change of Status) but had a consultation with Mr A in early March 2020 which is not on PAS. This patient would have had a procedure done in late March 2020 except for COVID-19 resulting in all elective procedures being cancelled from approximately w/c 16 March 2020.

Recommendations Specific to Review of Mr A's Practice:

Recommendation 2.1	The Trust should consider charging for the identified private activity. Internal Audit appreciate that this needs to be considered, and may not be feasible, in the wider context of a patient recall.
Management Action	**ACCEPTED** This has been considerd by the Trust and it was felt it would not be appropriate to charge these patients.
Responsible Manager	Medical Director
Implementation Date	July 2021

General Recommendations Regarding Trust Process:

Recommendation 2.2	The Trust should develop a written procedure around the use of protected review clinic appointments. The Trust should also introduce monitoring of compliance with the procedure.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Functional Support Services and Operational ADs
Implementation Date	February 2022

Recommendation 2.3	Trust Guidance and Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) should be re-issued and sign-off by doctors engaging in private practice. Where concerns are raised about a consultants' compliance, the Department of Health's framework *Maintaining High Professional Standards in the Modern HPSS should be followed*.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Also see recommendations in section 1

3 REVIEW OF MR A's COMPLIANCE WITH RELEVANT PRIVATE PRACTICE GUIDANCE/AUTHORITIES – DATA ANALYSIS

Internal Audit completed data analysis using information provided by the Trusts Acute Informatics department. Internal Audit were provided with the following reports from PAS, TMS, Pre Operative Assessment Unit:

- Patient Level List of Elective Inpatient Admissions, Daycases and Regular Attenders for Mr A Date of Admission only between 01/01/2019 and 30/06/2020 from PAS
- Patient Level List of Outpatient Attendances (Including Outpatient Urodynamic Attendances) for Mr A Appointment Date only between 01/01/2017 and 30/06/2020 from PAS
- Patient Level List of Outpatient Urodynamic Attendances for Mr A Appointment Date Only between 01/01/2019 and 30/06/2020 from PAS
- Patient Level List of Imaging Exams Performed which were Requested by Referring Clinician Mr A Exams Performed between 01/01/2019 and 30/06/2020 from NIPACS
- Patient Level Report of Theatre Cases Carried out by Mr A – By hospital, theatre and operation date based on operation date between 01/01/2019 and 30/06/2020 from TMS.
- Pre-operative Assessment Database for Urology with the Trust Identifying Mr A's patient's for pre-op assessments performed between 01/01/2019 and 30/06/2020

3.1 Pre-Operative Assessments

All elective patients who require a General Anaesthetic whilst undergoing a procedure are required to have a Pre-Operative Assessment (POAs) to assess their fitness for surgery. The Trust deem the optimum time to complete a patients' POAs is between 13 weeks and approximately 3 weeks ahead of planned admission date for surgery. Consequently to ensure this happens in a timely manner and no patients scheduled for theatre are overlooked, it is essential that all elective theatre lists are prepared and notified to the POA team 6 weeks in advance of the theatre date.

Theatre rotas are compiled by the Head of Service for Theatres, detailing which surgeons have access to the theatres at each session. When Consultants become aware of the theatre rota they then select the patients for each list, any who require pre op should be sent to the pre op assessment unit. Mr A selected his own patients and arranged his own theatre lists. It is understood that Mr A would have provided his secretary with a list of patients to be booked into his theatre lists and she would have completed an "Arrange Admission List".

Completion of POA

According to Trust PAS report provided, during the period January 2019 to June 2020, there were a total of 1,096 elective procedures performed on 576 of Mr A's patients. In consultation with the Head of Urology and Pre-operative Assessment Manager, Internal Audit analysed a PAS report of all elective procedures performed on Mr A's patients during January 2019 to June 2020. With the Trust's expert input, we were able to eliminate procedures where a pre op assessment was not required from our analysis. These cases related to procedures done under a local anaesthetic; or where the patient had previous surgery and the previous POA was still valid.

For 351 of the 1,096 procedures performed by Mr A, a POA was required. In 86 (25%) of these 351 cases, a POA was not completed. Internal Audit reviewed these 86 cases with the Pre-Operative Assessment Manager and found:

- In 24 procedures, the patient was assessed upon admission rather than having a scheduled POA ahead of time. An appropriate POA in line with Trust requirements was not therefore conducted.
- 62 procedures required a POA for the procedure but this was not completed. In 2 of these procedures, the patient did not attend/complete their POA but a POA had been requested in both cases. Both patients underwent surgery nonetheless.

Lack of POA as Potential Indicator that Patient was Seen Privately and then Treated in NHS

Internal Audit reviewed these 86 cases further from information on PAS and NIECR to establish if there was any information that pointed to these 86 cases being private patients. This work identified:

- In 49 procedures, the patient had an appropriate footprint on PAS.
- For the remaining 37 procedures, the patient had either no outpatient appointment (according to the PAS data provided by the Trust) or there was a short timeframe between being seen at an outpatient appointment and the date of surgery. Internal Audit selected a sample of 23 of these procedures for further analysis on PAS and NIECR in conjunction with the Head of Urology. In 22 of the 23 procedures whilst a pre-op assessment was required, the patient was not deemed to be private as they had come in initially through ED and been given date for surgery on discharge, another Speciality or another Consultant was involved in their care. 1 of the 23 procedures related to a private patient who was subsequently treated in the NHS. No Change of Status form had been completed.

Timeliness of POA

As outlined above, the optimum time for a patients' POAs to take place is between 13 weeks and approximately 3 weeks ahead of planned admission date for surgery. In effect, PoAs are valid for a period of 13 weeks pre-admission for surgery.

On review of 265 procedures where a POA was undertaken for Mr A's patients, Internal Audit noted:-

- There were only 8 procedures (3%) where the POA was conducted within the timescale required by the Trust, in advance of surgery.
- 252 procedures (95%) were added to the POA list less than 21 days before their admission:
  - 105 procedures (40%) were added to POA list 5 days or less before admission
  - 131 procedures (49%) were added to POA list 10 days before admission
  - 16 procedures (6%) were added to POA list between 11 and 20 days before admission
- In 5 (2%) cases, there was insufficient information to confirm the timeliness of the POA.

3.2 Elective Surgery With No Outpatient Appointment

From the PAS data received from the Trust Acute Information Department, Internal Audit joined elective surgery data in the period 01/01/2019 to 30/06/2020 to outpatient appointments in the period 01/01/2017 to 30/06/2020. The purpose of this analysis was to establish patients who had surgery but did not have an outpatient appointment potentially indicating that they may have been seen privately for an outpatient appointment by Mr A prior to surgery.

Note: We considered outpatient information for a longer period than the audit period to factor in the waiting list times.

We found that there is no record of a Trust outpatient appointment (either pre or post surgery) for 220 patients who had at least one elective procedure (total 284 procedures) between 1 January 2019 and 30 June 2020.

Where a patient had surgery and no outpatient appointment, the patient could potentially have been a private patient as the normal patient route for elective surgery is to be seen at an outpatient appointment and then if required, listed for elective surgery.

Internal Audit reviewed the 284 procedures where there was no recorded Trust outpatient appointment on PAS. With the expert input of Head of Service for Urology, 138 records were excluded from further analysis because the nature of the procedure did not involve the need for an outpatient appointment (for example stent replacement/removal); or the waiting time for the procedure appeared in line with Trust waiting list; or the patient (5 cases) was declared as a Change of Status patient.

Out of the remaining 146 records, Internal Audit selected a sample of 54 records (relating to 50 patients) which the Head of Service for Urology then reviewed on PAS and NIECR, particularly considering whether referrals had been received for these cases and where patients had been seen in relatively short-timeframe that there were valid clinical reasons for this. Internal Audit then walked through 21 of these 50 patients with the Head of Urology to validate the data. This work identified:

- 1 patient who was initially referred by a GP in January 2018 but was then discharged from this referral on PAS in July 2019 to attend Mr A privately. This patient was added to Mr A's Day Surgery waiting list from the same date in July 2019 as an Urgent case. This was done retrospectively on PAS on 20 August 2019, approximately a week before the patient had their Pre-Op Assessment in late August 2019. The patient had their procedure in early September at CAH Day Surgery Unit, 2 weeks after being entered onto the waiting list on PAS (albeit the entry was made retrospectively to an earlier time in July). The Trust has advised that the normal waiting time for this procedure is 91 weeks.
  In effect, this patient changed from NHS to private and back to NHS in one day, with no Change of Status forms. This is a blatant breach of proper process and is an example whereby a significant advantage has been gained in terms of speed of treatment, by paying privately for an outpatient appointment.
  In the absence of an approved Change of Status form, this is arguably a private patient having a procedure using trust facilities and staffing.
- In 2 cases, there was no outcome letter completed for the procedure potentially indicating that the patient may have transferred back to the private sector for review. It should be noted that the Trust believe that these are poor administration issues rather than private patients.

3.3 Elective Surgery with an Outpatient Appointment

There were 812 records (356 patients) out of the 1,096 (576 patients) that had elective procedures who also had an outpatient appointment in the period under review.

From review of a sample of 29 of these patients, Internal Audit noted 4 occasions where the patient may have potentially been a private patient:

- 1 patient (a retired consultant) who had been seen privately by Mr A in 2017 was then seen in 2020 in the Trust as an NHS patient. A change of status form had not been completed.
- 1 patient was under the care of another urology consultant on PAS but the patient was seen by Mr A. There was no rationale as to why Mr A became involved in the patient's care.
- 1 patient was seen within 2 days of a red flag referral. Internal Audit observed that as per a letter on NIECR, this patient was a close relative of a GP.
- In 1 case, there was no outcome letter completed following the procedure, which potentially could be an indicator that the patient may have been reviewed privately following the procedure. It should be noted that the Trust believe that these are poor administration issues rather than private patients.

3.4 Other Observations

During the course of the audit, Internal Audit identified a number of other issues:

- There were 371 radiology diagnostic tests requested by Mr A from Urology Outpatients in the period 1 January 2019 to 30 June 2020 where the patient had no outpatient/surgical procedure, as per the PAS reports provided by the Trust. Upon further investigation and sample checking by Internal Audit in conjunction with the Head of Service for Urology, Head of Diagnostics and a Urology Consultant, it was identified that these cases were not all Mr A patients. When a junior doctors signs in with their own log-in into NIPACS (Sectra), their request will default to the last Consultant they ordered a scan on behalf of. The junior doctor should amend this to the name of the consultant they are actually making the request on behalf of, however Internal Audit was advised that this is not routine practice. Therefore scan requests are being attributed to

consultants when the patient wasn't actually under their care. If a consultant makes the request themselves, this is not an issue as system maps directly to them it doesn't default to the last user. This means the audit trail on the system in terms of the requesting Consultant is incorrect in some cases and could mean that the test results go to the wrong Consultant, potentially creating a patient safety issue.

- The referral date on PAS, which is the date the referral of the patient is received by the hospital and will be the date the patient enters any relevant waiting lists, should not be changed however the date can be changed on the system. Internal Audit noted instances where the date had been changed, affecting the patient's position on the waiting lists. In the context of this audit, Internal Audit observed referral dates being changed to later dates rather than earlier dates.
- When a patient is entered onto PAS, a registration will be opened for the episode of care, this registration should be closed when a patient is discharged with their treatment complete. Open registrations on PAS should be reviewed on an ongoing basis. Instances were observed where the patient had been discharged but the registration had not been closed.
- Up to 2020 there was no mechanism for electronic signoff on NIECR. From 2020 this became available and is reportedly monitored however it is not routinely used across the Trust. Internal Audit queried how the Trust ensures that consultants are getting their own patient results – and where advised that there is a monthly check completed of all patients who are recorded as "DISCHARGE AWAITING RESULT" by Consultant secretaries. Internal Audit were advised that this is not conducted routinely. Internal Audit were advised that there 1,000 records on NIECR not signed off by Mr A.

General Recommendations Regarding Trust Process:

Recommendation 3.1	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned admission date for surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including Urology.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director of ATICS
Implementation Date	September 2021

Recommendation 3.2	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director of ATICS, Assistant Director Functional Support Services
Implementation Date	September 2021

Recommendation 3.3	The Trust should liaise with BSO in order to resolve this referring Consultant recording error in the NIPACS system.
Management Action	**ACCEPTED**

Responsible Manager	Director Performance & Reform
Implementation Date	February 2022

Recommendation 3.4	The processes for registration should be reviewed and training given to all appropriate staff on the correct use of PAS, including consultant secretaries.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Recommendation 3.5	The processes surrounding electronic and manual sign off and review of the "DISCHARGE AWAITING RESULT" should be strengthened and monitored.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Medical Director Clinical Directors and Assistant Operational Directors
Implementation Date	February 2022

See also recommendation 1.4

4 INTERACTION OF MR A's PRIVATE WORK WITH HSC SERVICES AND FACILITIES

A Code Of Conduct For Private Practice - Recommended Standards Of Practice For HPSS Consultants (November 2003) states that HSC facilities, staff and services may only be used for private practice with the prior agreement of the HSC employer.

Internal Audit were advised by the Trust that Mr A's private practice did not interact with HSC services and facilities. However as per the findings in this report, there are a number of issues and exceptions that would indicate a degree of interaction – particularly for services that could not be performed or delivered from Mr A's home practice.

The queries around the timing of changes of status outlined in this report, mean there is a risk that Trust staff have been involved in the administration or treatment of patients that should have been categorised as private.

General Recommendations Regarding Trust Process:

See recommendations in section 1-3

5 CRAIGAVON UROLOGICAL RESEARCH EDUCATION (CURE)

In line with the Terms of reference of this review, Internal Audit also considered whether the Trust has any involvement with CURE - Craigavon Urological Research & Education, to understand if there was a flow of money into the Trust and to check, as much as is possible from review of Trust records and engagement with Trust staff, whether any Directors/staff benefited from the operation of the company.

According to the Companies House website/Articles of Association, a previous Trust Chairperson and Mr A set up CURE in 1996 as a 'Charitable Company Limited by Guarantee and not having Share Capital'.

The objectives of CURE are:

- To advance education for the public benefit in Urological disorders.
- Conducting and commissioning research into Urological disorders and the effective treatment of persons suffering from Urological disorders and to disseminate the useful results of such research.
- Raising public awareness and understanding of Urological disorders and their treatment and promoting training in the treatment of Urological disorders.

The CURE committee is currently made up of Mr A and three other people - 2 of whom are current Trust employees (1 Consultant Urologist and 1 Specialist Nurse in Health Promotion). The CURE committee secretary is a previous Trust employee.

Whilst these Trust staff are members of the CURE Committee, Internal Audit were advised by Senior Trust staff that their role should be separate and independent from their roles in the Trust. Internal Audit met with the two Trust staff who are currently on the Committee of CURE who both confirmed that their role within CURE is entirely independent of their job with the Trust. The Trust advised of some historical Trust involvement with CURE (pre-creation of SHSCT) including preparation of CURE accounts. Internal Audit also note that the registered office of CURE (until July 2012) was on the Craigavon Area Hospital site.

From discussion with Trust Management and Trust staff involved with CURE, there is no indication of any flow of money into the Trust or Trust involvement in fund raising in recent years.

Internal Audit understands from the Committee members that Trust staff may apply to CURE for funding. A written request is completed and will be reviewed/approved by the CURE committee. If approval is granted by the Committee, the staff member will pay for the course and on submission of relevant paperwork invoices, a cheque from the CURE bank account is made payable to the applicant.

It should be noted that Internal Audit did not have access to CURE financial records as part of this review and therefore do not have visibility over payments made by CURE to Trust staff.

Trust procedures do not provide guidance in respect of staff involvement in independent organisations with a potentially perceived affiliation to the Trust by their nature.

General Recommendations Regarding Trust Process:

Recommendation 5.1	The Trust should review the appropriateness of Trust staff being office bearer/cheque signatories in Charities where due to the close associations, the reputation of the Trust may be impacted by the actions of these charities. Trust procedures should be developed for this area and the potential for such charities to be seen in effect as an unofficial Charitable Fund at ward level, should be

	considered.
Management Action	ACCEPTED
Responsible Manager	Director of Finance
Implementation Date	October 2021

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in in fulfilling their responsibilities.

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

Minutes of a virtual confidential meeting of the Governance Committee held on Tuesday, 16th November 2021 at 2.00 p.m.

PRESENT:

Ms E Mullan, Non-Executive Director (Chair)
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mr B Beattie, Interim Director of Older People and Primary Care
Mrs A Magwood, Director of Performance and Reform
Mr C McCafferty, Interim Director of Children and Young People's Services/ Executive Director of Social Work
Mrs M McClements, Director of Acute Services
Dr M O'Kane, Medical Director and Interim Director of Mental Health and Disability Services
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing, Midwives and Allied Health Professions
Mrs S Judt, Board Assurance Manager (Minutes)

1. **DECLARATION OF INTERESTS**

Ms Mullan asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

2. REVIEW OF MR A's COMPLIANCE WITH RELEVANT AUTHORITIES/GUIDANCE IN TERMS OF HIS PRIVATE WORK

The Chair advised that the above-named Internal Audit report had been remitted to the Governance Committee from the Audit Committee meeting held on 14th October 2021 given the clinical governance issues identified.

The Chief Executive stated that the Internal Audit review focused primarily on Mr A's change of status private patients work during the period 1 January 2019 to 30 June 2020. All the management actions have been agreed and will be taken forward within the timelines identified. He advised that this report is a review of one aspect of Mr A's practice and reviews of other aspects of his work are underway. The learning from these various strands will be taken forward through the structures put in place within the Trust and updates provided to Trust Board on emerging issues.

Discussed ensued on the Internal Audit recommendations.

Recommendation 2.1

This recommends that the Trust should consider charging for the identified private activity. Ms Donaghy raised the following points:-

i) The report does not state who should be charged and she asked why did the Trust determine that this recommendation applies to the patients/recipients of the private care? Did the Trust consider at any time that this recommendation may relate to Mr A being charged for the health care that he obtained free of charge for his private patients? If so, what was the outcome of that consideration and if not considered, why not?
ii) Has the Trust quantified the cost of the healthcare provided to Mr A's private patients?
iii) Does the Trust consider that recompense should be sought from Mr A in line with policy and procedures (and precedent) within the Trust?

Dr O'Kane advised that this recommendation has been considered by the Trust and it was felt it would not be appropriate to charge these patients. As there was no evidence of private activity declared to the Cash Office in Daisy Hill Hospital during the audit period by Mr A and no invoices raised for private treatment, both these indicated that Mr A did not perform private work on HSC premises. Dr O'Kane advised that advice had been sought from the Department of Health with regard to seeking recompense from Mr A, but their advice is that there is no mechanism to do so.

Recommendation 2.3

Ms Donaghy welcomed the fact that a number of recommendations in the report address strengthening the policies and procedures regarding the management of Consultants undertaking private practice. She raised the point that this recommendation states that *'Where concerns are raised about a Consultant's compliance, the Department of Health's framework 'Maintaining High Professional Standards in the Modern HPSS should be followed'* and asked if the Trust management accept that this is an adequate process? Ms Donaghy also asked if there was any other process, disciplinary or otherwise, in place to aid the Trust in the future management of private practice by Trust Consultants should a similar case to the current one arise?

Mrs Toal advised that for cases such as the one involving this Consultant, the MHPS, as the overarching framework, would be followed. Conduct concerns are one of the strands of the framework. Mr Wilkinson and Mrs Toal both emphasised the importance of robust Trust policy and procedures being in place to ensure appropriate behaviours.

Recommendation 1.4

The findings in the report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The report recommends that the Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue. Ms Donaghy asked the following questions:-

i) Is this an administrative process or will it be a robust process engaging with all Consultants to provide assurance that procedures are being followed?
ii) If the latter, can Trust Board be provided with a plan on how this will be undertaken and will those Consultant specialisms most likely to attract private work be reviewed as a priority?

Mrs McClements stated that as part of the revised process to govern the declaration of private practice, medical staff engaging in private practice will be required to provide signed confirmation that they are aware and will abide by the Trust Guidance on Private Practice and the regional Management of Private Practice in Health Service Hospitals in Northern Ireland (2007). Dr O'Kane provided assurance that systems were being strengthened as regards private patients and advised that the Trust has developed a private practice appraisal template to be signed off by the respective Clinical Director before appraisal.

Mr McDonald referred to the defined time period of this Internal Audit review i.e. 1 January 2019 – 30 June 2020 and queried the need to go back further in terms of Mr A's practice. He also raised the fact that the analysis conducted was largely based on the data provided by the Trust and Internal Audit did not walk through each individual patient's journey on their patient file and therefore the analysis may not be fully complete. Dr O'Kane stated that clinical concerns relating to Mr A's practice is a function of the look back exercise. She reminded members that previous concerns were raised in relation to Mr A in March 2016 and managed within the MHPS framework. Dr O'Kane stated that the transfer of private patients to the NHS goes back over 28 years of Mr A's practice and she was not sure what would be gained by going back over this without any robust hospital system in place to check. Mrs McClements advised that the current look back covers the 18-month period prior to Dr A's retirement. The focus of this is to provide assurance in respect of the safety of the patients involved and any probity issues identified will also be addressed. As issues come to light, there may be a need to go back over a longer timeframe.

Mrs McCartan, Audit Committee Chair, stated that Mrs McClements had attended the Audit Committee meeting on 14th October 2021 for discussion on this item. Issues raised included wider learning generally and strengthening of systems of internal controls in relation to Job plans and appraisals/validations for all Consultants.

Mrs Leeson sought assurance that both private and NHS patients are seen based on clinical need. Dr O'Kane provided assurance that this was the case.

Mrs Leeson raised the Neurology Public Inquiry and the decision of voluntary erasure of Dr Watt's name from the medical register. She asked about the likelihood of this happening with the Urology Public Inquiry and if so, raised her concern that patients would not get answers to what had happened. Dr O'Kane acknowledged that this could happen and advised that there has been a significant level of medico-legal requests from patients associated with the Neurology Inquiry.

In terms of next steps, it was agreed that Audit Committee will monitor the implementation of the Internal Audit recommendations and a progress update on the recommendations will be brought to the Governance Committee in February 2022.

The meeting concluded at 2.30 p.m.

SIGNED: _____ ***DATED:*** _____

Mullan, Eileen

From: Judt, Sandra
Sent: 19 September 2023 16:48
To: Mullan, Eileen; Eileen Mullan
Subject: FW: FOR NOTING: Committee Chair reporting to Trust Board
Attachments: Committee Chair Report to Trust Board Template.docx

Fyi.

Sandra Judt
Board Assurance Manager
Southern Health & Social Care Trust
Personal Information redacted by the USI
(028) Personal Information redacted by the USI (Internal: Personal Information)

From: Judt, Sandra
Sent: 19 September 2023 16:48
To: McCartan, Hilary <Hilary.McCartan Personal Information redacted by the USI >; Leeson, Pauline <Personal Information redacted by the USI >; Donaghy, Geraldine <Personal Information redacted by the USI >; McDonald, Martin <Personal Information redacted by the USI >; Wilkinson, John <Personal Information redacted by the USI >; OKane, Maria <Personal Information redacted by the USI net>; Teggart, Catherine <Personal Information redacted by the USI >; Trouton, Heather <Personal Information redacted by the USI >; Toal, Vivienne <Personal Information redacted by the USI >; WilsonDoP, Elaine <Personal Information redacted by the USI >; McCafferty, Colm <Personal Information redacted by the USI >; Austin, Stephen <Personal Information redacted by the USI >; McGall, Jan Personal Information redacted by the USI >; Beattie, Brian Personal Information redacted by the USI <Personal Information redacted by the USI >; Reid, Cathrine (Personal Information redacted by the USI) <Personal Information redacted by the USI >; Reid, Trudy <Personal Information redacted by the USI >; Rogers, Ruth <Personal Information redacted by the USI >
Cc: McCormick, Susan <S Personal Information redacted by the USI >; Gribben, Laura <Personal Information redacted by the USI >; Comac, Jennifer <Personal Information redacted by the USI >; Gregory, Louise <Personal Information redacted by the USI >; Willis, Lisa <Personal Information redacted by the USI >; Mallagh-Cassells, Heather <Personal Information redacted by the USI >; PADirectorofP&RSHSCT <Personal Information redacted by the USI >; Alexander, Ruth <Personal Information redacted by the USI >; Burns, EmmaL <Personal Information redacted by the USI >; Griffin, Tracy <Personal Information redacted by the USI >; PADirectorofACS <Personal Information redacted by the USI >; Hogan, Kerri <Personal Information redacted by the USI >; Girvan, Victoria <Personal Information redacted by the USI >
Subject: FOR NOTING: Committee Chair reporting to Trust Board

MESSAGE FROM TRUST BOARD CHAIR

Dear all

RE: Reporting from Confidential Committee meetings to Confidential Trust Board Meetings

At the Governance Committee held on the 07th September 2023, I identified a gap in our reporting from confidential committees through to the confidential Trust Board. To remedy this, I have outlined below the revised approach to be implemented with immediate effect. Please see attached Committee Chair template which has been updated to include issues for escalation to Trust Board.

1. Confidential Committee Meetings – reporting to Confidential Trust Board	• Where there has been a confidential Committee meeting, Committee Chairs are asked to complete the updated template attached which now includes details for issues for escalation to Trust Board. • Minutes of confidential meetings should also be provided.
2. Open Committee Meetings – reporting to Public Trust Board meetings	• Committee Chairs are asked to complete the updated template attached and detail issues for escalation to Trust Board.

A standing item will be now be included on all Confidential Trust Board agendas for Confidential Committee updates.

Regards

Eileen

Southern Health and Social Care Trust

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(Name of Committee)

Committee Chair Report for Board Meeting on (date)

The X Committee ('the Committee') met on (date). The following is a summary of the areas considered at the meeting to update the Board. The formal record of the meeting remains the approved minutes.

1. Summary of areas considered

(Agenda items with a note where applicable)

2. Issues for escalation to Trust Board

3. Action(s) requested/required of Trust Board

- Note the areas considered and issues for escalation
- Note previous minutes
- Approval of Terms of Reference and Annual Workplan

(Name)
Non-Executive Director - Chair
On behalf of the X Committee
(Date)

Southern Health and Social Care Trust

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REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 27th September 2018
Title:	Bluestone and Dorsy Workforce Action Plan to support safe care and whole systems patient flow
Lead Director:	Mrs C Harney Interim Director Mental Health and Disability
Corporate Objective:	Promoting safe, high quality care
Purpose:	Information

Summary of Key Issues for Trust Board

High level context:

There has been an ongoing and growing historical reliance on the use of bank/agency staff to provide safe staffing levels within the Acute MH and LD In-Patient Units. The growth of community MHD services coupled with the continuing regional shortfall of trained mental health and learning disability registered nurses has added to an ever increasing capacity gap in maintaining the required levels of staff within the Bluestone/Dorsy Units. The Interim Director of MHD has escalated this service pressure to SMT which is now identified as a corporate risk and a proactive recovery/control plan has urgently been put in place.

Progress Update:

- Tabled as a corporate SMT agenda item since 2018
- Formal alert issued re WF and Bed Pressures on 24th August 2018 to the DoH, HSCB and RQIA.
- WF data and Summary Action Plan report to support safe and effective care at the request of CNO's office, DoH, and RQIA approved for sharing by SMT on 12th Sept 2018.
- Immediate internal WF analysis to determine safe levels of staffing linked to bed capacity.
- The Trust CEX formally wrote to CEX at the HSCB in July 2018 to confirm progress on the Regional review of In-Patient Bed pressures and the urgent need for an established regional risk matrix to determine safe thresholds of staffing.
- HSCB/PHA are currently establishing a review team to conduct a regional review of Acute MH In-Patient Beds that will take account of the wider patient flow systems.

Action Plan:

- Active engagement with staff side is an integral and ongoing part of this work plan.
- There are ongoing regional WF communications/ meetings with Deputy CNO re normative staffing and MH WF pressures.
- The Trust continues to influence the HSCB to confirm progress on the regional review of In-Patient Bed pressures and the need for a regional Risk Matrix to determine safe thresholds of staffing.
- Ongoing engagement with the MHD, RQIA and HSCB. Formal meeting scheduled on 12th Oct 2018 with the RQIA, the Trust CEX, the EDoN/AHPs and lead staff, and, MHD SMG leads.
- Early analysis on WF capacity to safely manage Bluestone/Dorsy Units, adopted use of a daily sitrep tool with an escalation protocol.
- **On 19th Sept 2018 SMT endorsed the following:-**
    - the need to sustain fully functioning MH/LD In-Patient Units to meet the needs of our most acutely ill and complex patients to facilitate patient flow, a positive impact on the crisis/home treatment services and the wider internal and regional patient system flow.
    - that the lesser risk is stepping down community facing routine elective work rather than cease admissions or incur any bed closures. A dialogue with commissioner regarding the latter was held at the Trust/HSCB meeting on 2st Sept 2018.
    - A contingency plan for the utilisation of MH community routine elective staff and the subsequent impact of this action on performance trajectories.
    - A WF plan has been scoped to address this and a schedule is planned for up to Dec 2018.
    - Some urgent “at risk” posts have been approved immediately.
    - Scoping of WF backfill options to support continued compliance with the routine community facing elective trajectories to avoid growth in these waiting times.
    - The establishment of a “Directors Oversight Project Board Group” to design the future model for the Bluestone/Dorsy Units. A dedicated project re structure is being established.

Southern Health and Social Care Trust

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Minutes of a confidential meeting of Trust Board held on Thursday, 27th September 2018 at 10.00 a.m. in the Boardroom, Trust Headquarters, Craigavon

PRESENT

Mrs R Brownlee, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Dr A Khan, Acting Medical Director
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Interim Executive Director of Nursing & Allied Health Professionals

IN ATTENDANCE

Mrs E Gishkori, Director of Acute Services
Mrs C Harney, Interim Director of Mental Health and Disability Services
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Director of Older People and Primary Care
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager

APOLOGIES

None

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting. She reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held on 30th August 2018 were agreed as an accurate record and duly signed by the Chair.

4. PROGRESS UPDATES

i) Irrelevant information

Mrs Harney spoke to the written update. This provides confirmation that the Trust is not aware of any clients who are known to services that are availing of privately arranged respite within Irrelevant information redacted by the USI. Mrs Harney pointed out that Irrelevant information redacted by the USI can offer private respite provision to other individuals subject to the placement meeting the criteria for the home or their statement of purpose as required by RQIA. She advised that the Home Owners have been asked to inform the Trust in a timely way of any persons availing or respite or placement through a private arrangement within Irrelevant information redacted by the USI.

5. **SAI ID** Personal information

Mrs Harney spoke to the written update on a serious adverse incident involving a patient in Irrelevant information redacted by the USI. She advised that the patient broke a window pane in a bedroom and used a shard of glass that lead to a very serious self-injury. Mrs Harney outlined the engagement with the patient's family and the support to staff following the incident. She went on to explain that the incident raised a concern about the glass specification in the windows in Irrelevant information redacted by the USI

and stated that there may be potential learning for other facilities in the Trust area and regionally in relation to glass safety. All required alerts have been shared and any follow up regarding local and regional learning will be completed following confirmation from Estates with whom there is a scheduled meeting on 28th September 2018.

6. **BLUESTONE AND DORSY WORKFORCE PRESSURES**

The Chief Executive stated that this service pressure is a standing item on the SMT agenda and there has been proactive engagement with RQIA and steps taken to address the challenges. Mrs Harney advised that a workforce plan is in place up to December 2018. The Chair asked that in light of this staffing pressure, if other services were being stood down. Mrs Harney advised that some resources from routine elective work within community mental health teams was re-directed to in-patients. Mrs Trouton gave assurance that safe patient care was being maintained in Bluestone and Dorsy. Discussion ensued in which members raised concern at the impact workforce pressures are having on the delivery of Trust services, particularly in the wider mental health area. At the suggestion of the Chief Executive, members agreed to write as a Trust Board to the Department in relation to workforce planning.

Action: Chair and Chief Executive

7. **REGIONAL FINANCIAL UPDATE – 2018/19 SAVINGS PROPOSAL**

Ms O'Neill spoke to short paper and advised that regionally across the HSC system, there is a deficit of some £15-£16m. Trusts have been asked to undertake an urgent review to determine what additional low impact savings could be identified to bridge this regional gap. Ms O'Neill stated that the Trust continues to work closely with the Department on this issue.

At the request of the Chair, Mrs McClements and Ms O'Neill, left the meeting for Item 8.

8. **FEEDBACK FROM REMUNERATION COMMITTEE**

The Chair advised that the Remuneration Committee had met earlier that day to consider the starting salary of Mrs McClements, Director of Older People and Primary Care and Ms O'Neill, Director of Finance, Procurement and Estates. It was the recommendation of the Remuneration Committee that given both Mrs McClements' and Ms O'Neill's previous acting positions, they would move across to their new roles on the same salary.

Trust Board approved the recommendation of the Remuneration Committee.

Mrs McClements and Ms O'Neill, returned to the meeting at this point.

9. **ANY OTHER BUSINESS**

The Chair advised that the Chief Executive and herself had discussed the timing of Trust Board meetings going forward, taking on board the feedback received. She stated that in order to fully address the large and complex agendas, a full day commitment for Trust Board meetings would be required going forward.

This was discussed and it was agreed that time would be spent at the Board Development Day in November to further explore the best use of Trust Board time.

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 25th October 2018
Title:	Update Bluestone and Dorsy Workforce Action Plan to support safe care and whole systems patient flow.
Lead Director:	Mrs C Harney Interim Director Mental Health and Disability
Corporate Objective:	Promoting safe, high quality care
Purpose:	Information

Summary of Key Issues for Trust Board

High level context:

There has been an ongoing and growing historical reliance on the use of bank/agency staff to provide safe staffing levels within the Acute MH and LD In-Patient Units. The growth of community MHD services coupled with the continuing regional shortfall of trained mental health and learning disability registered nurses has added to an ever increasing capacity gap in maintaining the required levels of staff within the Bluestone/Dorsy Units. The Interim Director of MHD has escalated this service pressure to SMT which is now identified as a corporate risk and is a standing item on SMT to address the recovery/control plan.

Progress Update:

- Continues to be tabled as a corporate SMT agenda item since July 2018.
- A Trust Directors Oversight Group and a sub-group structure to address, Workforce, Governance/Quality of Care, Patient-Flow, Culture, E Technology themes has been established.
- Implementation of a phased approach to the workforce plan for Dorsy and Bluestone with immediate, medium and long term actions. Some actions proposed fall outside the Trust's locus of control. As follows:-
    - As yet there is no regional sign off or funding stream decision on Delivering Care Phase 5 Normative staffing for MH in-patient units.
    - The Delivering Care Phase 5 Normative staffing exercise has not been completed regionally for LD in-patient units.

- RQIA/Trust "serious concerns" meeting was held on Fri 12th October 2018 which outlined the Trust's full action plan.

Action Plan:

- **SMT endorsed the following:-**
- Recruitment on a permanent basis the 2 Band 5 posts uplifted to Band 6 posts. These received regional funding for 18 month period through the C&S monies.
- Recruitment of a band 7 clinical tutor post.
- Recruitment of a Lead Band 8a LD Nurse.
- Considered medium/long term proposal/costs for the recruitment of the normative staffing levels to Bluestone and the implications of DOH funding becoming available for this.
- Considered early scoping re availability/costs of MH/LD workforce from England as learning from BHSCT
- A longer term MDT workforce plan for Bluestone/Dorsy will be developed and approved at Directors Oversight Group and presented to SMT.
- The case for regional transformation investment into MDT rehabilitation and the community infrastructure to support patient flow by the Trust continues to be made to HSCB.
- The long term recommended environments for the LD In-patient population will be considered by the Directors Oversight Group.

Internal/External Engagement

- Engagement with front line staff ongoing to seek their views on support systems to maximise WF recruitment and retention within Bluestone making it an attractive place to work.
- Leadership walks are on-going and staff feedback from community workforce input to the in-Patient wards has been positive.
- Front line staff have indicated that they feel supported by the MHD and the Trust Senior Management Team.
- There is ongoing engagement and partnership working with Staff Side.
- A training action plan is being actively progressed with the EDoN/AHPs professional team input.
- Plans to build reliance for staff will be progressed.
- Ongoing engagement with DoH, HSCB, PHA and RQIA.

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

Minutes of a confidential meeting of Trust Board held on Thursday, 25th October 2018 at 10.15 a.m. in the Mid Ulster Council Chamber, Dungannon

PRESENT

Mrs R Brownlee, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Dr A Khan, Acting Medical Director
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Interim Executive Director of Nursing & Allied Health Professionals

IN ATTENDANCE

Mrs E Gishkori, Director of Acute Services
Mrs C Harney, Interim Director of Mental Health and Disability Services
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Director of Older People and Primary Care
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

None

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting. She reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held on 27th September 2018 were agreed as an accurate record and duly signed by the Chair.

4. MATTERS ARISING

i) **Bluestone and Dorsy Workforce Action Plan**

The Chief Executive stated that this service pressure continues to be a standing item on the SMT agenda to address the recovery/control plan. A Trust Directors Oversight Group and a sub-group structure have also been established.

Mrs Harney spoke to the written summary update. She advised of the implementation of a phased approach to the workforce plan for Bluestone and Dorsy and stated that a short term immediate action plan has been implemented, that medium to long term actions were discussed by the SMT the previous day with agreement to bring a draft paper to SMT for an investment proposal to be discussed with the HSCB and the PHA on 7th December 2018.

Mrs Harney reported that Leadership walks are ongoing and that staff feedback from community workforce input to the in-patient wards has been positive. The Chair referred to the RQIA/Trust 'serious concerns' meeting on 12th October 2018 and asked that outside RQIA visits/inspections, would Trust senior management have picked up any culture issues in the units during leadership walks.

Mrs Harney provided assurance that leadership walks have always been a part of practice in MHLD albeit a formal template is not completed. She stated that Dorsy has become a long stay unit with a cohort of complex patients and this has created a difficult and challenging environment for patients and staff. Mr Wilkinson made the point that culture is dynamic and will change with the patient population. He raised concern about the perception of the Heads of Service and Assistant Directors with regard to a change in culture, as they are key to action being taken. Reference was made to the regional review undertaken by Mary Hinds and Mrs Leeson asked that this report would be shared with members and this was agreed.

Mr McDonald welcomed the proposal to use some of the Directorate's allocation to meet staff resourcing costs and asked about the amount available. Ms O'Neill advised that the process was being worked through and agreement would be sought from the Commissioner to use some of the mental health allocation to take forward some of the actions.

The Chief Executive concluded the discussion by advising that once this service pressure was identified, a series of actions were put in place quickly. Staff understand the need for change and the next step is to ensure the resourcing of some of these actions.

5. **UPDATE ON WHISTLEBLOWING CONCERN IN CHILREN AND YOUNG PEOPLE'S SERVICES**

Mr Morgan and Mrs Toal updated members on the actions taken by the Trust to date. They advised that the independent review report has now been received. In terms of next steps, this will be shared with Trade Union colleagues and then Mrs Toal and Mr Morgan will arrange to meet with teams to share and discuss the report with them. The report will also be shared with Mr Wilkinson. A programme of work will be put in place to take forward improvements, agreed by staff. An update will be provided to the Governance Committee.

6. **ANY OTHER BUSINESS**

The Chief Executive raised the recent reporting in the Press regarding Trust underspend in adult learning disability services. He advised that the figures quoted were a misinterpretation of a FOI request. Mrs Harney stated that the Trust spends a considerable amount of money on respite services for adults with a learning disability.

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 29th November 2018
Title:	Update Mental Health/LD In-Patient Units Workforce Pressures
Lead Director:	Mrs C Harney Interim Director Mental Health and Disability
Corporate Objective:	Promoting safe, high quality care
Purpose:	Information

Summary of Key Issues for Trust Board

High level context:

The ongoing and increasing regional shortfall of trained mental health and learning disability registered nurses has for many years now created a reliance on the use of bank/agency staff to provide safe staffing levels within the Trust MH and LD Acute In-Patient Units.
In addition the growth of community MHD services has attracted in-patient staff to employment within this sector creating an ever increasing staffing capacity gap within the in-patient Units. Whilst regional workforce planning has increased the numbers of training places for this cohort of specialist nursing registrants it will take up to 3-4 years to attain the required WF supply.

Strategic context:-

- The Regional HSCB led review of Acute MH in-patient beds will commence in the last quarter of 2018/19.
- Whilst there are ongoing Regional Trust/DoH meetings re on Delivering Care Phase 5 Normative staffing for MH in-patient units as yet there is no regional sign off or funding stream decision achieved to implement this plan.
- DoH have confirmed that the normative staffing exercise will be commenced regionally for LD in-patient units.

Trust context:-

The Interim Director of MHD has escalated this service pressure to SMT which is now identified as a corporate risk and has been a weekly standing item at SMT since July 2018 to address the recovery/control plan.

Progress Update:

- A Trust Directors Oversight Group and a sub-group structure have been established.
- Implementation of a phased approach to the workforce plan for Dorsy and Bluestone with immediate, medium and long term actions.

Action Plan:

- **Short term** actions through over-time, bank, redeployment of staff, band uplifts have maintained safe levels of staffing.
- SMT consideration of securing MH/LD workforce from England to facilitate the required cover over holiday/winter periods.
- For **medium-long term** a proposal position paper will be endorsed by SMT and tabled at a Trust/HSCB/PHA meeting scheduled for 7th Dec 2018 to agree a joint approach to achieving the normative staffing levels within the in-patient MH units. A proposal to seek agreement to use some of the MH allocation and agree the business case approach to fund the presenting financial gaps will be addressed.
- The case for regional transformation investment into MDT rehabilitation and the community infrastructure to support patient flow by the Trust continues to be made to HSCB.
- The long term recommended environments for the LD In-patient population will be considered by the Directors Oversight Group.

Internal/External Engagement

- Active engagement/co-production/workshops with ward managers and front line staff are ongoing to seek their views on support systems to maximise WF recruitment and retention within Bluestone, making it an attractive place to work.
- Leadership walks are on-going and staff feedback regarding community workforce deployment into the in-patient wards has been positive.
- There is ongoing engagement and partnership working with Staff Side.
- EDoN/AHP led professional governance audits have demonstrated safe and effective care.
- A training action plan is being actively progressed with the EDoN/AHPs professional team input.
- Plans to build resilience for staff are ongoing.
- Ongoing engagement with DoH, HSCB, PHA and RQIA.

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

Minutes of a confidential meeting of Trust Board held on Thursday, 29th November 2018 at 9.45 a.m. in the Boardroom, Trust Headquarters, Craigavon

PRESENT

Mrs R Brownlee, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Dr A Khan, Acting Medical Director
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Interim Executive Director of Nursing & Allied Health Professionals

IN ATTENDANCE

Mrs E Gishkori, Director of Acute Services
Mrs C Harney, Interim Director of Mental Health and Disability Services
Mrs M McClements, Director of Older People and Primary Care
Mrs V Toal, Director of Human Resources and Organisational Development
Ms C Stoops, Assistant Director of Corporate Planning (*for Mrs Magwood*)
Mr C McCafferty, Assistant Director, Corporate Parenting (*for Mr Morgan*)
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mr M McDonald, Non-Executive Director
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Mrs A Magwood, Director of Performance and Reform

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting. She reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held on 25th October 2018 were agreed as an accurate record and duly signed by the Chair.

4. MATTERS ARISING

i) **Bluestone and Dorsy Workforce Action Plan**

The Chief Executive stated that this service pressure continues to be a standing item on the SMT agenda with the focus now on medium – long term actions. Mrs Harney spoke to the progress update and highlighted the key actions. She advised that SMT has approved 17 Band 5 uplifts to Band 6 using the available mental health non ring fenced budget allocation to create a more senior profile on the inpatient wards. SMT has also approved securing Mental Health/Learning Disability workforce from England to facilitate the required cover over holiday/winter periods. Members noted the Trust/HSCB/PHA meeting scheduled for 7th December 2018 to agree a joint approach to achieving the normative staffing levels within the in-patient mental health units.

Mrs Leeson commented on the fact that the Executive Director of Nursing/AHP led professional governance audits have demonstrated safe and effective care and queried why staff do not want to work in the in-patient wards. Mrs Harney stated that the workforce pressures have arisen due to the fact that junior staff have moved to more senior posts in the community and it is hoped that the creation of a

more senior staffing profile in the inpatient wards will address this issue. Mrs Harney also spoke of the active engagement/ co-production/workshops with ward managers and front line staff to seek their views on support systems to maximise workforce recruitment and retention within Bluestone, making it an attractive place to work. Mrs Trouton provided some examples of actions that are being actively progressed with the Executive Director of Nursing/AHPs professional team input. The Chair asked if there was recognition at Department level that insufficient numbers of nurses were being trained to which Mrs Trouton advised that the Trust continues to work with the Department to influence an increase to the supply of registered nurses with an increase of 200 places across nursing and midwifery since 2016. Mrs McCartan asked if the pay award for 2018/19 would assist in attracting people to nursing. Mrs Toal stated that from a pay award point of view, Northern Ireland is still behind the rest of the UK, particularly in relation to nursing pay scales. Ms Mullan referred to the continued pressures across various sections of the workforce and the increasing cost of the flexible workforce and raised the need for a broader Northern Ireland skills agenda for the public sector.

5. REFLECTION ON BOARD DEVELOPMENT DAY

Members individually reflected on the Board Development Day held on 15th November 2018. All agreed this was a useful day and particularly valued the time out together to get to know one another and to think and develop ideas together. The input from the King's Fund on the use of dialogue techniques for conversation and creating a culture of collaboration, co-production and learning was also welcomed. Mrs Toal stated that the Board Development Day was a starting point and the next Board workshop would focus on Board values and behaviours.

6. SHSCT MID-YEAR ACCOUNTABILITY MEETING – JANUARY 2019

Members were advised that the Trust's Mid Year Ground Clearing meeting had taken place on 22nd November 2018 and there were no

issues that required to be escalated to the Chair and Chief Executive's Mid Year Accountability meeting with the Permanent Secretary on 10th January 2019. Members discussed and agreed agenda items they would like raised at the meeting on 10th January 2019.

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 24th January 2019
Title:	Bluestone/Dorsy Workforce Update
Lead Director:	Barney McNeany Director of Mental Health and Disability
Corporate Objective:	• Promoting safe, high quality care • Making the best use of resources • Supporting people and communities to live healthy lives & improve their health and wellbeing • Being a great place to work, valuing our people
Purpose:	Information

Summary of Key Issues for Trust Board

Context:

- Service and bed flow pressures within all Acute MH in-patient units across the region are long-standing and remain on-going.
- Following escalation of long-standing Trust's concerns a regional review, led by HSCB/PHA, has been commissioned for completion by 31st March 2019.
- All Trusts are experiencing difficulties recruiting and retaining registered MH and LD registered nurses, most keenly experienced in Southern Trust in-patient mental health facilities.
- Escalation to SMT in July 2018 resulted in plans to address the workforce issues and bed flow issues within Bluestone and Dorsy.

Over the **short term** the capacity of workforce has been enhanced through:-

- Use of overtime
- Redeployment of MH staff involved in elective casework.
- Use of agency staff from England.
- Securing agreement of **HSCB/PHA** to develop a
- business case to address the underlying deficits

Key issues/risks for discussion:

- There is no regional sign off or identified funding stream for '*Delivering Care'* Phase 5 for **MH** in-patient units.
- Workforce demand for **MH & LD** will continue to outstrip supply from the training institutions over the next 3 years.
- IPT investments in other much needed services in **MH & LD** are likely to attract staff away from In-Patient wards.
- Following the Trust's escalation to **DoH** seeking priority for a normative staffing analysis, '*Delivering Care'* for **LD** in-patient units is now to commence regionally.
- Trust concerns were formally escalated to **DOH** for an urgent decision regarding the normative staffing investment for **MH**.
- We have plans awaiting approval to implement ***e-Roster*** in **MH & LD** to better support resource allocation.

Summary of SMT challenge/discussion:

The workforce position is consistently changing and the workforce need is dynamic.

Bluestone has recruited 18 new registrants, proportionate to the numbers trained regionally. However we continue to lose staff to retirement, promotion, and to new posts, internal and external to ST, better suited to staff's work life balance. Agency staff from England, together with use of bank staff and overtime, has eased our staffing pressures. This has allowed the 9.0WTE staff per week redirected from Elective PMHC and Support and Recovery community services to return to their substantive posts. This was proving unsustainable due to an increase in urgent referrals and waiting lists, and the impact on Service Users.

Proposed action is:-

- Continue to use agency staff for period- 1st December 2108-31st March 2019 to provide a sufficient WF and to facilitate our community staff returning to their community teams. Anticipated Cost is £235,719 an application has been made through transformation slippage to offset this.
- We have moved to uplift 17 x Band 5s to Band 6 (E-Reqs in progress) using the available MH non ring-fenced budget allocation (cost 150K) to create a more senior profile on the in-patient wards improving consistent access to senior decision making to support safe and effective care. Uplifts will provide an attractive career progression route retaining

staff both within the unit and from our community services.

- Following the Trust meeting with HSCB/PHA in Dec 2018 a detailed Business case is required to use our existing Mental Health allocation to work towards normative staffing levels.
- Continue engagement exercises with permanent staff, staff side representatives and agency/bank personnel to identify improvements.
- Keep focus on these actions through the Director's oversight group and leadership walkarounds.

Human Rights/Equality:

SMT approval will support an equitable approach for SHSCT service users and staff.

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

Minutes of a confidential meeting of Trust Board held on Thursday, 24th January 2019 at 9.30 a.m. in the Boardroom, Trust Headquarters, Craigavon

PRESENT

Mrs R Brownlee, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Interim Executive Director of Nursing & Allied Health Professionals

IN ATTENDANCE

Mrs E Gishkori, Director of Acute Services
Mrs M McClements, Director of Older People and Primary Care Services
Mr B McNeany, Director of Mental Health and Disability Services
Mrs A Magwood, Director of Performance and Reform
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mr J Wilkinson, Non-Executive Director
Dr M O'Kane, Medical Director (Dr Shahid Tariq deputising)

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting, particularly Mr Barney McNeany to his first formal Trust Board meeting. The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. **CHAIR'S BUSINESS**

The Chair reminded members of the 15 minute reflection session at the end of the public section of the Trust Board meeting.

4. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held on 29th November 2018 were agreed as an accurate record and duly signed by the Chair.

5. **MATTERS ARISING**

i) **Bluestone and Dorsy Workforce Action Plan**

Mr McNeany spoke to the progress update and advised that medium and long term actions are in place and monitored by the Directors' Oversight Group. Mr McNeany referred to the workforce pressures and in response to a question on the use of agency staff, he advised that the agency staff secured from England, together with use of bank staff and overtime, has eased the staffing pressure on the Acute Wards and had allowed community staff to return to their community teams. The plan is to continue to use agency staff to 31st March 2019 to provide a sufficient workforce. Members noted the continued engagement exercises with permanent staff, staff side representatives and agency/bank personnel to identify improvements.

ii) **SHSCT Mid-Year Accountability Meeting**

Members were advised that the Trust's Accountability meeting with the Permanent Secretary had been postponed from 10th January 2019. This has been re-arranged for 27th February 2019 and an update will be provided at the next confidential Trust Board meeting.

6. **EU EXIT PLANNING**

The Chair welcomed Dr T Boyce, Mrs L Gordon and Mr S Gibson to the meeting. The Chief Executive noted the fluid situation and advised that the message from the Department of Health in December 2018 was to plan for a No Deal Exit and align activity with normal business continuity arrangements. Members were advised of the risks to the delivery of health in the areas of workforce, medication, supplies of goods and services and cross border emergency preparedness and the preventative and mitigation plans in place. Operational Directorates are considering remaining residual risks. The Trust has completed a self-assessment template scoping the issues/risks and this was shared with members.

Members welcomed the comprehensive update which provided assurance on the Trust's preparedness plans for a No Deal Exit and commended all staff involved in this work.

7. **NEWRY COMMUNITY TREATMENT AND CARE CENTRE (CTCC)**

Ms Charlene Stoops, Project Director and Ms Caroline Brown, Programme Manager, HSCB, were welcomed to the meeting to update members on the current position regarding the development of the Newry CTCC. Members noted that planning approval remains outstanding and while some adjustment on the programme can mitigate, delays at this stage have impacted on the planned completion dates by approximately 2-3 months moving planning completion from Summer 2021 to Autumn 2021. Formal approval of a final business case by Trust Board for submission to the DOH is planned for 28th March 2019.

The Chair reminded members that following discussion at the Trust Board meeting in October 2018, it was agreed that given the time delays from Outline Business Case, there was a need to review and assure that the service model agreed remains fit for the future and will support the Trust's wider strategic and transformation agenda.
To that end, Ms Stoops and Ms Brown reminded members of the service model and updated on the project risks, timelines and future approvals as well as an overview of the contractual arrangements.

Members discussed the fact that GP commitment still remains a risk for the project due to a number of financial and contractual issues which are outside the Trust's control. 3 GP practices have indicated their interest in relocating to Newry CTCC. Members were advised that the HSCB are discussing options with Newry & District GP Federation and the Department of Health has agreed to consider an options paper prior to final business case submission. Mr McDonald asked if the options considered the potential for a comprehensive development scheme with a negotiated agreement with GPs to relocate to the CTCC to which Ms Stoops advised that options for this could only be looked at by the preferred bidder from a commercial perspective and that the procurement process for Newry CTCC involved only 3 of the practices.

Ms McCartan raised the impact of the absence of a Minister and functioning Assembly as well as ensuring Value for Money and the right service model is in place. Ms O'Neill provided assurance that a Value for Money assessment was undertaken and included at the original business case approval stage. Ministerial direction is for revenue budgetary treatment and the Trust will ensure that best value for money is obtained for the revenue spend on an annual basis.

At the request of the Chair, Mr McNeany left the meeting for Item 8.

8. FEEDBACK FROM REMUNERATION COMMITTEE

The Chair advised that the Remuneration Committee had met earlier that day to consider the starting salary of Mr McNeany, Director of Mental Health and Disability. It was the recommendation of the

Remuneration Committee that McNeany would receive a 10% increase on existing earnings in keeping with Senior Executive Pay and Grading Scheme guidance.

Trust Board approved the recommendation of the Remuneration Committee.

Mr McNeany returned to the meeting at this point.

The meeting concluded at 10. 50 a.m.

SIGNED: _____

DATED: _____

Building a progressive Inpatient Mental Health Service

Trust Board (Confidential)

March 28th 2019

Southern Health and Social Care Trust

Quality Care - for you, with you

Background

- The Trust currently provides in-patient Mental Health services at:

Bluestone Unit on the Craigavon Area Hospital site;

- Adult and older age mental health care;
- Psychiatric Intensive Care Unit;
- Dorsy Unit, Learning Disability Inpatient care.

Gillis Unit, St Luke's Hospital site, Armagh

- Dementia Assessment Unit

Background

- The Trust is committed to working with staff to provide a progressive, sustainable mental health in-patient service
- Service modernisation is needed to meet the increasing challenges facing the service
- Increasing levels of complex patients require an effective, sustainable service with an enhanced multi-disciplinary approach

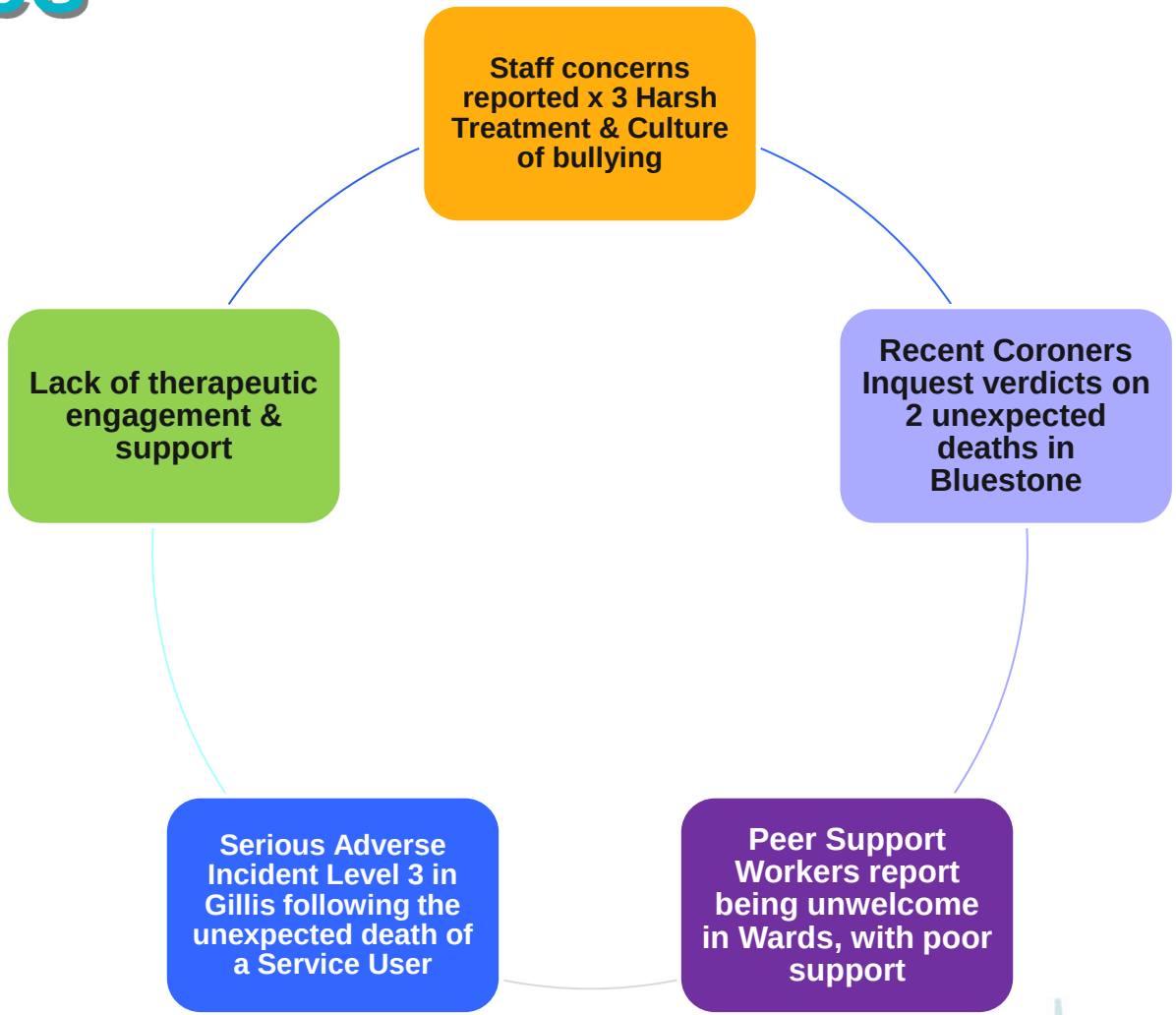
HSC Southern Health and Social Care Trust

Issues

- The Trust has identified a number of issues which require a co-ordinated, systematic review

- The Trust is seeking assurance as to the safety and effectiveness of the service and therefore has initiated the Royal College of Psychiatrists 'Invited Review' service.

Issues



HSC Southern Health and Social Care Trust

Royal College of Psychiatrists 'Invited Review' Service

- RCoP will carry out an Invited Review
- The Invited Review service is commonly used within the NHS
- An external review is part of the Board Assurance Framework
- Process is supported by the Department of Health
- It is a positive opportunity to shape services which will meet needs of our patients in future

Terms of Reference

- Review the culture within **in-patient** mental health services in the Southern Health and Social Care Trust.
- Make recommendations that will have a positive impact on staff and patient culture in Mental Health In-Patient Services. Recommend and identify effective models of care and identify practice that needs improvement and specific challenges faced by these services.
- Using NHS national benchmarking, Royal College of Psychiatrists Centre for Quality Improvement and other patient safety standards, make recommendations on the optimal use of existing resources, specifically identifying a multi-disciplinary model of care aligned to these standards and benchmarks.
- To review existing leadership culture and structures and make recommendations for how these may change to ensure the delivery of safe, compassionate, effective, high quality services to meet the needs of the population in the Southern Trust including any anticipated demographic shifts.

HSC Southern Health and Social Care Trust

Invited Review

- The review team will be on site from April 8th to April 12th
- They will review records; meet staff, patients, carers and independent advocates; and present recommendations for service modernisation
- It is likely to take three months and the outcome will be reported back to Trust Board

Southern Health and Social Care Trust

Southern Health and Social Care Trust

Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 28th March 2019 at 9.30 a.m. in Dromantine Retreat & Conference Centre, Newry

PRESENT

Mrs R Brownlee, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Dr M O'Kane, Medical Director
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Interim Executive Director of Nursing & Allied Health Professionals

IN ATTENDANCE

Mrs E Gishkori, Director of Acute Services
Mrs M McClements, Director of Older People and Primary Care Services
Mr B McNeany, Director of Mental Health and Disability Services
Mrs A Magwood, Director of Performance and Reform
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs J McKimm, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

None

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting, particularly Dr O'Kane to her first formal Trust Board meeting. The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. In relation to agenda item 6, Dr O'Kane declared an interest in the Royal College of Psychiatrists Invited Review Scheme, but is not involved in this instance.

3. **CHAIR'S BUSINESS**

The Chair reminded members of the 15 minute reflection session at the end of the public section of the Trust Board meeting.

4. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held on 24th January 2019 were agreed as an accurate record and duly signed by the Chair.

5. **EU EXIT PLANNING**

The Chair welcomed Mrs L Gordon and Ms Teresa Cunningham to the meeting. The Chief Executive noted the fluid situation and stated that the Trust continues to plan for a No Deal EU Exit and align activity with normal business continuity arrangements. He referred members to the document in their papers (DoH EU Exit Operational Readiness Guidance) which provides detail of the operational arrangements now in place across NI and the actions all organisations are expected to take. The Chief Executive advised that the Southern Trust is in line with these arrangements.

Mrs Gordon outlined the steps taken to inform staff and Ms Cunningham spoke of the arrangements within the Trust for emergency planning and stated that in the event they would be required, situation reports would be provided from a central point within the Trust for onward circulation to regional colleagues.

Members discussed the significant amount of staff time spent on planning and preparing for a no deal exit and commended all staff involved in this work.

6. ROYAL COLLEGE OF PSYCHIATRISTS INVITED REVIEW

The Chief Executive spoke of the Invited Review process the Trust is intending to undertake with the Royal College of Psychiatrists in April 2019 to look at the in-patient mental health service and potential improvement plans.

Mr McNeany explained the background to the review which he stated would provide further independent assurance as to the safety and effectiveness of the service. The Invited Review will consider the existing service model and present recommendations for service modernisation. The invited review is likely to take three months and the outcomes will be reported to Trust Board in August 2019.

Members discussed the Terms of Reference and particularly the review of culture within the in-patient mental health service. They welcomed the direction of travel and the Trust's open and transparent approach to this work. Communication with staff about the review was raised to which Mr Neany explained that a communication plan was in place and staff were being spoken to that morning. Mrs Toal stated that she felt sufficient supports have been built into the process to respond to any concerns and to provide assurance.

7. SH&SCT MID-YEAR ACCOUNTABILITY MEETING

The Chair and Chief Executive verbally reported on the meeting which took place on 27th February 2019. They advised that this was a good meeting with the Permanent Secretary recognizing the Trust's indication of a breakeven position by the end of the financial year and acknowledging the hard work and good financial stewardship to get to

that position. The financial position 2019/2020 and capitation were also discussed. Final minutes will be shared with members, once available.

8. **ANY OTHER BUSINESS**

Mr Morgan spoke of the recent tragic event in Cookstown and verbally updated on the Trust's involvement and support being provided.

SIGNED: _____

DATED: _____

DRAFT

Southern Health and Social Care Trust

Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 29th August 2019 at 9.45 a.m. in the Bronte Conference Room, Banbridge Health and Care Centre

PRESENT

Mrs R Brownlee, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Dr M O'Kane, Medical Director
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Interim Executive Director of Nursing & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Mr D Douglas, Assistant Director, Children and Young People's Services *(for Mr Morgan)*
Mrs M McClements, Interim Director of Acute Services
Mr B McNeany, Director of Mental Health and Disability Services
Mrs A Magwood, Director of Performance and Reform
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)
Mrs P Keenan, Boardroom Apprentice
Ms C Ramsay, QUB Mentee, CPANI Public Board Mentoring Scheme

APOLOGIES

Mrs S Rooney, Non-Executive Director
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Mrs E Gishkori, Director of Acute Services

1. **‘BEING OPEN’ – WHERE DOES THIS START? - THE BOARDROOM**

The Chair welcomed Mr Peter McBride, Chair, Being Open Sub Group under Worksteam 1 – Duty of Candour of the Inquiry into Hyponatraemia Related Deaths (IHRD).

Mr McBride welcomed the opportunity to attend the meeting and set the scene by asking members the question – ‘How are you going to change the culture of the Trust to be more open?’

Mr McBride referred to the O’Hara report and the recommendation to further embed a ‘being open’ culture alongside a statutory duty of Candour to be enacted in Northern Ireland. He stated that whilst there are many examples of changes in culture within the HSC system, there is still work to be done. The challenges with the forthcoming legislation were highlighted particularly what action can now be taken to create a more open and transparent system in which people feel safe and incentivised to be open.

The need for a consistent approach across each of the Trusts was acknowledged. Mr McBride spoke of the importance of policies and procedures to create a framework to incentivise rather than de-incentivise where there is support and protection for staff and that there is learning when things go wrong. He emphasized that governance and leadership are critical.

Ms Ramsay asked how success would be measured to which Mr McBride acknowledged the challenge of this for Boards as there will be a responsibility on Trusts to measure this. As a Board, members need to reassure themselves confidently that the Trust is a candid and open organisation. In response to a question from Ms Ramsay, Mr McBride advised that they had been looking at other organisations, both nationally and internationally, and he cited some interesting learning from the rest of the UK around the organisational Duty of Candour.

Ms Mullan referred to policies and procedures and asked that given that individuals all work differently, how would organisations make openness a way of working for everyone. Mr McBride acknowledged that policies and procedures are only part of the solution and whilst

explicit guidance is important, support and training will also be required to ensure a culture of greater openness. He spoke of Board members as role models and that how as a Trust Board, members behave and react, sets the tone of the organisation.

The Chief Executive asked how the Board assures that it is genuine and champions openness. He stated that there is work to be done for Board members, as senior leaders, to develop confidence to work in a more open way. Mrs Toal spoke of the power of staff and service user stories and highlighted the challenge of how to bring policies and procedures to life. Mr McBride advised that one area of feedback from staff was about creating a culture that allows more reflective practice.

Mr Wilkinson asked how to get the message out that openness pays off. This is an issue discussed at 'See something, say something' and using staff and service user stories to get the message across.

Mr McBride stated that the first reaction to introducing a statutory Duty of Candour was that it was seen as punishment for not being open whereas cultural change will happen when people are incentivised to be open. He acknowledged that finding a way to be explicit about the organisation's culture is challenging and suggested describing it in personal terms.

Mr McDonald acknowledged that impetus needs to come from the Board. He suggested that being open needs to be part of the handbook for NEDs. Mr McBride stated that in his view, openness is the filter and members should look at what they do through the lens of openness.

The Chair thanked Mr McBride for a thought provoking discussion and introduction to 'being open'. She referred to the HSC values presentation at the open section of the meeting and spoke of the Board's commitment to this work.

2. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting. The Chair particularly welcomed back Mrs McCartan following her recent knee surgery.

On behalf of Board members, [redacted]

The Chair also welcomed Ms Colette Ramsay and Mrs Paula Keenan, Boardroom Apprentice, to the meeting.

The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

3. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

4. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting held on 23rd May 2019 were agreed as an accurate record and duly signed by the Chair.

5. MATTERS ARISING

i) Update on [redacted]

A short update was included in members' papers. Mr McNeany advised that following the last Trust Board meeting, Counsel has now been identified to take forward the work and it is hoped to have Counsel's Opinion in the early Autumn. He noted that DLS queried the need for such an opinion and have r[redacted]

The Chief Executive informed members of further correspondence between the Home Owners and himself and stated that has not altered the position. In response to a question from Ms Donaghy, the Chief Executive advised that the Trust would be responding to the recent correspondence and he agreed to share this with members. Ms Donaghy spoke of the length of time for this matter to be resolved, to which the Chief Executive advised that this matter was not within the gift of the Trust to resolve, but within the Home Owners. Ms Donaghy raised the fact that the Trust has met with

RQIA to discuss both the on-going and outstanding safeguarding issues and a further meeting is planned. Both Ms Donaghy and Mr Wilkinson asked if the RQIA had ongoing safeguarding issues. Mr McNeany referred to legal action by RQIA at one point, but advised that this had been withdrawn. The Chief Executive stated that it was important to stress that the Trust is the commissioner of the service and therefore has a statutory duty to ensure that the service meets the requirements in its contract with the Trust. RQIA is responsible for the inspection regime which is separate.

The Chair confirmed that updates to Trust Board are only required when there is significant changes which require Board oversight.

ii) **Building a progressive Inpatient Mental Health Service**

Mr McNeany reminded members of the terms of reference of the Royal College of Psychiatrists Invited Review. He spoke to the key findings and reported that a total of 52 recommendations were made grouped across 8 specific areas which the Trust's action plan is focused on. In relation to reporting on progress against the recommendations to Trust Board, Mr McNeany explained that the Reviewer will re-visit the Trust in November 2019. He agreed to continue to update Trust Board with regard to progress.

Mr Wilkinson noted that one of the Terms of Reference of the Review was to make recommendations that will have a positive impact on staff and patient culture in Mental Health In-Patient Services. He asked to what extent were service users involved in the initial discussions with the Review Team and how will they be involved in implementing this recommendation. Mr McNeany advised that the Invited Review had met with service users directly and had also asked to meet independent advocates. The Trust's Mental Health Forum had facilitated this. In response to a question from Mrs McCartan as to whether additional resources would be required to implement the recommendations, Mr McNeany advised that significant investment in Bluestone will be required and a revised Investment Proposal Template (IPT), based on the Royal College Recommendations with regard to skill mix and enhancing the multi-disciplinary team, is nearing completion and funding has been identified to meet the enhanced costs.

He added, however, that workforce will continue to present a particular challenge as it is doing across all of Mental Health in Northern Ireland.

6. **INTERIM FINANCIAL STRATEGY – POST INDICATIVE ALLOCATIONS 2019/20**

Ms O'Neill spoke to a paper which informed Trust Board of the initial impact of indicative allocations for 2019/20 and identified the next steps required. She sought Trust Board approval of the Interim Financial Strategy and approval to set an unbalanced budget in the interim to facilitate appropriate stewardship and accountability of resources.

Ms O'Neill advised of an overall regional funding gap of £64.5m, £52.6m to be addressed by Trusts of which £1.2m has been applied to the Southern Trust, £1.1m of which is pharmacy prescribing. She reported that for the third consecutive financial year the Trust has been successful in negotiating out a share of the regional recurrent cash releasing efficiency target, this would have been another £7m savings requirement for the Trust, (£21m over 3 years). After taking into account the opening gap, new and emerging pressures, estimated expenditure requirements for 2019/20 and all income streams, the maximum funding gap to be addressed is £6.6m. Ms O'Neill stated that measures of £3.6m had been identified, this includes pharmacy prescribing measures and natural slippage on some full year allocations, leaving an unresolved gap of a maximum of £3m. Ms O'Neill stated that she was pleased to report that a further £0.5m has now been negotiated and with the figures for auto-enrolment now further refined, the unresolved gap was now £2m. This will be the first response to the Trust Delivery Plan which includes £800k for independent sector domiciliary care increase.

Ms O'Neill advised that following Trust Board approval in principle to the interim resource budget, the proposal was to now release an interim budget to all budget holders to the maximum of the funding currently available. This will facilitate robust stewardship, accountability and is best practice.

Mrs McCartan welcomed the Interim Financial Strategy and the indicative allocations. She congratulated the Trust on the additional funding support secured.

Trust Board approved the Interim Financial Strategy and the Interim Resource Budget for 2019/20

Finance Report

Ms O'Neill presented the Finance Report for the four months ending 31st July 2019. She stated that the current deficit was £1.3m and, given that this was an agreed interim budget, the overspend expected was c £600k. She explained that two main issues causing the variance were transformation and continued unscheduled care pressures. In response to a question from Mrs McCartan, the Chief Executive advised that further detail on winter plans would be brought to Trust Board with the focus for this year being on ambulatory care.

Ms O'Neill advised that the finance report would continue to be reported to the confidential section of the meeting until the TDP was approved.

7. **INDEPENDENT SAI REVIEW INTO THE CIRCUMSTANCES WHICH RESULTED IN THE DEATH OF** Personal Information redacted by the USI.

The Chief Executive advised that the Independent Review Panel has issued their final report which was shared with the Trust and the family in July 2019. Subsequent to the issue of the report, the Personal Information redacted by the USI family met with the Permanent Secretary who issued an unreserved apology on behalf of the HSC and the Chief Executive met with the family the previous week. The Chief Executive referred members to the Executive Summary included in their papers and stated that Trust Board are asked to note the recommendations which are both at a system wide level, and specific to individual Trusts. He further advised that a regional programme of work will be developed to begin to address the recommendations, with appropriate local structures being developed.

The Chief Executive stated that it was important to emphasis the impact on staff involved in this case and support continues to be provided to them. He noted that the Personal Information redacted by the USI family are very involved

to ensure that there is learning and steps put in place to improve services. Mr McNeany stated that a number of changes have already been made within the Trust and work has started and will continue with other agencies to ensure a collaborative approach.

8. **MINUTES OF SH&SCT MID-YEAR ACCOUNTABILITY MEETING HELD ON 3rd JULY 2019**

The minutes of the meeting held on 3rd July 2019 were noted. The Chair advised that this was a positive meeting, chaired by the Permanent Secretary, with open and honest discussion.

At the Chair's request, Mr B Beattie left the meeting for the next item

9. **FEEDBACK FROM REMUNERATION COMMITTEE**

The Chair advised that the Remuneration Committee had met on 12th June 2019 to consider the starting salary of Mr B Beattie as Interim Director of Older People and Primary Care Services. The Chair sought Trust Board retrospective approval of the Remuneration Committee's recommendation to apply a 10% uplift to Mr Beattie's salary on his commencement as Interim Director of Older People and Primary Care Services.

Trust Board approved the Remuneration Committee's recommendation.

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust

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BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 26th September 2019
Title:	Update Bluestone, Dorsy & Gillis Royal College of Psychiatrists' Review
Lead Director:	Mr Barney McNeany Director Mental Health and Disability
Purpose:	For assurance/information

Key strategic aims:

- To provide safe and effective Mental Health In-patient care

Key issues/risks for discussion:

External Assurance

SMT has received the Royal College of Psychiatrists Invited Review Service report which provides additional independent external assurance into In-Patient Mental Health Services in Bluestone/Dorsy & Gillis Units.

Summary of SMTdiscussion:

- SMT discussed Trust Board's request to provide a more detailed report identifying the key findings and recommendations and how these will be implemented.

Human Rights/Equality:

There are none identified.

Southern Health and Social Care Trust

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BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 30th January 2020
Title:	Update Bluestone, Dorsy & Gillis Royal College of Psychiatrists' Review
Lead Director:	Mr Barney McNeany Director Mental Health and Disability
Purpose:	for assurance/information

Key strategic aims:

- To provide safe and effective Mental Health In-patient care

Key issues/risks for discussion:

External Assurance

Trust Board has received the Royal College of Psychiatrists Invited Review Service report which provides additional independent external assurance into In-Patient Mental Health Services in Bluestone/Dorsy & Gillis Units.

Attached is the Division's Action Plan which brings together the recommendations of the RCPsych Invited Review Report, RQIA inspection reports and internal work arising from the work-streams being overseen by the Director's Oversight Group, by way of an update on progress for information and assurance.

Summary of SMTdiscussion:

- SMT asked that Bluestone's performance with regard to NHS Benchmarking is noted at Trust Board by way of a Verbal update from the Director, to include an update on the Patient Safety Thermometer.

Human Rights/Equality:

There are none identified.

Bluestone Action Plan: Jan 2020 Update

This report is given a RAG status as follows:

Priority

Priority 1: 0-6 months
Priority 2: 6-12 months
Priority 3: Greater than 12 months.

RAG	**No of objectives in each area**
White - Completed	**4**
Green – In progress and **on track**	**33**
Amber – In progress / outside timeframe	**3**
Red – **Stalled and outside timeframe**	**1**
Blue – Not yet commenced.	**9**

Theme	**Actions**	**Update**	**Priority (1, 2, 3)***
1. Culture	1a. Complete the 2nd group of Caring Cultures and present outcomes.	Complete. Presented to Director MHD and EDN. A 'Better You, Better Care' event was held to celebrate outcomes from the Caring Cultures work in November	Complete