this. Mrs Leeson welcomed the comprehensive paper and further service user/community partner evaluation work. In terms of the 3-5 day delivery target, the Chair stated it was important to monitor this closely along with the additional emergency cost.

Mr Knipe queried Mrs McClements earlier comments regarding the £2.00 per item redemption fee and clarified how the current voucher scheme operated. The Chair thanked Mr Knipe and all those who had speaking rights for their input into the meeting.

The Chair referred members to page 7 of the document, and stated that in light of discussion, Trust Board approval is sought to proceed with the following, subject to further evaluation work undertaken within a 6 period.

- Implementation of the Hybrid service model as described
- Negotiation of a small uplift to the voucher redemption fee per item within affordability levels and
- Rationalisation of the number of items currently provided through the community equipment service voucher scheme

The Board approved the Community Equipment Service – Hybrid Service Model subject to a 6-month evaluation being undertaken (ST900/19)

ii) Summary of Capital & Revenue Proposals in excess of £300,000 (ST901/19)

Mrs Magwood presented the summary of proposals with a capital/revenue value in excess of £300,000 that have been developed between 27th September 2018 and 24th January 2019. As in previous reports each project has a risk management process in place to identify and seek to manage / mitigate any impact on successful delivery of the investments proposed. Mrs Magwood advised this paper includes reference to a number of revenue proposals developed in response to the Confidence and Supply Transformation Fund.

Mrs Rooney referred to page 4 of the document and the business case for the Neurology Non-Contract Specialist Assessment Service. Mrs Rooney declared an interest in this item as Vice Chair of the Northern Ireland Neurological Charities Alliance.

Speaking Rights

The Chair welcomed Michelle Gildernew, MP, Sinn Fein, to address the meeting.

At the outset, Ms Gildernew thanked the Chair for the opportunity to address the meeting on Oakridge Day Centre. She advised she had rasied her concerns in the past with the Chief Executive, stating the facility was not fit for purpose and would not meet today's Health and Safety standards. Ms Gildernew also drew member's attention to the impact on both parents and children leaving Sperrin View Special School and transitioning to Oakridge Day Care Centre. She praised the staff at Oakridge, however emphasised the need for urgent replacement of the current building.

Ms Gildernew acknowledged a previous outline business case had been approved by the Department of Health in 2015 however she noted disappointment that no funding had been identified to move the project forward. Ms Gildernew welcomed the updated Business Case and Option 4, for the replacement of Oakridge Day Centre on the Drumglass site, Dungannon, for adults presenting with a learning disability and associated conditions. The Chair assured Ms Gildernew the Trust has worked hard to progress the revised Business Case to this stage. Mrs Magwood commended all staff involved and stated the next stage will be submission of the business case to the Department of Health for approval. The Chief Executive reiterated the Chair's comments and advised that the Trust Senior Management Team (SMT) have reviewed all the needs to provide person centred services to individuals and ensure safety, quality of care and dignity are delivered.

The Board approved the Summary of Capital & Revenue Proposals in excess of £300,000 (ST901/19)

iii) Trust Procurement Strategy 2018-2021 (ST902/19) and Trust Procurement Board Annual Report 2017/18

Trust Procurement Strategy 2018-2021

Ms O'Neill presented the Trust Procurement Strategy for approval and explained the document is a 3 year rolling plan, the purpose of which is to outline the key aims and objectives which should be applied by the Trust in addressing a range of key procurement issues. The requirement to have a Trust procurement strategy is documented both in the Standing Financial Instructions of the Trust and the DoH circular HSC(F) 22/2018.

The strategy is linked to the regional Strategic Procurement Plan.

Members considered the document and welcomed the content.

The Board approved the Trust Procurement Strategy 2018-2021 (ST902/19).

Trust Procurement Board Annual Report 2017/18

Ms O'Neill presented the above-named Annual Report for information and pointed out the report demonstrates procurement activity undertaken during the financial year ended 31 March 2018. In terms of future reporting, Ms O'Neill advised that in line with the Trust's strategic aims and objectives for Procurement, the Trust Procurement Board will report annually to Trust Board via the Audit Committee. Members welcome the content of the report and the work undertaken in year.

9. OPERATIONAL PERFORMANCE

i) Performance Report (ST903/19)

Mrs Magwood presented the Performance report for approval, demonstrating December 2018 performance and reporting against 2018/19 Commissioning Plan Directive Objectives and Goals for Improvement.

Members considered the performance Dashboard and discussion ensued. In response to a question from Mrs McCartan on the impact of the 18 medical beds on performance, Mrs Gishkori advised members the unit was working well and in light of increased ED attendance the beds provide much needed additional admission capacity and this has had a direct impact on 4 and 12 hour performance in CAH.

In light of media coverage around antimicrobial resistance, the Chair raised Antibiotic usage. Mrs Magwood referred to the new performance trajectory around antibiotic consumption and prescribing and stated the Trust was above the baseline target in a number of areas. She assured members actions were being taken forward to address gaps including the addition of staff to the Antimicrobial Stewardship (AMS) team which should enhance stewardship in this area.

Ms Donaghy noted concern at the number of patients waiting for scanning and imaging and highlighted in particular those waiting beyond their clinically indicated timescale for a planned Endoscopy repeat procedure.

Mrs Magwood pointed out the challenges around training specialist nurses, however she advised that additional in-year recurrent funding has assisted to provide additional in-house and independent sector capacity.
Mrs McCartan referred to the longest wait in terms of inpatient and day case waits within Urology at 257 weeks. Members recognised challenges within Urology regionally. Mrs Magwood assured members controls are in place to review and manage lengthening access times.
The Chair referred to the challenges within Psychological Therapies where recruitment and retention issues continue to impact capacity. The Chief Executive advised that the current model is not fit for purpose and there is no funding allocated in year by HSCB to facilitate additionality from the independent sector in this area. Mr McNeany stated that an internal review of Psychological Therapies has been agreed to be undertaken in Quarter 4 of 2018/19 to deliver a strategic framework for the Trust. In addition, Mr McNeany advised that work remains ongoing regionally in terms of workforce issues and parity with other regional models. The Chair highlighted the increasing challenge of patients presenting with early onset dementia and the lack of funding for this cohort.

In response to the Chair, Mrs Magwood highlighted improvements in some areas. Ms Mullan referred to the workforce challenges and asked if a whole system approach could be taken to alleviate the pressures. The Chief Executive welcomed the publication of the regional Workforce Strategy and spoke from an internal perspective of work to make the organisation an attractive place to work. It was agreed that the regional workforce strategy would be circulated to Trust Board members.

The Board approved the Performance Report (ST903/19)

ii) Finance Report (ST904/19)

Ms O'Neill spoke to the above named report and advised the cumulative outturn at month 9 is a deficit of £1.223m however she noted movement in-month with a surplus of £107k recorded.

Members considered the areas of overspend causing most concern as at month 9 December 2018. Ms O'Neill emphasised the need for all Directors to continue to review their current expenditure trends now and identify areas for potential cost containment/reduction to ensure that the current overspend is returned to balance. Members noted that when compared to December 2017 figures, the Trust is currently paying for an additional 375 WTE's.

Ms Donaghy referred to the stagnant position in terms of full time recruitment and asked whether the Trust have increased the use of non-contracted staff to ensure staff and patients stay safe. Mrs Giskori alluded to the increasing need for 1:1 patient care and ensuring safe rotas. Ms O'Neill pointed out the Organisation has experienced an increase in spend year on year, however some of this will be offset by winter resilience money. The Chair asked about prompt payments. In responding Ms O'Neill welcomed the 1.9% improvement on November performance, however she alluded to an expected dip in performance in January due to the Christmas and New Year holiday period.

Ms O'Neill advised the Trust continue to forecast break-even position at financial year end. The Chair welcomed this and thanked Ms O'Neill for providing a detailed report.

The Board approved the Finance Report (ST904/19)

iii) Human Resources Report (ST905/19)

Mrs Toal presented the Human Resources Report which outlines key workforce productivity information including staffing levels, sickness absence, flexible workforce costs and Agency/Bank Usage. Mrs Toal advised the quarterly update on recruitment will be included within the HR report in March 2019.

In terms of increasing levels of sickness, Mrs Toal updated on the work being taken forward to address the issue by both the employee relations and health and wellbeing teams. Furthermore members noted a review of Occupational Health was scheduled for discussion at a future Senior Management Team (SMT) meeting. Mrs Toal acknowledged the increased levels however, reminded members the Southern Trust remains the lowest in terms of cumulative sickness absence when compared across the region.

Discussion ensued around flexible costs and members welcomed a pilot undertaken with the Emergency Department (ED) resulting in a reduction in the number of locums required. Mrs Toal emphasised the need to explore taking this way of working forward into other areas and also encourage the transition of flexible staff to permanent staff. Members noted rostering work was being taken forward along with the Acting Director of Nursing to look at decreasing the use of locum and agency spend.

Mrs Toal referred to International recruitment and advised that Dr O'Kane and herself, had a positive meeting with the contracted agency for medical recruitment and 4 doctors are close to commencement. In response to a question from the Chair, Mrs Toal advised the 4 posts will be in place by 1 April 2019.

Action – Chief Executive

Ms O'Neill left the meeting at this point

10. PRESENTATION:

Research and Development Annual Report 2017/18 (ST906/19)

The Chair welcomed Dr Sharpe, Associate Medical Director for Research and Development (R&D) and Dr Arava, Consultant Anaesthetist, to the meeting along with Miss Knox, Research Manager. By way of introduction, Dr Tariq commended the work undertaken by the R&D team within the Trust and emphasised the importance of ensuring this work continues to be properly resourced and research staff encouraged to undertake innovative studies within the Trust.

At this point, Dr Arava updated members on the area of research he had been involved with along with Dr Alison Blair on the development of an important Clinical Trial with Ultrasound guided PECS II Block for breast surgery – an audit of quality of post-operative analgesia. Members welcomed the pilot audit project undertaken in advance of the research study and agreed this work showcases an excellent example of research undertaken with relatively modest financial support.

Dr Sharpe spoke to the remainder of the presentation. He outlined the main elements of the Annual Report and particularly highlighted the achievements accomplished over the past year. Members noted the Trust had received 48 research applications for the period, a slight decrease on 2016/17 when 57 applications were received. Dr Sharpe referred to the R&D key priorities for 2018/19.

At this point, the Chief Executive asked how the Trust turns innovative research into practice/products. In responding Dr Sharpe advised that the Trust seek advice on patenting and Universities offer assistance with product development. He went on to advise that ABC Council is keen to progress further education and working in partnership with the private sector to pursue commercialisation of research innovations.

At this point Mrs Rooney, Chair of the Endowments and Gifts Committee referred to the reduced 2016/17 allocation of Charitable Funds for R&D. She assured Dr Sharpe the Endowments and Gifts (E&G) Committee remain committed to supporting R&D and are currently working with the 4 Directorate wide Fund Managers to scope historical funds with specific elements to research.

In conclusion, Dr Sharpe emphasized the importance of continuing to pursue funding opportunities at all levels to support research within the Trust and also the need to explore 'protected time' for staff to progress innovative research studies. Mr Gibson stated he would bring this to the attention of the Medical Director following the meeting.

The Chair commended the R&D Department and their work and assured Dr Sharpe of the Trust Board's continued support for the various initiatives being taken forward.

The Board approved the Research and Development Annual Report 2017/18 (ST906/19)

11. BOARD COMMITTEES

i) Governance Committee

- **Minutes of meeting held on 6th September 2018 (ST907/19)**

Ms Mullan presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the meeting held on 6th September 2018 (ST907/19)

- **Key issues from the meeting held on 6th September 2018**

Ms Mullan advised of the key issues raised at the meeting held on 6th September 2018.

ii) Patient & Client Experience Committee

- **Minutes of meeting held on 20th September 2018 (ST908/19)**

Mr Wilkinson presented the Minutes of the meeting for approval and highlighted the key discussion points.

The Board approved the Minutes of the meeting held on 20th September 2018 (ST908/19)

- **Key issues from the meeting held on 11th December 2018**

Mr Wilkinson advised of the key issues raised at the meeting held on 11th December 2018.

12. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Unallocated Child Care Cases

Mr Morgan spoke to the above named report, advising a total of 104 unallocated cases as at 31st December 2018, a disappointing increase on the previous reporting period (28th September), when 93 unallocated cases were reported. Mr Morgan advised the growth in the number of Looked After Children (LAC) along with a significant spike in referrals for October and November had attributed to the rise in unallocated cases. Members were assured action has been taken to mitigate risks and strengthen the system with Team Managers reviewing unallocated cases waiting 6 weeks and Assistant Directors reviewing those waiting over 8 weeks.

For the period under review, there were no unallocated cases within Gateway and no Child Protection issues not being investigated. Mr Morgan advised it was important to note that at the end of October 2018 the Southern Trust were the best performing Trust regionally with 82 unallocated cases. In conclusion, Mr Morgan updated members in terms of ongoing work with IT software PARIS in regards to exploring the capture of live data to ensure patients receive a service in a timely matter. In response to a question from Ms Donaghy on sick leave not covered, Mr Morgan advised his Directorate was the best performing in terms of sickness leave and clarified that this refers to short periods of sickness.

ii) HCAI Report

Dr Tariq presented the HCAI report and members considered the detail. Mrs Trouton pointed out there has been an increase in MRSA bacteraemia cases with 3 noted in December 2018, the first this financial year. The Root Cause Analysis (RCA) is complete and 2 of the 3 cases have been identified as not preventable. For the same period there have been 30 C. difficile cases within the Trust and 38 MSSA bacteraemia, 10 of which have been identified as preventable.

The Chair referred to the Trust's recently launched 3 year IPC Strategy and stated she would expect to see progress and sustained improvement in HCAI incidence as key elements become embedded across the organisation. Mrs Trouton advised that good work continues in terms of hand hygiene compliance. The Chief Executive referred to page 10 of the report and pointed out the improvement in terms of Medical compliance.

Mrs Rooney asked if staff have a difficulty assessing IPC training and education. Mrs Trouton acknowledged the day to day pressures on staff time, however she assured members staff are encouraged to take time out to complete this essential training.

iii) Executive Director of Nursing

Mrs Trouton presented the above named report which provides a summary of the activity and developments within the Nursing and Midwifery and AHP professions since last reported to Trust Board in September 2018. She highlighted the key elements within the report focusing on i) Workforce issues including recruitment and retention of staff, ii) the impact of Transformation projects on AHP workforce and iii) Midwifery services in the future.

The Chair welcomed the most recent Band 5 Recruitment Day held in December 2018 and its combined approach seeking nursing recruits from adult, mental health, learning disability and CAHMS services. She asked how many of the 159 posts offered took up positions within the Trust. Mrs Trouton agreed to provide a breakdown however she explained that it would be sometime before a firm position was available as a number of posts were offered to 2nd year students.

Action – Mrs Trouton

Members discussed staff retention and the importance of ensuring nursing and AHP staff feel supported in their practice. Ms Donaghy referred to the gaps in formal supervision across Acute and Transitional Care services and asked about the associated risk. In responding Mrs Trouton referred to the pressures in unscheduled care and the associated impact on formal 1:1 supervision. She assured members informal supervision is taking place however recognised the gaps in terms of recording formal documentation.

Mrs Trouton confirmed that she expects the remaining 5% of NMC nursing registrants to revalidate by the end of the first cycle in March 2019.

13. PROPOSED MEETING DATES 2019

The Chair presented revised meeting dates for both formal Trust Board meetings and Directors' Workshop's for the calendar year 2019. Members approved the revised dates.

The Board approved the proposed meeting dates for 2019 (ST909/19)

14. APPLICATION OF TRUST SEAL

Ms O'Neill 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 (ST910/19)

15. ANY OTHER BUSINESS

The Chair asked each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles. Mr Morgan updated members on round table discussions regarding the Welfare Reform and the associated impact on the Southern Trust. Mr Morgan advised he would provide a summary paper to a future Trust Board meeting.

Action – Mr Morgan

At this point Mrs Toal reminded members of the upcoming Charity Gala Ball and thanked all those attending for their support.

The meeting concluded at 3.45 p.m.

SIGNED: _____ DATED: _____

Southern Health and Social Care Trust

Quality Care - for you, with you

Minutes of a Trust Board meeting held in public on Thursday, 23rd May 2019 at 11.30 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
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
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
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 C Cassells, Assistant Director, Financial Management
Mrs J McKimm, Head of Communications
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary (Minutes)

APOLOGIES

Apologies were recorded from Mrs McCartan, Non-Executive Director and Mr Wilkinson, Non-Executive Director.

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting and in particular Mrs Carol Cassells, Assistant Director of Finance and Financial Management, deputising for the first part of the meeting for Ms O'Neill, Director of Finance, Procurement and Estates Services. At this point members were reminded of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/iPads are used for accessing Board papers only during the meeting.

The Chair was pleased to welcome five members of Trust staff from the Nursing and Allied Health Professionals (AHPs) Directorate, including Ms Ferguson, Assistant Director of Nursing (Workforce and Education) and stated that she would welcome their feedback in terms of what they will learn at today's meeting and how they take this learning back to their colleagues.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest noted.

3. CHAIR'S BUSINESS AND VISITS INCLUDING NON-EXECUTIVE DIRECTORS' BUSINESS AND VISITS

The Chair drew members' attention to her written report detailing events she 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 noted.

4. CHIEF EXECUTIVE'S BUSINESS AND VISITS

The Chief Executive presented his summary report. At a local level, he referred in particular to the recent Northern Ireland Audit Office (NIAO) report on Locum Doctors highlighting the continued reliance regionally on locum doctors provided via agency. He assured members the Trust continue to take a proactive approach to stabilising the workforce. The Chief Executive went on to speak about the Department of Health (DoH) consultations on proposals to reshape stroke care and breast assessment services. He pointed out both consultations had been extended until 19th July 2019 and a series of public engagement events have been planned for June 2019.

At this point, the Chief Executive highlighted alcohol and obesity as being among a number of factors that can have longer term effects on the populations health and wellbeing. He emphasised that addressing these issues will impact the future direction of health care and advised he had been working collaboratively with a number of other Trusts on this. Mrs McClements referred to the success of the Daisy Hill Pathfinder Project in terms of developing health care and achieving the right model through co-production. She stated this framework would form a good basis for the Trust to move health and wellbeing forward in a strategic way. Mr McDonald welcomed the evidence of a new transformational approach to health care in the future.

5. MINUTES OF MEETING HELD ON 28TH MARCH 2019

The minutes of the meeting held on 28th March 2019 were agreed as an accurate record and duly signed by the Chair.

The Board approved the minutes of the meeting held on 28th March 2019.

6. MATTERS ARISING FROM PREVIOUS MEETINGS

Members noted the progress updates from the relevant Directors to issues raised at the previous meetings.

7. STRATEGIC

i) PRESENTATION: NEW BUILD ASEPTIC UNIT AT CRAIGAVON AREA HOSPITAL

The Chair welcomed Dr Boyce, Director of Pharmacy and Mrs Waddell, Head of Acute Planning to the meeting to present the New Build Aseptic Unit at Craigavon Area Hospital (CAH). By way of introduction, Mrs Magwood referred to a number of staff involved in the project including those from planning, pharmacy and estates and commended their professionalism and hard work on achieving such an excellent outcome.

Dr Boyce began by explaining Aseptic dispensing. Mrs Waddell guided members through the progress of the project and spoke of its benefits including good clinical adjacencies, additional capacity, improved staff morale and enhanced quality of patient care. Mrs Waddell stated delivery of the project had presented challenges and learning would be shared with departmental Construction and Procurement Delivery (CPD)

colleagues. Mrs Gishkori very much welcomed the new facility and advised there were a number of dates Non-Executive Director colleagues could visit prior to the unit becoming operational in June 2019.

In conclusion, the Chief Executive commended all staff involved in the project and advised he had recently visited the new Aseptic Unit and alluded to the immense difference it will make to ensuring staff are valued in their work space. Members noted improvement works will now be considered within the Pharmacy division. The Chair thanked Dr Boyce and Mrs Waddell for their informative presentation.

8. OPERATIONAL PERFORMANCE

i) Performance Report (ST926/19)

Mrs Magwood presented the report and reminded members that in the absence of a draft Commissioning Plan Direction (CPD) for 2019/20 the Trust continues to monitor performance against the Objectives and Goals for Improvement (OGI) set out in 2018/19. Members noted the assessment set out in the corporate scorecard reflects that made by the Trust via the Trust Delivery Plan (TDP) and demonstrates the anticipated level of performance to be achieved/not achieved by March 2019.

At the outset of discussion, the Chair advised that performance reporting had been part of the recent Internal Audit Review of Board Effectiveness and this would be further discussed at the forthcoming Board Workshop on 13th June 2019.

Mrs Leeson referred to the internal review of Psychological Therapies and stated she felt the core issue for the increase in long patient waits is the shortage of trained Psychologists along with challenges in terms of workforce retention. The Chair referenced the recent review of bandings for a number of posts during early 2018/19 and asked if this had not assisted in bringing the Trust more in line with regional counterparts as an 'employer of choice'. Mr McNeany alluded to significant challenges in that all Trusts are recruiting from the same pool where resources are limited due to a relatively small number of training places.

Ms Donaghy welcomed the funding for additional AHP elective capacity to manage review assessments and asked if these patients are fast tracked for treatment. Mrs Gishkori advised that all urgent cases are fast tracked however review assessments are classed as routine. Mrs Magwood advised the Trust has a range of bids with the HSCB at present for additionality to address the issues.

The Chair referred to the longest waits for assessment within Speech and Language Therapy (SLT) and asked about the assessment/review process as well as, how patients are communicated with in terms of waiting lists. In responding, Mrs McClements explained the process from initial referral and the crucial role played by GP's. She went on to outline the communication lines for urgent cases and those whose symptoms have changed. Mrs Gishkori assured members the Trust engage with key stakeholders regularly and work is ongoing collaboratively within the Acute and Primary Care Directorates to address priority areas for staffing. Mrs Trouton referred to the level of vacancies across AHPs and updated members on a piece of internal Trust work being undertaken at present by Mrs Harney. She went on to state that it has been proposed that a regional AHP recruitment campaign be progressed across England and the Republic of Ireland (ROI) as part of the AHP Regional Workforce Review Implementation plan with the support of the Strategic Resourcing Innovation Forum. However the Trust anticipates recruiting prior to this through the internal mini-campaign.

In response to a question from the Chair on the impact of funding in respect of patient waits, the Chief Executive alluded to the challenges for the Trust in terms of identifying the greatest need balanced with limited resources. Mrs Magwood stated the SMT had taken a risk based approach to patient waits aimed at targeting red flag and urgent referrals in the absence of non-recurrent funding.

Mr McDonald referred to page 8 and raised concern at patients within Adult Mental Health waiting longer than 9 weeks to access Eating Disorder Services. Mr McNeany spoke about the increase in the number of referrals and stated along with vacancies and long term staff absences the service continues to be challenged; however he advised work remains ongoing to expand capacity.

Members noted 78% of carers assessments offered in the quarter of December 2018 had declined and asked what is being done to improve? Mr McNeany advised that the Trust is piloting the 'Carers Conversation Wheel', as an alternative to the NISAT Carers Needs and Support Plan. This is easier to use and feedback from staff and carers is very positive.

Mrs Rooney asked about Diagnostics and challenged on the 84 week longest wait for an echocardiogram. Dr O'Kane advised that this is being addressed.

In drawing discussion to a conclusion the Chair raised the large number of areas within the Corporate Dashboard assessed as red. The Chief Executive referred to Table 1, which sets out a summary of areas where performance is assessed as better than anticipated. He highlighted in particular the challenge on elective and stated it will take a significant financial commitment to deliver green, however he emphasised the Trust must deliver on those targets/indicators assessed as achievable.

The Board approved the Performance Report (ST926/19)

9. BOARD COMMITTEES

i) Endowments & Gifts Committee

- **Minutes of meetings held on 28th January 2019 (ST927/19) and 25th March 2019 (ST928/19)**

Mrs Rooney presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of meetings held on 28th January 2019 (ST927/19) and 25th March 2019 (ST928/19)

- **Committee Terms of Reference (ST929/19)**

The Revised Terms of Reference were presented for approval.

The Board approved the revised Terms of Reference (ST929/19)

- **Committee Work Programme 2019 (ST930/19)**

Mrs Rooney presented the Committee Work Programme 2019 for approval.

The Board approved the Committee Work Programme 2019 (ST930/19)

ii) Audit Committee

- **Minutes of meetings held on 14th February 2019 (ST931/19) and 11th April 2019 (ST932/19)**

Mr McDonald presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the meetings held on 14th February 2019 (ST931/19) and 11th April 2019 (ST932/19)

– **Reports from meetings held on 11th April 2019 and 9th May 2019**

Mr McDonald presented written reports from the meetings held on 11th April and 9th May 2019 for consideration.

10. DAO (DOF) 03/19: PARTNERSHIPS BETWEEN DEPARTMENTS AND ARM'S LENGTH BODIES: NI CODE OF GOOD PRACTICE

The Chief Executive spoke to the Departmental circular and accompanying 'Partnerships between Departments and Arm's Length Bodies': NI Code of Good Practice. He welcomed the document in terms of setting out how Arms' Length Bodies can work in a collaborative way and also as a good framework on how we build relationships with the DoH. The Chair advised members would have another opportunity to consider the NI Code of Good Practice at the Directors' Workshop in June 2019.

11. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Draft Annual Report on the Discharge of Delegated Statutory Functions and Corporate Parenting Report 2018/19 (ST933/19)

Mr Morgan, Executive Director of Social Work, presented the above-named report for approval. Mr Morgan reminded members of the responsibility the Trust holds as a Corporate Parent and spoke about the importance of considering the document from a strategic perspective particularly in terms of capacity and demand issues and recruitment/skill mix. At this point, Mr Morgan pointed out the 6 monthly Corporate Parenting Report for October 2018 – March 2019 will be included on the agenda for approval at the next meeting on 13th June 2019.

Mr Morgan introduced Ms F Leyden, Assistant Director of Social Work Governance, Workforce Development and Training and Ms K Lavery, Head of Social Work and Social Care Governance. Ms Lavery took members through the detail of the report which includes the Southern Local Adult Safeguarding Partnership (LASP) Annual Report. Ms Lavery spoke of the breadth of information reported across all

Directorates and she highlighted the key areas of challenge, namely i) workforce demands, ii) domiciliary care services, iii) staff recruitment/retention and iv) increased referrals.

Discussion ensued in which Mr McDonald raised the lack of commissioning pathway for those under 65 with dementia and asked how Trust Board could influence this. In responding, Mr McNeany advised a regional group is in place taking forward work on the overall dementia pathway, however there is now recognition from within the DoH that this cohort of patients is growing and progress should move forward through the regional forum. At local level, Mr McNeany advised the Trust has finalised planning to implement services for those diagnosed with early onset dementia, however members were reminded funds will be drawn from the annual budgetary allocation. Mrs Magwood advised the Trust continue to meet with the Commissioner on the matter.

Ms Mullan welcomed the support provided by both Disability and Mental Health services with PIP (DLA) applications and asked how this would be sustained going forward. Mr McNeany stated that this has placed additional pressures on teams who do not have the capacity to provide this much needed support. The key challenge is workforce and he advised of his intention to bring a paper to SMT specifically on the social work workforce within mental health and disability services. He also highlighted the potential of the voluntary sector to assist in providing bespoke welfare rights advice.

Under Adult Learning Disability, Mrs Rooney highlighted the increase and complexity of calls to the Crisis Response Service and asked if there has been any progress in terms of addressing the associated risks presenting as a result of alcohol/drug (dual diagnosis) related incidents. Mr McNeany advised that the DoH have requested a review of Learning Disability model across all 5 Trusts will a new/revised regional model to be completed and costed by 2020.

Mrs Leeson referred to the Children and Young People's Services Programme of Care. She welcomed the detail within the report and the good Governance arrangements around social work. Mrs Leeson asked about post adoption support services funded through Transformation monies and also Children with Disabilities (CwD), an area which is grossly under-funded. In responding, Mr Morgan emphasised the importance of support mechanisms and referred to the very successful 'Home in Time' project and pointed out that post adoption process, ongoing needs require recurrent funding. Members noted that

Transformational funding will cease in March 2020 however, the Chief Executive assured members that the Trust continues to lobby regionally for recurrent funding. Internally, work is ongoing in relation to identifying funding opportunities to secure much required services post March 2020. Mr Morgan spoke of the development of a CwD Strategy.

The Chief Executive noted that bureaucracy was a key thread running through the report and asked if the value of the investment in PARIS for example has been eroded by the time commitment required to use it. Ms Leyden referred to a number of ICT systems on top of paper based forms which create a huge burden for staff. She referred to a number of ongoing initiatives seeking to address this, including the regional review of Understanding the Needs of Children in Northern Ireland (UNOCINI), along with internal mechanisms including workarounds to avoid recording duplication. Ms Leyden spoke about the importance of a more relationship built approach into the future to ensure ongoing improvement of services provided to children and their families and she stated a 20% increase in uptake of carers assessments has been evidenced over the past few months.

In regards the area of Adult Physical and Sensory Disability, the Chair asked a number of questions on behalf of Mr Wilkinson. She began by referring to page 80 and enquired about pressure on the social work supervision structure, asking how the issues were being addressed. In responding, Mr McNeany acknowledged the pressure on social work supervision when team leaders are from other professional backgrounds. He pointed to the importance of ensuring a strong team complement of social workers in mental health and disability and advised a number of social work team leader posts have been created. Mr McNeany emphasised the need for a rebalancing of the workforce in community teams to better reflect this need.

The Chair referred to page 81, annual service user audits and asked how these are managed and if results can be fed into the Patient Client Experience Committee. Members were advised that across the Physical Disability teams the Annual service user audit was completed and feedback positive. Issues raised have been taken forward. Mr McNeany emphasised the need to integrate feedback into the locality. Mr Morgan advised that within Children and Young People's Services, learning from audits is taken forward through the social work governance forum.

The Chair raised the scarce Psychology input within Community Physical Disability teams. In responding, Mr McNeany stated that whilst the Trust has invested in Adult Learning and Sensory Disability

Services, he acknowledged the benefit additional Psychology input would bring to Community Physical Disability teams. Mr McNeany noted however the relative scarcity of Psychologists which is limited to the number of training places.

Members noted the Local Adult Safeguarding Partnership Annual Report 2018/19. This demonstrates the work which is being undertaken by the SHSCT and its partners in delivering a high quality Adult Safeguarding Service.
In conclusion, the Chair thanked Ms Leyden and Ms Lavery for a very informative presentation and extended her appreciation to all staff involved in the compilation of this report.

The Board approved the Draft Annual Report on the Discharge of Delegated Statutory Functions and Corporate Parenting Report 2018/19 (ST933/19)

ii) Unallocated Child Care Cases

Mr Morgan spoke to the above named report and advised a total of 60 unallocated cases as at 30 April 2019, a significant decrease on the previous reporting period (30 December), when 104 unallocated cases were reported. Members welcomed the improved position. Mr Morgan stated analysis would indicate the highest trend in unallocated cases is within CwD. Mr McDonald referred to the last Audit Committee meeting on 9th May 2019 and advised the Internal Audit Report on the Management of CwD had highlighted significant delays in the timescales for processing of UNOCINI referrals to the service. He stated members were assured that of the 30 referrals tested, lessons learned will be taken forward. A sample of other cases not in the audit will also be reviewed. Members welcomed the work underway to address the issues.

iii) HCAI Report

Dr O'Kane presented the HCAI report and advised that 2019/20 year to date (May 2019), there has been 1 case of MRSA bacteraemia however, for the same period there have been 8 C. difficile cases within the Trust and 6 MSSA bacteraemia, 1 of which has been identified as preventable. Dr O'Kane reminded members HCAI PfA targets for 2019/20 have not yet been confirmed by the DoH, therefore 2018/19 targets will be used until a new target is agreed. Dr O'Kane referred to the disappointing spike in C. difficile cases, however pointed out the cases do not appear to be linked. She went on to advise Dr Damani,

Clinical Director of Infection Prevention and Control has agreed to work with the team in the continued implementation of the IPC Strategy and along with work ongoing regionally Dr O'Kane stated she would envisage improvement into the future.

The Chair asked about 'Bare below the Elbow' compliance with hand hygiene. Mrs Trouton said the message should be clear to staff, who must comply with the dress code policy and IPCT independent audit results are fed back to Operational Directors for corrective action on a monthly basis. In response to a question from the Chair on hand hygiene compliance in the Community setting, Mrs McClements stated she would check if activity audits were available and update members at a future meeting.

Action – Mrs McClements

In conclusion, Dr O'Kane advised that hand hygiene is communicated effectively through IPC nurses, however continued observation and challenge by Ward managers is essential. Members welcomed the clear and concise update provided.

iv) RQIA Review of Governance of outpatient services – early findings of safeguarding

The Chief Executive referred to the recent RQIA Review of Governance of Outpatient Services conducted within the Belfast Trust and stated the outcome had identified emerging learning relevant for all Trusts. In light of this, members noted the DoH had issued correspondence asking each Trust to review the current position of their outpatient departments/services with regard to safeguarding, focusing on a number of specific areas. Mr Morgan stated he had commenced some initial work in this regard across a number of disciplines and once feedback has been collated a report will be compiled and presented to Trust Board.

Action – Mr Morgan

12. ANY OTHER BUSINESS

The Chair asked each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles. There were no issues to report.

The Chair advised that Mrs Rooney's Non-Executive Director term has been extended by the Public Appointments Office/DoH for one year, to 28th August 2020. The Chair stated she was pleased the Trust will continue to benefit from Mrs Rooney's expertise in the months ahead.

The meeting concluded at 3.00 p.m.

SIGNED: _____ DATED: _____

Southern Health and Social Care Trust

Quality Care - for you, with you

Minutes of a Trust Board meeting held in public on Thursday, 29th August 2019 at 11.30 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 of Children and Young Peoples Services *(for Mr P 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
Mrs P Keenan, Boardroom Apprentice
Ms C Ramsey, QUB Mentee, CPANI Public Board Mentoring Scheme
Mrs S McCormick, Committee Secretary (Minutes)

APOLOGIES

Apologies were recorded from Mrs S Rooney, Non-Executive Director, Mrs E Gishkori, Director of Acute Services and Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work.

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting and in particular Mr B Beattie in his role as acting Director of Older People and Primary Care and Mr D Douglas, Assistant Director of Children and Young People's Services, deputising for Mr P Morgan. The Chair also welcomed back Mrs H McCartan, Non-Executive Director, following her recent surgery. At this point, members were reminded of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/iPads are used for accessing Board papers only during the meeting.

The Chair was pleased to welcome seven members of Trust staff from the Human Resources and Organisational Development Directorate, including Ms M Williamson, Deputy Director of Human Resources – Workforce and Organisational Development and stated that she would welcome their feedback in terms of what they will learn at today's meeting and how they take this learning back to their colleagues.

The Chair also welcomed and introduced Mrs P Keenan, Boardroom Apprentice programme and Ms C Ramsey who is undertaking the Queen's University Post Graduate School Joint Mentoring Scheme in conjunction with the Commissioner for Public Appointments NI.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest noted.

3. PRESENTATION: 'HSC VALUES'

The Chair welcomed Mrs M Williamson to the meeting to present the new "HSC Values": i) Working Together, ii) Compassion, iii) Excellence and iv) Openness and Honesty. By way of introduction, Mrs Toal set the scene and advised that Board members will already be familiar with these having spent some time developing a set a Board behaviours aligned to the new values. Mrs Toal outlined that the core theme running through these values and behaviours is "Every Contact Matters".

At this point, Mrs Williamson asked members to think about what the values really mean for them individually, as a Trust Board team and as an organisation and she emphasised the challenge in how these are embedded in everyday practice. She stated that behaviours provide a

guide for how individuals bring their values to life and define how they are expected to approach their work. Mrs Williamson pointed out these values and behaviours send a clear message to patients, service users, families and carers about the care and support they should expect and how this should be delivered and highlighted to members the cost of getting it wrong.

Mrs Williamson continued by outlining the plans for communicating and embedding the HSC values and behaviours across the Trust and the importance of seeing cultural change implemented. The Chair welcomed this work and stated it was a good basis for further discussion by Trust Board at its Board Development Day in November 2019.

Discussion ensued and Ms Mullan highlighted the importance of introducing these values/behaviours at the beginning i.e. the recruitment stage. Mrs Toal advised that a regional working group has been set up to look at embedding the new values/behaviours across the system in terms of values based recruitment. Mr McDonald referred to Mr McBride's comments earlier in the morning on 'Openness' and taking this forward with each other and our service users. He emphasised the importance of being more explicit into the future and how training sends out a clear message. Mr Wilkinson asked if the Trust could demonstrate through policies and procedures that these values/behaviours are core to the function of the organisation and he referred in particular to the area of staff wellbeing. In speaking from a Human Resources perspective, Mrs Toal acknowledged significant work ahead in terms of re-thinking current policies and procedures to allow the new values/behaviours to embed and create a new culture.

The Chair welcomed the helpful presentation delivered by Mrs Williamson and stated the Chief Executive along with the Trust Senior Management Team (SMT) will be progressing this work and members will have opportunity for further discussion into the future.

In conclusion, Mrs Williamson advised that a number of informal drop in sessions with 'hard to reach staff', have been arranged for the incoming week, to raise awareness about the HSC Values and added this was an excellent opportunity to engage with this cohort of staff. Members welcomed this and it was agreed dates would be circulated to Trust Board members following the meeting.

4. CHAIR'S BUSINESS AND VISITS INCLUDING NON-EXECUTIVE DIRECTORS' BUSINESS AND VISITS

The Chair drew members' attention to her written report detailing events she had attended since the previous meeting, together with details of some good news stories and innovative work across the Trust. She welcomed the quality outcomes detailed within the report. A list of Non-Executive Directors' business and visits was noted.

5. CHIEF EXECUTIVE'S BUSINESS AND VISITS

The Chief Executive presented his summary report. At local level, he referred in particular to the Royal College of Nursing (RCN) decision to ballot its members on strike action over pay and "unsafe" staffing levels. Negotiations between the Union and Department of Health (DoH) have taken place in regards to seeing members' wages brought into line with their NHS counterparts. The Chief Executive went on to welcome the Southern Trust's Acute hospital network success, after being named among the top 40 hospitals in the UK. He added that the award showcases the Trust's achievements in healthcare quality, improvement and performance.

6. MINUTES OF MEETINGS HELD ON 23RD MAY AND 12TH JUNE 2019

The minutes of meetings held on 23rd May and 12th June 2019 were agreed as an accurate record and duly signed by the Chair.

The Board approved the minutes of meetings held on 23rd May and 12th June 2019.

7. MATTERS ARISING FROM PREVIOUS MEETINGS

Members noted the progress updates from the relevant Directors to issues raised at the previous meetings.

8. STRATEGIC

i) Royal College of Psychiatrists Invited Review

At the outset, the Chief Executive set the item in context and reminded members the Trust had recently undertaken an Invited Review process with the Royal College of Psychiatrists to look at the in-patient mental health service and potential improvement plans. He stated the review had considered the organisation's existing service model and presented

recommendations for service modernisation and improvement. Members noted that in response to the Invited Review Report, an Action Plan has been agreed to address the main recommendations and this has been shared with the Health and Social Care Board (HSCB). In addition, a number of other improvement approaches identified from staff engagement activities and service user feedback will be taken forward.

At this point, Mr McNeany updated members on progress post review. He stated work streams aligned to the recommendations are progressing, with a clear focus moving forward and work is underway along with Planning and Reform/Finance Directorates in terms of service development.

Ms Donaghy welcomed the additional independent external assurance into In-Patient Mental Health Services in Bluestone/Dorsy & Gillis Units provided through the Invited Review Report and particularly the commencement of the workforce plan. Mr McNeany reminded members workforce resources continue to be a challenge and stated consideration was being given to in-house training options and collaborative working with the Open University. Mr Wilkinson asked how the Trust will measure progress against the Review. Mr McNeany advised the Lead Reviewer will re-visit the Trust in 6 months and ongoing review of the Action Plan will be taken forward through the Directors Oversight group.

Mrs Trouton spoke to the nursing workforce supply issues and Mr Douglas updated around the shortage of trained social workers and options being explored to address this.

In concluding discussion, members welcomed the independent external assurance provided through the Invited Review Report and noted that further progress will be provided to Trust Board in a timely manner.

9. TRUST BOARD SCHEME OF DELEGATION TO COMMITTEES (ST948/19)

The Chair presented for approval the Trust Board Scheme of Delegation to Committees and reminded members this was an annual requirement in line with good governance practice. The Chair reminded members that the Trust Board is currently supported by 5 sub-committees to which it has delegated specific powers. Members noted and welcomed the proposed establishment of an additional Committee – a Performance Committee, the purpose of which will be to further improve the

effectiveness of the Board and strengthen the Trust's integrated governance structure.

The Chair drew attention to the inclusion of the powers to be delegated and exercised by the new Performance Committee. She stated that in light of this, the Trust Standing Orders will require update and this will be taken forward in 2019/20.

The Board approved the Trust Board Scheme of Delegation to Committees (ST948/19)

10. BOARD COMMITTEES

i) Performance Committee

- **Terms of Reference (ST949/19)**

At the outset the Chair reminded members of the ongoing work around performance monitoring and how Board performance reporting could be further improved. As a result, to enable a more dedicated focus on Trust Performance, a Performance Committee is to be established. The Committee will have appropriate delegated authority and clearly defined Terms of Reference.

Members discussed the Terms of Reference. Members raised the potential for duplication with the work of the other Board sub Committees. Mrs Magwood stated that a draft work plan will be agreed by the Committee at its first meeting and this will be kept under regular review. Ms Mullan welcomed the establishment of the Committee to explore performance in more detail and explore new ways of working. Mr McDonald sought assurance that the Committee had authority to identify key issues/risks for alerting Trust Board. The Chair confirmed that as a sub-committee of Trust Board the Performance Committee would report to Board level any significant issues of concern. This will be made explicit in the Terms of Reference. The Chair advised that the first meeting of the Performance Committee will take place in October 2019.

The Board approved the Committee Terms of Reference (ST949/19)

ii) Patient & Client Experience Committee

- **Minutes of meeting held on 7th March 2019 (ST950/19)**

Mr Wilkinson presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the meeting held on 7th March 2019 (ST950/19)

- **Feedback Report from meeting held on 13th June 2019**

Mr Wilkinson presented a written report from the meeting held on 13th June 2019 for consideration.

At this point, the Chief Executive updated members regarding the proposed new focus of the Patient and Client Experience Committee. In order to see improvement implemented, he advised that he had been discussing with Mr Wilkinson, Chair of Patient and Client Experience Committee and Mrs Trouton, Director for Patient and Client Experience, on the creation of a new post with responsibility for data collection.

- **Revised Terms of Reference (ST951/19)**

Mr Wilkinson presented the revised Terms of Reference for approval and advised that the Committee had endorsed same, at its meeting on 13th June 2019.

The Board approved the Terms of Reference of the Patient and Client Experience Committee (ST951/19)

11. OPERATIONAL PERFORMANCE

i) Performance Report

Mrs Magwood presented the report for information purposes. At the outset she advised the Trust has recently received the draft Commissioning Plan Direction (CPD) for 2019/20 from the Health and Social Care Board and a response is required to the plan via the Trust Delivery Plan (TDP) for 2019/20 by 4 October 2019. The TDP will make an assessment of the anticipated level of performance that can be achieved against each OGI, including 6 new objectives. In the interim the Trust will continue to report on the OGIs set out in 2018/2019.

Mrs Magwood stated the key risks continue to relate to increasing demand against capacity. She referenced performance against key areas including cancer pathway target, elective targets against diagnostic services, patient waits for review/intervention and new waits for first

assessment in mental health services. . Mrs Magwood emphasised patient waits will continue to grow in the absence of significant investment.

Mrs Magwood assured members that the Trust continues to lobby with the HSCB for additionality and currently this is being directed to Urgent and Red flag demand.

In relation to challenges against diagnostic reporting, Mrs Magwood stated the Trust continue to implement a skill mix approach including reporting radiographers, however she advised that the overall system is challenged in this area due to workforce constraints. The Chair asked about Psychological Therapies to which Mr McNeany spoke of the internal review and stated that whilst the number of Clinical Psychologists has improved, recruitment of this workforce remains a challenge.

Mrs Leeson referred to page 9 of the report and raised concern at the high number of carers' assessments that were declined (78%). Mr Beattie noted the 4,292 assessments offered and advised that, the service is now monitoring its ability to meet increased demand and ensure assessments completed. He also advised work is ongoing to address the matter through a regional group on which the Trust has representation. The Chief Executive reminded members with regards to the ongoing work across learning disability division, piloting the 'Carers Conversation Wheel'.

Ms Mullan noted the assurance re direction of capacity to Red Flag and Urgent demand in the first instance in light of ongoing reduced core and additional capacity. Mrs Magwood highlighted particular challenges such as the 62 day cancer target. Mrs McClements acknowledged disappointment at the cohort of patients waiting beyond the 62 day target and advised regarding a targeted piece of work being undertaken to address waits.

In response to a question from Mrs Keenan as to whether there is reporting at 3 month review against the breastfeeding target at 6 months, Mrs Magwood advised that this timeline aligns to the health visiting follow up but agreed to confirm if this information is available.

Action – Mrs Magwood

ii) Human Resources Report (ST952/19)

Mrs Toal presented the Human Resources Report which provides an update on the Trust's Health and Wellbeing agenda, specifically referring to the review and future of Occupational Health and Wellbeing Services and the work of the new Consultant Clinical Psychologist. The report also provides an update on resourcing pressures across both the Medical and Non-Medical workforce and outlines key workforce productivity information.

The Chair welcomed the appointment of Dr McGurk to the Trust as Consultant Clinical Psychologist and members duly noted the breadth of the role. Ms Mullan commended the report and asked if the Trust had evidenced the value of the additional post taken up by Dr McGurk and if it was being well received. In responding, Mrs Toal stated that initially work has been balanced between Health and Wellbeing promotion and supporting staff 'out with teams'. Early indications show staff are benefiting from 1:1 sessions. In terms of Children and Young People's Services, Mr Douglas updated on positive feedback from within the family intervention team and stated improvements have already been visible with staff on the ground, but that it was still very early days.

At the invitation of the Chair, Dr McGurk stated that the provision of the post has had an impact on productivity as a result of the support mechanisms now at the disposal of staff. The post brings with it meaningful change and enhances the Trust as a good place to work. Mrs Toal added the post is a live example of the changing strategic approach within the area of Occupational Health and Wellbeing.

Under workforce issues, Ms Mullan asked if the Trust was seeing a shift in light of the 56% drop in the number of bank staff providing ad hoc cover during June 2019. Mrs Toal advised this was the case as it was proving more and more difficult to fill shifts with bank staff due to the agency pay rates. Discussion ensued around the challenges regionally in terms of pay disparity. The Chair acknowledged workforce vacancies as a huge challenge right across Health and Social Care. She referred to the increasing number within Midwifery, asking if this was due to staff retirement and if the issue was discussed at the Transformation Implementation Group (TIG). She also highlighted the huge investment in International Recruitment which has not had the significant impact expected. In responding, Mrs Toal referred to the Workforce Strategy which looks at work to be done around training places, but that despite the additional investment, this was not coming in any way close to meeting the demands for a number of professions. At this point, Mrs

Keenan asked if staff trying to maintain a work life balance had any bearing on the high dependence on agency cover. Mrs Toal acknowledged there was an element of this amongst staff, as they could choose when they worked. She pointed out the Trust's ability to offer flexible working is exceptionally difficult in terms of ensuring unsocial hours shifts are covered from a service perspective.

The Chair welcomed the clear and concise update provided within the Report.

The Board approved the Human Resources Report (ST952/19)

12. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) HCAI Report

Dr O'Kane presented the item and advised that 2019/20 year to date (August 2019), there has been 2 cases of MRSA bacteraemia, both considered non-preventable. For the same period there have been 23 C. difficile cases within the Trust and also 22 MSSA bacteraemia, 2 of which have been identified as preventable. Dr O'Kane stated that while the Trust is within HCAI PfA targets for C. difficile and MRSA there has been a raise in the number of CDI incidence, with 23 cases recorded across clinical areas since the commencement of the financial year 2019/20. Dr O'Kane assured members the Infection Prevention Control (IPC) team have been engaging and supporting staff, patients and families to assist in preventing further incidence. The team continue to work with clinical staff to reinforce the importance of hand hygiene and commode audits.

Dr O'Kane updated on concerns relating to Antimicrobial resistance. She advised that Dr Boyce, Director of Pharmacy has been working to establish internal controls to reduce the use of antibiotics supported by detailed reporting.

Ms Mullan referred to hand hygiene compliance to which Dr O'Kane advised IPC nurses continue to effectively communicate the issue, however continued observation and challenge by Ward managers is essential.

The Chair asked about staffing within the IPC team. Mrs Trouton welcomed the supplemented senior role in place to alleviate pressure due to staff sickness over the summer months. She also updated on recruitment and development of the IPC team as a result of recent investment.

13) BOARD REPORTS

i) Functional Services Annual Report 2018/19 (ST953/19)

Mrs McClements presented the above named Annual Report which summarises the key achievements and issues across nine service areas. Key objectives for 2019/20 are also included within the report. She highlighted the four areas of service aligned to the Controls Assurance monitoring requirements and members noted the overall compliance recorded against each area.

Members welcomed the report. In response to a question from Ms Donaghy on an area within Decontamination Services, Mrs McClements provided assurance that the risk is logged on the Medicine and Unscheduled Care Divisional Risk Register, the equipment in question is being processed safely and compliant at an acceptable level. Staff training is planned for the Autumn. Ms Mullan referred to Security and very much welcomed the engagement process with staff teams and their input assisting in solutions across a number of areas and added she would like to see this developing further. Mrs McClements concurred with this important work headed up by Mrs A Carroll.

At this point, the Chair spoke of the vital role played by Domestic Services and in light of earlier discussion around HSC Values, she emphasised the necessity of ensuring staff feel appreciated within their role. Mrs Toal reminded members the informal drop in sessions with support staff arranged for the incoming week will be an excellent opportunity to engage with this cohort.

The Board approved the Functional Support Services Annual Report 2018/19 (ST953/19)

14) BOARD GOVERNANCE SELF-ASSESSMENT TOOL (ST954/19)

The Chair reminded members the tool had been extensively reviewed separately by herself and the Non-Executive Directors and the Chief Executive and the Senior Management Team and collectively discussed and agreed at a Directors' Workshop on 13th June 2019. Members agreed the RAG ratings applied.

The Board approved the Board Governance Self-Assessment Tool (ST954/19)

15i) PROPOSED MEETING DATES 2020 (ST955/19)

A list of proposed dates for meetings during 2020 was considered and agreed by members. The Chair advised that venues for these meetings will be confirmed in due course.

The Board approved the Meeting Dates 2019 (ST955/19)

15ii) TRUST BOARD ANNUAL PLAN OF BUSINESS 2020 (ST956/19)

The Chair presented for approval, the Trust Board Annual Plan of Business for the calendar year 2020.

The Chief Executive advised that the plan reflects work undertaken by Board members at a Directors' Workshop in October 2018 on effective Board reporting. He pointed out there are a number of statutory reports that are required to come to Trust Board, however through scoping, a number of other reports were identified that could be best addressed through an appropriate Board Sub Committee. The Chief Executive welcomed the Plan for 2020 and members noted sub-committee work plans will be developed and agreed in 2020 to include reports previously presented to Trust Board as appropriate.

The Board approved the Trust Board Annual Plan of Business 2020 (ST956/19)

16. APPLICATION OF TRUST SEAL (ST957/19)

Ms O'Neill sought approval for the Application of the Trust Seal to contract documentation as outlined in members' papers.

The Board approved the Application of Trust Seal (ST957/19)

17. ANY OTHER BUSINESS

The Chair asked each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles. From Children's and Young People's Services, Mr Douglas referred to a recent early alert and advised a PSNI investigation is ongoing.

At this point, Mr McNeany advised that the SMT had undertaken Zero Suicide Training in June 2019 and stated he would circulate the training link to Non-Executive Directors following the meeting. The Chair

welcomed this and reminded Non-Executive Directors of the wider on-line mandatory training requirements and asked each to ensure compliance.

In conclusion, the Chair reminded Trust Board members to remain at the end of the meeting for a time of reflection on the proceedings of the day.

The meeting concluded at 3.00 p.m.

SIGNED: _____ DATED: _____

Southern Health and Social Care Trust

Quality Care - for you, with you

Minutes of a Trust Board meeting held in public on Thursday, 30th January 2020 at 11.30 a.m. in The Egerton Room, Annaghmore Parish Centre

PRESENT

Mrs H McCartan, Non-Executive Director (deputising for the Chair, items 1-8)
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work (deputising for the Chief Executive)
Ms G Donaghy Non-Executive Director
Mrs P Leeson, 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 M O'Kane, Medical Director
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Interim Director of Acute Services
Mr B McNeany, Director of Mental Health and Disability Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mr B Beattie, Acting Director of Older People and Primary Care
Mrs J McKimm, Head of Communications
Mrs P Keenan, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary (Minutes)

APOLOGIES

Mrs R Brownlee, Chair (items 1-8)
Mr S Devlin, Chief Executive
Mrs E Gishkori, Director of Acute Services

1. CHAIR'S WELCOME

Mrs McCartan welcomed everyone to the meeting and congratulated Mrs Trouton on her recent appointment to the role of Executive Director of Nursing, Midwifery and AHPs. At this point members were reminded of the principles of Board meeting behaviours and asked that mobile phones are turned to silent and laptops / iPads are used for accessing Board papers only during the meeting.

At the outset, Mrs McCartan took the opportunity on behalf of the Trust Chair and Non-Executive Director colleagues, to thank the Chief Executive, Directors, their teams and staff across the Trust at all levels for their commitment, resilience, compassion and determination to continue to deliver safe and effective care to patients and service users across the Trust during these challenging times, particularly during the last two months. As a Non-Executive Director she stated it was a privilege to serve on a Trust Board with colleagues of this calibre.

On behalf of the Trust Chair and Trust Board, Mrs McCartan congratulated Health Minister Robin Swann on his recent appointment and stated that Trust Board members looked forward to meeting him when he visited the Trust on 18th February 2020.

At this point, Mrs McCartan was pleased to welcome five members of Trust staff from the Children's and Young People's Directorate and stated that she would welcome their feedback in terms of what they will learn at today's meeting and how they take this learning back to their colleagues.

2. DECLARATION OF INTERESTS

Mrs McCartan requested members to declare any potential conflicts of interest in relation to any matters on the agenda. Ms Mullan declared an interest in item 15 Boardroom Apprentice and stated that she and Mrs Keenan, Boardroom Apprentice, would leave the meeting for discussion on this item.

3. SERVICE IMPROVEMENT / LEARNING FROM SERVICE USER EXPERIENCE: SAFETY AND QUALITY IN CHILDREN AND YOUNG PEOPLE'S SERVICE

Mrs McCartan welcomed Dr Ahmed Khan, Associate Medical Director / Consultant Paediatrician to the meeting to present the work on safety and quality being undertaken across Children and Young People's Services.

At the outset, Mr Morgan thanked Dr Khan for his exceptional work and commitment to date and highlighted the need for additional resources to drive the Safety and Quality Strategy.

Dr Khan thanked members for the opportunity to highlight the number of initiatives that have taken place across the Children and Young People's Service. The Safety and Quality Newsletter and report for 2018 were included in members' papers.

Dr Khan guided members through his presentation that included the 'Journey So Far' detailing the two new Paediatric Centres. The Paediatric Centre includes an extensive ambulatory service. He spoke of the cardiac service available to patients which the Trust is the first Trust outside of Belfast to provide this service. Dr Khan highlighted the 6 key themes that explain basic safety awareness for everyone. He reported on the 'What Matters to You' events.

Dr Khan reminded members of the Paediatric Safety and Quality Strategy 2019 – 2024 and spoke of the staff engagement that was attended by multi-professional teams and their views and suggestions were incorporated into the strategy. Service Users, Parents and Carers were also invited to share their views.

Mrs McCartan thanked Dr Khan for the tremendous work that has been accomplished and asked when the Strategy will commence. Dr Khan advised the Strategy will be published in June 2020; however work has already begun to take the Strategy forward.

Mrs Magwood welcomed the strategy and spoke of the importance of aligning it with the Trust's Quality Improvement Strategy, Corporate Plan etc. Mrs McClements referred to the poster on slide 21 which advises the Strategy was built on three pillars; heart, hands and head and felt this approach could be up scaled up and used across the organisation. Dr Khan commented this is the intention and will discuss this further with Dr O'Kane. Dr Khan spoke of the support he has received from senior management and Mr Morgan to drive the strategy and culture of learning forward. He added that an additional resource of a Safety and Quality Officer would be beneficial and felt each Directorate should have this particular role to keep the momentum going.

In responding to a question asked by Mrs McCartan, Dr Khan stated the culture of learning was already embedded in the Children and Young People's Directorate and Dr O'Kane stated that the challenge was how to replicate this across the organisation.

Mrs Rooney congratulated Dr Khan and his team on producing the strategy and poster.

Dr Khan advised that the videos included in the presentation will be circulated to members after the meeting. In drawing discussion to a conclusion, Mrs McCartan thanked Dr Khan for his informative presentation.

4. CHAIR'S BUSINESS AND VISITS INCLUDING NON-EXECUTIVE DIRECTORS' BUSINESS AND VISITS

Mrs McCartan drew members' attention to the written report detailing events the Trust Chair 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 noted.

5. CHIEF EXECUTIVE'S BUSINESS AND VISITS

In the absence of the Chief Executive, Mr Morgan presented the Chief Executive's Business summary report. He referenced item 4.0 Suicide Prevention and stated the Health Minister has advised this is a top priority for him and his department. Dr O'Kane referred to item 18 on Coronavirus where the number of people infected with a new virus in China is increasing. She assured members the Trust is taking the situation very seriously.

6. MINUTES OF MEETING HELD ON 24th OCTOBER 2019

The minutes of the meeting held on 24th October 2019 were agreed as an accurate record and duly signed by the Chair.

The Board approved the minutes of the meeting held on 24th October 2019.

7. MATTERS ARISING FROM PREVIOUS MEETINGS

Members noted the progress updates from the relevant Directors to issues raised at the previous meetings. Mr Beattie advised a full update on the Community Equipment Hybrid model will be provided at the June 2020 meeting.

8. BOARD COMMITTEES

i) Performance Committee

- **Committee Chair Report from meeting held on 9th December 2019**
  Mrs Rooney presented the Committee Chair Report which demonstrated key issues raised at the meeting held on 9th December 2019.

- **Minutes of meeting held on 17th October 2019 (ST980/20)**
  Mrs Rooney presented the minutes for approval and highlighted the key discussion points.

  The Board approved the minutes of the meeting held on 17th October 2019 (ST980/20)

- **Revised Terms of Reference (ST981/20)**
  Mrs Rooney presented the revised Terms of Reference for approval.

  The Board approved the Revised Terms of Reference of the (ST981/20)

- **Committee Work Plan 2020 (ST982/20)**
  Mrs Rooney presented the Committee Work Plan 2020 for approval.

  The Board approved the Committee Work Plan 2020 (ST982/20)

  Ms Mullan stated that it was important to ensure there were clear lines between each of the Board Committees to avoid duplication of work and that the demarcation between governance and performance was clear. Mrs Rooney assured members that discussions about the differentiating factors between performance and governance had taken place at the Performance Committee and on that basis; the Committee set its terms of reference to ensure there was no duplication with the work of the Governance Committee.

  There was discussion on performance reporting. Mrs Magwood clarified that the corporate dashboard would continue to be circulated to Board members each month and discussed at each Performance Committee meeting.

ii) Governance Committee

- **Committee Chair Report from meeting held on 5th December 2019**

Mrs Rooney presented the Committee Chair Report which demonstrated key issues raised at the meeting held on 5th December 2019.

- **Minutes of meeting held on 5th September 2019 (ST983/20)**
  Ms Mullan presented the minutes for approval and highlighted the key discussion points.

  The Board approved the minutes of the meeting held on 5th September 2019 (ST983/20)

- **Committee Work Plan 2020 (ST984/20)**
  Ms Mullan presented the Committee Work Plan 2020 for approval.

  The Board approved the Committee Work Plan 2020 (ST984/20)

iii) Patient & Client Experience Committee

- **Minutes of meeting held on 19th September 2019 (ST985/20)**
  Mr Wilkinson presented the minutes for approval and highlighted the key discussion points.

  The Board approved the minutes of the meeting held on 19th September 2019 (ST985/20)

- **Committee Work Plan 2020 (ST986/20)**
  Mr Wilkinson presented the Committee Work Plan 2020 for approval.

  The Board approved the Committee Work Plan 2020 (ST986/20)

Mrs Brownlee arrived to the meeting at this point

9. BOARD REPORTS

i) Estates Services Annual Report 2018/19 (ST987/20)

Ms O'Neill presented the Estates Annual Report for 2018/19. She stated that the report provides assurance to Trust Board on the effective and efficient use of resources, promoting best value from the Trust Estate and supporting corporate initiatives. She reminded members that Estates Division was transferred under Finance and Procurement in October 2018 and noted her thanks to Mrs Toal who was the responsible Director up until then. Ms O'Neill thanked Mr Bloomer, Assistant Director of Estates for preparing the Annual Report.

Ms O'Neill reported that the minor works schemes completed were valued at £1.6m. She advised the Estate Operational Service responded to 42,000 calls to the Estates Helpdesk which is the equivalent of 162 calls per day, which highlights the large number of requests the team deal with on a daily basis. The total asset value of the Trusts land and property is valued at £280m. Ms O'Neill commented that £800,000 capital has been secured to address the backlog of maintenance requests and is hopeful they will be completed by the end of the financial year. She spoke of the Fire Risk Assessments and reported that in 2018/19 136 fire risk assessments were carried out. The target of 274 fire risk assessments could not be achieved due to the need to balance limited staff resources across all priorities such as providing training, conducting simulated drills, providing advice and investigating incidents. Ms O'Neill advised the Trust is liaising with the Northern Ireland Fire and Rescue Service who will assist in the Trust meeting its target.

Ms O'Neill stated the Estates team face many challenges in terms of an aging estate; rising expectations and standards, constrained funding and staffing resources, the team continues to deliver a good service which is both critical to, and valued by, the organisation.

Mrs Keenan referred to statistics on Waste and Recycling on page 43 and asked if there is an initiative for improvements. Ms O'Neill informed members that all general waste produced by the Trust does not go into land fill. She reported that the Trust is second in the region for recycling, however there is always scope for future improvements.

In responding to a question asked by Mrs Leeson, Mrs Magwood confirmed that John Mitchell Place will be incorporated into the new Newry Community Treatment and Care Centre.

The Board approved the Estates Annual Report 2018/19 (ST987/20)

10. OPERATIONAL PERFORMANCE

i) Finance Report (ST988/20)

Ms O'Neill spoke to the report and advised the cumulative outturn at month 9 is a deficit of £1.4m. Factors attributing to the variance continue to include: transformation funding, ongoing unscheduled care pressures and winter beds. She reminded members that Pay expenditure exceeds the budget by £3.8m and this is largely associated with medical and nursing. Ms O'Neill highlighted the flexible payroll

arrangements costing £50m, an increase of £11.5m more than the same nine month period last financial year.

Prompt Payments was discussed. The performance in the month of December was 89.5%, with cumulative position of 90%. This is comparable with the month of November, however is below the performance of other HSC Trusts in month. Ms O'Neill spoke of the high number of agency invoices and the backlog; therefore the team have allocated a staff member to assist the Nurse Bank in clearing this backlog. Ms O'Neill reminded members that the Directors have responsibility to ensure their teams are signing off all invoices on time. Mrs Toal commented that reducing the off contract agency spend would have an impact on the number of invoices through the system.

At this point, Ms O'Neill reminded members the Trust secured additional non-recurrent funding to support unscheduled care pressures and the normative nursing cost pressure in the Acute Mental Health Wards. Whilst this additional funding will not remove the cost pressure in full, it is a significant contribution.

In response to a question asked by Mrs McCartan on table F, Ms O'Neill noted that 25% of capital expenditure has been utilised and was confident and provided assurance the remainder will be spent by the end of the financial year.

A discussion ensued on capital monies and the Chair asked how the Trust highlights the importance of spending this money to staff. Ms O'Neill spoke of the work that BSO and PALS carry out to continually send messages to those staff to ensure monies are spent in advance of deadlines. Mrs Toal added a newsletter has been developed to highlight this to staff.

The Board approved the Finance Report (ST988/20)

11. STRATEGIC

i) People Strategy

Mrs Toal gave a short presentation on 'Developing our People Strategy 2020 – 2023' She advised that this will focus on what is needed to lead, support and manage our people for sustainable results. Mrs Toal advised of engagement sessions with staff using the staff survey results to start the conversations. She noted that the areas that they will

be focused on are health and wellbeing, leadership, recognising and valuing our staff, communication and engagement.

In relation to health and wellbeing, Mrs Toal explained that the Trust met with the BMA and together they agreed to produce the doctors' rotas 6 weeks in advance which feedback from doctors has been positive, as this approach provides them with a work life balance. She felt that this method has helped improve the effectiveness of the organisation. The Leadership Walks have been discussed thoroughly with the Senior Management Team and a revised approach has been developed.

Ms Donaghy felt it was difficult for staff to be released and asked what measures have been put in place to ensure all staff can avail of these engagements. Mrs McClements provided assurance that staff will be released on a rotational basis.

Ms Mullan asked for those staff that do not feel comfortable engaging in face to face conversations has other options such as an online questionnaire be put in place. Mrs Toal commented that the idea behind the Coffee Conversations was to create a level of openness and honesty, however for future engagements online surveys will be considered.

The Chair noted that the development of the People Strategy will be an area for further discussion at the next Directors' Workshop.

Action: Mrs Toal

ii) Royal College of Psychiatrists Invited Review – Update on Bluestone, Dorsy and Gillis

Mr McNeany spoke to the above named report. Members were provided with the Mental Health Division's action plan which brings together the recommendations of the Royal College of Psychiatrists Invited Review Report, RQIA Inspection reports and internal work arising from work-streams being overseen by the Directors' Oversight Group. Also included was the NHS Safety Thermometer Bluestone Unit position update which Mr McNeany stated looks at specific issues and he noted the Bluestone Unit's 'harm free score' is 89% compared to the national score of 90%.

Gaps in the workforce were discussed. Mr McNeany stated the unit continues to struggle with significant demands on staff given that the

level of occupancy consistently exceeds 100%. Workstreams have been developed to review patient experience and a series of engagements will take place. Mr McNeany commented a meeting took place with staff where all disciplines were invited to discuss the report, which was well attended. Feedback received focused on safeguarding issues and staff feel there is a level of scrutiny in relation to Mental Health Services e.g. Muckamore Abbey. He assured members mitigating measures have been taken to address staff anxiety. Meetings with the Ward Manager have been re-established. Mr McNeany commented Dr O'Kane and himself will be meeting with Psychiatry colleagues to address concerns next week.

Mrs McCartan noted the action plan references a caring culture and asked for further information. Mrs Trouton explained a 'Better You, Better Care' event was held to celebrate outcomes from the Caring Cultures work in November which recognises the contribution of nursing staff. She noted this was an excellent approach and useful exercise and aim to hold this type of event again.

Mrs Rooney drew attention to item 10 of the action plan that Dorsy is to transition to Learning Disability Division is under consideration. Mr McNeany spoke of the benefits of this movement and an active discussion is taking place by the assistant director to whether this will change. Mrs Rooney spoke of her recent Leadership Walk and noted the improvements. Mr McNeany commented on difficulty in obtaining packages for patients in the community as they are complex and the impact this creates for in-patient beds.

Members requested the full Royal College of Psychiatrists Invited Review report be shared with members.

Action: Mr McNeany

iii) Summary of Capital and Revenue Proposals in excess of £300,00 (ST989/20)

Mrs Magwood presented the summary of proposals with a capital / revenue value in excess of £300,000 that have been developed between 26th September 2019 and 30th January 2020. As in previous reports, she advised that each project has a risk management process in place to identify and seek to manage / mitigate any impact on successful delivery of the investments proposed.

The Chair asked for an update on the implementation of the Mental Health Capacity Act to be provided at a future Trust Board meeting.

Action: Mr McNeany

The Board approved the Summary of Capital & Revenue Proposals in Excess of £300,000 (ST989/20)

iv) Transformation Programme Sustainability Update

Mrs Magwood spoke to the Transformation Programme Sustainability Update. She noted that the programme has allowed the establishment of over 100 Transformation projects, which span both acute and community services. The total investment for the Trust for 2018/19 was £8.9m. For 2019/20, spend is anticipated to be a total of £16.2m. To date the investment has supported the recruitment of 310 headcount / 232.9 wte staff.

Mrs Magwood advised that the Trust has developed a monitoring and evaluation framework which reviews progress against key performance indicators and this continues to be managed via the local Trust Transformation Programme Board. Whilst a robust evaluation is not yet completed, early indications recognise the positive impact these initiatives are having on patients and service users across the system.

Mrs Magwood further advised that the Trust has submitted a sustainability response to the Department of Health, which shares a plan outlining a longer term strategy over the next 3 years, which is based on repurposing an element of demography funding subject to positive evaluation and also repurposing other recurrent funding which is currently being utilised on a non-recurrent basis.

In response to a question asked by Ms Donaghy, Ms O'Neill explained the reasoning for repurposing the demography funding.

The Chair requested that an update be provided to Trust Board at a future meeting.

Action: Mrs Magwood

12. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Corporate Parenting Report for 01.04.2019 – 30.09.2019 (ST990/20)

Mr Morgan presented the above named report and explained the Trust is required to provide a 6 month report to HSCB to provide assurance on compliance and to ensure Trust Board is briefed on its corporate parenting responsibilities.

Mr Morgan reported on the high level of activity and stated the number of Looked After Children known to the Trust has increased to 582, an increase of 12 from last reporting period, however he noted the significant demands on placements available. He reported that 560 Children and Young People were registered on the Child Protection Register, which is the highest regionally. Overall there are 5234 children in need in the Southern Trust area and 20% of these children have a disability. In relation to placements available the CYP team are sourcing community based placements to relieve the pressure on Carrickore and Oaklands.

Mrs Magwood pointed out that there are a high number of referrals where the source is reported as 'other' which doesn't provide enough information. Mr Morgan agreed and reminded members the template is owned and constructed by the HSCB and it is not fit for purpose at this stage. He added a piece of work has been taken forward to address this.

Mr Wilkinson noted the challenge of providing placements for Children with disabilities and the provision of short breaks and asked if there were alternatives. Mr Morgan commented that the team are sourcing what is available in the community with the view to provide parents with better quality short breaks. He assured members that parents will be engaged with at all times.

Mr Wilkinson asked what the Trust is doing to ensure that better accommodation choices are available for those young people leaving care. Mr Morgan stated work is underway with Estates and Human Resources to secure areas for accommodation. The Newry and Dungannon areas will be particularly focused on. The funding for this area is significantly lower compared to other Trusts. Mrs McCartan noted her concern on the transition Young People face when they turn 18. Mr Morgan assured members Young People are supported before and after they turn 18 and packages are in place to address this.

Mrs Leeson, as the nominated Non-Executive Director for the Adoption Panel noted the increase in siblings and complex needs in this area, however commended the excellent work carried out in community to increase the number of potential parents coming forward.

The Board approved the Corporate Parenting Report for the period 01.04.2019 – 30.09.2019 (ST990/20)

ii) Welfare Reform Update

Mr Morgan spoke to this report which aims to raise awareness on the implications of the Welfare Reform, on sections of the Southern Trust population.

There are currently 370,000 people in Northern Ireland live in relative poverty and this has remained stable throughout the last ten years.

Mr Morgan provided background to the issue and the impact it will have on the community and increased demand on the social services. Through mitigation packages agreed by the Northern Ireland Affairs and Working Pension Committee people have been protected from a range of welfare reforms including the bedroom tax and benefit cap, through the provision of Welfare Supplementary Payments. Mr Morgan noted as of 10th January 2020, the Executive will extend existing Welfare mitigation measures beyond March 2020; when they are currently due to expire. This will delay in dealing with the issue and will still have a significant impact on the community the Trust provides services for. A Cliff Edge coalition has been set up by a group of over 100 organisations in NI to share concerns about this potential 'cliff edge'.

Mr Morgan added the Trust is liaising with the local councils and voluntary sector for their input to ensure there is a consistent approach from all authorities. He commented the ABC Council has the highest rate in the use of food banks.

Mr Morgan proposed to co-chair the establishment of a working group with a Non-Executive Director and the Chair stated she would be in contact with the Non-Executive Directors for a nomination. Mrs Keenan commented if bedroom tax is implemented and people have to downsize they could potentially be moved further away from their support network which will have an adverse effect on their health and wellbeing. She asked when the group is established to consider involving the Housing Executive. Mr Morgan welcomed the suggestion and advised the intention of the group is to obtain a baseline of what the situation is in the community and the implications faced.

The Chair requested an update on the at a future Trust Board meeting.

Action: Mrs Brownlee, Mr Morgan

iii) Medical Director Report

Dr O'Kane spoke to this report which focuses on undergraduate and postgraduate Medical Education and report on key indicators relating to Medical Workforce.

Dr O'Kane guided members through the report highlighting the key issues. She noted the ongoing service pressures which are having an impact on training for trainee doctors. There are increasing difficulties in engaging senior doctors in providing training due to workload pressures and pension impact. The gaps in rotas require locum expenditure to maintain those rotas. Dr O'Kane advised the Trust is currently reviewing and strengthening its processes surrounding locum doctors and is developing guidance for medical managers. Mrs Toal added the new Deputy Medical Director post for Medical Education and Workforce will have responsibility for developing locum doctors.

Dr O'Kane spoke of SWOT UP charity which equips potential medical school applicants with information about all aspects of applying to study medicine at university. An event was run in November 2019 which sold out and provided students with invaluable experience to help them prepare for their medical school application process.

In relation to the National Training Survey, Dr O'Kane informed members the GMC undertake a survey of all doctors in training annually. She reported the Obstetrics and Gynaecology division in Craigavon was rated the best place to train in the UK. The survey highlighted that Acute Medicine was the busiest division in nationally. She did note those areas that require further improvements and reported in members' papers.

Dr O'Kane spoke of the Annual Medical Career Symposium for sixth form students which took place on 22nd January 2020. The event was well attended by nearly 60 students from local schools.

At this point, the Chair referenced the global email circulated on 21st January 2020 highlighting the recent audit that revealed a large number of Cerebral Spinal Fluid specimens were received in the laboratory without a specimen time stated on the form and received over the target maximum transport time of 2 hours. The Chair requested this be further explored and assurance provided to the next Governance Committee, which Dr O'Kane agreed to provide.

Action: Dr O'Kane

iv) Executive Director of Nursing, Midwifery and AHPs Report

Mrs Trouton presented the above named report which includes information on the education, development and quality of the Nursing, Midwifery and AHP workforce.

Members noted that a total of 163 pupils have attended a nursing or midwifery placement from April 2019 to December 2019. Mrs Trouton stated that the purpose of the placements is to provide increased knowledge of nursing and midwifery practice and opportunities, allowing pupils to make better informed decisions about future career choices.

Mrs Trouton referred to the recruitment plan on page 5 where it demonstrates the number of people per job role and division interviewed, successful and in post after 3 months. She advised the resourcing team have created a process to monitor and evaluate outcomes from the recruitment days. Mrs Toal added they plan to recruit on a regular basis in smaller numbers as this seems to be the best approach to attract staff.

v) Inquiry Report into Hyponatraemia related Deaths Progress Update

Dr O'Kane presented the progress update for the Inquiry Report into Hyponatraemia related Deaths. The purpose of report is to provide Trust Board with an update on the Trust's responses and oversight arrangements in respect of the report and accompanying recommendations. Regional work streams are progressing, with regional direction from the Department of Health on how the Trust can ensure compliance with the recommendations.

Dr O'Kane spoke of the challenges faced in obtaining 100% compliance in relation to auditing fluid prescribing in children. The oversight group continues to work with operational directorates to improve compliance in fluid prescription and monitoring of fluid balance.

13i. <u>DAO (DOF) 05/19: PARTNERSHIP AGREEMENT TEMPLATE</u>

The Chief Executive referred to the template in members' papers that confirms the publication of the Partnership Agreement Template which will supersede the Management Statement / Financial Management Statement incorporated within Managing Public Money NI. It also sets out the background to the development and subsequent agreement of the template. He stated that the Partnership Agreement will be phased

in from 1 April 2020 and it is recognised that this process will take time to fully implement and the Department of Finance will work closely with all departments.

13ii. DAO (DOF) 06/19: PROPORTIONATE AUTONOMY FOR ALBS

Members noted the above named circular. The Chief Executive advised the Proportionate Autonomy for ALBs is intended to help departments and ALBs assess the nature of their relationship when completing future Partnership Agreements.

Following discussion it was agreed to further explore items 13i and 13ii at a future workshop.

Action: Chief Executive

14. REGISTER OF INTERESTS 2019/20

The Chair advised that the Register of Interests for Board Members had now been updated for 2019/20 and was available on request from the Chair / Chief Executive's office.

Ms Mullan and Mrs Keenan left the meeting at this point.

15. BOARDROOM APPRENTICE SCHEME (ST991/20)

The Chair referred to the letter included in members' papers from the Chief Executives' Forum regarding the Trust participating as a host board in the Boardroom Apprentice scheme 2020. The programme seeks to develop a diverse pool of potential Board members and to move the Board member role from aspiration to reality.

After discussion it was agreed the Trust would participate in the 2020 scheme. Members noted there will be a detailed memorandum of understanding which will be signed between the Host Board and the Boardroom Apprentice. It includes an information sharing agreement, confidentiality and reflects directly back to the host board's code of practice and standard operating procedures.

The Chair advised the programme requires a Board Buddy and advised nominations from both Non Executive and Executive members will be requested in August 2020.

The Board approved participation as a host board in the Boardroom Apprentice Scheme (ST991/20)

Ms Mullan and Mrs Keenan returned to the meeting at this point

16. APPLICATION OF TRUST SEAL (ST992/20)

Ms O'Neill 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 (ST992/20)

17. ANY OTHER BUSINESS

The Chair asked each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles. There were none noted.

In conclusion, the Chair reminded Trust Board members to remain at the end of the meeting for a time of reflection on the proceedings of the day.

The meeting concluded at 3.40 p.m.

SIGNED: _____ DATED: _____

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

Minutes of a Virtual Meeting of the Performance Committee held on Thursday, 3rd September at 9.30 a.m.

PRESENT:

Mrs P Leeson, Non-Executive Director (Chair)
Mrs R Brownlee, Trust Chair
Ms G Donaghy, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mrs A Magwood, Director of Performance & Reform
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Dr M O'Kane, Medical Director
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professionals
Mrs L Lappin, Head of Performance *(for Mrs Leeman)*
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs L Leeman, Assistant Director Performance Improvement

1. WELCOME AND APOLOGIES

Mrs Leeson welcomed everyone to the meeting and noted the apologies above. She informed members that Mrs Siobhan Rooney's term of office as Non-Executive Director ended on 28th August 2020. The Committee acknowledged Mrs Rooney's contribution and commitment as Chair of the Performance Committee since its

inception. Mrs Leeson advised she will take on the role of Chair of the Committee and Mr John Wilkinson, Non-Executive Director, will join the committee on a temporary basis.

2. DECLARATION OF INTERESTS

Mrs Leeson asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

The Chief Executive provided an update on the recent Covid-19 outbreaks in Craigavon Hospital. He advised that efforts continue to be focused on managing the situation and stated that staffing challenges remain within 3 South and the Haematology ward. He spoke of the actions taken to reduce the number of cases within the hospital, namely:- visiting has been suspended, face coverings are mandatory for everyone on site, the importance of social distancing has been reinforced and the introduction of wardens throughout the hospital site. The Chair welcomed the update and noted the challenging and difficult weeks ahead for staff involved.

4. MINUTES OF PREVIOUS MEETING HELD ON 21ST MAY 2020

The Minutes of the meeting held on 21st May 2020 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING

Members noted the progress updates from the relevant Directors.

AHP workforce supply gap was discussed. Mrs Trouton informed members of agreed uplifts to Physiotherapy, Occupational Therapy, Speech & Language Therapy and Radiography undergraduate intake numbers at Ulster University from October 2020/21. However, the numbers are small.

Ms Donaghy referred to page 5 of the minutes in relation to the number of unscheduled care attendances with a GP letter and queried if this was still a problem. The Chief Executive explained the

'No More Silos' work streams will begin to address this through Urgent Care Centres, however, until the Urgent Care Centres are established, unscheduled care attendances to ED with a GP letter will continue to be a challenge.

6. CORPORATE PERFORMANCE SCORECARD

Mrs Magwood presented the monthly Corporate Performance Scorecard – July 2020 for approval. She advised that item 8 Year-End Performance Report is to be read in conjunction with the scorecard. The document provides information to the Committee in support of its function in overseeing delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines. Members noted the scorecard summarises actual performance against i) 2019/2020 Commissioning Plan Objectives and Goals for Improvement (OGIs), ii) Performance Trajectories and iii) Key performance indicators (KPIs).

Mrs Magwood drew members' attention to the challenges since the last report to Performance Committee and particularly noted the impact of Covid-19 on performance, particularly the elective position. She highlighted challenges in the following areas: diagnostic test – decrease in percentage of waits <9-weeks and growth in waits >26-weeks. Out-Patient waits for first assessment and increase in waits beyond clinically indicated timescale for review. In-Patient / Day Case Waits and Planned Repeat Treatments – decrease in percentage of waits <13-weeks and growth in waits >52-weeks. Increasing volumes of patients waiting beyond their clinically indicated timescale for planned repeat treatment.

Mrs Magwood stated that the Trust has received in-year investment of £200,000 for the 7th Urology Consultant. Recruitment is currently ongoing and it is anticipated that the 7th Consultant will be in post in Quarter 4. She did note that the additional capacity created by this post will be targeted to the red flags and urgent cases with little anticipated impact on routine waits.

Mrs Magwood stated that as part of the Trust's Rebuild Plans services continue to seek to increase core capacity in line with

relevant clinical guidance and Covid-19 precautions. The Trust's Covid response impacted on the level of available outpatient accommodation and noted that work is ongoing to assess the current accommodation that can be utilised for face to face outpatient assessments and to allocate this to the greatest demand. Furthermore, as part of the Rebuild Plan, the Trust is seeking to continue with virtual assessment as well as face to face and services are seeking to maximise this where possible.

The Chair noted the areas for concern, ongoing difficulties and the lack of recurrent investment. She referred to the Year-End Performance report section where it includes a snapshot of a number of areas where the Trust's performance is either more or less favourable than the Regional performance. Mrs Magwood highlighted work force challenges and funding available which impacts performance. She spoke of the 'no more silos' work that is being undertaken which it is hoped will contribute to improvements in performance.

The Chief Executive referred to table 2 within the Year-End Performance report which provides a summary of the 71 OGIs, comparing the Trust Delivery Plan assessment to the Year-End assessment. The table demonstrates that there were 60 (84%) OGIs that matched or were better than the End of Year Assessment to the TDP Assessment. He did note his disappointment on those targets that were less favourable at Year End Assessment compared to the TDP assessment.

Mrs Toal joined the meeting at this point

Ms Donaghy asked if performance going forward will be measured against the re-build plans. Mrs Magwood explained that the Department of Health agreed not to allocate new targets, however the targets will continue to be monitored through the accountability meetings with the Chief Executive alongside the re-build plans with the opportunity for potential suggestions and improvements.

Mr Wilkinson noted the areas that have not met their target in the Trust Delivery Plan and asked if there are any risks associated with those particular areas. The Chief Executive spoke of his concern in

relation to Acute hospital discharges into the community. He advised that progress was being made, however Covid-19 impacted this work. A working group has been established to review the patient flow; however the volume of patients is high. The Chair asked that this is an area of focus for the next report.

Action: Mrs Magwood

Mrs Toal stated that sickness absence levels had been on the rise pre Covid, and the levels of Covid related absences were increasing.

Members approved the Corporate Performance Scorecard

7. CORPORATE RE-BUILD PLAN

The Chief Executive spoke to the Corporate Re-build Plan included in members' papers for information. He informed members that the Department of Health has suspended work on the Commissioning Plan Direction for 2020/2021 and the Minister has directed that for the next two year period Trusts should commence service planning, delivery and deployment of resources to stabilise and restore service delivery as quickly as possible. This planning will balance the delivery of Covid-19 and non- Covid-19 activities and has been reflected in phased delivery plans for service rebuild which have been developed and shared with the public by all Trusts including, Phase 1 Rebuild Plan: June 2020 and Phase 2 Rebuild Plan: July – September 2020. Delivery plans for Phase 3 Rebuild Plan: October – December 2020 are in development will be submitted to the Department of Health on 23 September.

In addition to Rebuild plans, the Trust will also develop in parallel Surge Plans in keeping with the Department of Health's Regional Surge Planning Framework which should be published in late August. This surge Plan will reflect how the Trust intends to manage demand for unscheduled care in the October 2020 – March 2021 period.

Mrs Magwood commented on the performance management arrangements that are in place which include daily operational calls and Bi-weekly SMT bronze meetings, fortnightly monitoring of performance against a regionally agreed set of activity projections, monthly reporting to SMT on progress against Rebuild Plans, Chief

Executive Accountability Arrangements and external arrangements. Mrs Magwood reminded members that the Trust continues to report against the CPD objectives via its monthly corporate scorecard.

Mrs Brownlee spoke of the importance of Trust Board being kept updated on the Re-build plans and asked that an update be provided at the September Trust Board meeting. Mrs Magwood agreed to take this forward.

Action: Mrs Magwood

Mr Wilkinson asked for further information on the Phase 3 Re-build plan. Mrs Magwood stated that the winter surge plan would normally be developed at this time of the year with 9 measures in place. She advised that this has now been re-purposed to contribute to the re-build and surge plans. The Chief Executive added that the Management Board have agreed in principal the regional surge plans to address ICU capacity.

A discussion ensued on the Regional Engagement Strategy. The Chief Executive advised that this was discussed and approved at the Management Board. The Strategy includes regional and local responsibilities and each Trust will adopt the strategy and engage with staff. The Chair asked that the Regional Engagement Strategy be shared with members which the Chief Executive agreed to undertake.

Action: Chief Executive

8. YEAR END PERFORMANCE REPORT

Mrs Magwood presented the Year End Performance report for approval. She advised that the report was presented to Trust Board in June 2020; however the data was incomplete in some areas and members had asked that a more up to date report be presented to the Performance Committee.

Members discussed the content of the report along with item 6: Corporate Performance Scorecard.

Members approved the Year End Performance Report

9. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. Integrated Performance Report: *Support to Carers and Adult Community Services – performance issues and actions to include Executive Director Professional issues.*

The Chair welcomed Mr Brian Beattie, Acting Director of Older People and Primary Care, Mr Barney McNeany, Director of Mental Health and Learning Disability, Mr Gerard Rocks, Assistant Director of Promoting Wellbeing and Ms Kathy Lavery, Directorate Lead Social Worker in Mental Health to the meeting. Members were provided with a comprehensive presentation, focusing on Adult Community Services, Support to Carers and Self-Directed Support / Direct Payments.

Mr Beattie began by discussing Adult Community Services. He explained that the Indicator of Performance (IoP) standard seeks delivery of care management assessments within 5 weeks, which was being achieved in the main. He reported that a very small volume of patients waited in excess of 5 weeks. Mr Beattie informed members that the standing down of Delegated Statutory Functions (DSF) reporting, including Annual Reviews as part of the Covid-19 management response, further impacted on recent performance.

Short Breaks were discussed. Mr Beattie reported that there has been an overall increase in Short Break hours over the last 4 years, with the volume of Short Breaks delivered as community based hours having also increased. However, non-bed based breaks continue to reflect less than 45% of the total hours delivered. Demand for bed based breaks may reflect acuity of cohort, predominantly elderly. Investment in OPPC Integrated Care Team (ICT) staffing will support increased work with service users and families to ensure they access Short Breaks in keeping with their preference.

Mr Gerard Rocks presented information on support to carers in the Community & Voluntary Sector. He reported that during the Covid-19 crisis a COVID Community Helpline was created, which helped 2150+ beneficiaries between April - June responding to concerns re: access to food, medicine and social contact. Mr Rocks also highlighted that

information on a range of supports in the community is emailed regularly to carers on the Trust Carer's Register, which reaches 900+ carers. He spoke of the number of services contracted by SHSCT to provide Local Community Support as outlined in the presentation.

Mr Beattie highlighted the number Short Breaks for Young Carers available that are commissioned by the Trust and advised that these are provided by Action for Children. He spoke of the challenges in creating enough places versus the number of young carers requiring short breaks.

Ms Lavery presented information on the Carers Conversation Wheel, which had been co-produced by staff and carers in the South East Trust. It has been piloted in the Adult Physical Disability and Community Addictions services within the Southern Trust. Within both services the uptake of carers assessment had increased. It also highlighted that there was a reduction of inappropriate offers, which was a positive result. Ms Lavery commented that both pilots involved carers and carer representatives and were conducted using Quality Improvement (QI) methodology. Following the pilots, it is intended to roll the model out across all Directorates. Mr McNeany commented on the success of the pilot particularly using the QI method and felt this supports staff and carers. Mrs Toal asked if the terminology of 'carers assessment' could be amended to 'carers conversation'. Ms Lavery explained that as this is a statutory function the terminology cannot be changed.

In relation to Self-Directed payments, Mr Beattie reported that the Trust did not achieve the target of 955 direct payments in 2019/20. However, 910 service users were in receipt of direct payments, which demonstrates a 4.8% increase against the 10% target.

The Chair thanked Mr Beattie, Mr McNeany, Mr Rocks and Ms Lavery for the informative presentation.

Mr Beattie, Mr McNeany, Mr Rocks and Ms Lavery left the meeting at this point.

10. INFECTION, PREVENTION AND CONTROL, ANTIMICROBIAL STEWARDSHIP REPORT

Dr O'Kane presented the Infection, Prevention and Control, Antimicrobial Stewardship report for assurance purposes. The paper provides data from April 2019 to July 2020 for PFA targets.

Dr O'Kane reported that the Trust saw an increase in Clostridium Difficile in 2019/20 with a significant rise in October 2019. She assured members that this was managed using the 'outbreak' management plan and an action plan was developed and implemented, which has resulted in a reduction of Clostridium Difficile cases.

Dr O'Kane explained that the IPC team and Microbiologist, while continuing to support the management of Covid-19 in the Trust and with the Independent Sector providers, are refocusing attention on C difficile, AMR and Gram negative bacteraemia with the current resources. The Infection Prevention and Control team and Microbiologists have provided advice and support to clinical / operational teams and care homes on the prevention of transmission of Covid-19, including zoning of Trust and Independent Sector provider's premises for managing PPE on sessional basis. Local testing has also been implemented.

Dr O'Kane informed members that one Consultant Microbiologist has resigned, however recruitment is underway with interviews scheduled by the end of September 2020.

In response to a question asked by Ms Donaghy, the Chief Executive advised that a bid has been submitted for additional resources to the IPC team to deal with the hospital and care home surge, however the main issue is the skill set and expertise within Infection Control that is required. Mrs Trouton explained that Nursing staff can develop their skills into the Infection Control area, however this takes time and requires staff to undertake training and complete courses.

Mr Wilkinson enquired if the repeated use of antibiotics has an impact on the number of infections. Dr O'Kane explained that the long term use of antibiotics, particularly in the older population poses a

significant increased risk of Clostridium Difficile and antibiotic resistance.

Dr O'Kane left the meeting at this point

11. UNALLOCATED CHILDCARE CASES REPORT

Mr Morgan spoke to the above named report and advised there was a total of 21 unallocated cases as at 31 July 2020, a decrease on the previous reporting period (31 March), when 44 unallocated cases was reported. He informed members that there was a high level of Child Protection and LAC activity associated with complexity of cases; however there were no unallocated Child Protection or LAC cases.

Mr Morgan reported that during COVID-19 contingency arrangements within the social work staff from the Parenting Service, Court Children's Service and Signs of Safety team were redeployed to support the Family Intervention Service. Partnership arrangements were strengthened between Children's Gateway Service, Armagh Down Women's Aid, Barnardo's, SPACE N.I. and NIACRO to provide early intervention outreach support to families affected by domestic violence and abuse that had a domestic incident notification made by the PSNI to Children's Gateway Service during the Covid-19 pandemic.

Vacancies were discussed. Mr Morgan highlighted that vacancies across the Gateway, Family Intervention and CWD Service have improved due to the immediate recruitment of final year social work students. Funding has also been secured for 3 senior social work practitioners to strengthen the CWD service. Recruitment for these posts is underway.

12. EXECUTIVE DIRECTOR OF NURSING, MIDWIFERY AND AHPS REPORT

Mrs Trouton presented the Executive Director of Nursing, Midwifery and AHPs report which provides assurance on the standards of professional practice of Nurses, Midwives and Allied Health Professionals (AHPs) working in the Trust. The indicators are taken from SHSCT Nursing and AHP Assurance and Accountability

Framework and include areas regarding workforce, education training, and quality of practice. This report is reflective of the Covid-19 surge impacts. Mrs Trouton informed members that the Chief Nursing Officer and the region stood down the need to collate Nursing Quality Indicator data at this time but the Trust is currently working closely with frontline teams to re-establish this reporting infrastructure.

Mrs Trouton referred members to page 4 of the report which demonstrates the vacancy rates of all Bands between April and June 2020, which is monitored fortnightly. She reported that the number of vacancies has decreased from 227 to 156 for the time period. Mrs Trouton informed members that in April this year 119 final placement pre-registration Nursing and Midwifery students joined the Nursing and Midwifery workforce in the Trust in Band 4 roles under the NMC Emergency Standards for Education, contributing to patient care during the COVID-19 pandemic.

AHP Workforce was discussed. Mrs Trouton referred to the table on page 7 that provides information on each Trust's vacancy rates by AHP profession as at 31st March 2020. The report highlights that the Southern Trust has 104 AHP vacancies (9.7%) which is the highest in the region, along with the Western Trust. The Trust's highest vacancy rate is in Physiotherapy and Mrs Trouton noted this is largely within the Older People and Primary Care Directorate. Mrs Toal added that the workforce team is reviewing the recruitment and retention process within Physiotherapy.

Mrs Trouton spoke of the flexible pool within the Trust. She informed members that Occupational Therapy and Physiotherapy have 36 unfilled vacancies within the flexible pool across these areas. Mrs Trouton assured members that the AD Steering Group is focusing particular attention on these areas with the view to increase AHP clinical elective activity and reduce waiting times.

Mrs Brownlee felt that the recruitment process to appoint AHPs was prolonged and asked how this will be addressed. Mrs Toal stated that she will raise this issue with Shared Services and feedback at the next meeting.

Action: Mrs Toal

Mrs Brownlee noted her concern on the long waiting lists for AHPs and asked how those patients are kept updated. Mrs Trouton advised she will take this forward with Mr Brian Beattie, Acting Director of Older People and Primary Care and feedback at the next meeting.

Action: Mrs Trouton

13. Performance Reporting - External Assurance

i) NHS Benchmarking Report – Management of Frailty in Acute Setting

The Chair welcomed Mrs McClements to the meeting to present the above named item. Mrs McClements referred to the report included in members papers and explained that the Trust is a member of the NHS Benchmarking Network (NHSBN) and in 2018/2019 agreed to participate in a scheduled review of the Management of Frailty and Delayed Transfers of Care. The report is to provide information to the Committee regarding performance management arrangements to monitor the management of frailty services in acute settings and to provide assurance that a range of mechanisms are in place and new improvement opportunities identified. Mrs McClements guided members through the report highlighting the findings. She noted that this work is in conjunction with the Acute, Mental Health, Older People and Primary Care and Planning teams.

Mrs McClements highlighted that the Southern Trust has the lowest percentage of Geriatricians relative to other NI Trusts and lower number of beds; however the Trust has the shortest length of stay for inpatient frailty patients. She added that pre covid-19 the Trust had a frailty ward; however in the current climate it has not been possible to sustain this but the intention is to reinstate it. Mrs McClements advised that the teams are currently focusing on increasing their training for frailty identification which will assist to define the skills, knowledge and behaviours that staff need in order to effectively support people living with frailty. She added that support from the commissioner is critical.

Mrs Brownlee reminded members the low number of Consultant Geriatricians within the Trust has been raised previously and a piece of work was commissioned to review this. She asked for an update on this work. Mrs McClements assured members that the actions identified through that piece of work resulted in the development of the "older persons assessment units" (Geriatrician led), greater focus on frailty work, internal networking across sites and services supported by Geriatricians and succession planning opportunities. Mrs Magwood gave assurance that workforce and infrastructure were on her agenda with the new Director of Commissioning. Mrs Brownlee asked that this matter continues to be an area of focus and any updates to be provided to the committee in future.

Action: Mrs McClements

Mrs McClements left the meeting at this point

14. TERMS OF REFERENCE

Members reviewed the revised Terms of Reference and endorsed it for Trust Board approval on 24th September 2020.

15. COMMITTEE WORK PLAN 2021

Members reviewed the committee work plan for 2021. As previously discussed the Corporate Re-build Plan will be included for each quarter. Members approved the Committee Work Plan for 2021.

16. MEETING DATES FOR 2021

The proposed dates for 2021 were approved.

17. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.30 p.m.

Signed _____ ***Dated*** _____

Subject: FW: CONFIDENTIAL FROM THE CHAIR: URGENT COMMUNICATION
From: Judt, Sandra <[redacted]>
To: Brownlee, Roberta <[redacted]>
Sent: 6/11/2020, 2:15:44 PM

Letter to Mrs. Brownlee 10 June 2020.docx

ATT00001.htm

Letter to Mr Devlin 10 June 20.docx

ATT00002.htm

Letter to Mrs Toal 09 June 2020.docx

ATT00003.htm

fyi – forwarded to NEDs as below.

Regards

Sandra

Sandra Judt

Board Assurance Manager

SH&SCT

Trust Headquarters

68 Lurgan Road

Portadown

Craigavon

BT63 5QQ

Tel: [redacted]

Email: [redacted]

From: Judt, Sandra
Sent: 11 June 2020 14:06
To: Rooney, SiobhanNED; Donaghy, Geraldine; Leeson, Pauline; McCartan, Hilary; Mullan, Eileen; McDonald, Martin; Wilkinson, John
Subject: CONFIDENTIAL FROM THE CHAIR: URGENT COMMUNICATION

Please find attached confidential information from the Chair.

Regards

Sandra

Sandra Judt

Board Assurance Manager

SH&SCT

Trust Headquarters

68 Lurgan Road

Portadown

Craigavon

BT63 5QQ

Tel: Personal Information redacted by the USI

Email: Personal Information redacted by the USI

From: Brownlee, Roberta
Sent: 11 June 2020 14:01
To: Judt, Sandra
Subject: Fwd: URGENT COMMUNICATION

Sent from my iPad

Begin forwarded message:

From: "O'Brien, Aidan" <Personal Information redacted by the USI
Date: 10 June 2020 at 23:26:08 BST
To: "Brownlee, Roberta" <Personal Information redacted by the USI>
Subject: URGENT COMMUNICATION

Dear Mrs. Brownlee,

I attach a letter addressed to you as Chair of the Southern Health & Social Care Trust Board.

I also attach letters sent to Mr. Devlin on 10 June 2020, and to Mrs. Toal on 09 June 2020.

I would be most grateful if you would bring the contents of these letters to the attention of the non-Executive members of the Board.

I would be grateful if you would acknowledge receipt of this communication.

Aidan O'Brien

Personal Information redacted by the USI
[redacted]

Mrs Roberta Brownlee,
Chair
Southern Health & Social Care Board
Trust Headquarters
Craigavon Area Hospital
Portadown
BT63 5QQ

10 June 2020

Dear Mrs. Brownlee,

I attach a letter which I sent to Mrs. Vivienne Toal, Director of Human Resources & Organisational Development, last evening, and a letter which I sent to Mr. Shane Devlin, Chief Executive, earlier today.

The point of both letters was to advise that I had submitted, on 06 March 2020, an application for pension benefits to become payable with effect from 30 June 2020, to coincide with an intent to withdraw from full time employment from that date, and with the intent to return to part time employment from 03 August 2020, having received the assurance of support from colleagues and line managers to do so, and without being informed by the Trust of any impediment to my doing so. I was then advised by telephone on Monday 08 June 2020 that I would not be permitted to return to part time employment in August 2020 due to the 'Trust's practice of not re-engaging people with ongoing HR processes'. If I had been informed of this practice by the Trust, I most certainly would not have submitted any notification of intent to withdraw from full time employment.

You will be aware that the ongoing HR processes to which reference has been made are the Formal Investigation (initiated on 30 December 2016 and completed on 01 October 2018) and a Formal Grievance (submitted on 27 November 2018 and not yet addressed). The Formal Grievance included an appeal of the Outcome of the Formal Investigation. That appeal has not been addressed, 20 months later.

I now feel all the more aggrieved by the Trust's claim to have a practice of not re-employing personnel if there are ongoing HR processes, when the Trust has been primarily responsible for the ongoing status of those HR processes, and not having been informed by the Trust, my employer, of that practice. It is important to note that it is the same Directorate which has failed to have my grievance and appeal addressed after 20 months in contravention of its own policy, the same Directorate which has accepted and processed my intent to withdraw from full time employment, and which would have been cognisant of my intent to return to part time employment as that intent is an integral part of the application proforma, and which would have been cognisant of a

Trust practice which would be an impediment to returning to part time employment, and about which I was not informed.

As a consequence, I have had no other option but to revoke my intention to withdraw from full time employment. I have already deferred payment of pension benefits earlier today.

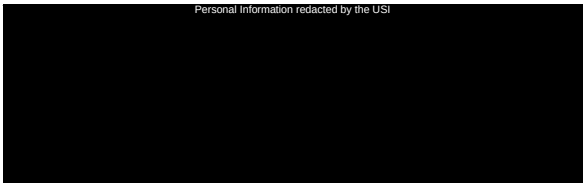
It will have been 28 years ago tomorrow, Thursday 11 June 1992, that I was appointed to the post of Consultant Urologist at Craigavon Area Hospital. From then until 1996, I single-handedly provided a 24 hour service. From 1996, with the assistance of increasing numbers of colleagues, I have endeavoured to contribute to the development of urological services by the Trust. Nevertheless, those services remain severely inadequate. Covid-19 has further exacerbated that inadequacy. By August 2020, there will be patients waiting up to six years for admission for surgery. By then, there will be patients waiting over three years for outpatient consultations following referral, and for review following investigation or management.

Today, Mr. Robin Swann, Health Minister, referring to a framework for rebuilding health and social care services in Northern Ireland, said that 'this strategic approach is about throwing absolutely everything we can at those waiting lists and those missed diagnoses and treatments that were put on pause during the Covid-19 pandemic'. The Minister advised that Northern Ireland has the longest waiting lists in the UK and Ireland. The Southern Trust's longest, surgical waiting lists are urological. Yet, the Trust finds it appropriate to prohibit me from part time employment in the face of such need due to ongoing HR processes for which the Trust has been responsible.

I do appreciate that you, and your non-Executive colleagues, have been appointed to the Trust Board by the Health Minister, and that the Trust is accountable to the Board, on behalf of the Minister, across a number of key areas, including the delivery of health and social care objectives, financial probity and governance. I write to ask you to bring to the attention of your non-Executive colleagues, the contents of this letter, and of those sent to Mr. Devlin and Mrs. Toal. In doing so, I have not made reference to any of the issues subject to the Investigation, or to any content of the Grievance or of the Appeal. I write to inform you and your colleagues of the severity of the lack of the Trust's compliance with its own Policies and Procedures, the severity of the impact of its lack of compliance upon a member of its staff, and the consequential impact upon the delivery of services expected by the Minister.

I hope that you and your non-Executive colleagues may be able to have some bearing in attempting to resolve this ongoing situation. For me, personally and professionally, it is very important that I can continue to work, but with a better work life balance. It is also most important for me that the Formal Grievance and its included Appeal are addressed. I am certainly prepared to work constructively with the Trust to achieve a just and satisfactory resolution, and particularly to the benefit of patients.

Yours sincerely,



Personal Information redacted by the USI
[redacted]

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

09 June 2020

Dear Mrs. Toal,

During January 2020, I had family reasons to consider significantly reducing my workload in order to create a better work to life balance going forward. I did so particularly in the context of the potential pension risks that prevailed at that time.

I had already consulted with Mr. Malcolm Clegg of the Directorate of Human Resources with regard to options available to reducing my workload while protecting my pension entitlement, including that of part time employment. During February 2020, I also discussed this option with Mr. Michael Young, Lead Clinician in Urology, who offered his full support to my returning to part time employment if I withdrew from full time employment. I discussed the option with Mrs. Martina Corrigan, Head of Service for Urology, who assured me of her full support to return to part time employment. I discussed the option with Mr. Mark Haynes, Assistant Medical Director, who was similarly supportive, discussing the nature and amount of clinical work which I would wish to undertake. In doing so, I assured him that I would continue to participate in the Urologist of the Week rota.

Owing to those conversations, on Friday 06 March 2020, I confidently submitted an application for scheme retirement benefits, with a proposed retirement date of Tuesday 30 June 2020, and confirmation of my availability and commitment to return to agreed part time employment from Monday 03 August 2020.

Since then, we have experienced the further disruption to urological services resulting from Covid 19. As you are aware, we had already been providing urological services with a reduced number of consultant urologists since July 2019. Covid 19 has further exacerbated the difficulties in providing an adequate service. I was therefore prepared to offer to return to work in July 2020 to support my colleagues in providing increasing services to those in most urgent clinical need.

Having made enquiries, during the last week of May 2020, as to whom I should meet to arrange an agreed return to part time employment, I was advised by Mrs. Corrigan on Monday 01 June 2020 that she would discuss the matter with Mr. Haynes. On further enquiry on Friday 05 June 2020, she advised that Mr. Haynes would be in contact with me. Yesterday afternoon, I received a telephone call from Mr. Haynes, with Mr. Ronan Carroll in attendance, to advise that, following discussions with the Medical Director and with Human Resources, he had been instructed to advise me that “it

was the 'practice' of the Trust not to re-engage people while there are ongoing HR processes". He confirmed that these issues were those of the Formal Investigation (initiated in December 2016 and concluded in October 2018) and my Formal Grievance (submitted in November 2018).

I had not received any written or other communication since I submitted the AW6 Form on 06 March 2020 regarding confirmation of its receipt or of processing the application, until one sent at 12.39 pm today, claiming that I had telephoned the Medical HR Department yesterday, Monday 08 June 2020, with regard to Medical HR acknowledging receipt of my 'retirement letter'. This claim is untrue. I telephoned to request a copy of the AW6 Form which I had submitted on 06 March 2020. I did not mention any letter. I did not send a letter to Medical HR. I sent a letter to Mrs. Martina Corrigan. I find it so distressing to be once again met with such misrepresentation.

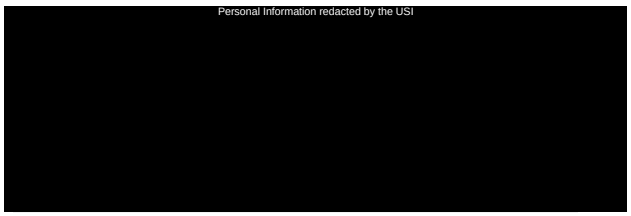
I wish to unequivocally emphasise that, until yesterday, I had not received any advice or indication that such 'ongoing HR processes' would be an impediment to my returning to part time employment, including from any of the personnel named in paragraph 2 above. It was the duty of my employer to inform me that ongoing HR processes prohibited my returning to part time employment. Had I been informed of such, I certainly would not have submitted the AW6 Form on 06 March 2020, with the self-evident pecuniary and reputational loss and damage that yesterday's development entails, in addition to disabling my ability to be appraised and revalidated. On the contrary, it was the absence of information regarding any factors prohibiting part time employment, and the support offered that underpinned my lodging the Form on 06 March 2020.

I therefore notify you that I now revoke my application for retirement benefits and indication of my withdrawal from full time employment, both with immediate effect. I will advise BSO of this notification. I therefore require, by 5.00 pm on Thursday 11 June 2020, the Trust's confirmation that my full time employment shall continue.

I also require full disclosure of all Trust policies relating to the Trust 'practice' referred to above. I require it by return by 5.00 pm on Thursday 11 June 2020.

Whilst I hope that this issue can be resolved by 05.00 pm on Thursday 11 June 2020, I must stress that otherwise all further correspondence in this matter shall immediately flow from the solicitor I have instructed to conduct proceedings.

Yours sincerely,



Aidan O'Brien

STRICTLY PRIVATE & CONFIDENTIAL

Personal Information redacted by the USI
[redacted]

Mr. Shane Devlin
Chief Executive
Southern Health & Social Services Board
Trust Headquarters
Craigavon Area hospital
68 Lurgan Road
Portadown
BT63 5QQ

10 June 2020

Dear Mr. Devlin,

On 27 November 2018, I lodged with you a Formal Written Grievance. I submitted it to you in person as I had already lost faith in the integrity of the Directorate of Human Resources. In lodging my grievance with you, I retained a confidence that you would ensure that the Grievance would be progressed in a timely manner, and in compliance with the Trust's Grievance Procedure. The Grievance included an appeal of the Case Manager's Outcome of the preceding Formal Investigation. Now almost 20 months later, neither the grievance nor the appeal has been addressed, even though I was assured by Mrs. Toal in writing in June 2019, and most recently on 22 May 2020, that arrangements were being made to convene the grievance hearing.

I attach a letter which I sent to Mrs. Toal last evening. It will inform you that I was advised on Monday 08 June 2020 that I would not be facilitated to return to part time employment from 3 August 2020 due to a 'practice of the Trust not to re-engage people with ongoing HR processes'. The letter to Mrs. Toal details the support which I had been given to return to part time employment and the absence of any advice from the Trust that ongoing HR processes would be an impediment to my returning to part time employment. I have notified Mrs. Toal that I revoke my application for retirement benefits and of the indication of my withdrawal from full time employment, both with immediate effect.

In making every effort to resolve this impasse, I write to ask you to ensure that the Grievance is addressed as soon as is possible, and so that it can be completed by Friday 26 June 2020. With confidence that the Grievance will be upheld, and that its included appeal will be equally so, there then would be no outstanding HR processes.

I would be grateful for an acknowledgement of receipt of this letter.

Yours sincerely,

Personal Information redacted by the USI
[redacted]

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

August 2016

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to one of the four domains contained within the Board Assurance Framework and to the relevant Trust Corporate Objectives as detailed below:-

Four Accountability domains contained within the Board Assurance Framework

- Domain 1 Corporate Control
- Domain 2 Safety and Quality
- Domain 3 Finance
- Domain 4 Operational Performance and Service Improvement

Corporate Objectives

1: Provide safe, high quality care.
2: Maximise independence and choice for our patients and clients.
3: Support people and communities to live healthy lives and improve their health and wellbeing.
4: Be a great place to work, valuing our people.
5: Make the best use of resources.
6: Be a good social partner within our local communities.

OVERVIEW OF CORPORATE RISK REVIEW AS AT 31st AUGUST 2016

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	8	5		13

The Corporate Risk Register has been reviewed by SMT on two occasions since the last Governance Committee meeting. Changes include:-

New risks identified by SMT or escalated from Directorate Risk Registers	• Business Services Organisation (BSO) Shared Services Centres – Payroll/Travel & Recruitment (and included in the merged workforce risk detailed below) • Lack of Data Processing Contract with BSO
Risks removed from the Register	• Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation status • Achievement of Statutory Duties/Functions - Level of Residential Home/Nursing Home/Domiciliary Annual Reviews not completed. • Medical Appraisal system

Merged risks	Following risks have been combined into one workforce resourcing risk:- • BSTP/Recruitment Shared Services • Inability to recruit/retain Consultant medical staff for specific specialties • Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital • Inability to recruit registered nursing staff • GP Out of Hours Service – inability to attract adequate cover for GP shifts • Health Visiting Service – impact on families due to decreased staffing levels • Reduced ability to provide 24/7 laboratory service at Daisy Hill Hospital due to insufficient Biomedical Scientists • Failure to attract/appoint required staff and delays in recruitment processes in mental health/disability inpatient wards, community teams, supported living and day care facilities • I.T. Department – workforce shortage due to insufficient resources and long term sickness levels. Following risks have been combined into one maintenance and development of Trust Estate risk:- • Insufficient capital to maintain and develop Trust Estate • High Voltage Capacity • Anticipated failure of legacy telecoms infrastructure • Design and fabric of Aseptic Suite, Craigavon Area Hospital • Construction activity on Trust sites leading to increased risk of • significant service disruption • ICT Maintaining Existing Services
Risks where overall rating has been reduced	None
Risks where overall rating has been increased	None

SUMMARY OF CORPORATE RISKS AS AT AUGUST 2016

DOMAIN 1: CORPORATE CONTROL				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
1	**Revalidation Arrangements –** Implementation of Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016	1 & 4	**HIGH**	**8**
2	**Appraisal –** lack of evidence of compliance with a fully embedded appraisal (KSF) system	1 & 4	**MEDIUM**	**10**
3	**BSO Shared Services:** Payroll/Travel and Recruitment	4&5	**MEDIUM**	**11**
4	**Data Processing –** lack of contract with BSO	1&5	**MEDIUM**	**13**
5	**Infrastructure** – Insufficient capital to maintain and develop Trust Estate (facilities, equipment, ICT Estate etc.) to support service delivery and improvement	1	**HIGH**	**14**

DOMAIN 2: SAFETY AND QUALITY				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
6	**Workforce Resourcing – Workforce Shortages**	1	**HIGH**	**21**
7	**Achievement of Statutory Duties/Functions –** robust case management processes	1	**MEDIUM**	**30**
8	**Capability of Trust systems of assessment and assurance in relation to quality of Trust services**	1	**MEDIUM**	**31**
9	**Healthcare Acquired Infections (HCAI)**	1	**MEDIUM**	**33**
10	**Safeguarding of residents from risk of potential financial abuse**	1	**HIGH**	**35**

DOMAIN 3: FINANCE				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
11	**Achievement of recurrent financial balance**	5	**MEDIUM**	**38**
12	**Management and monitoring of procurement and contracts –** lack of compliance with best practice guidance	5	**MEDIUM**	**38**
DOMAIN 4: OPERATIONAL PERFORMANCE AND SERVICE IMPROVEMENT				
13	**Achievement of Commissioning Plan Standards and Targets**	1	**HIGH**	**42**

DOMAIN 1: CORPORATE CONTROL					
CORPORATE OBJECTIVES: 1 & 4 – PROVIDING SAFE, HIGH QUALITY CARE & BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
RISK AREA/CONTEXT: REVALIDATION ARRANGEMENTS					
Risk No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
1	Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016 Organizational processes and registrant support arrangements have been in place since 1st April 2016. On average 53 registrants / month [266, 8%] revalidated in the period April – August inclusive. However, **451** (**15%**) registrants are due to revalidate in the next 2 months (i.e. September or October 2016) - the months most nurses concluded their training.	• SMT agreement that 50% of Nursing Governance Co-Ordinators (NGCOs) hours would be allocated to supporting organisational and registrant readiness for revalidation. • A Professional Revalidation Support Team (an extension of the Medical Revalidation Team) has been established to support organisational arrangements and assurances. • Nursing and Midwifery Revalidation information management system to provide assurance on revalidation status of nurses and midwives in the Trust. • NMC Revalidation Implementation Group, chaired by the Executive Director of Nursing, to support and direct registrants and managers.	The Nursing Governance Co-Ordinators (NGCOs) continue to support directorate managers and registrants in preparing for effective and timely NMC revalidation. The Assistant Director of Nursing Governance and the NGCOs have developed tools and proformas to support nurses and midwives in evidencing compliance with revalidation requirements and in preparing registrants for their reflective discussion and confirmation meetings. The Nursing and Midwifery Revalidation information management system is now live and holds information on over 3,000 NMC registrants' PIN, annual fee and revalidation dates. Standard Operating Procedures have been developed to provide timely reports to nursing and midwifery managers and heads of service. Monthly revalidation reports are issued to individual nursing / midwifery managers to support local arrangements on the timely	**Executive Director of Nursing**	**HIGH**

	Although the support arrangements have met the needs of smaller numbers / month, the test will be if this significantly larger cohort successfully revalidates in September and October. If successful the risk rating will be reviewed and lowered.		reflective discussion and confirmation meetings for those they have responsibility for. Monthly revalidation reports provide assurance to the Executive Director of Nursing, SMT and Trust Board in relation to the progress on the implementation of the NMC revalidation arrangements. The AD Nursing Governance has worked with the AD Nursing Workforce Development and Training and Clinical Education Centre to agree a planned approach to ongoing support programmes.		

DOMAIN 1: CORPORATE CONTROL					
LINK TO CORPORATE OBJECTIVES: 1 & 4 - PROVIDING SAFE, HIGH QUALITY CARE & BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
RISK AREA/CONTEXT: FULLY EMBEDDED APPRAISAL SYSTEM					
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
2	Lack of evidence re compliance of a fully embedded appraisal (KSF) system	There are a variety of mechanisms in place to ensure appraisal takes place:- • Medical Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings • Action Plan in place and reviewed quarterly • Staff Attitude Survey results provide staff view • Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.	<u>Knowledge and Skills Framework</u> Work ongoing with Directors and Heads of Services to support staff and managers when completing their KSF documentation to increase uptake within each Directorate KSF reports continue to be collated monthly and forwarded to Directors. Regular reports regarding uptake levels across the Trust continue to be presented to SMT PDPs are now being recorded on HRPTS as a qualification. There has been a slight increase in the extent to which KSF is being implemented across the Trust – 53% as at 31st July 2016, although this is still short of the Internal Audit target of 60% by September 2016. Work is continuing to improve mandatory training levels within the Trust.	**Director of HR and Organisational Development**	**MEDIUM**

DOMAIN 1: CORPORATE CONTROL

LINK TO CORPORATE OBJECTIVES 4 & 5 - BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE & 5 – MAKING BEST USE OF RESOURCES

RISK AREA/CONTEXT: Shared Services Centres – Payroll / Travel & Recruitment

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
3	**Shared Services** • **Payroll & Travel SSC** – risk to accuracy of payroll as control environment not yet stabilized. Negative media publicity and impact on Trust's reputation as a good employer.	• Customer Forums are in place for monitoring the performance of services in Shared Services Centres • Monthly KPI data shared with the Trust, but this is currently not complete data set • Progress updates to Audit Committee with attendance by BSO, as required • Regional audit of BSO Payroll Shared Services, currently six monthly • Trust participation in a number of grups to provide assistance on progressing improvements in Payroll Shared Services Centre	• Ongoing communication/engagement with Managers as regards timely completion of paperwork • Internal Audit Report – Payroll Shared Services, March 2016 – limited assurance • Internal Audit re-audit September 2016 • Quarterly BSO Assurance Reports circulated to Audit Committee members regarding progress on Internal Audit recommendations • Trust participation in new governance arrangements post BSTP to monitor shared services performance and achievement of benefits realisation	**Finance Director**	**MEDIUM**

	• **Recruitment Shared Services Centre (RSSC):** The speed of response / time to fill urgent posts poses a risk for front line services. This risk has the potential to increase as Recruitment Shared Services continues to be rolled out to all Trusts – there is a risk that standards will drop and the urgency of Trust services will be lost.	• Continued involvement in regional work / RSSC issues. Assurances to be sought from RSSC Head of Service regarding maintenance of standards and improvement on time to fill urgent positions. Monitoring reports on performance against standards also be provided by RSSC. • Monitoring and ongoing review of all aspects of the pre-employment checks including Occupational Health checks. • Identification of any internal issues, which may be contributing to the timeliness of recruitment exercises.	Regular engagement with RSSC managers to monitor activity and review particular operational issues of concern/shortfalls in service delivery. An issues log is maintained by the Head of Resourcing. There are also regular meetings with RSSSC and Occupational Health to specifically address any blockages and share planning information. Since May 2016, RSSC has been implementing a Recovery Plan in recognition of the level of service not yet being at the desired level and the Trust is working actively and collaboratively in the implementation of this plan. The purpose of this plan is to make improvements in key areas such as shortening the length of time taken to fill posts, improving communications and customer service, enhancing he E-Recruitment system and providing quality management information and KPI monitoring. This will involve the standardization of processes at key stages of the recruitment process, as well as the development of clear operating principles, roles and responsibilities for all stakeholders. A local action plan is also in place to address issues/ delays within the control of the Trust. Communication with Trust managers is ongoing to ensure they fulfil their responsibilities and are supported to do so via training, comprehensive user guides	**Director of Human Resources and Organisational Development**	

			and access to a local helpdesk. A permanent 'Recruitment Liaison Officer' post is being established and is currently advertised permanently (August 2016).		

DOMAIN 1: CORPORATE CONTROL					
CORPORATE OBJECTIVES: 1 & 5 – PROVIDING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES					
RISK AREA/CONTEXT: Lack of Data Processing Contract with BSO					
Risk No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
4	Lack of 'Data Processing' Contract with BSO as per Information Commissioner (ICO) guidelines. Risk of financial penalties/ fines and adverse publicity in the event of a data loss or breach.	• Trust ICT Security policy • Trust performance in application/ use of HCN re anonymized data	• This Risk requires ongoing monitoring in line with development of electronic and shared systems approaches in HSC. • The Trust has engaged Department of Legal Services (DLS) to assist with development of an appropriate contract. Risk escalated and shared on regional basis via NI Electronic Care Record Information Governance Workstream	**Director of Performance & Reform**	**MEDIUM**

DOMAIN 1: CORPORATE CONTROL (also linked to Domain 3 Finance and Domain 4: Operational Performance and Service Improvement)					
CORPORATE OBJECTIVE: 1 – PROVIDING SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: INFRASTRUCTURE – Maintenance and development of Trust Estate (facilities, equipment, ICT etc.) to support service delivery and improvement					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
5	Insufficient capital (and associated revenue) funding to maintain and develop Trust Estate (including I.T. Estate) to support service delivery and improvement Specific risks include:- • High Voltage capacity limit on supply to Craigavon Area Hospital • Anticipated failure of legacy Telecommunications infrastructure • Failure of infrastructure within drainage to remove sewage from wards at Craigavon Area Hospital • Design and fabric of Aseptic suite, Craigavon	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. • Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas:-	• On-going prioritisation and bidding process for capital in place • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k • A review of maintaining existing services (for the next 5 years) has been carried out. This review has identified that funding in the region of £119 million is required to address risk areas including: Critical Telecommunications infrastructure; Infection control and Health & Safety issues in patient areas; Medical Gas infrastructure and ventilation system risks; Structural repairs to DHH. This requirement could be significantly	**Director of Human Resources and Organisational Development/ Director of Performance and Reform**	**HIGH**

	Area Hospital • Construction activity on Trust sites leading to increased risk of significant service disruption • Maintenance and development of existing ICT Estate Each of these risk areas are set out below		reduced should the replacement of CAH proceed. • Work is now being progressed on the main business case for major redevelopment at CAH site. • Prioritisation of highest Estates risks being undertaken to inform allocation of available capital and revenue funding for 2016/17.		

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption • Peak Lopping installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed. • Installation of new Combined Heat and Power plant is complete and G59 approval from NIE (to permit parallel generation) is in place. This will provide increased resilience through an additional source of supply for the site.	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the risk. • CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion September 2016	Human Resources & Organisational Development	

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	Anticipated failure of legacy telecoms infrastructure leading to significant service disruption and potential consequential harm to service users. **System Support:** Increased risk of in-cohesive maintenance, system support, due to gaps in out-of-hours provision of cover. Construction of the new Paediatric unit at Craigavon Area Hospital has highlighted an additional resilience risk relating to critical cable routes for telecoms and IT infrastructure	**Hardware:** • The Trust have entered into a comprehensive contract (VDCP) with BT to manage the existing network and support the structured replacement of individual legacy systems. The existing Siemens DX switches, which serve telecoms users for approximately 60% of the Trust, reach end of supported life in November 2017.At present, in the event of a failure, BT VDCP through Siemens guarantee a repair within 4/8 hours depending on service level agreement. • After November 2017, BT will no longer provide a guaranteed service agreement and it will be "best endeavours" i.e. only if parts can be sourced (used stock of whatever) etc. they will try and fix it. If the fault is software related there is unlikely to be a fix. A fault will leave the Trust without internal/external communications for a	• SMT approved Capital Funding of £342,000 (2015/16) for the provision of a Core Telephony Platform to provide the centralised telephony foundation and continuity for the existing Avaya Telephony infrastructure deployment. Planned completion end March 2016. • Requirement for additional funding to replace 5 systems on core DX sites including St Lukes, Tower Hill, Craigavon Hospital and Daisy Hill Hospital. [5 systems c£450k each] • Requirement for additional funding to replace 4 systems serving Medium and Small sites (62). [4 systems c£425k each] • Replacement of Core System and roll-out of Handsets being progressed on a phased basis – £950k revenue funding has been approved to progress this during 2016/17 • Proposals being developed for independent secure cable route to improve resilience .	**Human Resources & Organisational Development**	

		considerable period. These phone systems are well beyond their expected life and desperately need to be replaced.			

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	Design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding).	• Increased environmental monitoring to check for failures of sterility in the unit • Expiry dates of all products prepared has been reduced to a maximum of 24 hours.	• Confirmation of the funding for the business case for a new build aseptic suite co-located with the Mandeville Unit was received at the end of July. The design team have met with the aim of commencing the build in March/April 2017. • Recent deterioration in the fabric of the building has been addressed through an interim plan involving urgent minor works to the aseptic suite which was completed in mid-May 2016. • The external auditor revisited the suite on 26th July 2016. Their report is awaited. From discussions with the lead auditor on the day, it is expected that their report will still class the unit as high risk, but will recognise the work that has been done to manage this risk whilst the new unit is awaited.	**Director of Acute Services**	

	Increased risk of significant service disruption due to high degree of construction activity on Trust sites	• Use of competent 3rd parties- Professional Design Teams & Contractors- competency is part of procurement assessment • Competent staff and comprehensive procedures • Wide stakeholder engagement on all projects • Project specific information- pre-construction information, construction phase plan and Health & Safety File • Use of in-house rules 'Requirements for contractors' in work schemes • Use of work permits for higher risk work processes • Communications team & global email used for wider general & public communications • Annual plan of works	• Recruitment of 'project compliance officer' type of role who would provide a constant presence on work schemes to review Health and Safety, permit compliance, quality, etc. to be progressed in 2016/17 • Longer term planning of work schemes and allocation of funding to spread (on-site) work schemes over the entire year rather than in the 4th quarter which is generally the case. • c£500k funding approved for the creation of additional car parking spaces on the Craigavon Area Hospital site during 2016/17 • On Craigavon Area Hospital site provide an additional site entrance/ exit – design proposals to be developed 2016/17 • Updates to 'Requirements for contractors' document underway	**Director of Human Resources and Organisational Development**	

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	Availability of capital (and associated revenue) funding to maintain and develop existing ICT estate, including server infrastructure, data storage, etc and support to ICT service modernization Specific risks relate to ability to implement planned upgrades / infrastructure as foundation to support developments in ICT innovation and limits these developments within the Trust All ICT resources are Currently targeted at Maintaining existing levels. Specific risks include-: Capacity to expedite/support mobile working roll out which subsequently (impacts on front line service capacity workforce risks below)	• ICT infrastructure requirements in terms of maintaining existing services have been prioritized in the IT Business plan approved by Trust Board and shared with HSCB. • Retention and disposal protocols in place • E-mail Archiving policy and procedure approved by SMT March 16.. • Bids for funding continue to be made to Capital Allocations Group and e-health division of HSCB for access to slippage. IS Technology partners utilised to provide support in line with available NR resources. Prioritisation is being given to maintaining existing services and replacement of existing devices to upgrade them and minimize support requirements. Service requests for more laptops and mobile devices are currently being declined.	• On-going prioritisation and bidding process for capital in place • Policies and procedures in place to manage ICT storage capacity. • A business case is underway to outline the full costs (including staff support) associated with further IT users. • All internal business cases for IT innovation include the recurrent support costs for both infrastructure requirements, licensing and service desk. A number of vacancies previously held as part of corporate contingency have been released in 16/17 The Trusts technology partner Hewlett Packard is providing temporary non-recruitment staffing to support Trust operational management in 16/17 A business case is being developed to outline full costs (including staff support) associated with further IT users within the Trust. Processes in place to ensure all internal business cases for IT innovation include the recurrent support costs for both infrastructure requirements, licensing and service desk.	**Director of Performance and Reform**	**HIGH**

DOMAIN 2: SAFETY AND QUALITY

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE

RISK AREA/CONTEXT: WORKFORCE RESOURCING – WORKFORCE SHORTAGES

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
6	**Workforce Resourcing Risk – Workforce shortages** The Trust is facing a number of workforce resourcing risks, including the following key risks: **Medical shortages** • Consultant Medical Staff in Dermatology, Emergency Medicine, Breast Surgery and Radiology • SAS Medical Staff in Anaesthetics, General Surgery, GP Out of Hours, Urology, Dermatology, Emergency Medicine and Paediatrics	**Key controls to include:** • Ongoing recruitment (including overseas) campaigns • Use of Locum agencies • Risk Assessment highlighting controls/action in place • Trust Senior Oversight Group for ED DHH • Escalation procedures in place to alert senior management of any changes in rota for ED DHH • Daily review by Senior Management of night reports and follow up on issues on ED DHH • Daily audit of notes for ED DHH • Close monitoring of all Breast referral waiting times • Submission of HSCB Unscheduled Care Escalation plan (6th May 2016)	**Dermatology Medical:** A Dermatology trainee is now required to rotate to Craigavon one day per week. This should encourage trainees to apply for Consultant posts in Craigavon. Two retired Consultants continue to undertake some Waiting List Initiatives (WLI) clinics for Dermatology. There has also been an increase in expanding nurse led clinics. However there is still a requirement for a new (3rd) Consultant post which will be difficult to fill. **Emergency Medicine:** The Southern Trust has advertised Consultant ED posts to cover on the Daisy Hill Hospital (DHH) site, but so far have been unsuccessful. 2 Consultants were recently appointed to CAH. There is another advert out closing in August 2016 for Consultant ED CAH (with sessions in DHH) – no applicants to date.	**Human Resources & Organisational Development/ Medical Director/Director of Acute Services**	**HIGH**

			The Trust is regularly raising the requirement for ED locums with all contracted agencies and other known non-contracted agencies. Apart for occasional ad-hoc cover, it has been very difficult to secure any 'longer term' cover. Ongoing review of ED DHH medical rota to ensure senior doctors are on duty until midnight. Opening of observation area from 22.00 – 08.00 for patients who have no definite diagnosis and have not been assessed or discussed with a Registrar. Recruitment of senior nursing staff to be on duty 24/7. **Breast Service** The Trust has secured the services of a part time Breast radiologist until 31st December in the first instance to support service provision. As an interim measure The Northern, South Eastern and Belfast Trusts are offering additional clinics to see a proportion of Southern Trust red flag referrals to reduce the waiting time for the triple assessment appointment to clinically acceptable levels. Transfers of patients have occurred over recent weeks and we are seeing waiting times falling. A number of our own surgical Breast medics have increased their job plan capacity which now enables them to undertake additional sessions in house , again to increase capacity and reduce		

			waiting times. The Breast service has met with Dr Gerry Millar to explore options for further GP training on the management of Breast Pain to enable these patients to be appropriately assessed and treated in their own GP surgery and further that we would train a small number of GP's with specialist interest in Breast pain who could assist with specific breast pain clinics working in conjunction with secondary care colleagues to manage this group of patients outside of the triple assessment clinics so increasing capacity for suspect cancer patients. There are further discussions planned and underway with other Trusts regarding the potential for a more sustainable network, providing cross Trust working to enable the provision the required capacity in Symptomatic breast services to meet Southern Trust demand. There are plans by the HSCB to review Breast services from a regional perspective with a view to supporting a sustainable service design to meet the needs of the whole population. This is expected to commence in the Autumn 2016 **<u>Radiology</u>:** The position remains unstable. Four consultant posts were advertised in April 2016 with only one applicant who has since been appointed. The remaining posts will be re-advertised in September 2016		

		• Business Continuity Plan for GP Out of Hours Service • Medical Managers with medical responsibility for the GP Out of Hours service • On Call Manager system for GP Out of Hours Service • Daily monitoring of GP Out of Hours rotas and appropriate contingency plans deployed based on resources available • Pharmacy Service in place in GPOoHS until March 2017 • Any concerns raised by GPs on the safety of the service will be escalated and addressed by Trust and HSCB. • Contract with Dalriada Out of Hours for additional Nurse Triage 6pm-8am from December 2015.	The Trust engaged with A Team Recruitment regarding the recruitment of medical staff at SHO level from the EU. A total of 10 doctors have now accepted offers – 2 paediatrics, 7 surgery, and 1 ED DHH. It is expected that the doctors will be ready to commence once requirements for GMC registration are processed by end of December 2016. **<u>GP Out of Hours</u>:** • The Trust has escalated the risk to HSCB and DHSSPS, and has had joint meetings. • Action Plan in place including actions from reviews. • The process of over-seas GP recruitment commenced in December 2015. • 2016/17 HSCB and Trust additional costs scheme implemented in June 2016. • Twice daily operational meetings to review medical cover and contingency actions implemented. • Capacity and demand work is ongoing. Review of workload of clinicians is ongoing by Clinical Lead. • HSCB Local Enhanced Service scheme to attract GPs to work in the service circulated to all GPs by HSCB in July 2016. • Rates have been enhanced over July and August due to annual leave	**Director of Older People and Primary Care**	

			of GPs to secure cover. • KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB. • Urgent KPI response in 20mins, Jan–Mar 84% and Apr–Jun 86% - there is an improvement in the KPI. • Vacant shifts, Jan–Mar 35% and Apr- Jun 26% - there is a reduction in the % vacant shifts.		

	Nursing shortages • Inability to recruit Registered Nurses across all areas, including Health Visiting Service	• Ward Sister/Charge Nurse management of available staff on a shift by shift basis • Assistant Director/Head of Service (Operational) oversight regarding availability with possible redeployment of staff to respond to prioritised need • Escalation to Operational Director as required • Open registration for Nurse Bank • Open Recruitment for Adult Band 5 Nurses with interviews scheduled every 2 weeks • E-rostering roll out • International Recruitment • SHSCT staff attend all local university job fairs to promote working in the SH&SCT	**<u>Registered Nurses</u>:** • International recruitment is now progressing on a regional basis.. • EU and non-EU recruitment drives commenced in May 2016 with a recruitment exercise in the Philippines, Italy and Romania (92 posts have been offered for SHSCT from the Philippines to date and 17 posts offered from the campaign in Italy). A further campaign is planned for October. • Rotational Programmes continue to be a unique attraction to working in the SHSCT. Further roll out continues to be explored within and across Directorates, with anticipated interest of approximately 25-30 student nurses for a programme to commence in September 2016. • Department of Health announced increase to adult pre-registration training places by 100 commencing September 2016. Associated work has commenced to further access student placements across the Trust • SH&SCT have worked with OU and Department of Health to maximise funding and been successful to increase significantly the number of places on the OU PRNP commencing September 2016. SH&SCT have 23 staff commencing in September 2016, 7 of these staff are entering stage 2 of the programme with a further 16 commencing stage 1 of the programme. In addition 5 staff have	**Executive Director of Nursing/ Human Resources and Organisational Development**	

		Health Visiting Service: • Control measures in place include step down i.e. universal contacts to non-vulnerable families have been reduced; • Utilisation of bank (limited supply) and additional hours of existing health visiting staff; • Drop in clinics available to ensure rapid access to HV if parent worried or concerned about an infant / child; • Rota system is in place to equitably allocate clinic cover, new births, movement in visits and new safeguarding cases; • Team managers to notify HoS and Named Nurse for Safeguarding Children if they are unable to allocate a child protection case. • Provision of universal contacts is being monitored across service/teams on a quarterly basis through IoP report and this information is sent to Director/DHSSPS/HSCB/PHA	been given a deferred place for stage 2 of the programme in 2017 • Collaborative approaches to local recruitment by the 5 HSC Trusts are being taken forward through the Regional Recruitment Working Group **Health Visiting Service:** • Ten Health Visiting students are currently training in the Trust but won't complete until September 2016. External recruitment was progressed and a new waiting list has been developed with 4 candidates and BSO is in the process of offering permanent posts. It is unlikely that all our permanent vacancies will be filled until the next cohort of students qualifies in September 2016. • In communications with the HSCB and PHA regarding the Health Visiting workforce, assurance has been given that SHSCT are proactively processing vacancies in order to appoint staff as soon as possible. • The Trust is currently waiting for confirmation from the PHA regarding regional normative staffing range using information from regional Ecat caseload weighting tool. • This situation is exacerbated by the reduced capacity of the Family Nurse Partnership team (detailed on the CYP Directorate Risk Register).	**Director of Children and Young People's Services**	

	Failure to attract/appoint required staff and delays in recruitment processes in mental health/disability inpatient wards, community teams, supported living and day care facilities	• Use of Agency • Cyclical recruitment monitored and reviewed to ensure waiting lists are updated • Creation of the training role with specific interest in disability and mental health	• Additional hours for existing workforce has improved the situation temporarily • Transfer of staff to meet need is becoming increasingly difficult as many services are also stretched due to staffing pressures Introduction of a local transfer policy to assist this process • Undertake recruitment drives for adult practitioners with advertising specific to Mental Health and Disability Directorate – currently ongoing. • Undertake recruitment drives initially within CAMHS, then CAMHS & Adult Mental Health and if no success then externally for specific training posts. • Creation of local banks • Improve linkages with Southern Regional College to facilitate career advice on Health and Social Care related roles and visible presence at open days	**Director of Mental Health and Learning Disability**	

	Reduced ability to provide 24/7 laboratory service at Daisy Hill Hospital due to insufficient Biomedical Scientists New Regional IT implementations such as NIECR, BSTP and HRPTS have not included recurrent funding for local IT support	• Shadow rota in place from 1st July 2016 • Ongoing training in blood transfusion • Procedures in place in absence of Biomedical Scientist support on site	• The laboratory service is currently training as many Biomedical Scientists as is possible to function on the Daisy Hill Hospital rota. However, training in all aspects of Blood sciences and Blood transfusion takes a significant period of time. • Approval has been given to recruit 4 additional Biomedical Scientists and these are being advertised in September 2016. . The issue has been raised at the Regional Pathology Network Board.	**Director of Acute Services**	

DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Achievement of Statutory Functions/Duties					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
7	The Trust should have robust case management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Case Management process.	• New Trust Case Management Guidance	• Mental Health, Learning/Physical Disability and Older People and Primary Care training completed. • Internal Audit of Case Management completed. Heads of Services tasked with taking forward required actions. • Restructuring process by Heads of Service completed within the Mental Health and Learning Disability Directorate.	**Director of Mental Health and Disability/ Director of Older People and Primary Care**	**MEDIUM**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
8	Capability of Trust systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 1. Monitoring and assurance of implementation/ compliance with Standards and Guidelines 2. Effectiveness of processes in place to review all intelligence from incidents, complaints, litigation and user feedback to highlight areas of risk and safety to drive improvement 3. Effectiveness of processes in place to disseminate and share learning from incidents, complaints and user feedback across the organisation	• Standardised process in place for the dissemination of Standards and Guidelines across the Trust • Web-based incident reporting in place across the Trust • Screening and investigation procedures in place in operational directorates with regards to incidents and complaints • Clinical and Social Care Governance information presented in dashboard format to SMT Governance and Governance Committee using trends over time to highlight risk • Guidelines in place for Directors setting out triggers for presentation of SAIs to SMTand Trust Board • Directorate, Division and Professional Governance Fora in place with reporting arrangements to SMT Governance, Governance Committee and Trust Board • Mortality and Morbidity structure in place across all clinical specialties • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback	• Standards and Guidelines database to be updated to improve tracking of compliance and reporting functionality – September 2016 • Ongoing improvement of processes to disseminate learning across the Trust via - Learning Letters - Safety Alerts - Professional Forums - Mortality and Morbidity meetings - Incident screening processes • Develop corporate system to track compliance and report on RQIA reviews action plans – December 2016 • Develop the use of Clinical and Social Care Governance Audit to provide assurance of compliance and identify risk – September 2016 • Implementation of the Trust's Quality Improvement Framework.	**Medical Director**	**MEDIUM**

		to Chair and Chief Executive • Executive Director Reports to Trust Board • Continuous Improvement support function to front line staff – capability and capacity building for service improvement • Trust Annual Quality Report • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy .			

DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: HCAI					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
9	• Risk to achievement of HCAI Priorities for Action targets • Risk to patient safety • Lack of automated HCAI surveillance system linked to Trust laboratory system • Lack of appropriate isolation facilities (including negative pressure facilities in Daisy Hill Hospital) within the Trust hospital network • Increasing emergence of infections (CPE/VHF) • HCAI outbreaks in tertiary services • Depletion in IPC Nurse staffing	• Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored IPC training • Manual surveillance systems in place. Independent and self-audit programme • Comprehensive governance structure in place, including bi-monthly HCAI Strategic Forum and monthly HCAI Clinical Forum meetings • Outbreak /incident management plan in place • Establishment of antimicrobial management team to oversee antimicrobial stewardship • HCAI Root Cause Analysis process in place • CDI 'trigger' system in place • Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self and independent audit using the RQIA Augmented Care Audit tools. • Learning outcomes from RCAs being shared with senior and junior medical staff. • Engagement opportunities to be created with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases • Embedding Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters across community and acute sites – this requires resource. • Engagement with PHA on Regional Surveillance system funding and procurement to recommence • Enhanced communication to front line clinical staff via HCAI e-Alert • Suite of procedures and guidelines to support the prevention, management and control of CPE. • Enhanced HCAI RCA information management system and system developed to further improve meta-	**Medical Director**	**MEDIUM**

	• Reduction of Microbiological medical workforce from four to two Doctors through loss of a Staff Grade and Special Registrar attachment • High bed occupancy rate and limited isolation resource • Increased Estates new builds and refurbishment reduce number of facilities available	• Close liaison between IPC Team and Patient Flow Team • Close liaison between IPC Team and Estates colleagues	analysis of C Difficile cases • Re-launch of IV Programme in Acute sites to address increasing MRSA/MSSA bacteraemia • Electronic C Difficile database is under significant review and a new model is being created in this regard. • Implementation of a CDI 'trigger' system that will act as new early warning criteria to identify potential CDI outbreaks earlier • Development of Clinical Antibiotic Stewardship champions to implement new Antibiotic Stewardship Policy • Seeking funding that will support continuous drive to recruit suitable IPC staff • Appointment of locum Staff Grade and seek funding to secure this as a permanent post		

DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Safeguarding of residents from risk of potential financial abuse					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
10	Safeguarding of residents within Irrelevant information - Historical and ongoing risk to residents of potential financial abuse.	• Review of Residents within the Care Management process. Residents' reviews are held more frequently if required. • Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out of 5 moved • Liaison with the residents, relatives/families where appropriate. • Weekly Trust meetings to review status & regular updates provided to Trust Board / SMT. • Regular updates from Trust Irrelevant information group provided to DHSS/HSCB/RQIA/Other Trusts • Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel.	• Ongoing liaison with the residents, relatives/families where appropriate. • Suspension of new admissions/respite beds remains in place. Current controls to remain as agreed by SMT and Trust Board and QA by independent "critical friend" review (January 2016) • Updates routinely provided to Trust Board • Trust staff attended a meeting in Irrelevant information redacted by the USI offices on 8th July 2016. The home owners did not meet directly with Trust staff but communicated via their solicitor. on 15th July 2016 Irrelevant information redacted by the USI wrote to the Trust outlining a proposed way forward regarding day care meals, transport invoices (but not historical transport monies owed as per safeguarding investigations) and clients "A" (mobility car) and "B" (statutory disregard monies owed: £50). No agreement was	**Director of Mental Health and Disability Services**	**HIGH**

		• Regular advice/support/ direction by Trust Legal Advisers • Contract Review Meetings with Irrelevant information and quarterly operational meetings with Irrelevant information as part of the contract compliance process. • Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives. • Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff. • Trust addresses any identified concerns/queries raised by DHSSPSNI/RQIA. • Adult Safeguarding Process. Remaining residents have care and protection plans which have been put in place and updated as required. • Contacts with RQIA • Trust "Procedure for Responding to RQIA Alerts & Other Performance Management issues within Social Care Contracts". • Ongoing processes with OCP / RQIA / NMC / HSCB	reached re additional payments monies owed. Irrelevant information redacted by the USI quoted case law and invited the Trust to reconsider its position on suspension of admissions. The Trust responded via its legal advisers on 27th July 2016 advising that the Trust's decision to suspend new admissions remains in place. The Trust legal advisers considered the case law example provided and do not accept its application in this case.		

		re SAI, Disclosure & Barring Service (DBS) • Trust assumed responsibility for mobility monies which are now held in PPP accounts and payment is only made on receipt of verified invoices. • New Trust Case Management Guidance and Training Programme completed.			

DOMAIN 3: FINANCE

LINK TO CORPORATE OBJECTIVE 5: MAKING THE BEST USE OF RESOURCES

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
11	Achievement of recurrent financial balance	• Contingency Plan in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	• Whilst it is early in the financial year and TDP approval still awaited, the first 4 months outturn would indicate in-year breakeven. It is hoped this can be maintained through a range of non-recurrent measures, including natural slippage on allocations.	**Director of Finance and Procurement and Operational Directors**	**MEDIUM**
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
12	Management and monitoring of procurement and contracts – not compliant with best practice guidance Lack of regional formalised guidance/agreed approach for management of social care procurements under threshold value of £589k	• Guidance on Direct Contract Award processes issued and reminder global emails circulated regularly. Follow up training and advice available as required from Head of Purchasing and Supply • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out with follow up sessions also delivered	**GENERAL** • Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing (Central monitoring ceased in October 2013)	**Director of Finance and Procurement**	**MEDIUM**

			• Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Trust continues to highlight in Governance Statement the lack of central resource in Trust for contract monitoring • BSO PALs undertake contract monitoring for those regional contracts awarded through them **ESTATES** • Proposed models brought forward by PALS and Trusts on regional basis to address procurement deficit for Estates services agreed by Directors of Finance. Recruitment of Phase 1 PALS team complete. Recruitment of Trust Team underway – anticipated completion November 2016 • Measured Term Contract (MTC) in place which mitigates risks to procurement for schemes <£45k • Volume of works being undertaken balanced against resources to facilitate compliance • Actions arising from Internal	**Director of HROD**	

		• Regional Steering and Working Groups established.	Audit report either complete or in progress. • Recruitment of additional Procurement Officers and 2 x replacement Estate Development Officers to be completed in second quarter of 2016/17. **SOCIAL CARE PROCUREMENT** • Regional Procurement Board via Social Care Procurement Group have agreed approach to social care procurement for overthreshold contracts (c£589k). No approach agreed for allocation of funding under this value. • Internal plan to be developed to secure necessary resources, skill and capacity to take forward a limited number of social care procurements as part of hub and spoke model with Trust staff operating under the influence of the Centre of Procurement Excellence (CoPE) • Capacity sought via HSCB transitional funding in 2014/15 for social care procurement of key projects including (Learning Disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid	**Director of Performance and Reform; All Directors**	

			approved, however recruitment has been suspended due to financial pressures. • Internal resource diverted to provide procurement support to key mental health directorate projects in 2014/15 enabling change. This capacity has been extended into 2015/16. • Further capacity established in October 2015 to support domiciliary care procurement from redirected internal resources. • Trust proceeding to recruitment of two substantive posts further to agreement with BSO/PALs on job roles		

DOMAIN 4: OPERATIONAL PERFORMANCE AND SERVICE IMPROVEMENT					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Achievement of Commissioning Plan Standards and Targets					
No	**Description of Risk**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
13	***a) Waiting times in excess of Commissioning Plan Standards / Targets across***: • Out-Patients; • Diagnostics (including Endoscopy); • In-Patients and Day Cases (Acute; CYPS; Mental Health; and OPPC areas) • AHP professions	INTERNAL MONITORING: 1. ***Fortnightly Operational Performance meetings:*** • Acute Directorate 2. ***Monthly Operational Performance meetings***: • Mental Health & Disability Directorate • Children and Young People's Services Directorate • Older People and Primary Care Directorate 3. ***Monthly Operational AHP Performance*** - Cross- directorate ***4. Monthly reporting to Senior Management Team and Trust Board*** 5. ***Monthly exception reporting to Operational Directorates In-Year Assurance meetings with Chief Executive.***	**a) Access Times** **Outpatients** - Delivery of Service and Budget Agreement (SBA) volumes (where agreed) remains first priority within Operational Directorates. Prioritisation of Red Flag and urgent assessment/treatment. Delivery of routine patients will follow, based on chronological order. Recurrent capacity 'gaps', which have been agreed with Southern Local Commissioning Group remain in a range of specialty areas affecting routine access times across diagnostics, inpatients/daycases and outpatients. **Diagnostics** - Non-recurrent allocation received for additional Diagnostics imaging and reporting capacity (including Endoscopy) in 2015/16 and 2016/17. The volumes allocated does not address the gaps in all areas but assists with stemming the growth of long waits The additional diagnostic volumes	**Performance and Reform and Operational Directors**	**HIGH**

		EXTERNAL MONITORING: 6. **Monthly** Elective and Unscheduled Performance meetings with Health and Social Care Board **ACTION PLANNING:** 7. Implementation plans in place to reduce access times, where demand remains static, and additional ***recurrent*** capacity has been invested/ approved via IPT 8. Periodic plans developed aligned to ***non-recurrent*** allocations of available funding for elective access via HSCB 9. Operational plans under development to maintain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times.	allocated cannot be secured via in-house capacity alone and challenges have been faced securing Independent Sector capacity. The Trust is currently re:-testing market for available capacity (August 2016) Investment was received in 2015/16 to increase capacity in MRI and proposals have been submitted for a 2nd CT mobile (capital & revenue) with expect additional capacity on site in early 2017. **Inpatients/Daycases and Outpatients** - £700k of non-recurrent funding has been made available by Health and Social Care Board (HSCB) for elective areas in Q1/2 in 2016/17. This is insufficient to address the gap and as such the Trust has prioritised this to the following areas:- • Longest outpatients waits beyond clinically indicated timescales; • Outpatients waiting over 26 weeks; • Inpatient and Daycases waiting over 52 weeks; • AHPs The Trust will continue to re-direct any available internal resources to areas of greatest risk as funding becomes available or as operationally feasible (re Workforce capacity) throughout 2016/17		

	b) Plain film reporting only maintained at current level, which excludes films that have been categorised as IRMER'ised (Ionizing Radiation Medical Exposure Regulations) with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations		**AHP Access Times-** Additional capacity has been provided in AHP areas (from the £700k) funding where temporary staff can be secured. However, due to the short-term nature, the Trust has faced challenged in securing temporary resource to increase capacity. A regional demand and capacity analysis undertaken by PHA/HSCB concluded with formal gaps in capacity recognized by the commissioner. No specific funding has been provided. The Trust is seeking to prioritise within existing resources and demographic funding to address these gaps in part in 2016/17. Due to accrued backlogs, waits for routine patients will still be in excess of agreed position. Focus remains on urgent cases. **b) Diagnostic Imaging Reporting** Non-recurrent allocation for plain film reporting was received from HSCB in 2015/16 and 201617 for the recognised capacity gap in this area. Increasing demand coupled with manpower issues, is creating a more significant gap. An operational plan is in place to focus capacity on urgent and prioritised areas, including plain film chest x-ray The Trust has sourced additional capacity via two independent sector contracts which are predominantly utilised to support the gap in plain film reporting.		

			Internal additional reporting capacity has been focused on scanning and reporting CT, non-obstetric ultrasound and MRI examinations. HSCB has provided early recurrent funding for the implementation of plain film reporting by radiographers for ED films to partially address the gap. Trust has submitted proposal for training of radiographers to increase reporting capacity in plain film and non-obstetric ultrasounds. Whilst this has not been funded yet the Trust has agreed to prioritise a number of posts into training to reduce the lag time for implementation.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
	a) Out-Patient Review and Planned Treatment Backlogs ***Out-Patient Review Waiting List Backlogs in:*** • Acute; • CYPS; • MHD; and • OPPC	Internal and External monitoring controls included as in Corporate Risk 1 above. <u>ACTION PLANNING</u>: • Short-term validation exercise undertaken in Quarter 4 2014/15 within a limited number of Acute Services Directorate specialties • Operational workshop undertaken to review the ability to identify red flag and urgent reviews on the out-patient review waiting	**a) Outpatient Backlog** At the July position, there were a total of 16,450 patients waiting in excess of their clinically indicated timescale for review out-patient appointment (Dr-led acute, children's and older peoples services) and 1317 for mental health services. (Visiting Specialties managed by other Trusts are excluded). Longest routine waits extend back to 2013/14. • In 2015/16 Trust diverted internal resources to provide additional capacity for review patients; 5000 additional patients were seen		**HIGH**

	b*) Planned Patient Backlogs** • Acute only On-going risk with a significant volume of patients waiting ***past their clinically indicated review timescale in Outpatient and AHP services.	list and the processes for monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.	• In 2016/17 some additional review patients were prioritized for additional capacity from the £700k non recurrent allocation; however total volume of those waiting beyond clinically indicated dates has started to increase again. The Trust will continue to re-direct internal resources to areas of greatest risk as funding becomes available or as operationally feasible throughout 2016/17. Operational process are in place to ensure patients requiring clinically urgent review are prioritised. **b) Planned Patient Backlog** As at 1st August 2016, there were a total of 1560 patients on the planned treatment backlog. The longest waiting patient dates back to October 2014 and relates to Urology. 79% (1237) of the planned treatment backlog relates to Endoscopy with the longest substantial wait from January 2015. Non recurrent funding received in 2015/16 and allocated for 2016/17 is insufficient to meet the demand for new and planned repeat endoscopy. Priority is given to red flag, urgent and planned patients initially, then routine waits.		

			Operational processes have been established to prioritise those planned patients that require urgent review. In line with JAG accreditation requirements, the planned treatment backlog should not exceed 6-months. **c) AHP review backlogs** AHP backlogs for review are not as readily quantifiable. However, available information indicates significant review backlog volumes within Podiatry; Speech & Language Therapy; Dietetics; and Occupational Therapy**.** The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available however, ability to access staff on short term contracts remains challenging. Short term AHP capacity is prioritized from the £700k of non-recurrent funding made available in Q1/2.		

Southern Health and Social Care Trust

Summary Corporate Risk Register

January 2022

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register is linked to the relevant Corporate Objectives contained within the Trust's Corporate Plan 2017/18 – 2020/21 as detailed below:-

Corporate Objectives

1: Promoting safe, high quality care.
2: Supporting people to live long, healthy active lives
3. Improving our services
4. Making the best use of our resources
5. Being a great place to work – supporting, developing and valuing our staff
6. Working in partnership

The overall risk score is based on the cummulative assessment of the likelihood and impact of each risk trigger as summarized in the Risk Assessment Matrix below:

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels					
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**	**Total**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**	**25**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**	**20**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**	**15**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**	**10**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**	**5**

Risks are scored for inherent risk, residual risk and target level of risk. Each is defined below.

Inherent Risk is the current risk which exists before any management controls are applied. This enables decisions to be made about resources and the level of priority given to managing a risk.

Residual Risk is determined as the level of risk that remains after existing controls have been actioned. The residual risk gives an indication of how effectively a risk is being managed by existing controls.

Target Level of Risk is the level of risk that management has set as its target level of risk.

SUMMARY OF KEY DEVELOPMENTS

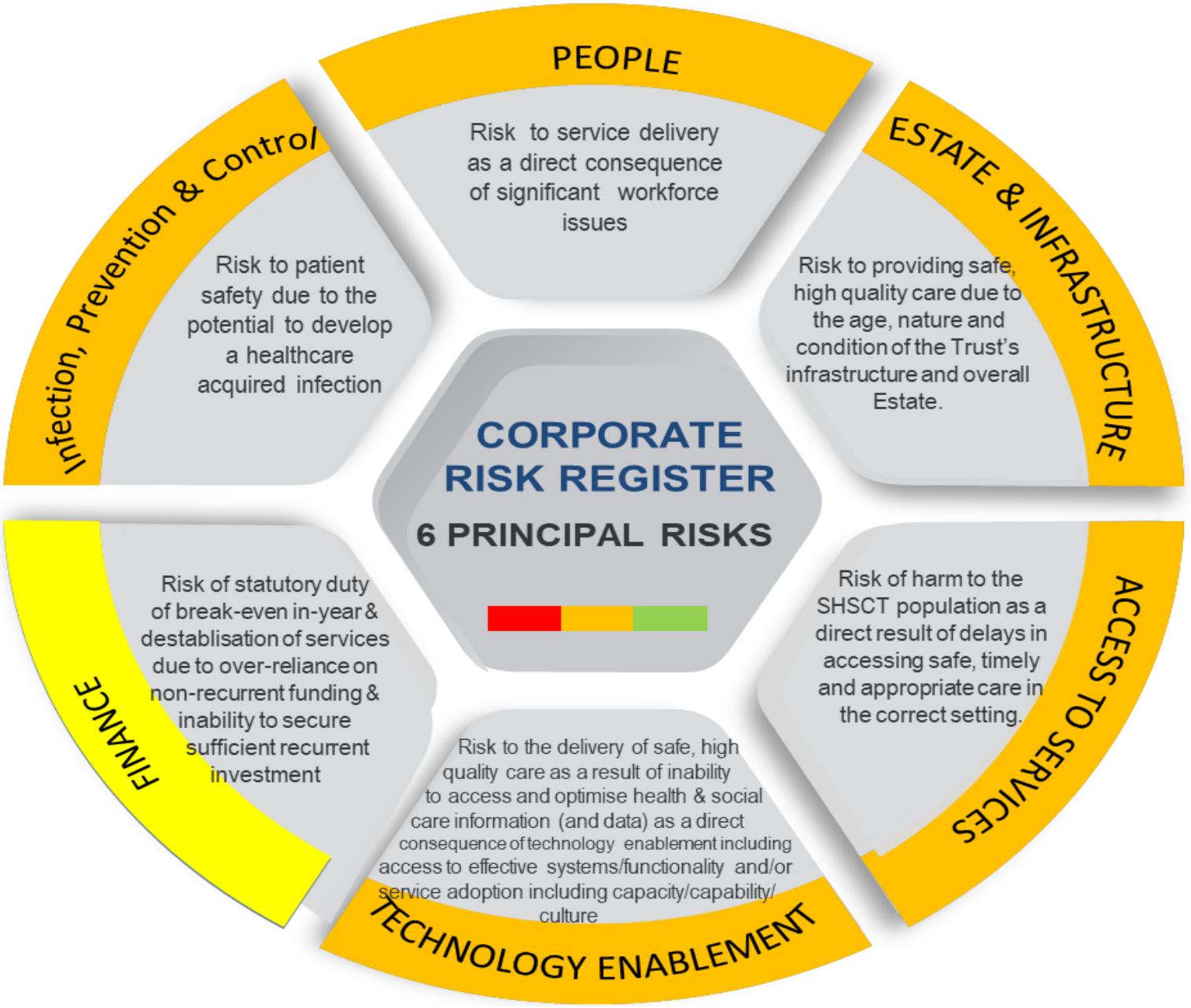
SMT continue to focus on building a more agile Corporate Risk Register around six principal risk areas. This document provides a summary of the risks and details the key actions planned by the SMT to manage these risks and achieve progress against the Trust's corporate objectives.

The high level risks identified in the Corporate Risk Register are underpinned and informed by risk triggers overseen at an operational level within Directorates and are captured in a supplementary document.

PROPOSED CHANGES TO THE REGISTER

(to be updated following SMT on 1st February 2022)

The diagram overleaf provides a snapshot of the risks on the Corporate Risk Register



1. People

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Lead Risk Owner**
Risk: Risk to the delivery of safe, quality and timely care as a direct consequence of significant workforce issues.					**Director of HROD**
Original Risk Rating	**Key risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
15 (5 x 3) HIGH	1.1	Risk to the consistent provision of high quality, safe medical care due to **medical** workforce shortages and vacancies within some specialties (exacerbated due to Covid-19)	**15 (5 x 3) HIGH**	1. Improvements in metrics / dashboards to demonstrate progress with vacancy fill rates **Further work to be commenced on producing metrics** 2. Workforce Plannings meetings for Medicine CAH/DHH and Emergency Medicine to produce the papers to feed into the IPTs in order to seek to secure additional funding **Hopefully IPT complete in next 1 - 2 weeks** 3.Development of e-rosters for Physician Associates 4. Ongoing International Recruitment using new framework and seek to secure agreement to fill posts at lower level and train up through Southern Academy 5. Apply for IMT3 level training post to replace current MTI / CF to enhance sustainability in DHH 6. Forward planning through Royal College for replacement MTIs for August 2022 7. Set in place Task & Finish Group to review the rotas at risk and work with BMA regarding their Fatigue Charter to work through actions to help recruit and retain doctors. **Rotas to be reviewed in conjunction with charter to ensure thet meet with requirements. Updated rotational junior doctor portal with information about rest and rotas**	**9 (3 x 3) MEDIUM**
	1.2	Risk to safe, high quality care due to a high volume of **medical locum** engagements for different periods of time with varying levels of experience/training and often in hard to fill posts.		1. Embedding of arrangements for established Locum Oversight meetings including development of dashboards, datasets etc. to manage locum usage 2. Locum rate proposal - continue to secure regional consideration 3. Review of Clinical Fellow pilot and impact on locums	
	1.3	Risk to the consistent provision of high quality, safe nursing care due to **nursing and midwife** shortages and vacancies across all Directorates, and high **nursing agency usage** (exacerbated due to Covid-19)		1. Resourcing dashboards for each acute ward, in first instance, to be finalised - vacancies, ML, SL, bank / agency, new starts / leavers along with heatmap of red areas to enable targeted recruitmen and retention action plans to be developed 2. Pilot of new Exit Interview approach 3. Agency reduction taskforce group to be established for acute services in first instance 4. Revised N&M Workforce Action Plan to be finalised with Year 2 actions (post covid) 5. Covid payment rate scheme to continue	
	1.4	Risk to staff **engagement, morale and health & wellbeing** due to workforce capacity / demand pressures. (exacerbated due to Covid-19).		1. Development of published version of People Plan and associated engagement plan 2. Progression of Long Covid business case for pilot staff service in Occupational Health 3. Development of a Health and Wellbeing Framework for 2021 - 2024 linked to the People Strategy 4. Continued roll-out of Creating a great place to work initiative (focusing on health and wellbeing, relationships and behaviours) supporting all our people, our managers / team leaders and teams - 5. Continuing initiatives focusing on supporting workforce groups - disability, age and race to include establishing Minority Ethnic Staff Network 6. Focused efforts on increasing appraisal compliance & development of reviewed appraisal system for Agenda for Change staff 7. Development of new staff support pathway into Occupational Health & Wellbeing Team	
20 (5x4) Extreme	1.5	Risk to the management of the Trust's statutory responsibilities under the Mental Health (NI) Order 1986 due to insufficient numbers of Approved Social Workers to provide a robust rota covering emergency assessments for detention.	**20 (5x4) Extreme**	1. All available ASWs to increase their rota commitment by an additional day/month (20 days which would considerably bolster the rota). Requires core team support for reduction of caseloads in recognition of extra responsibilitie. 2. Release of ASW availability from within existing resources 3. Consider additional payment for ASWs with management responsibility who cannot be afforded any easement 4. Improve Communication with Core Team line managers. Communication with ASW's 5. Continue to promote the ASW programme particularly across OPPC / CYPS	**12 (3x4) HIGH**

1. People

Corporate Objective Alignment: Promoting Safe, High Quality Care	**Lead Risk Owner**
Risk: Risk to the delivery of safe, quality and timely care as a direct consequence of significant workforce issues.	**Director of HROD**

Original Risk Rating	Key risks	Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating

REVIEW HISTORY

Review Date:	Jan-22

Summary of SMT Discussion:

1.1

a) Workforce planning meetings for Medicine CAH and DHH and Emergency Medicine are ongoing and Workforce planning papers have been developed for Medicine CAH and Medicine DHH & need to be fed into IPT bids to seek additional funding to support more consultant and SAS posts

b) Rotas at Risk summary has been updated to reflect current situation across service areas

c) Agencies assigned to International Medical Recruitment Project have been advised of current hard to fill vacancies and are working on CV's

d) Following the successful implementation of the Clinical Fellow model on the Junior Tier, we recruited 9 Gen Med CAH, 4 T&O, 5 x ED CAH, 2 Urology, 2 ED DHH (3 of which are international doctors)

e) 8 Physician Associates commenced in post in November 2021 (Mental Health, Card DHH, Diab & Endo DHH, Gen Surg, T&O, ENT/Urology, Medicine CAH, Ambulatory Med)

1.2

a) 2nd Locum Oversight for Medicine/Unscheduled took place on 8th October 2021. Work in meantime to progress review locums in use and possible alternatives to be explored. Work will commence to review dataset for other service areas to identify trends and areas for action within next 3 months. Actions from the meeting will drive future direction of the meetings and workforce planning. 3rd meeting scheduled for 26th November 2021

b) Metrics have been produced for Medicine/ED to highlight areas of high locum usage and high levels of rate escalation. Over the next 3 months, we will aim to expand these metrics to illustrate trends and patterns in other service areas also

c) Regional Locum rates proposal paper has been presented to regional Human Resources Directors and Medical Directors. Plan for Medical Directors to write to the DoH to pursue a way forward

d) Ongoing Regional work to develop the Medical and Dental Agency Framework to ensure that it is fit for purpose.

1.3

a) Safe staffing data is shared weekly at SMT meetings

1. People

Corporate Objective Alignment: Promoting Safe, High Quality Care	**Lead Risk Owner**
Risk: Risk to the delivery of safe, quality and timely care as a direct consequence of significant workforce issues.	**Director of HROD**

Original Risk Rating	Key risks	Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating

b) All data has been collated and is currently being prepared into dashboard style for presentation for Nursing & Midwifery Steering Group for ongoing informed discussion on actions to be taken with regards recruitment and retention activity in targeted areas. Linkages have been made with Informatics to develop QLIK dashboards
c) Agency reduction taskforce group yet to be established for acute services in first instance. However work is progressing regionally with Innovation Lab to progress programme of work to inform the overarching work associated with eliminating off contract agency usage
d) N&M Workforce Action Plan to be finalised with Year 2 actions (post covid) - corporate nursing staff diverted to supporting covid surge pressures - no progress in last 3 months due to other workforce pressures

1.4
a) Recruitment commenced for Band 8a and 7 psychology support in November Band 7 recruited in Jan 22. Band 8a to be readvertised - no applicants.
b) Structure of People Plan developed, workshop and public meeting with Trust Board has taken place. Engagement plan to now be taken forward.
c) Meeting with Will Young to set context took place on 10th June. Review postponed due to Will Young moving out of Leadership Centre. Maxine Williamson pursuing Leadership Centre for another consultant to progress. Another HSCLC consultant identified, proposal taken to SMT and plans in place to commence work on reviewing leadership and leadership development.
d) Development of our medical leaders - 'Nexus' programme for AMDs and CDs and 'Navigator' Programme for new consultants and SAS doctors. Nexus on hold due to service pressues and Navigator currently being rolled out.
e) BAME network underway, Menopause cafe, disability training, progressing mental health awareness training with Recovery College team.
f) Recognition Paper presented and approved through SMT. Recognition Day and HWB day during QI week long programme
g)Succession planning programme launched for band 7 and 8a and aspiring directors. Initiative started and underway.

1.5
a) Risk remains extreme due to sick leave / retirements / special circumstances due to covid and F2F contact not permitted. Capacity to be released from core teams remains challenging as all teams are struggling with staffing .
b) Full time ASW post has been advertised – this will significantly improve situation
c) ASW bank has been established

Any change to risk rating following review? **No**

2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources					**Risk Owner**
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.					**Director of Finance, Procurement and Estates**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
16 (4 x 4) HIGH	2.1	Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate.	**16 (4 x 4) HIGH**	* Plans to improve Equipment Management function The Equipment Management Committee (Cross Directorate) held its first meeting on 1.6.2021 and subsequent meetings are held quarterly to drive forward an overall body within the Trust in relation to equipment management. Sharepoint has also been utilised to provide a comprehensive outline resource under Estates Medical devices. The Estates Equipment Manager has also taken over the Trust's equipment priority list from Acute Directorate to provide a Trustwide list of equipment needs which is presented to Capital Allocation Group for funding allocation, when available. *Development of Annual Capital Plans via Capital Allocation Group * Ongoing submission to DoH to influence 10 Year Capital Strategy Director of Finance and Estates is a member of the DoH Strategic Capital Development and Estates Oversight Group, one of the main objectives is to provide strategic oversight, leadership and direction setting for capital development and estates related functions in pursuit of regional service delivery objectives. Director of Finance and Estates met with DoH officials to discuss a range of potential schemes that would facilitiate improved ventilation, increased sanitary facilities at ward levels of prioritised areas. £8.7m capital investment has now been secured for these schemes to complete March 2022 Develop estate to provide more single side room provision, toilet	**9 (3 x 3) Medium**

2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources					**Risk Owner**
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.					**Director of Finance, Procurement and Estates**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
				facilities, improved ventilation Develop estate to provide facilities that meet the requirements for social distancing. there is a shortfall in MRI capacity which presentsa safety risk. We have 2 scanners and require 3 to meet demand. There is broad support from commissioner and they are actively seeking an IPT. We would place the 3rd scanner in DHH. The Trust has sought the funding needed to address the infrastructure/power issue in DHH. Short term solutions including provision of a modular MRI scanner nearby DHH is beig scoped. .	
	2.2.	Risk of significant disruption to clinical services and clinical risk due to loss of electrical power (LV) to main Craigavon Area Hospital block		A further sum of capital was obtained in October 2021 to progress the design of Phase 2 so the Trust will be in a position of readiness to procure works early in 2022/23 should funding be made available	

2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources				**Risk Owner**
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.				**Director of Finance, Procurement and Estates**
Original Risk Rating (Likelihood x Impact)	**Key Risks**	**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
	2.3 Risk to the Trust's potential to respond adequately to Covid-19 and other transmissible organisms due to the inadequate number of single rooms across both acute hospitals to deal with the volumes of infectious patients requiring admission and care		£8.7m capital investment has been secured for schemes to faciltate improved ventilation, increased sanitary facilities and storage facilities and storage at ward levels - these schemes to be completed March 2022. These works will assist in addressing some of the deficiencies in wards, however, due to the design of wards i.e. based mainly in 4 and 6 bed wards, issues will not be fully addressed until redevelopment of wards to modern design standards has been achieved. Until the redevelopment can be achieved (a number of years away), the Trust will bid for further annual funding to take forward a series of interim schemes to continue to try and address risks in relation to nosocomial spread including negative ventilation rooms, new ward accommodation and ventilation upgrades to risk areas.	

2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources	**Risk Owner**
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.	**Director of Finance, Procurement and Estates**

Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
	2.4	i) Risk to the supply of clean linen to SHSCT, BCH & MPH due to the age and condition of existing equipment. This is causing a lot of breakdowns resulting in downtime and difficultity fulfulling orders		£1.2m Capital secured for the purchasing of a replacement tunnel washer and drying line. Installation of this equipment is due to be completed by March 2022. There are other equipment requirements on the CAG priority list.	
		ii)Risk to the Trust due to overdue servicing of medical equipment as highlighted in Internal Audit of Management of Medical Equipment 21/22. 2 priority 1 recommendations and 10 priority 2 recommendations to be implemented. Audit outcome was Limited		Priority 1 recommendation number 1 - The Trust should put in place an action plan to ensure that scheduled servicing of all medical devices are brought up to date this should focus initially on those Red or Amber devices which have not been serviced from 2019. Action being taken by Trust - Three additional engineers have joined the team over the past 4 months, Head of Service meets with team leads every two weeks. It is planned that all High risk equipment in use will be up to date by Mar 2022 and that +90% of Amber by June 2022. Implementation date March/ June 2022 Priority 1 recommendation number 2 -The Trust should ensure that there is a complete and up to date register of all medical devices. DECs should regularly be required to	

2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources	**Risk Owner**
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.	**Director of Finance, Procurement and Estates**

Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
				validate listings of medical devices under their control and provide a response to Estates. Action being taken by Trust - When BackTraq was initially implemented data was imported from several databases covering differing areas. Some of this data was incorrectly coded e.g. equipment allocated to CSSD, this has now been rectified. Equipment used in Cardiac Rehabilitation has been removed from use (due to COVID) these four devices are now in storage and have been condemned. Assets are at times sent with patients after they have been discharged, details are recorded at ward level. Completed implementation date was 30 September 2021	
REVIEW HISTORY					
Review Date:	**Jan-22**		**Risk Rating after review: High / Medium / Low**		
Summary of SMT Discussion:					

3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.					**Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 - 6 months**	**Target Risk Rating**
16 (4 x 4) HIGH	3.1	Clinical risk associated with delay in accessing planned services for assessment, diagnostics and treatment in accordance with clinical need	**16 (4 x 4) HIGH**	Regional clinical prioritisation of operative / theatre capacity to ensure available capacity directed to those most in need on an equitable basis. Continual review of service waiting lists to ensure those with greatest need are allocated capacity and routine users are offered access to available capacity on a chronological basis. Areas of risk will continue to be escalated to Directorate Senior Management Team meetings, SMT and HSCB. Opportunities have been achieved and continue to be identified to seek to increase capacity via sourcing of additional capacity, both internally and externally, via Independent Sector. Continue to scope Innovative approaches/new ways of working to service delivery. Development of Service Delivery plans for core services to seek to increase capacity back to pre-Covid levels.	**9 (3 x 3) MEDIUM**

3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.					**Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 - 6 months**	**Target Risk Rating**
	3.2	Risk to the consistent provision of safe, high quality care due to reduced capacity in Out of Hours services (examples are GP OoH, Crisis Response and Emergency Department services)		ED refurbishment to create additional space and avoid over-crowding and resultant risk Review of current GP OOH provision with temporary consolidation of current bases to reflect current available resources	
	3.3.	Clinical risk associated with delay in accessing inpatient beds in Acute, Mental Health or Paediatric services		No More Silos Local Implementation Group will focus on development of alternatives to inpatient, improvement on control room functions/oversight and focus on flow and discharge Development of Integrated Winter/Surge and Service Delivery planning and refresh for Business Continuity plans	
	3.4	Risk of deterioration of health and social functioning as a result of reduced access to a range of community services (examples include domicilary care, day care centres etc.)		Seek to increase capacity in IS for day centres	

3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.					**Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 - 6 months**	**Target Risk Rating**
	3.5	Risk to the ongoing supply of medicines due to EU Exit/NI Protocol when the grace period ends (currently extended), when NI will continue to follow EU rules and regulations for medicines and medical devices, whereas Great Britain (GB) will not, with implications for both the supply and regulation of medicines in NI. Key issues include: • Medicines licensing; • Medicines supply chain • Medical Devices.		Formation of a DoH led NI Protocol/EU exit medicine policy programme to progress related projects, including at an operational level, to ensure there is a minimal impact to NI customers and suppliers in relation to medicine availability, supply and pricing. There is also a need to ensure that there is equitable access to new medicines in line with GB. The programme will link with the EU Exit Transition Unit, responsible for providing specialist advice on medicines and pharmaceutical issues and for the development of medicine policy to address issues related to EU Exit/NI protocol.	

3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.					**Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 - 6 months**	**Target Risk Rating**
	3.6	Risk to the provision of food for patients & staff due to Suppliers having difficulities sourcing and supplying some food produce. As a knock on effect, Suppliers are reducing the number of deliveries per week resulting in larger orders being placed and needing storage. There are also procurement risks and need to increase frozen and storage space. The Trust has also had issues with the meats contracts due to EU Brexit standards and procedures. The same supplier supplied both raw and cooked meats. As a result of these issues the main kitchens in the hospitals had to purchase additional supplies and there was the potential of cross-contamination risks. This also led to an increased reliance on one food supplier. Th... hav... been other i... ...ith sent act...		Senior managers attending workshop regarding food procurement strategy going forward in HSC. Reviewing current areas along with estate to identify any protential solutions Discussions have been held with Hendersons to reduce the cross-contamination risks from the delivery of raw and cooked meats. Community facilities are continuing to purchase food supplies locally and the Assistant Director of Finance has been informed of this risk.	

3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care	**Risk Owner**
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.	**Operational Directors**

Original Risk Rating (Likelihood x Impact)	Key Risks	Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 - 6 months	Target Risk Rating
	There have been other issues with contracts including minimum order values and minimum quantities and the bakery items contract ending before its expiry date. When the fresh fruit and veg contract is re-tendered there may be restrictions with the number of delivery points. Food supply issues impact on menu planning both in the hospitals and Community facilities and there is the potential for increased complaints from service users due to limited menu choices.			

REVIEW HISTORY

Review Date:	**Jan-22**	**Risk Rating after review: High / Medium / Low**
Summary of SMT Discussion		

4. Technology Enablement

Corporate Objective Alignment: Promoting Safe, High Quality Care	Risk Owner
Risk: There is a risk to the delivery of safe, effective, high quality care as a result of inability to access and optimise health and social care information (and data) as a direct consequence of technology enablement (including access to effective systems/functionality and/or service adoption including capacity/ capability/ culture)	**Performance & Reform and Operational Directors**

Original Risk Rating (Likelihood x Impact)		Key Risks	Current Risk Rating (Likelihood x Impact)	Summary Priority Actions planned for the next 3 - 6 months	Target Risk Rating
16 (4 x 4) HIGH	4.1	There is a risk to the HSC network and organisations in the event of a cyber attack on HSCNI or a supplier/partner organisation resulting in the compromise of the HSC network and systems or the disablement of ICT connections and services to protect the HSC and its data. Risk of the Organisation being able to continue to deliver services to Patients/service users/Customers, loss of personal and organisational information and loss of public confidence as a result of a Cyber attack	**16 (4 x 4) HIGH**	Regional IT Policies have been developed and replace local Trust policies. These are available on Sharepoint. A Regional simulated cyber incident was planned involving the COVID related Regional systems for November 2021. This has been deferred. Another date has not been scheduled. Regional IG working group to be established to take forward the review of data flows from HSC/Partner organisations to mitigate further risks of compromise from connected organisations, based on learning from the QUB Cyber incident. The CDIO has not yet established this meeting. There was a network cyber threat in December 2021 (Apache Log4J) which required network and device scanning and significant engagement with 3rd party IT suppliers. The Trusts Cyber oversight Group has agreed that simulated cyber incidents need to be undertaken in the Trust to raise awareness of the potential impact to improve business continuity planning. The Group has also agreed that videos and other visual tools to raise the potential impact need to be made available to front line services. This will be ongoing over the next 6 months - aim to achieve by April 2022. BSO have awareded a Regional Contract to Deloitte for Cyber Incident Management support and expert advise in the event of a Cyber Incident based on learning from the HSE Cyber attack. The Pricewaterhouse Coopers Report on findings and learning from the HSE incident has been shared with Governance Committee. There are 21 Cyber Protection Projects from Regional funding and Internal Audit Recommendations but not enough staff to progress the implementation of this software. 6 projects have been prioritised this year for achievement by end of March 2022. External 'contract' resources are also being sourced to help implement other projects. Funding bids were made to DHCNI for addtional resources. 5 additional resources per Trust will be included in the Regional strategic Cyber Business which is planned for submission in February 2022. A new SRO has been appointed to the Regional Cyber Security Programme Board and meetings have been re-established. The local IT service desk team require better knowledge of what might indicate a cyber threat. Playbooks will be purchased to help with learning by February 2022 Regional email security gateways are not properly configured to catch all spam and cyber threats entering the Trust. BSO are working with suppliers to resolve this aiming to have resolution by February 2022 Elearning on cyber security is mandatory and has improved to 65% uptake. Further promotion on Cyber awareness will continue monthly on desktop messages and southern-i.	**9 (3 x 3) MEDIUM**
	4.2	Risk of achieving implentataton of Regional Technology implementation.There are a range of Regional programmes – Encompass, Labs replacement, HRPTS encompass, PACs upgrade, EQIP (HRPTS replacement) as well as digital shared services. The agenda is very large and diverse with limited additional resources in either the IT team or to help front line services with the business change. The risk is fundamentally that the Trust will not have the capacity to effect the change required to implement the digital initiatives.		Resources in the Trust are very low to facilitate the Encompass agenda. Trust has agreed to go at risk with a number of posts. These should be in post by end of March 2022. Nursing lead post in place. Trust has agreed appointment of CCIOS in each professional group. Funding is being negotiated with the Encompass Programme. Postholders should be in post by March 2022.Medical Lead posts to be interviewed on 4th February 2022. Encompass Governance Structure now in place in SHSCT. Transformational Board leads and reports to the Regional Encompass Programme Board. A risk register has been developed and shared Regionally. All Trusts have outlined the same risks in terms of readiness and capacity to implement 4 major IT transformational projects simultaneously. Ditial Shared Services is another transformation which is scheduled for implementation in the same period.	
	4.3	Risk associated with the reliance on digital technology to support service delivery, including information systems, clinical applications and data analysis tools such as Qlikview.The risk of loss of access must be minimised to defend the Trust against loss of access.		Continue to develop service Business continuity plans and regular testing of plans (ongoing across the Trust alongside plan to increase user awareness per 4.1) All new IT related procurement is considered and approved at the Technical Design Authority (TDA) to ensure appropriate due diligence has been carried before procurement and connection to the Trust's network. TDA meetings scheduled on a monthly basis. (on-going) External resource commissioned to carry out a review of the Trust's backup strategy. To be completed by Dec 2021 (Telefonica) Cyber security team continue to monitor threats through cyber monitoring software and make contact with services where devices or hardware is identified as security risk (ongoing). This is shared at Cyber Oversight Meetings for user awareness	

REVIEW HISTORY

Review Date:	Jan-22
Summary of SMT Discussion:	
Risk Rating after review:	**High / Medium / Low**

5. Finance

Corporate Objective Alignment: Making best use of resources **Risk:** Risk of financial stability and breach of statutory duty of break-even in-year .					**Risk Owner** Director of Finance, Procurement and Estates and all Operational Directors
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Additional Actions and Timeframe**	**Target Risk Rating**
12 (4 x 3) MEDIUM	5.1	Risk of breach of statutory duty of break-even in year	**12 (4 x 3) MEDIUM**	• Indicative allocations for the financial year 2021/22 have been released to Trusts, however, work continues with HSCB and DoH to understand the potential implications of the budget settlement on Trusts. Once further clarity is received in relation to the actual budget for the Trust, DoF will prepare an updated briefing for SMT and Trust Board. It is expected that this will be around September/October 2021. • Finance will complete a mid-year hard close, the purpose of which is to inform the finance strategy for the remaining months of the financial year. This is good practice. The hard close will be as at September 2021. Results from this will be known in November 2021 and findings from this will inform forecasts for the remainder of the financial year.	**6 (3 x 2) LOW**

5. Finance

Corporate Objective Alignment: Making best use of resources **Risk:** Risk of financial stability and breach of statutory duty of break-even in-year .					**Risk Owner** Director of Finance, Procurement and Estates and all Operational Directors
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Additional Actions and Timeframe**	**Target Risk Rating**
				• During 2021/22 The Director of Finance, prepared an update on “Return to Balance” – this document reminded all of the Trust’s statutory duty to break-even and that as a Trust we do not have the authority to spend in excess of the budget. It set out the key findings and recommendations from the Acute phase and also sought approval to move to the second phase which is within Mental Health and Disability. All recommendations were accepted and approved and work has now commenced within Mental Health and Disability. It is expected that this work will be reported on in Quarter 3 of the financial year.	

5. Finance

Corporate Objective Alignment: Making best use of resources **Risk:** Risk of financial stability and breach of statutory duty of break-even in-year .	**Risk Owner** Director of Finance, Procurement and Estates and all Operational Directors

Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Additional Actions and Timeframe	Target Risk Rating
	5.2	Risk of destabilisation of services due to over reliance upon non-recurrent funding and the Trust's inability to secure sufficient recurrent investment.		• Director of Finance is continuing to work with HSCB and Department of Health in relation to the capitation inequity gap. To date this work has been successful in ensuring that the Trust has not had to make £25m of recurrent savings. In addition the "Return to Balance" work identified a range of current expenditure areas that do require funding support and discussions have commenced with HSCB re same. • Director of Finance sought DoH approval for capitation to be discussed at the Strategic Finance Forum in November 2019 – a healthy debate took place and DoH agreed that whilst they had endeavoured to address some of the imbalance by not applying a savings target, the gap remained. Work on the equity gap continues with HSCB/DoH	

REVIEW HISTORY

Review Date:	**Nov-21**	**Risk Rating after review: High / Medium / Low**
Summary of SMT Discussion:		

6. Infection, Prevention and Control

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: Risk to patient safety due to the potential to develop a healthcare acquired infection. This risk is paired with the Trust's aging infrastructure risk					**Medical Director**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
12 (3 x 4) HIGH	6.1	Risk to patient safety due to the potential to develop a healthcare acquired infection	**12 (3 x 4) HIGH**	Review and update of IPC/AMS Strategy	**6 (2 x 3) MEDIUM**
				Develop audit team to provide assurance on all aspects of IPC	
				Develop a case to further develop an MDT infection service	
				Further develop diagnostic capacity to facilitiate early diagnosis to facilitate isolation and timely appropriate treatment to prevent AMR	

REVIEW HISTORY

Review Date:	**Jan-22**	**Risk Rating after review: High / Medium / Low**
Summary of SMT Discussion:		

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

September 2022

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to the relevant Corporate Objectives which remain unchanged for 2022/23 as detailed below:-

Corporate Objectives

1: Promoting safe, high quality care.
2: Supporting people to live long, healthy active lives
3. Improving our services
4. Making the best use of our resources
5. Being a great place to work – supporting, developing and valuing our staff
6. Working in partnership

Where relevant, risks have also been linked to the **3 Corporate priorities** contained within the Corporate Plan 2022/23 as detailed below:-

1. Stablishing, Rebuilding and Growing
2. Improving access to planned services for our patients
3. Supporting unplanned, urgent and emergency services

Risk scoring is based on likelihood and impact as summarized in the Risk Assessment Matrix below.

Risk Likelihood Scoring Table			
Likelihood **Scoring Descriptors**	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Risk Appetite: low (L); moderate (M); high (H) has also been included against each risk.

OVERVIEW OF CORPORATE RISKS AS AT SEPTEMBER 2022

The Corporate Risk Register remains a dynamic document which the Senior Management Team continually try and improve on. To that end, a deep dive into each corporate risk was undertaken by SMT during July and August 2022 with a view to populating a new streamlined Corporate Risk Register.

There are seven principal risk domains as follows:

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

Changes to the Register since August 2022

New risk

On 22nd September 2022, SMT agreed the inclusion of Risk No. 1.7 'Risk to the consistent provision of high quality, safe care to children, young people and families due to shortages and vacancies across the Health Visiting service' on the Corporate Risk Register.

There are currently 32 corporate risks, the risk ratings of which are outlined below.

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	8	24	0	32

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
1	**People**			
1.1	Risk to the consistent provision of high quality, safe medical care due to medical workforce shortages and vacancies within some specialties (exacerbated due to Covid-19)	1	**HIGH**	10
1.1a	Risk to the continuity of service provision within the Gillis Unit, St Luke's site, Armagh due to Consultant Psychiatry workforce shortages. Currently, there is only one permanent substantive Consultant Psychiatrist for the total Psychiatry of Old Age (POA) and Memory Service: three posts are vacant and one staff member remains on maternity leave until Autumn 2022	1	**HIGH**	13
1.2	Risk to safe, high quality care due to a high volume of medical locum engagements for different periods of time with varying levels of experience/training and often in hard to fill posts.	1	**HIGH**	14
1.3	Risk to the consistent provision of high quality, safe nursing care due to nursing and midwife shortages and vacancies across all Directorates and high nursing agency usage (exacerbated due to Covid-19)	1	**HIGH**	17
1.4	Risk to staff engagement, morale and health & wellbeing due to workforce capacity/demand pressures. (exacerbated due to Covid-19).	1 & 6	**HIGH**	19
1.5	Risk of potential harm to children due to Social Work vacancies impacting on the delivery of core Family Support & Safeguarding Services for children and families.	1	**HIGH**	21
1.6	Risk to the stability and effectiveness of Trust Board as a direct consequence of workforce vacancies at Senior Executive level and Non-Executive Director level.	1	**MEDIUM**	23
1.7	Risk to the consistent provision of high quality, safe care to children, young people and families due to shortages and vacancies across the Health Visiting service.	1	**HIGH**	24

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
2	**Estates and Infrastructure**			
2.1	Insufficient capital to maintain and develop Trust Estates works (works under £1.5m) and maintenance programme this year	3 & 4	**MEDIUM**	26
2.2	Inability to complete Estates project by year end during to delay in availability of materials, delay with contractors or internal Estates capacity	3 & 4	**MEDIUM**	27
2.3	Risk of harm to visitor, staff and patients safety resulting from legionella, fire hazards and poor maintenance	1, 3 & 4	**MEDIUM**	28
2.4	Lack of controls over Health and Safety	1 & 4	**MEDIUM**	29
2.5	Risk that Trust does not achieve Year 2 Sustainability plan due to lack of resources and staffing	3 & 4	**MEDIUM**	30
2.6	Servicing of medical equipment not carried out in timely manner due to items not being sent to Estates for servicing or due to resourcing issues	1, & 4	**HIGH**	31

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
3	**Access to Services**			
3.1	Risk to safe, high quality care due to delay in accessing elective services for assessment, diagnostics and treatment in accordance with clinical need due to a demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic	1	**HIGH**	32
3.2	If demand continues to outstrip supply and review appointments or planned assessment/ treatment are not completed in line with clinical timescales, due to demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic, then there is a risk of harm to individuals known to Trust services	1	**HIGH**	35
3.3	Clinical risk associated with delay in accessing inpatient beds in Acute, Mental Health, Beechcroft and Non Acute Hospitals	1	**HIGH**	37
3.4	Risk of deterioration of health and social functioning as a result of reduced access to a range of community services (examples include domiciliary care, day care centres, Carers Assessments etc.)	1	**HIGH**	40
3.5	Risk to the consistent provision of safe, high quality care due to reduced capacity in Out of Hours services (examples are GP OoH, Crisis Response and Emergency Department services)	1	**HIGH**	42
3.6	Risk to the ongoing supply of medicines due to EU Exit/NI Protocol when the grace period ends (currently extended), when NI will continue to follow EU rules and regulations for medicines and medical devices, whereas Great Britain will not, with implications for both the supply and regulation of medicines in N.I.	1	**HIGH**	44
3.7	Risk to the provision of food for patients and staff due to suppliers having difficulties sourcing and supplying some food produce.	1	**HIGH**	45
3.8	Risk to assuring compliance with agreed standards of care due to a reduced clinical audit capacity.	1	**MEDIUM**	46

4	Technology Enablement			
4.1	Risk to the HSC network availability in the event of a cyber attack on HSCNI or a supplier/partner organisation, resulting in the compromise of the HSC network and systems or the disablement of ICT connections and services to protect the HSC and its data. Risk associated with the reliance on digital technology to support service delivery, including information systems, clinical applications and data analysis tools such as Qlikview.	1	HIGH	47
4.2	Risk of achieving implementation of Regional Technology implementation due to the Trust not having the capacity to effect the change required to implement the digital initiatives.	1	HIGH	48

5.	Finance			
5.1	Risk of breach of statutory duty of break-even in year	4	HIGH	49
5.2	Risk of destabilization of services due to over reliance upon non-recurrent funding and the Trust's inability to secure sufficient recurrent investment	4	MEDIUM	51

6.	Infection, Prevention and Control			
6.1	Risk to patient, staff and visitor safety due to the potential to develop a healthcare acquired infection such as MRSA, C. difficile etc. In particular, the Covid-19 Pandemic with new and emerging variants poses unique challenges for IPC processes and there is a risk to the Trust's ability to respond adequately. (This risk is paired with the Trust's aging infrastructure risk and the People risk)	1	HIGH	52

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
7.	**Urology Services Public Inquiry (USI)**			
7.1	Organisational capacity to manage the range, and complexity of information required to support the USI. This includes general discovery requests, which are wide in their scope and cover significant areas of the Trust and the support required to comply with S21 requests. Moving forward to subsequent phases of the USI, organisational capacity and readiness in relation to preparations for the Public Hearing process will remain a challenge Capacity of legal team (DLS and Barristers) to support the USI, particularly with a number of concurrent Public Inquiries on-going	1	**HIGH**	55
7.2	Risk to service continuity as a result of Section 21 notices response times and Public Hearing preparations.	1	**HIGH**	56
7.3	Risk to health and wellbeing of staff	5	**HIGH**	57
7.4	Reputational risk exists in the process of the Public Inquiry – the public release of information and the Public Hearings which are likely to attract media attention.	1	**HIGH**	58
7.5	No funding stream identified	4	**HIGH**	59

1. PEOPLE

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-23 : Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.1 Risk to the consistent provision of high quality, safe medical care due to medical workforce shortages and vacancies within some specialties (exacerbated due to Covid-19)	Organisational risk in being able to continue to deliver services Potential impact on patient / client safety and quality of care delivery Reputational – loss of public confidence Impact on staff health and wellbeing in areas of high vacancy rates	**L**	Director of HROD Medical Director	Monitoring of vacancy position through Medical Staffing and Directorates International recruitment and targeted advertising Monthly medical recruitment report, fill rates, unfilled posts. Analysis and improvement of recruitment and advertising strategies Collaborative working with other Trusts, when required Independent Sector contracts	Score 15 (5 x 3)	Rating High	Score 9 (3 x 3)	**Rating** Medium	**Reports to Trust Board/Board Committees** Performance Committee deep dives per Division/ Service Medical Director reports **Reports Elsewhere** Monthly recruitment report to Medical Director, Chief Executive & Director HROD, copies to Divisional MDs JULY Monthly Recruitment Updat	Demand comes from more than vacant posts – but also need to identify what additional posts are necessary Updated and agile workforce planning is needed	Review of international recruitment progress to date on the contract by December 2022 Bids for recurrent funding for ED & Medicine submitted to Strategic Investment Group in June 2022. Has been tabled at SPPG for funding potential. May need to consider invest to save proposals where no funding available. Review in September 2022. Plan to review if appointment of specialist posts would help where we are unable to recruit consultants. Review by Oct 2022

				Greater use of alternative roles through advanced practitioners – nursing and AHPs and Physician Associates Escalation of pressures to DOH/ SPPG e.g. an early Alert was issued on 25.7.22 to DOH due to the risk with medical staffing in Haematology. Adverts now include a sentence asking for expression of interest from doctors who would wish to apply for Consultant posts, but are not yet eligible. A formal log is being kept. Appointment of overseas doctors via the Medical Training Initiative scheme.					Business cases for additional investment. Social Media advertising / BMJ advertising package Adverts	No E rostering system in place for medics	Work with DMDs and LNC to consider promotion of flexible job planning and other initiatives to retain staff and avoid further retirements. By Mar 2023 Explore E rostering solutions for medics by March 2023

				Consultant presence at Recruitment Fairs (e.g. Psychiatry Conference in Edinburgh June 22) Locum agencies to fill gaps.							

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.1a Risk to the continuity of service provision within the Gillis Unit, St Luke's site, Armagh due to consultant psychiatry workforce shortages. Currently, there is only one permanent substantive Consultant Psychiatrist for the total Psychiatry of Old Age (POA) and Memory Service: three posts are vacant and one staff member remains on maternity leave until Autumn 2022	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	**L**	Director of Mental Health and Disability	Co-location of Gillis and Willows Ward to allow the multi-disciplinary team to access on-site medical input and support. A review of Inpatient Memory Services is underway	Score 15 (5 x 3)	Rating High		Rating Medium	**Reports to Trust Board/Board Committees** Reported to Trust Board – May 2022 **Reports Elsewhere** SMT	Inpatient Memory Services review –what is optimum service for Southern Trust population?	Project Steering Group for Review of Inpatient Memory Services continues: public consultation planned for September/ October 2022 Recruitment campaign for Consultant Psychiatrist to be re-commenced September 2022.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.2 Risk to safe, high quality care due to a high volume of medical locum engagements for different periods of time with varying levels of experience/ training and often in hard to fill posts.	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	**L**	Director of HROD Medical Director	New Supporting Doctors in Difficulty Hub for Managers Monthly report of locum usage is issued to the service highlighting locum use, broken down in different data sets including expenditure. Centralised Medical Locum Team now part of Integrated Medical HR allows for streamlined oversight, identification of trends and consistent management of concerns.	Score 15 (5 x 3)	Rating High	Score 9	**Rating** Medium	https://view.pagetiger.com/Hub/doctors-in-difficulty-hub https://view.pagetiger.com/Medical-Staffing/shsct-locum-doctors Monthly locum reports issued to the service on their locum use and used for Monthly Oversight Committee.	Large volumes of Ad Hoc locums creates risk No Line managers for locums Locums have different RO's Induction of locums is not consistent	Development of the Page Tiger portal with videos to enhance induction materials available to locum doctors – **by Dec 22** Requirement for longer term locum doctors to have Job Plans – **by Mar 23** Engage with DOH for support and action in relation to regional paper relating to consistency in locum rates and enhancement of local medical banks. **Ongoing** ID Checks –To be reviewed with Deputy Medical Director to explore via Oversight Groups how this can be better managed. **By Mar 23** Formal Supervision arrangements for locums to be reviewed and strengthened **By Mar 23**

				Specific signposting page for Locum Doctors working in the SHSCT Deputy Medical Director for workforce now in post alongside a new SAS lead for Locum Governance Southern Trust has taken lead in finalising proposal to encourage development of local banks as alternative to agency and consistency in medical locum rates. Now with DOH for consideration. Specific Guidance for management of concerns with locum doctors. First Trust in NI to develop which has been shared with GMC and other Trusts for implementation elsewhere.							Identification of Locum Champions – to help mentor and support all locums – By Mar 23

				Protocol in place for engagement of Medical and Dental Agency Locums PALs oversight of current Medical and Dental Framework Monthly Oversight Committee for DMD to meet with AD for Service and AMD to review locum usage by specialty and identify plans for future.							

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.3 Risk to the consistent provision of high quality, safe nursing care due to nursing and midwife shortages and vacancies across all Directorates, and high nursing agency usage (exacerbated due to Covid-19)	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	**L**	Executive Director of Nursing, Midwifery and AHPs Director of HROD	Daily Senior Nurse oversight of staffing levels within Directorates at operational level supported by Safe Care to assess staffing levels on a daily basis in Acute Services. Directorate and other workforce analysis tools are in use for other Directorates to facilitate reporting status of Nursing and Midwifery Workforce Provision of Health roster workforce reports to operational teams to inform staff allocation.	Score 15 (5 x 3)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/ Board Committees** Quarterly recording Workforce report to Performance Committee. **Reports Elsewhere** Monthly Health roster reports to Operational Directors. Monthly Nursing workforce reports to SMT.	Improvement required in Trust data reporting to drive agency reduction locally. Lack of capacity in Nurse Bank / Agency management	Complete ward-by-ward agency workforce exit plans to reduce off contract agency staff and occurrence of Trust own staff through off contract agency - by end of September 2022 Completion of Invest to Save proposal for separate Band 8a Nurse Bank / Agency Business Manager. Commencement of data scientist in September 2022 with focus on agency expenditure and patient data to drive improvement in workforce decision making Commence secondary International Recruitment September 2022 and maintain International recruitment from the regional contract.

				Use of Bank and Agency and enhanced rates of pay for trust staff. Recruitment actions including local recruitment And regional and secondary International recruitment campaigns.							Alignment of QUB and OU nursing graduates to Band 5 posts. Open recruitment for Band 5 ongoing. Trust wide nursing and midwifery recruitment event November 22. The second year of the SRC pre nursing programme commences in Sept 2022 and the same programme being offered to Trust own staff. Launch and commence work against key actions within the Nursing and Midwifery workforce action plan 2022-2024. This includes recommendations from the Regional Retention Implementation report (DoH,2022). The focus continues on minimising all band 2/3 nursing assistant vacancies- ongoing

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.4 Risk to staff engagement, morale and health & wellbeing due to workforce capacity/ demand pressures (exacerbated due to Covid-19).	Human Resource impact – staff	**L**	Director of HROD	People Framework Health and Wellbeing Framework and Steering Group Clinical Psychology staff support and wellbeing service Inspire Contract Occupational Health Wellbeing Service Ongoing recognition of staff and teams People management policies, systems, processes and training	Score 15 (5 x 3)	Rating High	Score 9	**Rating** Medium	20220804 SHSCT 20220803 HWB HWB Notes 6 Jun 2022.docx OHWS - Managers Support Service OH Psychology overview New.pdf Occupational Heal and Well-Being ser 20220801 Dashboard Figures	People Framework requires to be launched. People & Culture Steering Group is required to drive People Framework Lack of support for staff with Long Covid New approach to appraisal needs rolled out. Lack of capacity for developing Raising Concerns programme	People Framework to be approved at September Trust Board 2022. People & Culture Steering Group to be established – October 2022. Long Covid Occupational Health Team recruitment ongoing. Team to be in place by mid October 2022. Roll out of new appraisal to be complete by March 2023. Development of F2SU Guardian roles and advertised in September. In place by November / December 2022.

				Raising Concerns Policy Management of organisational change policies and procedures Also – controls identified above in 1.1, 1.2. 1.3					20220315 ToR Trust Corporate Recognitio 22032022 Corp Recognition Steeri Flexible Working - All Documents Staff Conduct Your Appraisal Conversation - Pilo Appraisal Conversation - Guid CBH workshop slid - V5.ppt Creating a Great Place to Work 20220729 Your Right to Raise a Concern – \	Flexible working training / awareness for managers	Flexible working awareness raising for managers – by December 2022.
									Whistleblowing Management of Change 8b JD.pdf		

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.5 Risk of potential harm to children due to Social Work vacancies impacting on the delivery of core Family Support & Safeguarding Services for children and families.	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	**L**	Director of Children and Young People's Services	Prioritisation of child protection and LAC cases, in particular safeguarding visits Prioritisation of work across the Directorate in line with action plan Skill mix Regional recruitment initiatives 12 Band 4 Social Work Assistants are in the process of being offered posts within FSSG. Recruitment of additional 3 Band 4 Social Work Assistants within Corporate Parenting division to support transfer pathway.	Score 15 (5 x 3)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Executive Director of Social Work report to Trust Board – March 2022 Delegated Statutory Functions report to Trust Board **Reports Elsewhere** DSF Report to Strategic Planning & Performance Group (SPPG)	Regional recruitment initiatives remain ongoing however these are unlikely to bring about substantive social work recruitment within Gateway and FIT service, given the limited pool of social work new entrants regionally	Regional recruitment initiatives - ongoing Ongoing engagement with the SPPG and DoH on a regional basis

				CYPS have revised and approved the child's pathway and transfer procedure to include an earlier transfer of LAC children to Corporate Parenting Division. Regional Children's Leadership Improvement work streams have been implemented to review the Delegation Framework for Children's Services.							

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.6 Risk to the stability and effectiveness of Trust Board as a direct consequence of workforce vacancies at Senior Executive level and Non-Executive Director level.	Human Resource impact – staff Reputational risk Organisational risk Potential impact on patient / client safety and quality of care delivery	**M**	Director of HROD	Senior Executive restructuring Medical Director now appointed and due to take up post in November 2022 3 Operational Directors already advertised and to be appointed by end of September 22. Chair continues to raise Non Executive Director vacancies with Public Appointments Unit	Score 12 (4 x 3)	Rating Medium	Score 6	**Rating** Low (3 x 2)	**Reports to Trust Board/Board Committees** Senior Executive Restructuring updates to Trust Board Senior Executive Job Descriptions to Remuneration Committee **Reports Elsewhere** Report of Phase 1 restructuring – to TU Side, Trust staff.	Currently 4 of 11 Directors permanent. Director of Performance & Reform, Director of CYPS and Executive Director of Social Work to be advertised and appointed. 2 Non-Executive Director vacancies	All Director posts to be advertised and appointed by December 2022. Non Executive Director positions Competition programme, including SH&SCT vacancies – to be advertised by PAU in October 2022.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.7 Risk to the consistent provision of high quality, safe care to children, young people and families due to shortages and vacancies across the Health Visiting service.	Threat to compliance of the Regional Pre-School Child Health Promotion Programme (HCHF). Threat to compliance of pre-school vaccination programme. Reduced opportunities for early identification and intervention for infants/ children with underlying medical conditions or developmental delay. Threat to compliance with SBNI and Trust Safeguarding Children Policy & Procedure.	L	Director of CYPS Executive Director of Nursing	Implementation of step down model within the HV service, prioritising those families/children with the highest need. Systems in place to facilitate parents to be able to access the HV service when they have concerns. Within HV Service, a cross locality approach being undertaken to support HV teams with highest reduced staffing levels. Utilisation of Trust Bank and additional hours. Maintain referrals to Occupation Health in line with Trust policy and procedure.	Score 15 (5 x 3)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Monitoring and reporting of quarterly IoPs. Monthly staffing returns **Reports Elsewhere**	Regional lack of appropriately trained nurses available to recruit to undertake HV role. Regional gap in providing the number of HV training placement required to deliver full the Child Health Promotion Programme	Additional weekend clinics will be introduced. Communication Strategy will be developed. Influence the commissioning of additional regional HV training placements available. Avail of any regional opportunities to meet Normative Staffing levels within HV.

	Threat to compliance with Regional and Trust Health Visiting Policy & Procedures. Impact of long term deficits within HV on staff may contribute to further sick leave within the HV service and impact on morale			Proactive recruitment of additional HV. Maintain appropriate supports for staff including managerial and safeguarding children supervision. Recruitment of additional skill mix in the HV service. Escalation to PHA and DoH.							

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVES: Improving our services; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.1 Insufficient capital to maintain and develop Trust Estates works (works under £1.5m) and maintenance programme this year	Impact of physical safety to visitors/staff/ patients if Estates work is not undertaken. The Trust has a duty of care to protect those who use and enter its properties. Will lead to deterioration of Estate that if not adequately maintained, will further increase costs to public purse.	M	Director of Finance, Procurement and Estates	Capital funding of c£17m has been received for Estates work including invest to save in 22-23	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	**Rating** Low	**Reports to Trust Board/Board Committees** Estates Services Annual Report to Trust Board **Reports Elsewhere** Monthly Estates report to SMT Quarterly Governance meeting External audit check year end accruals	IPT for IV work at DHH with the DOH for approval. If not approved promptly, there is a risk that this work will not be carried out within the financial year Globally construction costs for building materials and contractors are increasing which could increase or delay projects	IPT with Permanent Secretary for approval and approval is imminent. Estates have contractors in place to commence work once approval is sought. PALS are monitoring the increased costs of construction and further funding will be bid for if costs increase.

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVES: Improving our Services; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.2 Inability to complete Estates project by year end due to delay in availability of materials, delay with contractors or internal Estates capacity.	Essential Estates work not being completed and consequently impacting on service and funding rescinded	M	Director of Finance, Procurement and Estates	Progress against projects is being monitored on monthly basis with report to SMT Action plan with timeframes in place for completion in place for all projects Experienced surveyors and architects employed in Trust to deliver projects PALS monitoring costs of building materials globally	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	**Rating** Low	**Reports to Trust Board/Board Committees** Estates Services Annual Report to Trust Board **Reports Elsewhere** Monthly reports to SMT Quarterly Estates Governance meetings	Globally construction costs for building materials and contractors are increasing which could increase or delay projects outside of Trust control	PALS continue to monitor the increased costs of construction and further funding will be bid for if costs increase.

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVES: Promoting safe, high quality care; Improving our Services; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.3 Risk of harm to visitor, staff and patient safety resulting from legionella, fire hazards and poor maintenance	Safety of visitors/ patients/staff at risk	L	Director of Finance, Procurement and Estates	Cycle of water testing by trained staff in line with national policy and guidance Fire safety audits carried out by experienced fire officers in line with national policy and guidance	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	Rating Low	**Reports to Trust Board/ Board Committees** Estates Services Report to Trust Board **Reports Elsewhere** Independent external annual assessment of water testing with report provided detailing areas for improvement NIFRS carry out annual review of fire procedures Internal audit review	Recommendations from external assessments being implemented (All low risk rating)	Actions plan in place to address recommendation with timeframes

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVE: Promoting safe, high quality care; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.4 Lack of controls over Health and Safety	Risk of physical harm to staff/ patients and visitors	L	Director of Finance, Procurement and Estates	H&S Committee meeting quarterly H&S quarterly updates to DoFPE	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	**Rating** Low	**Reports to Trust Board/ Board Committees** Annual H&S report to Governance Committee **Reports Elsewhere** Quarterly H&S Committee with Unions in attendance	Limited Assurance Audit in 2021-22 with 13 recommendations H&S Team are under resourced, staff off on Long Term Sick Leave/Maternity and not sufficient staff to appropriately carry out H&S function in organisation	Actions plan in place to address internal audit recommendations with expected implementation by 31 March 2023. H&S Committee oversight and monthly meetings with A/D and DoFPE oversight at quarterly Estates Governance meetings Two Agency staff in post and a review of staff is being undertaken.31/12/ 2022

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVE: Improving our Services; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.5 Risk that Trust does not achieve Year 2 Sustainability plan due to lack of resources and staffing	Trust is not being as sustainable as it should be nor increases carbon footprint	M	Director of Finance, Procurement and Estates	5 Yr sustainability strategy commenced 21/22 Estates on target to achieve actions from plan Plans in place to install renewable energy (solar panels) in 2022-23 Programme of works in place to install LV DHH and electric car charging points Tree planting programme on target c£2m received from SIB in 22-23 for sustainability invest to save schemes.	Score 8 (4 x 2)	Rating Medium	Score 6 (3 x 2)	Rating Low	**Reports to Trust Board/ Board Committees** Annual sustainability report to Trust Board **Reports Elsewhere** Monitored at monthly sustainability meetings Monitored by DFPE at Quarterly Governance Meetings	Increased waste due to covid Further improvements to reduce energy consumption in hospital buildings is required	Revisit the Sustainability strategy to ensure that Trust is working towards reducing carbon footprint. Rolling out renewable energy schemes across Trust.31/3/2023 Keeping abreast of evolving renewable energy option for hospitals, more efficient boiler scheme 31/3/20223

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVE: Promoting safe, high quality care; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.6 Servicing of medical equipment not carried out in timely manner due to items not being sent to Estates for servicing or due to resourcing issues	Medical equipment fails to operate correctly posing harm to patients	L	Director of Finance, Procurement and Estates	Servicing schedule in place Red risk items are given priority 3 additional service engineers appointed Monitored on weekly basis by DoFPE Global emails sent to trust staff as reminder to not use equipment unless it has been serviced Internal audit recommendation have been implemented with number of o/s items been reduced to those that are misplaced	Score 16 (4 x 4)	Rating High	Score 6 (3 X 2)	Rating Low	**Reports to Trust Board/ Board Committees** Internal Audit Report to Audit Committee **Reports Elsewhere** Monitored by Assistant Director, Estates and DoFPE on weekly basis through weekly servicing report Monitored by DFPE at Quarterly Governance Meetings Internal audit follow up	Many items cannot be found Staff still not sending in items in advance of servicing date Actions implemented following limited internal audit recommendation to be reviewed	Tracking system being explored 31/3/2023 Global reminders will continue with support from Directors (ongoing) Actions to be cleared by 30/9/2022

3. ACCESS T O SERVICES

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Improving Access to Planned Services for our patients

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
3.1 Risk to safe, high quality care due to delay in accessing elective services for assessment, diagnostics and treatment in accordance with clinical need due to demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic	There is a risk of secondary harm to the SHSCT population/ patients/ Service users and potential fatalities as a consequence of delays accessing safe, timely and appropriate care and treatment Unsatisfactory patient experience Loss of service user and stakeholder confidence	**L**	Director of Surgery and Elective Care	Regional clinical prioritisation of operative/ theatre capacity directed to those most in need on an equitable basis Mechanism in place to review service waiting lists to ensure those with greatest need are allocated capacity and routine users are offered access to available capacity on a chronological basis. Virtual consultations	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Monthly Acute cross Divisional Performance meeting for identification of risk Monthly Acute Directorate SMT Performance	Staffing constraints to maximise capacity including theatre capacity	Recruitment strategy and recruitment campaign to ensure staffing levels to provide timely, safe effective care Review of Nursing workforce etc. Review of Consultant Job Plans

				Effective booking of patients (IEAP guidance) Proactive pre appointment procedure triage/testing for Covid 19 to minimise cancellations Pre-operative assessment Effective discharge planning/ Enhanced recovery to reduce length of stay and ensure safe and effective discharge to maximise bed capacity Regular performance meetings Monitoring of outpatient clinics and elective procedures capacity Red flags reviewed weekly; other referrals reviewed monthly					and Governance meeting Monthly report on Rebuild/ Service Delivery Plan to SMT	Data on OPD and theatre utilisation is limited Data on e.g. triage, dictation, OPD outcomes etc. is limited Impact of emergency admissions and delayed discharges on bed availability risks cancelled activity	Review IT solutions to the management of PTLs and effective booking Review waiting list manager roles for consideration of implementation Review IT solutions to provide real time data to enable review of and maximisation of capacity Action plan including no more silos recommendations Given correlating delay within Cancer Pathways, there will be an increase in monitoring of sharing of reports to support improved compliance with 31/62 day targets

				Independent Sector contracts to deliver OPD, diagnostic and treatment capacity							Opportunities continue to be identified to seek to increase capacity via sourcing of additional capacity, both internally & externally via Independent Sector Continue to scope innovative approaches/new ways of working to service delivery Development of Service Delivery Plans for core services

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Improving Access to Planned Services for our patients

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
3.2 If demand continues to outstrip supply and review appointments or planned assessment/ treatment are not are not completed in line with clinical timescales, due to demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic, then there is a risk of harm to individuals known to Trust services	There is a risk of secondary harm to the SH&SCT population/ patients and potential fatalities as a consequence of delays accessing safe, timely and appropriate care and treatment Unsatisfactory patient experience Loss of service user and stakeholder confidence	**L**	Director of Surgery and Elective Care	Mechanisms are in place to categorise planned procedures and reviews into urgent and non urgent for assignment to appropriate waiting lists and to review service waiting lists to ensure those with greatest need are allocated capacity Effective booking of patients (IEAP guidance) Virtual consultations	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Monthly Monitoring information to assist with oversight and identify and escalate those requiring prioritisation	Staffing constraints to maximise capacity including theatre capacity Data on OPD and theatre utilisation is limited	Recruitment strategy and recruitment campaign to ensure staffing levels to provide timely, safe effective care Review of consultant job plans currently being undertaken to drive consistency Review IT solutions to the management of PTLs and effective booking Review waiting list manager roles

				Proactive pre appointment procedure triage/testing for Covid 19 to minimise cancellations Mechanisms in place for GPs to escalate change/ deterioration in condition						Data on e.g. triage, dictation, OPD outcomes etc. is limited Impact of emergency admissions and delayed discharges on bed availability risks cancelled activity	Review IT solutions to provide real time data to enable review of and maximisation of capacity Action plan including no more silos recommendations
			Director of Mental Health and Disability	Mechanisms in place for individuals to contact duty system for urgent review should there be a significant deterioration in clinical condition							
			Director of Older People and Primary Care	AHP Community Outpatient Services managed in keeping with IEAP requirements. Clinical triage and prioritisation in place					Active monitoring of AHP output activity including monthly reporting against Rebuild/ Service Delivery Plan		Ongoing work by AHP Services to deliver increased levels of activity

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
3.3 Clinical risk associated with delay in accessing inpatient beds in Acute, Mental Health, Beechcroft and Non Acute Hospitals	Patient safety risk	**L**	Director of Surgery & Elective Care Director of Medicine and Unscheduled Care Director of OPPC	Acute and OPPC No More Silos Implementation Group Surgery contingency plan. Emergency & General Surgery on single site(CAH) Joint Directorate (Acute, MHD and OPPC) meeting up to three times daily to review inpatient delays and promote effective flow through both Acute and Non Acute Hospitals Care Home Information Hub plus Community Discharge Hub in place	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Activity levels reported through NMS	Staffing constraints to maximise capacity	Recruitment Strategy and recruitment campaign to ensure staffing levels to provide timely, safe effective care Review of Nursing workforce within Acute Wards – October 2022 Work ongoing to improve performance and increase the robustness of Winter Plans/Contingency

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
3.3 continued	Patient safety risk	**L**	Director of Mental Health and Disability	**Mental Health** Mental Health / Learning Disability Home Treatment/Crisis Response Teams Dorsy - fortnightly delayed discharge meeting. Bluestone Bed coordinator Daily Bluestone/Dorsy Ward rounds	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Mental Health & Disability - Early Alerts / RQIA updates	Inpatient beds levels impacted by frequent requests for out of Trust admissions due to regional bed pressures (Dorsy & Bluestone). Facilitation of early discharge for these admissions.	Ongoing Regional discussions. Early Alerts submitted. Clinical assessment.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
3.3 continued	Patient safety risk	**L**	Director of Children & Young People's Services	Regional AD CAMHS Forum Community teams provide extensive on-site support to acute medical ward Admission Request Meeting (ARM) facility in place to request admission. Robust communication methods in place across CAMHS and appropriate stakeholders	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/ Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Weekly status report from Beechcroft reported to Director/ Assistant Director/ Head of Service	Beechcroft's current inability to accept admissions. Waiting list currently (regionally). No contingency plan identified by Beechcroft Ongoing difficulties with access to acute assessment beds	Beechcroft are working to address capacity issues by expediting discharges where possible, where additional supports are being put in place in the community. CAMHS reviewing how they can increase the crisis response service to avoid admission to Beechcroft through intensive community support. DoH has commissioned a regional CAMHS workforce review, which will include Beechcroft. Report expected Autumn 2022.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Improving Access to Planned Services for our patients

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
3.4 Risk of deterioration of health and social functioning as a result of reduced access to a range of community services (examples include domiciliary care, day care centres, Carers Assessments etc.)	Patient safety risk	**L**	Director of Mental Health and Disability/ Director of Older People & Primary Care Services	Day Care and Short Breaks Local re-mobilisation pathways developed to support increased day care /short breaks attendances. Increase in offers of direct payments/SDS Mental Health Strategies for early intervention and prevention Implementation of IAPT (Improving access to psychological therapies) model of care	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Day Care remobilisation report to SPPG	The Trust is heavily dependent on the Independent Sector for provision of short break beds provision. This provision is impacted by covid rates as are Trust day care facilities.	The Trust continues to focus on care assessments and care planning to ensure needs are identified and met. Seek to increase capacity in IS for day centres Developing and strengthening partnerships for improving health and well being.

				Domiciliary Care Care Bureau working with Commissioning Teams to ensure outstanding Domiciliary Care list updated and outstanding packages highlighted to Providers daily Carers Assessments – Active monitoring of activity levels (Assessments offered and completed)					Active monitoring of outstanding Domiciliary Care cases Weekly Community Information reports	The Trust and Independent Sector Providers deliver domiciliary care through a partnership approach, however there are recruitment difficulties	Work ongoing to increase domiciliary care capacity by frequent review and potential downturn of existing packages, plus active recruitment of domiciliary care workers. Work ongoing to increase Carers Assessment levels by active championing of this activity against regionally agreed targets

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
3.5 Risk to the consistent provision of safe, high quality care due to reduced capacity in Out of Hours services (examples are GP OoH, Crisis Response and Emergency Department services)	Patient safety risk	**L**	Director of Medicine and Unscheduled Care Services Director of OPPC	GP Out of Hours Temporary measures in place to increase the resilience of the service, including temporary consolidation of the model from 5 sites to 2 ED Phone First and Urgent Care Centres established to improve the provision of advice, guidance and triage of patients to ensure patients are dealt with in the right place Escalation and ED capacity plan	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Active monitoring of GP OoHs, Phone First and Urgent Care Centres NMS Performance Report		Review of current GP OoH provision with temporary consolidation of current bases to reflect current available resources, improving the ability of the services to recruit to vacant posts Development of Phone First, Urgent Care Centres and ambulatory services to reduce attendance/capacity within EDs

			Director of Mental Health and Disability	"Well Mind Hub" and Crisis Café development with PiPs Mental Health Integrated Liaison Service Operates 24/7 LD Crisis Response Service operates from 9am to 1am						Learning Disability – Development of Community Assessment and Rehabilitation Service (CARS) – proposed implementation March 2023.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ Assurance**	**Mitigating Actions with due dates**
3.6 Risk to the ongoing supply of medicines due to EU Exit/NI Protocol when the grace period ends (currently extended), when NI will continue to follow EU rules and regulations for medicines and medical devices, whereas Great Britain will not, with implications for both the supply and regulation of medicines in NI. Key issues include: Medicines licensing Medicines supply chain Medical Devices	Patient safety risk Organisational risk Reputational – loss of public confidence	**L**	Head of Pharmacy & Medicines Management	DoH led EU/ Northern Ireland Programme Board	Score 12 (3 x 4)	Rating High	Score 9	Rating Medium	**Reports to Trust Board/ Board Committees** Medicines Governance Report to Governance Committee **Reports Elsewhere** Updates from EU Exit/ Northern Ireland Protocol Programme Board Meeting	Medicines with a marketing authorisation valid only in GB (England, Wales and Scotland) labelled as PLGB, do not require a Unique Identifier and must not be supplied to Northern Ireland unless specifically approved by MHRA. Medicines Supply Pharmacist to be recruited to assist procurement team manage issues in relation to EU Exit/NI protocol	From 1st January 2022, a statutory instrument titled the Human Medicines (Amendment) (Supply to Northern Ireland) Regulations 2021 established the Northern Ireland MHRA Authorised Route (NIMAR). NIMAR provides a route for the lawful supply of prescription only medicines that are unlicensed in NI, where no licensed alternative is available. Pharmacist recruited on temporary secondment from 1st Aug 2022 to 31st March 2023. Approval now received to recruit permanently- post will be advertised at the end of this year.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
3.7 Risk to the provision of food for patients and staff due to suppliers having difficulties sourcing and supplying some food produce. Risk factors include: Procurement risks and need to increase frozen and storage space. Issues with the meats contracts due to EU Brexit standards and procedures. The same supplier supplied both raw and cooked meats leading to an increased reliance on one supplier. Other issues with contracts include minimum order values and minimum quantities and the bakery items contract ending before its expiry date.	Reputational risk – food supply issues impact on menu planning and there is the potential for increased complaints from service users due to limited menu choices Organisational risk in being able to continue to source and supply some food produce and impact on patients and staff	**L**	Executive Director of Nursing	Food procurement is managed by BSO PaLS either through EMM or E-Procurement. BSO PaLS have business contingency plans. The Trust has a Catering Contingency Plan in place which includes menu alterations as appropriate dependent on food availability. The Trust has a contact in place for the maintenance of refrigeration.	Score 12 (3 x 4)	Rating High	Score 9	Rating Medium	**Reports to Trust Board/ Board Committees** Functional Support Services Report to Governance Committee **Reports Elsewhere** SMT	BSO in conjunction with HSC Trusts need to develop a Food Procurement Strategy which is fit for purpose and meets the needs of all HSC customers.	Senior Managers have attended attend a workshop regarding Food Procurement Strategy and this was meant to be followed up with BSO completing a scoping exercise to assist in the development of a strategy but this has been delayed.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
3.8 Risk to assuring compliance with agreed standards of care due to a reduced clinical audit capacity	Clinical / Reputational risk – failure to assure compliance with relevant local, regional or National Audit Recommendations Organisational risk in being able to fully deliver the Trust's clinical audit programme HR impact – staff capacity and morale	**M**	Medical Director	On-going support and delivery of limited clinical audit function, both locally at clinical lead level and corporately at facilitated support and assurance levels. Clinical Audit Strategy 2022 – 2024 sets out 9 key objectives to strengthen delivery and assurance over the next 3 year period.	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	Rating Low	**Reports to Trust Board/Board Committees** National Audit Assurance Report to Governance Committee annually. This includes participation in annual audit programmes, key outcomes and progress on plans for improvement **Reports Elsewhere** Weekly SMT Governance paper	Whilst partial in year funds were approved by SMT on 14.7.2022 as the first phase to strengthen the assurance function in Q2/3 2022, resource implications to strengthen and improve the clinical audit function remain.	Critical Post paper 2022/23 approved July 2022 Funding paper for clinical lead and remaining corporate posts to be submitted during 22/23 for 23/24

4. TECHNOLOGY ENABLEMENT

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
					Score	Rating	Score	Rating			
*4.*1 Risk to the HSC network availability in the event of a cyber attack on HSCNI or a supplier/ partner organisation, resulting in the compromise of the HSC network and systems or the disablement of ICT connections and services to protect the HSC and its data. Risk associated with the reliance on digital technology to support service delivery, including information systems, clinical applications and data analysis tools such as Qlikview.	Organisational risk in being able to continue to deliver services and impact to service users associated with delays in care and treatment. Loss of personal and organisational information Reputational – loss of public confidence Service user safety risk in the event of digital records being unavailable	**M**	Director of Performance and Reform	Regional Cyber Security Programme Board (Director of P&R) Regional and Local Incident Management & Reporting Policies and Procedures Regional Cyber Incident Response Plan Trust level controls to Defend, Respond and Recover Trust Cyber Security Oversight Group Vulnerabilities software management (Tenable) Regional Cyber Security Policy Continued promotion of Operational Business Continuity Plans at Cyber Oversight Group and reference on Team Risk Registers	16 (4 x 4)	High	9 (3 x3)	**Medium**	**Reports to Trust Board/Board Committees** Internal audits Regional cyber security programme papers, minutes Monthly cyber dashboard and cyber oversight group (including KPI for cyber awareness training) Monthly desktop message Monthly staff update Range of monitoring software and monthly meetings Individual Directorate/Divisional/Team Business Continuity Plans with ICT preparedness reviewed	Regional delays continue. Regional security group has not yet been established. Whilst the Trust has made good progress in local cyber security Internal Audit recommendations, the regional recommendations remain outstanding. Cyber Awareness Training KPI Individual Directorate /Divisional/ Team Business Continuity Plans with ICT preparedness are in place in some services, but not all. Need for assimilated cyber event to test plans and apply learning	Deloitte has been commissioned to review ICT Business Continuity Plans and test Disaster Recovery Plans - Report March 2023 Advice will be sought from Deloitte as part of the commission on testing BCPs – March 2023 Consideration of ward based simulation for multiple-system downtime to be discussed at next Local Cyber Security Group – December 2022

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
4.2 Risk of achieving implementation of Regional Technology implementation. There are a range of complex high risk Regional programmes including: • Encompass (Single care record) • Labs (Pathology Blueprint), • HRPTS replacement EQUIP • NI Picture Archiving system NIPACS upgrade • Digital shared services. The agenda is very large and diverse with limited additional resources in either the IT team or to help front line services with the business change. The risk is fundamentally that the Trust will not have the capacity to effect the change required to implement the digital initiatives. Ongoing risk associated with multi-system implementation ongoing in parallel	Delay in implementation of new digital improvements with ongoing reliance on systems with limited lifespan; reduced resilience to cyber attack; inability to perform functions Staff morale and impact on sickness & absenteeism in the event that they don't feel supported and trained on use of new technology will impact on the ability to deliver services	**M**	Director of Performance & Reform	Encompass Strategic Assurance Group (regional) Encompass Readiness Group (Internal) Transformational Board with SMT monthly for escalations & updates Encompass programme board at Chief Executive level EQUIP Programme Group (Regional) Pathology Blueprint Programme Group (Regional)	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	Reports to Transformational Board (Encompass) Regional Digital (DHCNI) Programme Board DHCNI Portfolio Programme Board	Gaps in resources, both operational and IT, to lead and implement digital transformation across the Trust associated with workforce challenges and funding	Transformation Programme Board has highlighted resource risks to Encompass Regional SRO. Paper outlining gaps and risks prepared by DOP's and presented to Encompass SRO Resource Challenges with Regional portfolio shared by DOP's at DHCNI Programme Board Internal Shared Services Readiness Group to be established – December 2022

5. FINANCE

CORPORATE OBJECTIVE: Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
5.1 Risk of breach of statutory duty of break-even in year	Failure to meet DOH target Breach of Accounting Officer responsibilities Risk of qualification of Annual Accounts by external audit	**M**	Director of Finance, Procurement and Estates	Budgets have been allocated to budget holders and regular scheduled monthly reporting to all budget managers in Trust Regular scheduled budget meetings with all budget managers when deviations to budget are addressed to ensure breakeven	Score 15 (5 x 3)	Rating High	Score 6 (3 x 2)	Rating Low	**Reports to Trust Board/Board Committees** Monthly Financial Position report to SMT/Trust Board Reporting to Chief Executive Accountability Meetings **Reports Elsewhere** Monthly monitoring returns to SPPG/DoH	Current agreed Budget for 2022/23 remains outstanding Trust in a deficit position with risk of funding not being secured, particularly in absence of a functioning NI Executive Significant turnover of senior personnel in Trust has potential to lead to some instability in budget management Significant pressures remain across all services, with managers having many operational challenges to oversee, reducing capacity to keep close control on finances	• Indicative allocations for the financial year 2022/23 have been released to Trusts, however, work continues with SPPG and DoH to understand the potential implications of the budget settlement on Trusts, in particular due to political landscape. Once further clarity is received in relation to the final agreed budget for the Trust, DoF will prepare an updated briefing for SMT and Trust Board. It is expected that this will be in September/ October 2022.

				Continual support to budget managers on use of Collaborative Planning Budget and Reporting system including targeted one on one training for new budget managers and regular monthly refresher training via zoom Trust works closely with SPPG and DoH to secure funding to address deficits and pressures to enable the Trust to breakeven at year end					**Reports Elsewhere (cont'd)** Report to those charged with Governance by NIAO following year end audit. Internal Audit of Budgetary Control on regular cycle		Finance will complete a mid-year hard close, the purpose of which is to inform the finance strategy for the remaining months of the financial year. This is good practice. The hard close will be as at September 2022. Results from this will be known in November 2022 and findings from this will inform forecasts for the remainder of the financial year.

CORPORATE OBJECTIVE: Making best use of resources										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
5.2 Risk of destabilisation of services due to over reliance upon non-recurrent funding and the Trust's inability to secure sufficient recurrent investment.	Risk to medium to longer term planning of Trust Services to meet Corporate Objectives Risk of committing recurrent resources on the back of non-recurrent funding therefore with potential to increasing future financial deficit	**L**	Director of Finance, Procurement & Estates	Review and approval of Revenue IPTs and Capital Business Cases at Strategic Investment Committee Regular meetings with SPPG on financial plan and equity gap and early alerts to SPPG on pressures via Performance meetings with Commissioners	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	**Rating** Low	**Reports to Trust Board/Board Committees** Monthly Financial Position report to SMT/Trust Board Reporting to Chief Executive Accountability Meetings **Reports Elsewhere** Monthly monitoring returns to SPPG/ Reporting on Equity Gap to SPPG	There is still a significant element of the Trust budget provided on a non-recurrent basis each year. The impact of the current political instability is impacting on the DoH ability to agree budgets, particularly on a recurrent basis	Director of Finance is continuing to closely work with SPPG and Department of Health in relation to the capitation inequity gap. To date this work has been successful in ensuring that an element of budget previously non-recurrent has been made recurrent and SHSCT savings are less than that of other Trusts. There is now a full acceptance and recognition of the gap at commissioner level.

6. INFECTION, PREVENTION AND CONTROL

CORPORATE OBJECTIVE: Promoting safe, high quality care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
					Score 12 (3 x 4)	Rating High	Score 6 (2 x 3)	**Rating** Medium			
6.1 Risk to patient, staff and visitor safety due to the potential to develop a healthcare acquired infection such as MRSA, C. difficile etc. In particular, the Covid-19 Pandemic with new and emerging variants poses unique challenges for IPC processes and there is a risk to the Trust's ability to respond adequately. (This risk is paired with the Trust's aging infrastructure risk and the People risk)	May result in serious harm or death to a patient, prolonged Length of Stay, unsatisfactory patient experience Risk of HCAI for visitors Organisational risk in being able to fully deliver Trust services HR impact – staff capacity and morale Reputational risk – loss of public and stakeholder confidence Significant financial loss	**L**	Medical Director	IPC and microbiologist team IPC Strategy and IPC guidance including HH, PPE etc. Staff training Bronze SMT Bronze Operational Group Strategic and Clinical Forum meetings Augmented care group Laboratory testing and Surveillance and monitoring					**Reports to Trust Board/ Board Committees** Progress update report to Performance Committee **Reports Elsewhere** Reports to strategic forum Reports to AMS oversight committee Reports to the ventilation, water, environmental and decontamination committees	Increased workload of the IPC/ microbiology/ clinical/ Functional support services staff with the management of Covid-19 surges and outbreaks- limited ability to comply with the full remit of the IPC team, including outbreak report writing, updating strategy and GNB work streams	Develop a case to further develop an Multi-Disciplinary Team infection service Develop audit team to provide assurance on all aspects of IPC

				Patient and risk assessment for placement for both emergency, elective admission and OPD Isolation of patients with transmittable infections and those who are immuno-compromised Outbreak management groups Post infection reviews for learning and action Environmental Controls: Environmental decontamination programme and standards, segregation and safe disposal of waste process, programme of water safety and IPC design incorporated into refurbishments and new builds.						IPC strategy needs updated Absence of Regional IPC Strategy Compliance with mandatory training Limited face to face training due to pandemic Laboratory testing capacity for respiratory viruses is limited locally The IPC/ microbiology team have no access to IPC management /surveillance and epidemiology IT systems	Review and update of IPC/AMS Strategy Improve staff update of mandatory training Further develop videos to support on line mandatory training Further develop diagnostic capacity to facilitate early diagnosis to facilitate isolation and timely appropriate treatment to prevent AMR Continue to influence regionally for IPC management/ surveillance and epidemiology IT systems

				Antimicrobial Stewardship: Policies and Standards, and ward round						The aged Trust estates does not comply with HTM & HBN. Lack of ensuite isolation facilities, storage and ventilation. Poor finishes that inhibit the ability to clean	Continue to bid for funding to improve trust facilities including ensuite side room provision, ventilation, ED and ICU facilities. Improved environmental provision for day care etc. CAH and DHH site wide redevelopment Case for VHP and annual deep clean programme

7. UROLOGY SERVICES PUBLIC INQUIRY

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
7.1 Organisational capacity to manage the range, and complexity of information required to support the USI. This includes general discovery requests, which are wide in their scope and cover significant areas of the Trust and the support required to comply with S21 requests. Moving forward to subsequent phases of the USI, organisational capacity and readiness in relation to preparations for the Public Hearing process will remain a challenge Capacity of legal team (DLS and Barristers) to support the USI, particularly with a number of concurrent Public Inquiries on-going	Reputational Organisational HR impact	**L**	Programme Director of the Public Inquiry	Trust Public Inquiry Team Regular liaison with Trust legal advisors Lookback Group Quality Assurance Group DOH Urology Assurance Group SPPG/formerly HSCB Urology oversight group	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	**Reports to Trust Board/ Board Committees** Progress updates at each confidential Trust Board meeting **Reports Elsewhere** SMT Chief Executive regular reporting to Department of Health	Programme Board co-chaired by Chief Executive and Independent member has not yet met Clarity around the Public Hearing schedule awaited - Early clarity will assist in planning and preparing the Trust. Resource implications	First meeting of Programme Board scheduled for October 2022 The Trust will continue to use the experience gained by the UPI during the discovery and S21 response process which will add to its ability to deliver on USI requests. Identification of key resource requirements informed by experience of UPI to date. Staff recruitment in key support functions underway Completion mid-September. Additional legal cover to be sourced – completion September 2022

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
7.2 Risk to service continuity as a result of Section 21 notices response times and Public Hearing preparations.	Organisational risk – service delivery Reputational risk – loss of public confidence	**L**	Programme Director of the Public Inquiry	Liaison with USI in respect of projected timeframes for hearings Information shared with SMT to allow for service planning to accommodate S21 response timeframes	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	**Reports to Trust Board/ Board Committees** Progress updates at each confidential Trust Board meeting **Reports Elsewhere** SMT	Lack of confirmed timetable around schedule of Public Hearings limits Trust's ability to manage staff workloads accordingly. Uncertainly in relation to time that staff may be unavailable; witness may be required to give evidence more than once; need to identify level of preparation/ debrief required likely to vary between staff	The Trust continues to liaise with the USI to achieve a workable timeframe for response of S21s, and has highlighted the operational impact of the on-going discovery process -- managing on a case-by-case basis in conjunction with legal team Ongoing proactive engagement with USI continues in relation to S21 response deadlines and has been generally positively received Proactive identification of staffing impact and preparation of business contingency plans..

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
7.3 Risk to health and wellbeing of staff	HR impact – staff capacity and morale. Potential impact on staff sickness Impact on family life for staff involved in the UPI	**L**	Programme Director of the Public Inquiry	Occupational Health Support Psychologist is available for staff support Proactive regular check in sessions for PI Team and others as required is available Information in relation to psychological support is made available to all staff Inspire Line management support	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	**Reports to Trust Board/ Board Committees** Progress updates at each confidential Trust Board meeting **Reports Elsewhere** SMT	Lack of clarity around timeframe for public hearings limits timely engagement of key staff.	Consider need to allocate defined psychological support for public hearing process. Develop plans to pro-actively support staff engaged in public hearing process. This includes: Timing information; Briefing on what to expect ie attendance of observers; live-streaming; media coverage potential; website coverage. Arrangements to de-brief and follow up

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
7.4 Reputational risk exists in the process of the Public Inquiry – the public release of information and the Public Hearings which are likely to attract media attention.	Reputational – loss of public confidence	**L**	Programme Director of the Public Inquiry	Lookback Group Quality Assurance Group DOH Urology Assurance Group SPPG/formerly HSCB oversight group	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	**Reports to Trust Board/ Board Committees** Progress updates at each confidential Trust Board meeting **Reports Elsewhere** SMT Department of Health	Not all discovery process complete, therefore not all issues surfaced. Discovery relating to other participants not yet available to the Trust.	Consultations with staff and review of discovery information Full open and transparent discovery to ensure the Trust is aware of issues prior to publication. Ongoing process of assurance and learning

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
7.5 No funding stream identified	Potential Trust wide impact	**M**	Programme Director of the Public Inquiry	Monthly financial reporting	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	**Reports to Trust Board/ Board Committees** Progress updates at each confidential Trust Board meeting **Reports Elsewhere** SMT		Funding requirements shared with DoH.

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

Minutes of a virtual Confidential Meeting of Trust Board held on Thursday, 27th January 2022 at 8.45 a.m.

PRESENT

Ms E Mullan, 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
Mr J Wilkinson, Non-Executive Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Dr M O'Kane, Medical Director and Interim Director of Mental Health & Disability Services
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mrs S Hynds, Deputy Director, Human Resources (*for Mrs Toal*)
Mrs L Leeman, Assistant Director, Performance Improvement *(for Mrs Magwood)*
Mr B Beattie, Acting Director of Older People and Primary Care
Mrs M McClements, Director of Acute Services
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)
Ms S McKinney, Boardroom Apprentice

APOLOGIES

Mrs A Magwood, Director of Performance and Reform
Mrs V Toal, Director of Human Resources and Organisational Development

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting. She particularly welcomed Mrs Esther Boyd, Internal Audit, who was observing the meeting as part of the Internal Audit on Board Effectiveness.

2. **DECLARATION OF INTERESTS**

None.

3. **MINUTES OF PREVIOUS MEETINGS**

The minutes of meetings held on 28th October, 16th November and 2nd December 2021 were approved as accurate records.

4. **MATTERS ARISING FROM PREVIOUS MEETING HELD ON 2ND DECEMBER 2021**

i) Update on servicing and maintenance of Medical Equipment

Mrs Teggart spoke to paper which provides a summary of high risk medical devices in use in the Trust which are overdue planned maintenance. She noted that as at March 2020, 8.6% of high risk medical equipment was overdue service, increasing to 31% by March 2021 and 33% at time of internal audit in July 21. By November 2021, this had decreased to 25% and was currently at 14.8% as of 12th January 2022.

Members welcomed the significant work undertaken to reduce the risks.

5. **NEWRY CTCC**

The Chair welcomed Mrs A Turbitt, Head of Planning, to the meeting. Mrs Turbitt referred members to a paper which outlines a summary of the current financial issues relating to the project's affordability. She advised that the preferred bidder has advised CPD/ HSCB and Trust that the construction cost for the project had increased to circa £43m which is approximately £10m more than allowable indexation on the original tender costs would currently indicate. This increase is related

to both impacts of supply chain, Brexit and Covid-19 Pandemic. She provided assurance that engagement was ongoing between the Preferred Bidder and the HSC (Construction and Procurement Delivery (CPD) Health Projects/HSCB, SIB and Trust) to identify any potential solutions to ensure the scheme can remain viable and deliverable.

Members discussed areas of concern, namely the protracted delay to the scheme given the financial affordability issues particularly if no agreement can be reached and the risk that a consensus way forward with the preferred bidder is not reached that ensures compliance with Public Contract Regulations and good procurement practice. The risk of the scheme collapsing if the Preferred Bidder decides to walk away was also discussed and the associated Press and media backlash. Mr McDonald asked if there was scope to use Bill of Reduction which Mrs Turbitt undertook to explore.

Action: Mrs Turbitt / Mrs Leeman

The Chair stated that the current position remains fluid and asked that Trust Board is kept updated.

6. UPDATE ON DORSY UNIT

Dr O'Kane drew members' attention to a range of actions that continue to be undertaken to improve the service and ensure the safety of patients and staff. Mr McDonald welcomed the development of the triangulation of data and asked if this had identified any issues. Dr O'Kane stated that some cultural issues had manifested through some of this weekly data. Mrs McCartan referred to the fact that Muckamore was closed to admissions and the additional pressure on the Dorsy Unit due to the need to care for patients from other Trust areas. She asked if the Trust had escalated this pressure to the Department. Dr O'Kane provided assurance that these pressures had been escalated with early alerts submitted on a number of occasions. Dr O'Kane acknowledged the challenges of the current model in meeting the needs of patients and the Chief Executive advised that the unsustainability of the current model continues to be raised with the Permanent Secretary.

In relation to safeguarding issues and investigation, Dr O'Kane reported that the PSNI process remains ongoing.

7. **UPDATE ON** [redacted] Irrelevant information redacted by the USI

Dr O'Kane spoke to a paper which provides an update on the Intellectual Disability service model currently being provided at [redacted] Irrelevant information redacted by the USI. Members welcomed the fact that issues of concern were being addressed and noted the range of actions achieved to date.

Mr Wilkinson spoke of the importance of the independent advocacy role. Dr O'Kane spoke of the appointment of 2 Carer Consultants who have been actively supporting carers in [redacted] Irrelevant information redacted by the USI and Dorsy.

8. **UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY AND UROLOGY SERVICE INQUIRY**

Mrs Trouton provided an update on the following areas:

- **Urology Service Inquiry**

The Trust continues to work with the Urology Service Inquiry Team (USI) on providing evidence as outlined in the Section 21 notices. The Trust met with Senior Counsel in late December and outlined to them the difficulties that the Trust could be potentially facing in light of the ongoing pandemic and a letter was sent on the Trust's behalf to the USI detailing the predicted unscheduled and staffing pressures that the Trust would be facing during January. The USI took recognition of this correspondence and agreed not to send any section 21 notices to the Trust during the first six weeks of 2022 without first having a discussion via DLS on the timescales.

A number of meetings with key personnel (Chief Executive, consultant urologists, managers etc) and senior counsel are currently being set up and will commence from 1st week in February 2022.

- **Look back**

  Mrs Trouton advised that all patients in the first cohort will be seen by the end of March 2022. Ms Donaghy sought clarity on the fact that three Consultant Urologists have committed to WLI and have displaced PA sessions and admin into own time. Mrs Trouton explained that they are doing additional sessions as well as seeing patients in their own clinics.

- **Improvement**

  Members noted the establishment of a Quality Assurance Oversight Group, chaired by the Medical Director. This group will ensure there are effective quality assurance processes regarding medical professional governance and both clinical urology and cancer services within the Trust.

  The Chief Executive advised of the appointment of Mrs Jane McKimm as Programme Director for the Inquiry.

9. **ANY OTHER BUSINESS**

None

SIGNED: _____ **DATED:** _____

Governance Committee meeting held on the 05th September 2019

Confidential Section: 0925 - 0935

Apologies:

- Martin McDonald Non-Executive Director
- Esther Gishkori, Director of Acute Services

Update on investigation into Dr Duffins concerns

- Dr Duffin has been met with and the report shared with him. Action plan is no in place. There are regional and local learning points which have been welcomed.
- This now concludes this process with Dr Duffin

Open Governance Committee meeting: 0940 - 1245

1. Apologies:
   Martin McDonald – Non Executive Director
   Esther Gishkori – Director of Acute Services
2. Welcome to Trust Board Chair and Brian Beattie, Acting Director of OPPC
3. Declarations of interest – none
4. Chairs business
   Attendance at Cyber Security Training, which is taking place across a number of locations.
5. Minutes of meeting held on 21st May 2019 – approved
6. Matters arising – remaining items on the agenda
   a. Presentation on Obs and Gynae deferred to 05th December 2019 as the data requires to be looked at in more detail.
   b. Update on Stroke Services.
      i. Work being undertaken by Southern Trust will complement the regional work
      ii. Update to be provided to Trust Board in October/November
   c. All remaining items were included on today's agenda

6: Litigation

Claims management report was received for assurance.

Further detail was included following last committee meeting to support understanding.

A triangulated report on obs and gynae to deep dive into the stats to provide assurance that nothing systemically taking place.

7 Medicines Governance Report

One catastrophic incident which involved the death of a patient.
SAI has begun and family is involved.
Shortage of medicines is a key concern currently and not all related to the EU withdrawal. This is being monitored closely across the region through the Trusts.

8 Feedback from Audit Committee

8.1 Action plan on internal audit report on Morbidity and Mortality was noted for information.
8.2 Action plan on internal audit report on specific elements of infection prevention & control (IPC) Governance was noted for information.

Committed noted that these action plans belong to the audit committee for discussion.
Committed noted the helpful detail included within the action plans

9: Corporate Risk Register

Tax Charges for high earners has been discussed at SMT. This is resulting in staff withdrawing services due to the high level of tax being applied on additional work. This will become a named risk within the risk register.

GP OOH is being added back on the Corporate Risk Register. The Trust currently 17% participation form GP's. This is not sustainable. The Trust has put forward 1 2options for consideration to the Board/Department.

Deep dive was undertaken on the corporate risk – inability to manage patient care within clinically indicated times.

28K people on a waiting list across the full directorates
Urgent and red are being dealt with
Routine reviews don't have priority and there is no link back to the GP's
The monitoring and tracking is good

Big question is how we can work differently to help change the waiting lists for our patients and service users.

Action needed in

- Creating a culture of bringing ideas and developing solutions
- Multi-disciplinary teams and approach
- Patient taking a lead on the own care

An update to be provided at the next governance meeting.

10: Clinical and social care governance

10.1 Clinical and Social Care Governance Report

Revised report was presented. This is work in progress and further changes are expected following the Governance Review being undertaken by June Champion.
Report received for information.

Key points:

- Securing SAI Chairs – remains challenging
- Training for SAI Chairs to take place in September
- A number of SAI's to be concluded in the short term
- Getting SAI's staffed still proving challenging

10.2 Interim Safety and Risk Management Strategy 2019 – 2022 was presented

Committee approved

10.3 Management of Standards and Guidelines

Challenged remain in assuring all standards and guidelines ae being delivered in full.

Where there are change champions who are change leads – there is a rigorous process.

There is a possibility of using technology to support – but this is medium to long term.

Received for assurance.

10.4 Clinical and Social Care Governance Review

A review is currently being undertaken by June Champion from the leadership centre. First iteration is with the Medical Director for review.

Committee asked for the report to be shared. Chief Executive has yet to see it and will decide when he has had a chance to review.

11: Information Governance

11: 1 Cyber Security: Progress Update received for information

11: 2 Freedom of Information, Environmental Information and Subject access requests report received for information.

12: Update on Lessons Learned Committee

Dr O'Kane provided and update for information.

13: Minutes of SHSCT 2018/2019 End Year Ground Clearing meeting held on 05th June 2019 provided for information.

14: Proposed meeting dates for 2020 were approved.

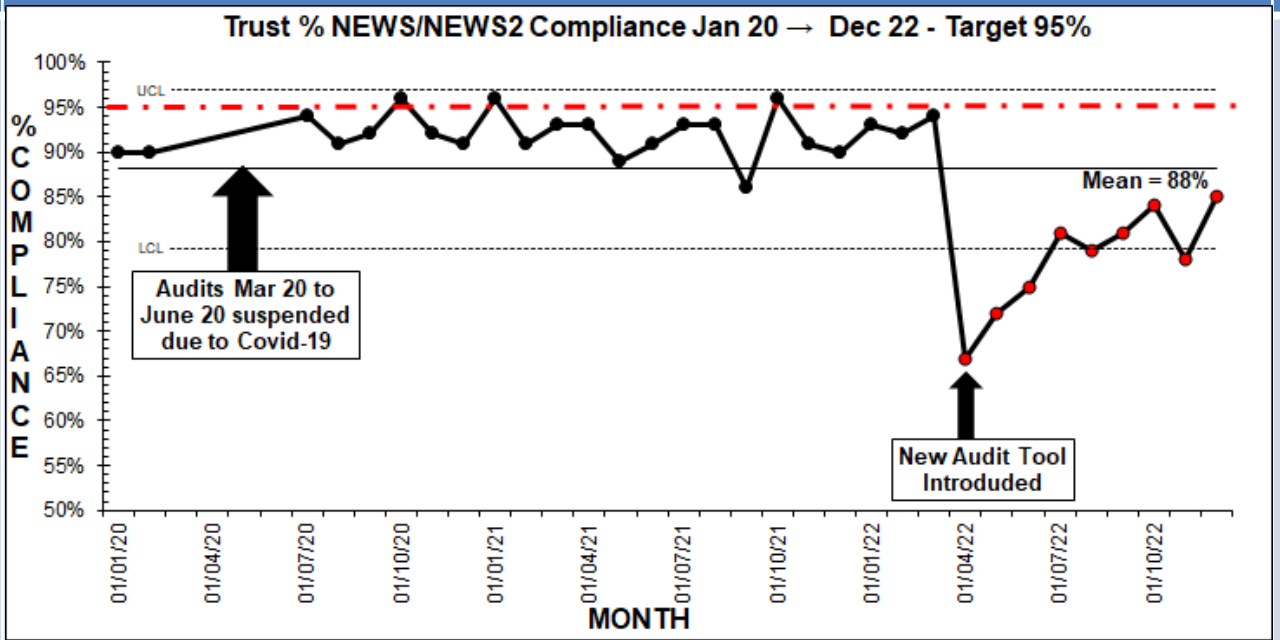
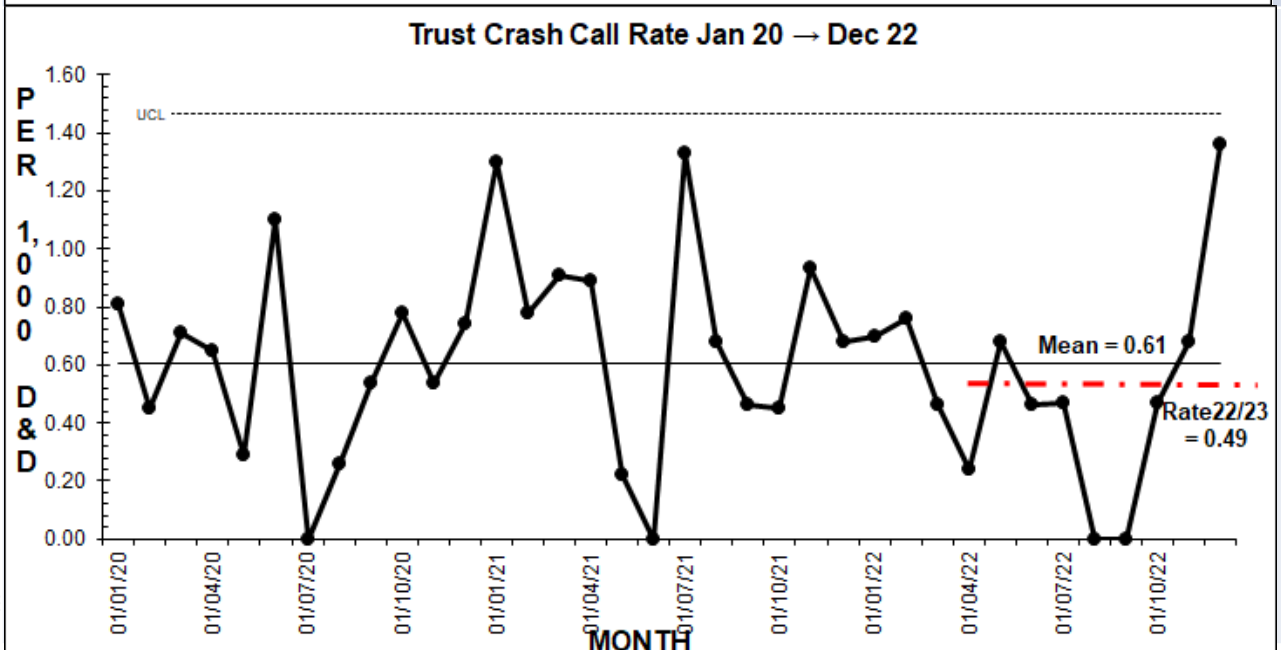
15: AOB

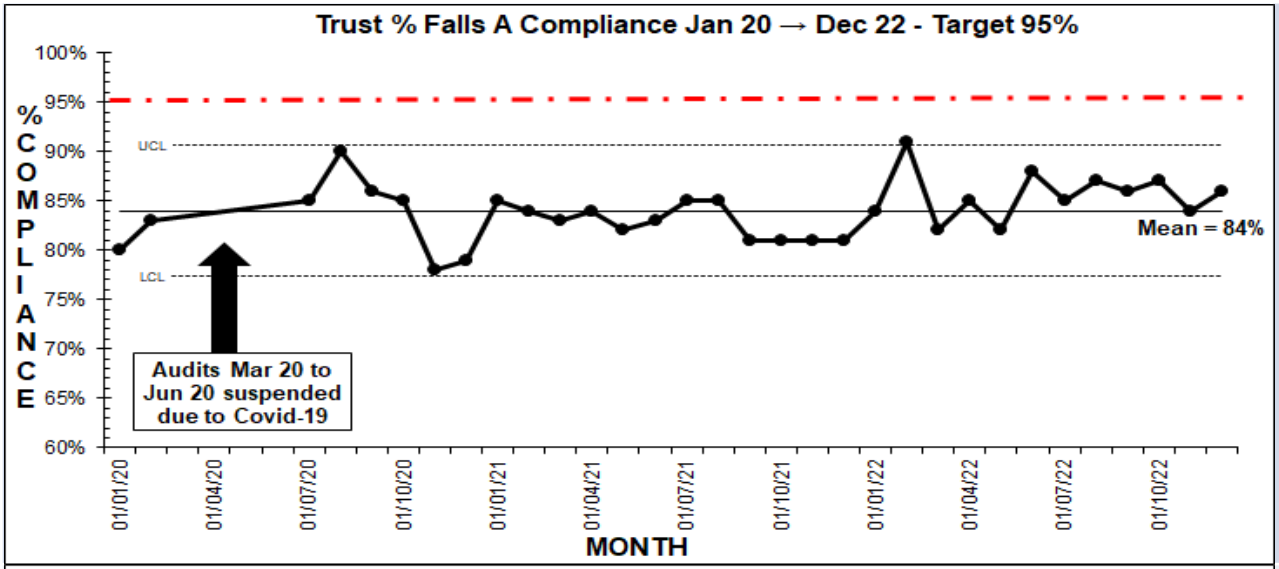
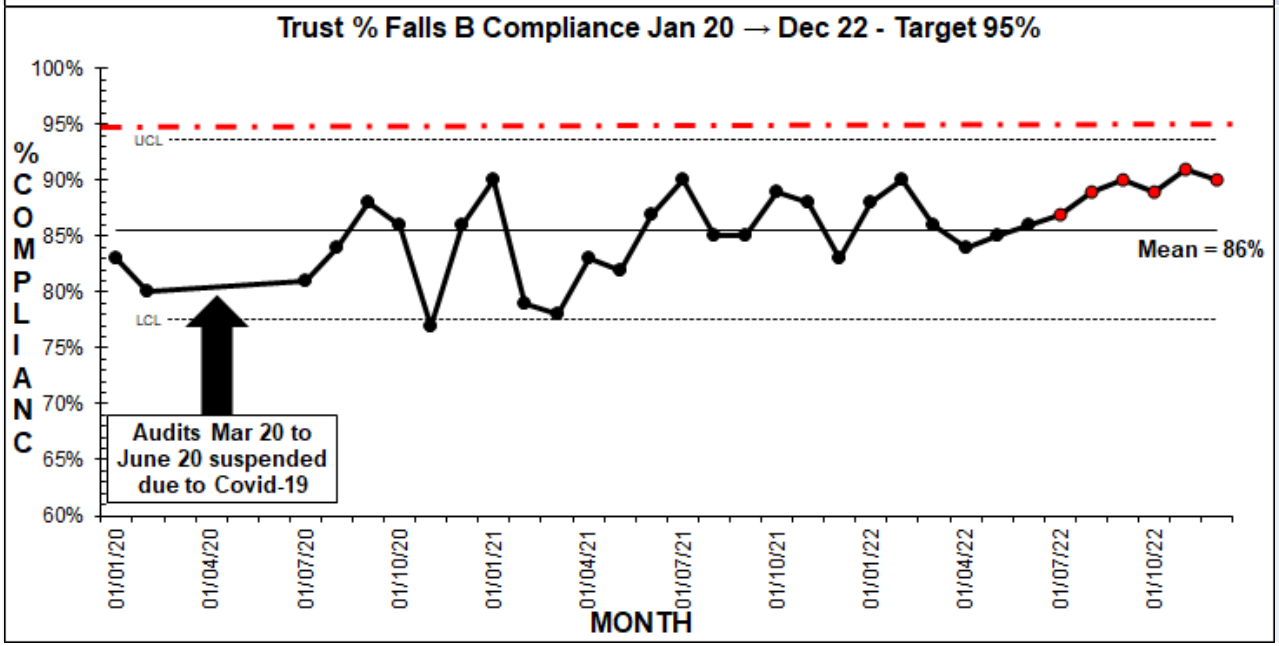
Organ Donation week – members were asked to share the message have the conversation.

Patient Safety Report

Quarter Three 22/23
Regional Patient Safety Indicators

Colum Robinson
Patient Safety Manager

Patient Safety intervention	DATA	Observations & Analysis
1. NEWS/ NEWS2: **Process Measure –** **Compliance with NEWS2 Bundle**		❖ NEWS – Q1 20/21 (Apr 20 → June 20) Audit was suspended by PHA due to Covid-19 ❖ NEWS2 replaced NEWS in May 21 ❖ NEWS Compliance Q3 22/23 (Oct 22 → Dec 22) was **82%**, up from **80%** in Q2 22/23 ❖ Significant decline in compliance in Q1 & Q2 22/23 attributed to the introduction of a new more robust Audit Tool, which is more compatible along side NEWS2 ❖ Overall Bundle Compliance remains below the Regional Target of **95%**
Outcome Measure – **Crash Call Rate**		❖ Trust Crash Call Rate for 22/23 stands at **0.49** per 1,000 Deaths & Discharges (**19** Crash Calls) compared to **0.63** per 1,000 Deaths & Discharges (**33** Crash Calls) in 21/22 i.e. no significant change in crash calls

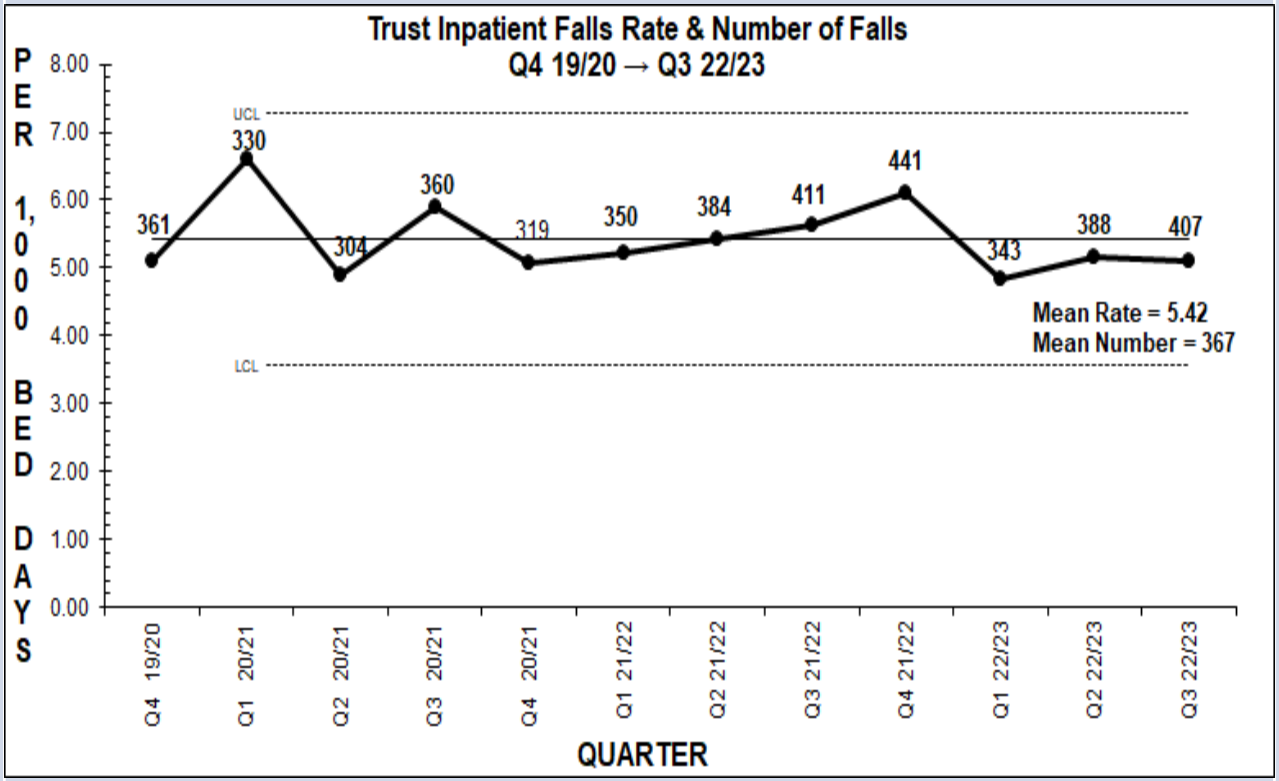
Patient Safety intervention	DATA	Observations / Analysis
2. Patient Falls : **Process Measure –** **FallSafe Bundle A Compliance**		❖ FallSafe – Q1 20/21 (Apr 20 → June 20) Audit suspended by PHA due to Covid-19 ❖ FallSafe Bundle A Compliance Audit Q3 22/23 (Oct → Dec 22) was **85%**, compared to **86%** in Q2 22/23 ❖ No significant change in FallSafe Bundle A Compliance ❖ Overall Bundle Compliance remains below the Regional Target of **95%**
Process Measure – **FallSafe Bundle B Compliance**		❖ FallSafe – Q1 20/21 (Apr 20 → June 20) Audit suspended by PHA due to Covid-19 ❖ FallSafe Bundle B Compliance Audit Q3 22/23 (Oct → Dec 22) was **90%**, compared to **89%** in Q2 22/23 ❖ FallSafe Bundle B Compliance has been above the Mean for the past 7 data points ❖ Overall Bundle Compliance remains below the Regional Target of **95%**

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

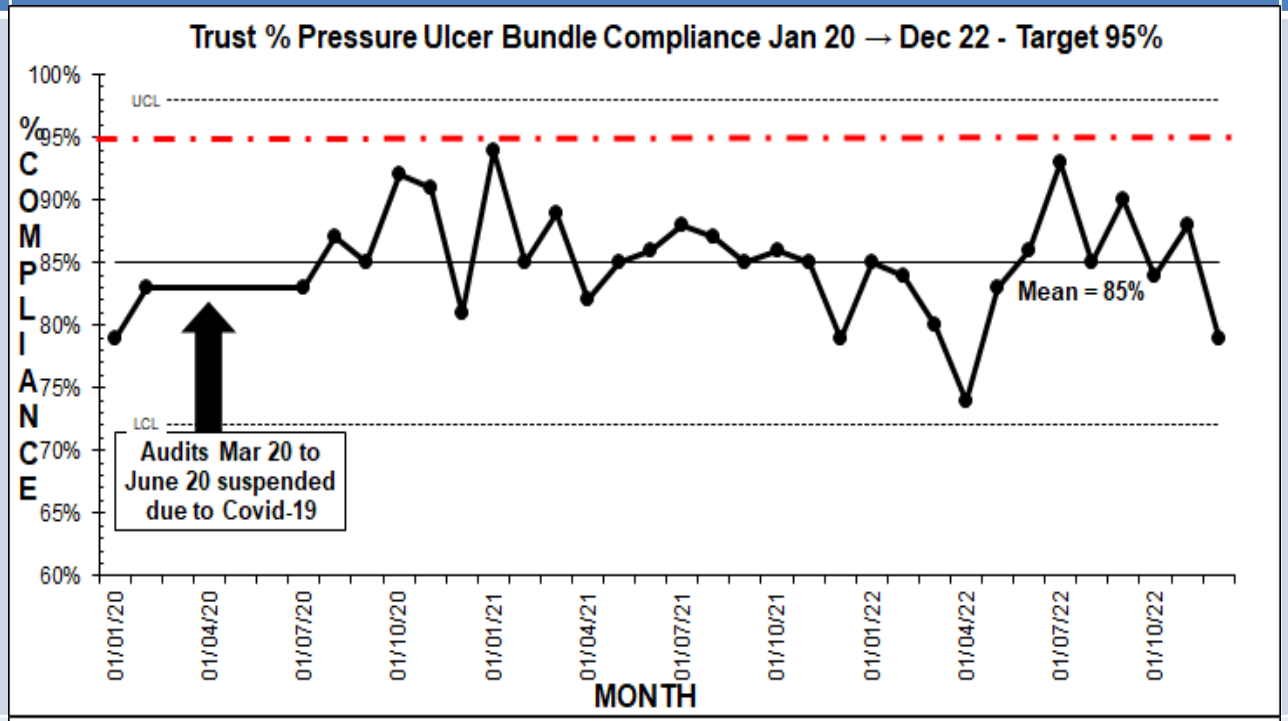
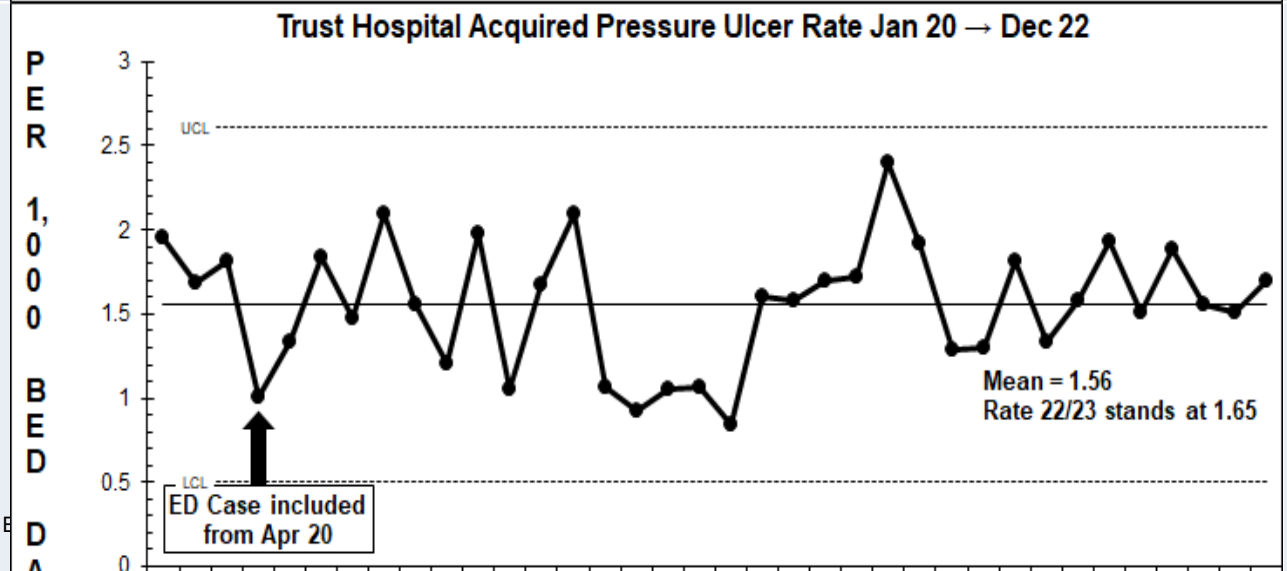
Patient Safety intervention	DATA	Observations & Analysis

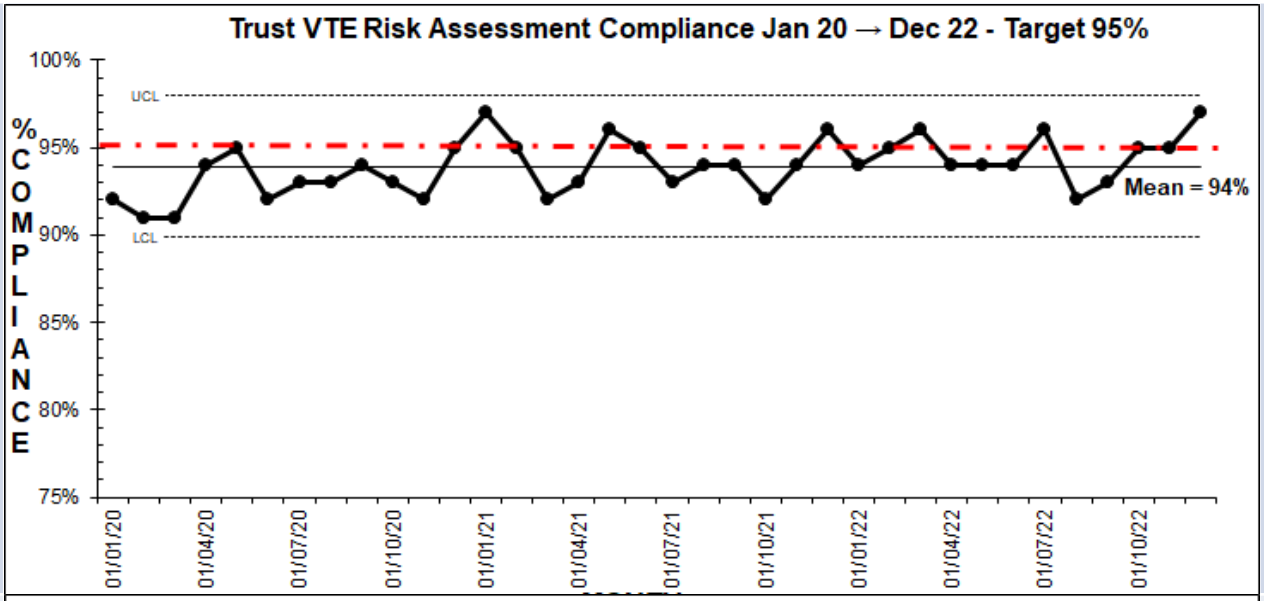
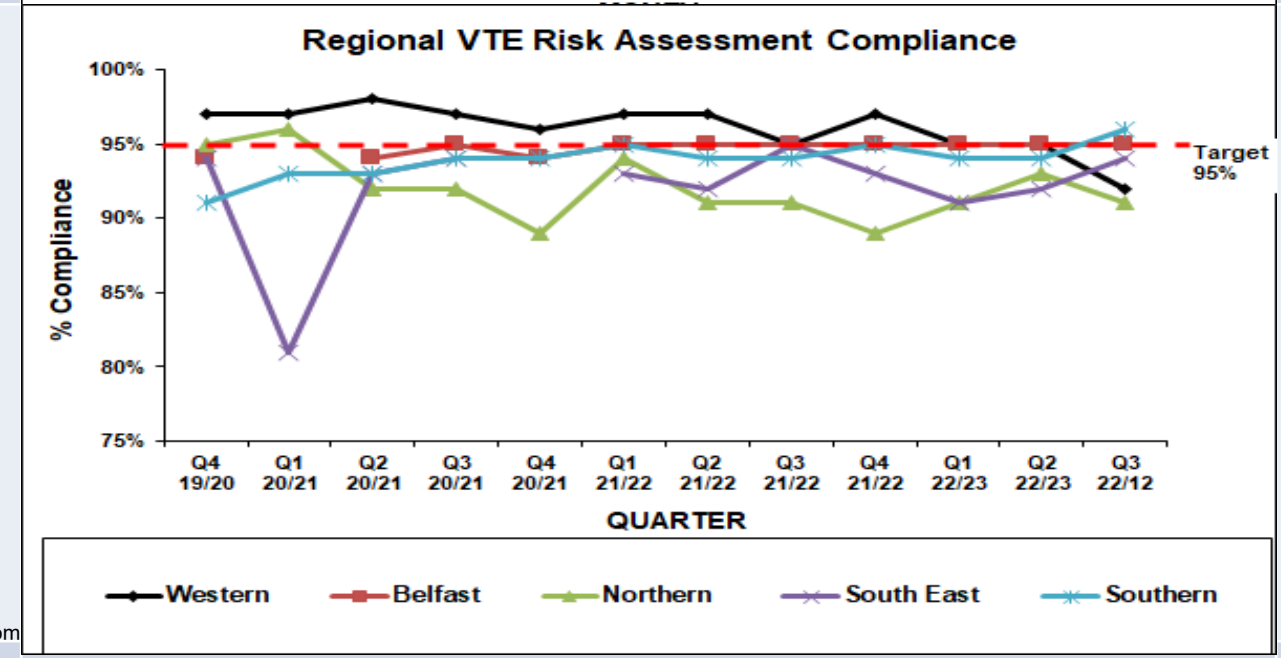
Outcome Measure –

Trust Patient Falls Rate



- Patient Falls Rate Q3 22/23 was **5.09 (407)** per 1,000 Occupied Bed Days, compared to **5.15 (388)** in Q2 22/23
- Patient Moderate & Above Falls Rate Q3 22/23 was **0.09 (7)** per 1,000 Occupied Bed Days same as Q2 22/23
- Trust Patient Falls Rate 22/23 stands at **5.03** per 1,000 Occupied Bed Days (**1,138** patient falls) compared to **5.60** per 1,000 Occupied Bed Days (**1,586** patient falls) in 21/22
- No significant change to either the number or rate of Patient Falls
- Variation in Rate/Number in Q1 & Q2 20/21 due to significant reduction in Occupied Bed Days due to Covid-19
- Of the 29 Wards monitoring their Patient Falls/Falls Rate using the Falls Walking Stick **18** wards **(62%)** saw a decrease in Patient Falls Rates in Q3 22/23 compared to the same period 21/22.

Patient Safety intervention	DATA	Observations & Analysis
3. Hospital Acquired Pressure Ulcers: **Process Measure –** **Bundle Compliance**		❖ Pressure Ulcer Audit – Q1 20/21 (Apr 20 → June 20) was suspended by PHA due to Covid-19 ❖ Pressure Ulcer Bundle Compliance Audit Q3 22/23 (Oct → Dec 22) was **84%**, compared to **89%** in Q2 22/23 ❖ There is no significant change to overall Bundle Compliance ❖ Overall Bundle Compliance remains below the Regional Target of **95%**
Outcome Measure – **Rate of Pressure Ulcers**		❖ Rate for 22/23 stands at **1.65**, compared to **1.46** in 21/22 ❖ To date in 22/23 **16** (**5%**) Stage 3 & above avoidable Pressure Ulcers were noted, compared to **35** (**11%**) in 21/22 ❖ Of the 30 Wards monitoring their Acquired Rate using the Pressure Ulcer Safety Cross, **14** wards (**47%**) have seen their rate remain the same or decrease in 22/23 compared to the same period 21/22. ❖ From Apr 20 acquired cases in ED's are included as per Regional Direction

Patient Safety intervention	DATA	Variation & Special Cause Analysis
4. VTE: Process Measure – **Compliance with completion of VTE Risk Assessment**		❖ Trust compliance Q3 22/23 was **96%**, up from **94%** in Q2 22/23 ❖ Trust compliance 22/23 stands at **94%**, same as 21/22 & just under Regional Goal of **95%** ❖ Risk Assessment Compliance in Oct, Nov & Dec 22 was equal to or above Regional Goal ❖ There is no significant change to overall Bundle Compliance ❖ Performance is reported to Acute Governance on a monthly basis, where Wards with a decline in compliance is highlighted
Comparison with NI Trusts		Q3 22/23 Regional Comparison: Southern **96%** Belfast **95%** Southeast **94%** Western **92%** Northern **91%**

Southern Health and Social Care Trust

Quality care – for you, with you

COVER SHEET

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

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

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Committee with a clear summary of the paper being presented, with the key matters for attention and the 'ask' of the Committee.* *It details how it impacts on the people we serve.*

1. Detailed summary of paper contents:

The purpose of this paper is to provide:

- An annual overview of the SHSCT's participation in the *NHS England Quality Accounts List* of national audits together with the rationale for any non-participation.
- An updated SHSCT position on the progression of recommendations arising from participation in national audits, including those relevant from previous years.
- The composite SHSCT programme of clinical audits centrally registered in the previous 12 month period.
- An update on progress work to strengthen the Trust's clinical audit function

2. Areas of improvement/achievement:

- Increased participation in National Audit Programmes across all Directorates

3. Areas of concern/risk/challenge:

- The on-going impact of service pressures on the ability to progress the implementation of recommendations and action plans for improvement.
- Section 4 – details specific issues highlighted across 26 audits regarding a range of organisational issues; from infrastructure and accommodation, clinical specialism availability, data sharing and staff pressures
- To ensure that all audits (international, national, regional and local) are reported; action planned and monitored on a regular basis within operational directorate governance arrangements.
- To ensure adequate representation of all Directorates / Divisions across national and local clinical audit programmes.
- Lack of regional direction on compliance with data sharing and GDPR requirements
- Strengthening the clinical audit function for assurance and improvement.

4. Impact: Indicate if this impacts with any of the following and how:

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

National Audit Assurance Report (NAAR)

National Audits: 2021/22 Report

Progress Update: 2022/2023

November 2022

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

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

1.0 Executive Summary

The purpose of this paper is to provide:

a) The annual overview of the SHSCT's participation in the *NHS England Quality Accounts List*[1] of national audits for 2021/2022 together with the rationale for any non-participation.
b) An updated SHSCT position on the progression of recommendations arising from participation in current national audits, including those still relevant from previous years.
c) An in-year update on the planned participation in the 2022/2023 list.
d) The composite SHSCT programme of clinical audits centrally registered in the previous 12 month period.
e) A progress update on the work to strengthen the Trust's clinical audit function

This report contains two significant sections:

- **Section 3:** summarises the top three performance indicators for each published national audit or confidential enquiry, as assessed by the clinical audit lead. It also outlines areas for improvement and the progress made in taking these forward. A sharepoint link to access the 2022 update is embedded. (A full text copy is also provided as an addendum to the report).

- **Section 4:** summarises the areas to raise awareness to SMT/ Governance Committee as assessed by the clinical audit lead these constitute – an area of concern / unidentified risk / good practice or barrier to improvement.

This is the third National Audit Assurance Report (NAAR) produced since the start of the SARS-CoV-2 global pandemic in 2019. In January 2022 HQIP issued the update to their 'Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic' guidance. The communication from Sir David Sloman, Chief Operating Officer NHS England and NHS Improvement, to NHS trusts stated 'given the importance of clinical audit in COVID and non-COVID care, clinical audit platforms will remain open for data collection. It should be noted clinical teams should always prioritise clinical care over data collection and submission.'[2]

Locally over the period April 2021 to March 2022, SHSCT continued to see involvement in national programmes restricted and limited as a result of the on-going pandemic situation. Since April 2022 an increase in participation in the 2022/2023 national programme has occurred, in particular in the Older People's and Primary Care Directorate (OPPC). Children and Young People's Services are

[1] Healthcare Quality Improvement Partnership (HQIP) commissions the Quality Accounts: list and further information – HQIP and includes the Outcome Review Programmes (National Confidential Enquiries)

[2] (Page 6; section B) Reporting and assurance; point 14).View the full letter here.

also to be commended this year for participating for the first time in the CYP mental health national benchmarking exercise, whilst Adult and Older People's mental health services were able to re-join their programme for national benchmarking for the first time since 2019. Such national benchmark programmes require significant data collation from across a range of departments to identify staffing complements and funding allocations alongside service activity levels. Corporate business partners are therefore integral to the successful completion of these submissions in supporting their respective service leads.

Progress in implementing current and previous action plans and recommendations remains vulnerable to the on-going effects of pressures on front line service provision. The SHSCT National Audit Programme continues therefore to be impacted as a direct or indirect consequence of:

1. Continued clinical pressures and impact on clinical and service capacity required for pandemic management. This is not unique to SHSCT but experienced across the entire HSC in Northern Ireland;

2. National Reports detailing clinical audit findings not being available from national host organisations in-year and publication subject to deferral. Clinical leads, have in making their submissions again this year, highlighted where this has been the case.

In light of this, clinical leads and their teams, supported by the corporate clinical audit function are to be highly commended for the level of participation and improvement progress that has been made across the national audits contained in this report.

In addition regional and local trust based audits continue but these also in 2021/2022[3] are noted as lower in number than those centrally registered in previous years[4]. The current composite programme is detailed in **Appendix 1a & 1b** of this report. **Appendix 2** details those national audits the Trust is not able to participate in, due mainly to the eligibility and inclusion of NI Health and Social Care Trusts and GDPR issues regarding sharing of patient identifiable information.

Appendix 3 provides a record of all the national audit reports disseminated to Directorates in the last year for awareness for local service or quality improvement.

Appendix 4 details the process for requesting 2022 audit updates to inform the compilation of this report.

[3] In year to November 21 – 51 centrally registered clinical audits

[4] In year to November 22 – 46 centrally registered clinical audits

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

2.0 National Audit Participation Summary 2021/2022[5]

The following reports are available to view via the SharePoint links provided: 2022 National Audit Assurance Report - All Documents

Audit / Enquiry Type	Directorate / National Programme	SharePoint Link to Audit Update
	ACUTE DIRECTORATE	
	Surgery and Elective Care	
	Anaesthetics, Theatres & Intensive Care Services, incorporating Surgery & Elective Care & Laboratory Services	
On-going annually	Intensive Care National Audit & Research Centre (ICNARC)	ICNARC
Historical	National Comparative Audit of Blood Transfusion Programme – Audit of Massive Haemorrhage	NCABT
Historical	Patient Blood Management in Adults Undergoing Elective, Scheduled Surgery	PBM Supporting Document PMB A1 Supporting Document PMB A2
	Integrated Maternity & Women's Health, incorporating neonatal services Maternal, Newborn and Infant Outcome Review Programme (MBRRACE-UK)	
On-going annually	MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2019 (report published October 2021)	MBRRACE-UK Perinatal Mortality Surveillance
On-going annually	MBRRACE-UK: Learning from Standardised Reviews When Babies Die. National Perinatal Mortality Review Tool Third Annual Report (Report published October 2021)	Learning from Standardised Reviews When Babies Die
On-going annually	MBRRACE-UK: Saving Lives, Improving Mothers' Care 2021: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2017-19 (Report published November 2021)	MBRRACE Saving Lives Improving Mothers Care 2021
Historical	Comparative Audit of Management of Maternal Anaemia and Iron Deficiency in the UK and ROI	Management of Maternal Anaemia and iron deficiency Supporting documents for maternal anaemia
Historical	Rapid Report 2021: Learning from SARS-CoV-2-related and Associated Maternal Deaths in the UK June 2020 - March 2021	Learning from SARS-CoV-2
Historical	MBRRACE-UK Perinatal Confidential Enquiry: Stillbirths and Neonatal Deaths in Twin Pregnancies	MBRRACE UK Stillbirths Neonatal Deaths Twin Pregnancies
	Trauma & Orthopaedics	
On-going	National Joint Registry	NJR
On-going	National Hip Fracture Database	NHFD
22/23 Update	Fracture Liaison Service Database	FLSDB
	General Surgery	
21/22 New	National Hiatal Registry	NHSR Supporting Document

[5] Update provided for any 2022/2023 participation that has been undertaken to date.

22/23 Update	National Emergency Laparotomy Audit	NELA
	Urology	
22/23 Update	Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder (MITRE) Audit 2022	MITRE BAUS
	Medicine and Unscheduled Care Division	
	Cardiology	
On-going annually	Adult Percutaneous Coronary Interventions	PCIS.
On-going annually	Cardiac Rhythm Management	CRM
On-going annually	Cardiac Rehabilitation	NACR
On-going annually	Myocardial Ischaemia National Audit Project (MINAP)	MINAP
	Emergency Medicine	
Historical	Cognitive Impairment in Older People	RCEM Cognitive Assessment
Historical	Care of Children in ED	RCEM Care of children
Historical	Mental Health (Self-Harm)	RCEM MHSH
21/22 New	Pain in Children	RCEM Pain in children
21/22 New	Fractured Neck of Femur	RCEM NOF
21/22 New	Infection Prevention Control	RCEM Infection Control
	Gastroenterology	
21/22 New	IBD Benchmarking Survey	IBD
	Renal / Nephrology	
On-going annually	Renal Registry	UK Renal Registry Supporting Document A1 Supporting Documents A2
	Respiratory	
21/22 New	BTS Smoking Cessation	BTS Smoking cessation Supporting Document - Smoking Cessation
21/22 New	BTS Management of Pulmonary Embolism	BTS PE Supporting Document - BTS PE A1 Supporting Document - BTS PE A2 Supporting Document - BTS PE A3
	Stroke Services	
On-going annually	Sentinel Stroke National Audit Programme	SSNAP.
	MENTAL HEALTH AND DISABILITY DIRECTORATE	
21/22 New	Prescribing Observatory for Mental Health (POMH-UK)	POMH - prescribing in depression POMH-Use of melatonin POMH-valproate POMH -Prescribing antipsychotic medication Supporting document - Prescribing for depression

Southern Health and Social Care Trust

Quality Care - for you, with you

On-going annually	Adult and Older Person's Mental Health Benchmarking	MHLD_NHSBN Supporting Information A1 Supporting Information A2
	OLDER PEOPLE & PRIMARY CARE DIRECTORATE	
22/23 Update	UK Parkinson's Audit: Transforming Care	Parkinson's UK
	CHILDREN AND YOUNG PEOPLE'S DIRECTORATE	
21/22 New	CYPS Mental Health Service Benchmarking	CYPMHS Benchmarking Supporting Report
Historical	Intermediate Care	No update
	CROSS DIRECTORATE AUDIT	
21/22 New	National Audit for Care at End of Life (NACEL)	NACEL
Historical	NHS Benchmarking Audit – Managing Frailty in Acute Settings	Managing Frailty in Acute Settings
	New National Confidential Enquiries	
	Medical and Surgical Outcome Review Programme (NCEPOD)	
21/22 New	Epilepsy – awaiting NCEPOD study report (published 08/12/2022)	NCEPOD Disordered Activity Epilepsy
21/22 New	Crohn's Disease – awaiting NCEPOD study report due Spring 2023	SHSCT participation completed
22/23 Update	Community Acquired Pneumonia	Participating and currently on-going in 22/23
22/23 update	Endometriosis	Participating and currently on-going in 22/23
21/22 New	Time Matters: A review of the quality of care provided to patients aged 16 years and over who were admitted to hospital following an out of hospital cardiac arrest	NCEPOD Time Matters
Historical	Inspiring change – non-invasive ventilation (NCEPOD)	No update
Historical	Non-Invasive Ventilation – Adults	No update
21/22 New	NCEPOD - Dysphagia in Parkinson's Disease " Hard to Swallow"	NCEPOD Hard to Swallow
	Child Health Clinical Outcome Review Programme (NCEPOD)	
21/22 New	Transition from Child to Adult Health Services - awaiting NCEPOD study report – release date unknown	SHSCT participation completed
22/23 update	Testicular Torsion	Participating and currently on-going in 22/23
	Mental Health Outcome Review Programme (NCEPOD)	
On-going	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Mental Health Clinical Outcome Review Programme	Towards Zero Suicide
21/22 New	Physical Healthcare of Inpatients in Mental Health Hospitals	NCEPOD Picture of Health
Historical	Treat as One (NCEPOD)	No update
	Maternal, Newborn and Infant Outcome Review Programme	
	detailed earlier in IMWH section	

3.0 2020-21 SHSCT Planned Audit Participation in the NHS England Quality Accounts List of National Audits.

Each audit's sharepoint link in the final column contains the Clinical Lead's updated position on the progression of recommendations arising from participation in national audits and confidential enquiries, including those from previous years that remain applicable[6].

SHSCT planned participation in NHS England Quality Accounts List 2021/22:						
SHSCT National Audit Plan	**Did SHSCT Participate in 2021/2022**	**National Audit Report Received for 21/22**	**Update provided in relation to 21/22 progress**	**No of recommendations from audit**	**Number complete**	**Link to Audit Recommendations / Action Plan**
ACUTE DIRECTORATE **Anaesthetics, Theatres & Intensive Care Services, incorporating Surgery & Elective Care & Laboratory Services**						
Intensive Care National Audit & Research Centre (ICNARC)	Yes Continuous National Audit	Yes	Yes	N/A	N/A	ICNARC
National Comparative Audit of Blood Transfusion Programme (NCABT) – Audit of massive haemorrhage (2018)	NCABT Audits for 2021/2022 not participated in locally.	Not Applicable	Yes	N/A	N/A	NCABT

[6] NB: Change to previous inclusion of Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme. SHOT provide recommendations that SHSCT act on to ensure safe transfusion practice. SHSCT participates in the SHOT reporting scheme (since 2004). Participation in SHOT does not equate to an audit and so no longer fits with the criteria for inclusion in this report.

SHSCT National Audit Plan	Did SHSCT Participate in 2021/2022	National Audit Report Received for 21/22	Update provided in relation to 21/22 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
Patient blood management in adults undergoing elective, scheduled surgery	Not Applicable Historical 2015 audit with re-audit in 2016 Recommendations implementation on-going	Not Applicable	Yes Compliance with recommendations - no change from 2021	21	12	PBM Supporting Document PMB A1 Supporting Document PMB A2
Trauma & Orthopaedics						
National Joint Registry	Yes Continuous Audit	Yes	Yes One recommendation moved to non-compliance	1	0	NJR
National Hip Fracture Database	No Continuous Audit but unable to submit data due to data access issues affecting all NI HSCTs	Yes	Yes	3	0	NHFD
Fracture Liaison Service Database	No – preparing to participate in 2022/2023	Yes	2022/23 progress	N/A	N/A	FLSDB
General Surgery						
National Emergency Laparotomy Audit	No – preparing for participation by NI Trusts as a region	Yes	2022/23 update	N/A	N/A	NELA

SHSCT National Audit Plan	Did SHSCT Participate in 2021/2022	National Audit Report Received for 21/22	Update provided in relation to 21/22 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
Urology						
Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder (MITRE) Audit 2022	No Participated April 2022	Not Applicable	2022/23 progress	N/A	N/A	MITRE BAUS
Integrated Maternity & Women's Health, incorporating neonatal services						
MBRRACE-UK: Saving Lives, Improving Mothers' Care 2021: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2017-19	Yes Continuous Audit	Yes	Yes	13 x New 27 x Improved Implementation 38 x On-going	8 20 27	MBRRACE Saving Lives Improving Mothers Care 2021
Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK June 2020 - March 2021	Yes Snapshot Audit	Not Applicable	Yes Compliance with recommendations saw no change from 2021	17	16	Learning from SARS-CoV-2
MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2019	Yes Continuous Audit	Yes	Yes	9 x New 10 x on-going	3 3	MBRRACE-UK Perinatal Mortality Surveillance

SHSCT National Audit Plan	Did SHSCT Participate in 2021/2022	National Audit Report Received for 21/22	Update provided in relation to 21/22 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
MBRRACE-UK: Learning from Standardised Reviews When Babies Die. National Perinatal Mortality Review Tool Third Annual Report (Report published October 2021)	Yes Continuous Audit	Yes	Yes	4 x New 5 x On-going	1 2	Learning from Standardised Reviews When Babies Die
MBRRACE-UK Perinatal Confidential Enquiry: Stillbirths and Neonatal Deaths in Twin Pregnancies	Yes Continuous Audit	Not Applicable Last report (Jan 2021)	Yes	9	7	MBRRACE UK Stillbirths Neonatal Deaths Twin Pregnancies
Comparative Audit of Management of Maternal Anaemia and Iron Deficiency in the UK and ROI	Not Applicable Historical snapshot audit 2018	Not Applicable	Yes recommendations are now progressing via the regional iron deficiency QI project	3	0	Management of Maternal Anaemia and iron deficiency Supporting documents for maternal anaemia
Cardiology	**Medicine & Unscheduled Care**					
Adult Percutaneous Coronary Interventions	Yes Continuous Audit	Yes	Yes Yearly update provided on Progress of Recommendations	3	1	PCIS.

SHSCT National Audit Plan	Did SHSCT Participate in 2021/2022	National Audit Report Received for 21/22	Update provided in relation to 21/22 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
Cardiac Rhythm Management	Yes	Yes	Yes Update is using local SHSCT 2020/2021 data	7	7 Compliant across all quality metrics	CRM
Cardiac Rehabilitation	Yes – but limited data entry due to C19 disruption and data sharing Continuous Audit	Yes	Accreditation status is based on NACR standards	N/A	N/A	NACR
Myocardial Ischaemia National Audit Project	Yes	Yes	Yearly Update Provided on Progress of Recommendations	3	0	MINAP
Emergency Medicine						
Cognitive Impairment in Older People	No Previous Snapshot Audit	Not Applicable (report received Feb 2021)	Yes	3	0	RCEM Cognitive Assessment
Care of Children in ED	No Previous Snapshot Audit	Not Applicable (report received Jan 2021)	Yes	2	0	RCEM Care of children
Mental Health (Self-Harm)	No Previous Snapshot Audit(s)	Not Applicable (report received Mar 2021)	Yes	4	1	RCEM MHSH

SHSCT National Audit Plan	Did SHSCT Participate in 2021/2022	National Audit Report Received for 21/22	Update provided in relation to 21/22 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
Fractured Neck of Femur (care in emergency departments) NEW	Yes Snapshot Audit (05/10/20 – 02/04/21)	Yes (June 2022)	Yes	2	0	RCEM NOF
Infection Control (care in emergency departments) NEW	Yes (on-going) (05/10/20 – 03/10/21)	Yes (March 2022)	Yes	1	0	RCEM Infection Control
Pain in Children (care in emergency departments) NEW	Yes (on-going) (05/10/20 – 03/10/21)	Yes (January 2022)	Yes	2	0	RCEM Pain in children
Nephrology						
Renal Registry	Yes Continuous Audit		Yearly Update Provided	Compliant	Compliant	UK Renal Registry Supporting Document A1 Supporting Documents A2
Gastroenterology						
IBD Benchmarking Survey	No	No (received May 2020)	Yes	3	0	IBD
Respiratory						
BTS Smoking Cessation NEW	Yes	Yes	Yes	N/A	N/A	BTS Smoking cessation

SHSCT National Audit Plan	Did SHSCT Participate in 2021/2022	National Audit Report Received for 21/22	Update provided in relation to 21/22 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
						Supporting Document - Smoking Cessation
BTS Management of Pulmonary Embolism NEW	Yes	Yes (published Oct 2022)	Yes	3	1	BTS PE Supporting Document - BTS PE A1 Supporting Document - BTS PE A2 Supporting Document - BTS PE A3
Stroke Services						
Sentinel Stroke National Audit Programme	YES Continuous Clinical Audit Biannual Organisational Audit	Yes	YES	6	0	SSNAP.
MENTAL HEALTH AND DISABILITY						
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) MH CORP	Yes Continuous	Yes	Yes Regional TWS QI work	N/A	N/A	Towards Zero Suicide

SHSCT National Audit Plan	Did SHSCT Participate in 2021/2022	National Audit Report Received for 21/22	Update provided in relation to 21/22 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
Prescribing Observatory for Mental Health (POMH-UK)	Yes – Currently On-going Continuous	Yes Some POMH-UK reports delayed and still awaited		See updates provided	See updates provided	POMH - prescribing in depression POMH-Use of melatonin POMH-valproate POMH -Prescribing antipsychotic medication Supporting document - Prescribing for depression
Mental Health Benchmarking	Yes	Yes	Yes	N/A	N/A	MHLD_NHSBN Supporting Information A1 Supporting Information A2

SHSCT National Audit Plan	Did SHSCT Participate in 2021/2022	National Audit Report Received for 21/22	Update provided in relation to 21/22 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
Physical Healthcare of Inpatients in Mental Health Hospitals **NEW Confidential Enquiry Report (22/23)**	Yes Clinical & Organisational Questionnaires Submitted 2021	No (published May 2022)	Update for 2022/2023 report	12	Update awaited	NCEPOD Picture of Health
	OLDER PEOPLE & PRIMARY CARE					
UK Parkinson's Audit Transforming Care	No Participated May – October 2022 Last participated in 2019	Not Applicable Awaited in 2022/2023	2022/23 progress	Current audit	Current audit	Parkinson's UK
NCEPOD - Dysphagia in Parkinson's Disease 'Hard to Swallow' **NEW Confidential Enquiry Report (21/22)**	On-going Clinician & Organisational Questionnaires submitted 2020	Yes	Yes	N/A	N/A	NCEPOD Hard to Swallow

SHSCT National Audit Plan	Did SHSCT Participate in 2021/2022	National Audit Report Received for 21/22	Update provided in relation to 21/22 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
	CHILDREN AND YOUNG PEOPLE'S DIRECTORATE					
CYPS Mental Health Service Benchmarking **New**	Yes	Yes	Yes	New report	N/A	CYPMHS Benchmarking Supporting Report
	CROSS DIRECTORATE AUDITS					
National Audit for Care at End of Life (NACEL) NEW	Yes Round 3	Yes	Yes	9	0	NACEL
Managing Frailty in Acute Settings Benchmarking	Yes Last participated in 2019/2020	Yes	Yes	New report	N/A	Managing Frailty in Acute Settings

Southern Health and Social Care Trust

Quality Care - for you, with you

4.0 Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

This section of the NAAR highlights areas where, despite staff or service efforts, it has not yet been possible to achieve the desired level of compliance with audit standards, or to fully implement action or improvement plan recommendations.

In this context clinical audit leads have been asked to highlight any key areas to be raised for the committees' attention and these are highlighted, under each audit in the following section.

1. INTENSIVE CARE NATIONAL AUDIT & RESEARCH CENTRE (ICNARC)

- There has been a significant change (Q1 2022/2023) in the number of high risk admissions from the ward. This suggests the patients are being admitted with less deranged physiology. This in turn suggests more timely admission to ICU.

- Delay in discharge to wards, remains a challenge. Timely discharge is of benefit to the patient, staff and the units' efficiency.

- Infection control measures depend on unit architecture, notably the number of side wards to isolate patients. Plans have been submitted to increase capacity with two extra side wards as soon as possible. This is phase one as it is expected another two bed spaces will be required to meet demand.

2. NATIONAL COMPARATIVE AUDIT OF BLOOD TRANSFUSION

- The National Comparative Audit of Blood Transfusion (NCABT) considers different topics or areas within blood transfusion each year. Most recently the 2022 topics were:
    - May - Acute upper gastrointestinal bleeding (AUGIB)
    - June - Patient blood management in paediatric surgery
    - September - Blood sample collection and labelling

- The Southern Trust was unable to participate on this occasion due to staffing pressures.

- This was discussed at the most recent meeting of the Trust Transfusion Committee (10th November 2022). Participation in future audits remains desirable if possible depending on staffing pressures.

3. PATIENT BLOOD MANAGEMENT IN ADULTS UNDERGOING ELECTIVE, SCHEDULED SURGERY

- The new Surgical Ambulatory Unit has resulted in the decant of the Preoperative Assessment Department into two different areas in CAH. This has led to a disconnect between clinical and admin areas. The Trust should consider investing in a Preoperative Assessment Department that allows us to prepare patients for surgery in the best way possible.

- The dream is to have a department that is visible, has a high profile within the Trust, is recognised by patients and above all, can deliver all the facets of preoperative preparation.

- Positive outcomes are driven by good preparation. This includes, IV iron, dedicated physiotherapy input for exercise prehabilitation, cardiopulmonary exercise testing in a suitable lab with adequate space, dedicated dietetics input for patients with malnutrition and a waiting area that lends itself to healthcare interventions with bespoke audio-visual messaging.

- Careful consideration must be given to the consolidation of CAH and DHH Preoperative Assessment Departments onto one non-acute site, preferably Armagh.

4. MOTHERS AND BABIES: REDUCING RISK THROUGH AUDITS AND CONFIDENTIAL ENQUIRIES ACROSS THE UK (MBRRACE-UK)

- Obstetric Medicine lead(s). Several of the recommendations highlight our weakness as a trust in the area of maternal medicine. Consideration should be given to training within consultant body/future Cons appointment and generation of Obstetric Medicine lead across the trust and development of a high risk maternal medicine clinic. There are excellent existing relationships between neurology, rheumatology, haematology and obstetrics. Further work is required to ensure standardisation of care across the trust for women with existing medical conditions and this would best be served by an obstetric medicine clinic. **Update 2022: This remains a key priority following MBRRACE. No progress since last summary report on this.**

- Ongoing work re: PPH. Introduction of the obstetrics Cymru proforma and additional skills and drills training has been valuable. Currently being audited. Massive obstetric haemorrhage is an ongoing concern as a trust and investment is needed in continuous improvement. Consideration should be given within job planning for an Obstetric simulation lead. **Update 2022:**

obstetric simulation began in 2022 with excellent results and direct impact on ability to share learning from recent SAIs. Obstetric simulation lead in job plan and newly appointed

- VTE remains the commonest cause of maternal death. There was a maternal death from VTE within the trust in 2020. Audit must be undertaken and QI to ensure robust systems in place to ensure rigorous risk assessment for VTE in all pregnant women. **Update 2022: VTE audit stalled due to staff problems, a key priority for audit in 2023**

5. MBRRACE-UK: LEARNING FROM STANDARDISED REVIEWS WHEN BABIES DIE NATIONAL PERINATAL MORTALITY REVIEW TOOL THIRD ANNUAL REPORT

- PMRT is progressing well since the appointment of the PMRT midwife. Whilst prior to appointment we were reviewing cases using PMRT as a template we did not have the funding to complete all the written reports therefore these remain on the system as uncompleted cases. The aim is that these will be closed off as discussed at M&M (minutes available) retrospectively.

- See above concerning any outstanding PMRT cases that are not yet closed off.

6. RAPID REPORT: LEARNING FROM SARS-COV-2-RELATED AND ASSOCIATED MATERNAL DEATHS IN THE UK MARCH-MAY 2020

- Position in October 2022 remains as per October 2021 linked to no maternal medicine lead raised at No. 4

7. COMPARATIVE AUDIT OF MANAGEMENT OF MATERNAL ANAEMIA AND IRON DEFICIENCY IN THE UK AND ROI

- Identification of women through routine screening at booking and 28 weeks gestation is generally good.

- Streamlining of follow-up and rechecking of low haemoglobin results and response to oral iron required.

- Maternity notes are handheld and will not permit direct entry of results at time of action – standardised letter to be formulated and/or record on NIECR.

- Anaemic population often from ethnic minorities where English not 1st language – attention will be needed to patient information leaflets in other languages.

- Maternal iron deficiency identified as a risk factor for IUGR and PTB as well as increased peripartum transfusion requirements. Regional and national audit data showed that we were missing opportunities to improve maternal antenatal hb levels. The dissemination now of a risk assessment for iron deficiency for every antenatal woman was a regional QI initiative as result of the national anaemia audit.

8. NATIONAL JOINT REGISTRY

- This is a rolling audit looking at numbers performed by Unit and Surgeon, and includes data on revisions by again surgeon and Unit. We have no outliers.

- The unit and surgeons are however performing very low numbers of cases and if this is to continue, will be highlighted as problematic.

- The snapshot audit of data accuracy remain good from a surgeon perspective but poor from a data entry and coding perspective (this is unchanged over the last 5 years).

9. NATIONAL HIP FRACTURE DATABASE (NHFD)

- Difficulties in uploading data from Fracture Outcome Research Database (FORD) in Northern Ireland, via BHSCT. After regional discussions, a plan has been put into place to facilitate this.

10. FALLS AND FRAGILITY FRACTURE AUDIT PROGRAMME (FFFAP) FRACTURE LIAISON SERVICE DATABASE (FLS-DB)

- Barriers to improvement- The main barriers to achieving the defined clinical standards for secondary fracture prevention relate to timeliness, with an existing backlog resulting in delayed assessment and long waiting times to commence anti-osteoporosis treatments.
- Patients with new fractures within the audit timeframe and potentially eligible for inclusion in the audit will not have been identified or assessed at the point of data closure.

- There are increased service pressures and demand is currently outstripping FLS capacity with requirements to manage the DXA backlog post Covid-19, including additional scans from a private provider and change of service IT system to facilitate audit with reduced efficiencies increasing clinical administrative time.

Key Performance Indicators (Please see definition details of KPIs) (KPI 1, KPI 2, KPI 4, KPI 5, KPI 7)

PARIS

- Transfer from an Access database for patient management to PARIS in order to facilitate data collection for FLSDB has resulted in difficulties and delays to processes.
    - Data for patients 2021 is held on both systems and PARIS FLSDB reports are not yet available.
    - Data entry to PARIS is more time consuming.
    - Lack of functionality within PARIS to carry data from assessment to letter template for editing and report generation requires duplication of data input for FLSDB and patient reports reducing efficiency.

Backlog

- The increased workload has also reduced the ability of the FLS to provide timely case identification currently delayed 6-7 months.
- Some patients may be treated at this stage without or while awaiting a DXA scan, however, if a DXA scan is required to inform treatment decision the current waiting time for scan and treatment recommendations is approximately 2 years.

DXA scans and reports

- Reduced DXA capacity during the COVID-19 pandemic increased waiting times for DXA scans up to 1½ - 2 years. A subsequent agreement with the private sector to provide DXA scans is reducing the radiology waiting list but without additional FLS staff, this has created a further waiting list within the Trust to provide the report with clinically evaluation of scans, fracture risk assessment and appropriate management plan.

Anti-osteoporosis medication and monitoring (KPI 9, KPI 10, & KPI 11)

- New NICE guidance supports wider use of specialist treatments at an early stage in the disease. Long waiting times for specialist clinics already exist in the Trust and this pathway change will likely increase demand.
- Follow-up monitoring checks have been suspended due to increased service pressures as detailed above.

Areas of good practice

- KPI 3 – Identification (spinal fractures) - Patients with vertebral fractures are a group recognised as at greatest highest risk of re-fracture. Following participation in the RCP FLSDB QI project, the FLS is trying to maintain the improvements achieved in identification and treatment of patients with vertebral fractures by screening of thoracic and lumbar X-rays on NIPACS although this case identification is currently delayed 6-7 months.

11. ADULT PERCUTANEOUS CORONARY INTERVENTIONS- BRITISH CARDIOVASCULAR INTERVENTION SOCIERTY (BCIS)

- The BCIS average for PCI per lab is around 350 per year. We typically undertake almost double that. The typical number of labs for a UK hospital with our case volume is 2-3 labs. Our lab capacity is inadequate, which is a patient safety risk.

- If the single cath lab X-ray equipment goes down mid case, our only back up is a general X-ray room rather than a cardiology room. This is considered inadequate and a patient safety risk.

- Our cath lab is now under-resourced. To maintain clinical practice at a contemporary standard, we need (i) access to contemporary imaging when indicated (ii) access to contemporary coronary technologies and (iii) be able to participate fully in national research.

- Our limited capacity leads to :
    - long waits for elective patients which is a concern from a patient safety
    - delay in scheduling 1N/AMU/CCU patients (hence suboptimal bed flow throughout the hospital and difficulty meeting NICE guidelines for patient access.

- The board are aware of our request for a second lab but have not approved. We would advise the trust to develop a second cath lab for pacing and devices for 2 days (a key service which is not adequately resourced) and which would also be PCI capable (allowing 1-2 days of additional coronary work and providing safety back up should lab 1 fail mid case). Such configuration is standard in similar sized interventional units across the rest of the UK.

12. CARDIAC RHYTHM MANAGEMENT

- All data is required to be anonymised, this is currently a time consuming manual process and makes it difficult to process with clinical pressures. We rely on IT to help format the information and the physiology team to perform the upload. The introduction of Encompass will streamline the process but until then we are working on uploading small batches of data throughout the year.

- Issues with anonymising data subset via CVIS reports. Despite several attempts with IT to format the data, the upload would not work through NCAP before the specific deadline. Contact was made with our IT department and NICOR help desk to resolve. IT have been able to complete the report since with the appropriate formats and we are collecting data and submitting on a 6 monthly basis going forward. Currently working towards 6 monthly submission in November 2022.

13. NATIONAL AUDIT OF CARDIAC REHABILITATION (NACR)

- The Cardiac Rehabilitation teams will have difficulty contributing to the NACR in future due to inadequate staffing levels and lack of admin support.

- The cardiac rehab teams have been unable to provide data to the NACR on a regular basis during this period due to the COVID pandemic. This is affecting how the service was provided with services having to modify their approach.

- Consequently ST data displays in the National Report are not reflective of the current position.

- There was also a retirement in the DHH team and Armagh/Dungannon team. These posts have been filled but NACR training only took place in July 2022.
- There is also an issue of outstanding ST/NACR data agreement. This has been with NACR for 1 year awaiting an updated data agreement. The SHSCT Cardiac Rehab teams have been advised to stop submitting NACR data until this is done.

14. MYOCARDIAL ISCHAEMIA NATIONAL AUDIT PROJECT (MINAP)

- Nice Guideline (GC94) recommend Acute Coronary Syndromes should have Coronary Angiography and PCI performed within 72 hours.

- This target is not being achieved because of capacity delays due to SHSCT only having one Cardiac Catheterisation Lab theatre which operates Mon – Friday 9-5pm. (**see No.11**)

- Currently only **31% of SHSCT patients** receive an angiogram within the 72 hour quality standard. **National Average is 66%.**

15. ASSESSING FOR COGNITIVE IMPAIRMENT IN OLDER PEOPLE (Royal College of Emergency Medicine, RCEM)

- Difficult to complete in very challenging environment – overcrowding. Trust working to address with various QIP projects including Purple Heart project.

16. MENTAL HEALTH (SELF-HARM) RCEM – NEW

- This following recommendation has two barriers
    - Patients at medium or high risk of suicide, harm or of leaving before assessment and treatment are complete should be **observed closely** whilst in the ED. There should be **documented evidence of action to mitigate risk**, such as continuous observation or intermittent checks (e.g. every 15 minutes), whichever is most appropriate
        - Given pressures within ED regarding capacity and staffing, it is difficult to implement this recommendation. A review with likely additional funding of staff at band 3 level would be required to implement this change. If that is not possible, it should be acknowledged that the department will struggle to fulfil this recommendation and it should be added to the risk register.

        - Fundamental concerns with regard to department footprint, patients absconding, exit block, crowding.

- Concerns remain regarding the designation of the ED regionally as “place of safety”, the interpretation of the absconding protocol / involvement of the PSNI and site security. The department would be keen to become involved in the Trust bodycam pilot currently being undertaken in Bluestone.

17. PAIN IN CHILDREN (RCEM)

- An increased number of paediatric trained emergency nurses working within the paediatric area of ED would allow for earlier recognition and improved treatment / compliance with standards.

18. FRACTURED NECK OF FEMUR (NOF)

- Meeting these standards will be impacted by ongoing exit block within the department.

19. INFLAMMATORY BOWEL DISEASE (IBD) BENCHMARKING SURVEY

- Gastroenterology are involved in general medical care with the GI ward having 50% bed occupancy with non GI issues.

- WTE gastroenterologists in post are split across GI and GMED responsibilities and significantly impacted during the pandemic period. Work load has led to difficulties with staff retention and recruitment with regional comparison indicating under resourcing and development of GI care. MDM requires job planned dedicated time for surgical specialty and audio-visual support.

- Increased Stoma Therapy provision required. Progress to be made on joint surgical / GI clinics for complex cases.

- Waiting times for endoscopy and MRI are longer than desired.

- Lack of Clinical Psychology input.

- No local Trust registry or database of IBD patients which results in no longer term surgical outcome reporting mechanism.

- Unable to submit identifiable patient data to the national IBD registry due to data sharing protocols

20. RENAL REGISTRY

- DHH Renal Unit was the second placed renal centre in the UK for patient satisfaction of level of service.

- DHH Renal Unit has the second highest percentage of patients on home therapy in NI

- DHH Renal Unit is above the national average for pre-emptive deceased donor transplant or live donor transplant.

- DHH Renal Unit has second highest percentage of patients transplanted in NI

- DHH Renal Unit is above the national average for dialysis patient survival.

- DHH Renal Unit is in the top quartile for kidney transplant function in the UK

21. SENTINEL STROKE NATIONAL AUDIT PROGRAMME (SSNAP)

- SSNAP scoring has seen some improvements in recent cycles but overall performance falls below the national average in a number of areas. Highlighted as the three key priorities. A Stroke Services update to Trust Board in October 2022 detailed a new project structure established to drive service improvement within both Stroke and Frailty services. The Project Steering Group is joint chaired by Interim Director of Medicine and Unscheduled Care and Director of Older People and Primary Care Services and Dr McCaffrey as Clinical Project Director. The first meeting of the Steering Group took place in early September. Two dedicated project teams have also been established for stroke and frailty respectively with specific action plans in development to support focused improvements in both areas. SSNAP will going forward be discussed at the project steering group

- Therapy access at weekends needs to be equitable across the trust. It is unacceptable and needs questioned as to why stroke patients receive no therapy at weekends in the majority of stroke wards. Consideration based on staffing deficiencies and therapy access needs given towards consolidation. Waiting on a delayed consultation is harming patient outcomes.

- Integration between acute and OPPC has been poor. The stroke pathway should be smooth, as should the transition of patients. There needs to be a targeted focus on the management of the stroke service and the flow of patients, but also staff.
- The strategic stroke committee needs reviewed including membership and terms of reference. This group should oversee stroke progress, have the necessary administrative support and work with targeted aims and objectives.

- TIA is an ambulatory speciality. The trust needs to provide a report as to how they will provide a 7-day service. Progress made through plans for an ambulatory pathway and virtual ward.

- The trust has completed audits on “Stroke mimics”, the biannual stroke organisational audit and audits for the non-acute sites and the community/ESD stroke teams in the past year. A rich resource of data against which performance is measured. The structures for the interrogation of this data and presentation to senior decision makers to bring about change have not been in place within

stroke. As described at (a) the new project steering group will address this going forward.

22. POMH-UK - PRESCRIBING FOR DEPRESSION IN ADULT MENTAL HEALTH SERVICES (RE-AUDIT 2021)

- Trust faired better than the total national sample (TNS) for care planning and identifying strategies to support same but room for further improvement.

- Trust needs to improve use of formal rating scale for outcome for depression and side effects of medication.

- Trust has lower use of lithium in patients with resistant depression than TNS and increasing prescribing of this may support TSZ initiative.

POMH-USE OF MELATONIN

- SHSCT data collection complete but POMH-UK report not yet available.

- Please note from POMH-UK
  - Due to staff shortages affecting the POMH team, please be advised that the reporting period for the following topics have been delayed:
  - Topic 21a: Use of melatonin. Data analysis is ongoing. We now expect reports to be released in January or early February next year.

POMH -PRESCRIBING ANTIPSYCHOTIC MEDICATION

- SHSCT data collection complete report not yet available.

- Please note from POMH-UK
  - Due to staff shortages affecting the POMH team, please be advised that the reporting period for the following topics have been delayed:
  - Topic 1h and 3e: Prescribing antipsychotics including high dose, combined and PRN. Reports will be released to members by the end of this year.

23. INPATIENT AND COMMUNITY MENTAL HEALTH BENCHMARKING

- Caution continues to be exercised when submitting and comparing indicators within the Mental Health data set due to:
  - definition interpretation both regionally and nationally. In light of this key metric data and relative positions have been used by SHSCT MH services to drive further investigation and improvement work.

- integrated nature of HSC in NI compared to England, Scotland and Wales.
- regional work initiated on data definition consistency, started prior to the pandemic needs to be re-instated.

- The division is to be commended this year for re-establishing the national benchmarking exercise

24. DYSPHAGIA IN PARKINSON'S DISEASE – 'HARD TO SWALLOW' PUBLISHED AUGUST 2021

- Raising Awareness:
  - To continue to raise the awareness of the content of this report and its recommendations to the attention of SHSCT SMT, Governance Committee, Trust Board and Trust Staff.
- Areas of Concern/Barriers to improvement**:**
  - Address capacity and workforce issues of SLT service/MDT workforce pressures/response times. This will include the SLT cover/dedicated SLT in ED during normal 5 day week working hours, which increases risk during OOH or weekends and consideration of 7 day service provision.

  - Review nursing admission/triage/assessment documentation in ED to include swallow screening and prompts to consider current or historical swallowing status of any patient in ED with recognised EDS difficulties. This has been raised with Regional Nurse Leads in PHA/SPPG and Regional guidance is being sought.

25. NATIONAL AUDIT OF CARE AT THE END OF LIFE (NACEL)

- There is the aim to develop a NACEL implementation group to look at all recommendations, nationally, regional and local, to develop an action plan and share with teams in acute/non-acute hospitals as well as Governance Committee, SMT / Trust Board and the PCEOL Locality Board.

26. Managing Frailty in Acute Settings 2022

- There is an urgent need to address frailty services to assist with the escalating pressure within NIAS, ED and acute medicine services. Frailty being 'everyone's problem' remains true, and will rely on training and awareness across all areas of acute service, none of which is currently mandatory.

- We have used the additional consultant recruitment 2020 to start projects described above within CAH, and this will need rolled across the Trust.

- Current gaps within consultant COE staffing in DHH are hampering further development on this site. There is a clear need to have pathways for specialist nurse development and to fully utilise the skilled resource within our existing physio and OT teams.

Southern Health and Social Care Trust

Quality Care - for you, with you

5.0 SHSCT Clinical Audit Work Programme 2022/23

Operational directorates develop a clinical audit work programme consisting of national, regional and trust-based audits, prioritised as follows:

Priority levels for clinical audits		
Level	**Audit type - projects identified through**	
Level 1 audits, **"external must dos"** (where the service is applicable to SHSCT)	• National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Enquires	1
Level 2 audits, other national audits and **'internal must dos'**	• National audits not contained within the HQIP list, or other clinical audits arising from: • Clinical risk • Serious untoward incident / internal reviews • National Institute of Health & Care Excellence • Complaints • Re-audit • Regional audits initiated by RQIA	2
Level 3 audits, 'Trust or Divisional priorities'	• Local topics important across the Trust or to the Division	3
Level 4 audits	• Clinician / personal interest • Educational audits	4

This aggregates into a composite organisational programme set out in the appendices to this report.

Appendix	**SHSCT Clinical Audit Work Plan**
Appendix 1a	The 2022/23 clinical audit work programme demonstrates planned participation in national audits; this participation is subject to compliance with GDPR requirements.
Appendix 1b	Trust's composite clinical audit work programme from centrally registered audits in the year to date.
Appendix 2	Rationale for non-participation in national audits in the NHS England Quality Accounts List

Southern Health and Social Care Trust

Quality Care - for you, with you

6.0 GDPR requirements – Position remains as reported in November 2018

Trusts in NI face challenges on sharing patient identifiable data for secondary use with external organisations, as Northern Ireland does not have equivalent legalisation to the NHS Act - Section 251.

The Trust's Director of Performance and Reform has endeavoured to find a regional resolution to this issue via the Strategic Information Group (SIG), where the topic received significant discussion however resolution was not immediately clear.

This issue was considered at the Information Governance Advisory Group (IGAG), Information Governance Network and at the Privacy Advisory Committee meeting held on 13th September 2018; however a regionally agreed way forward has yet to be determined[7]

In the interim, participation in national audits has been presented in this report (Appendix A) an on-going basis, taking a discretionary approach based on the benefit of participation in a national audit, versus any data protection risks. Many audits are participated in by all HSCTs in NI. On-going participation and information governance arrangements will be reviewed as part of an updated Clinical Audit Strategy.

It is recognised that participation in Clinical Audit is a fundamental driver for improving patient care, and the Trusts assumed position remains to participate in all audits.

[7] Position remains as advised by the Head of Information Governance, Directorate of Performance and Perform on 22nd November 2022

Southern Health and Social Care Trust

Quality Care - for you, with you

7.0 Strengthening Clinical Audit

Since October 2021 a number of developments have seen the process of strengthening the clinical audit function taken forward.

- The Senior Management Team approved a resource plan on 16th January 2022 for additional staff capacity in the central clinical audit team.

- On 21st June 2022 the new Clinical Audit Strategy was approved Clinical audit strategy_SMT_approval_21062022.doc.pdf

- The approval of in-year prioritised posts in July 2022 by the Strategic Investment Committee has initiated recruitment to the clinical audit function, based in the Medical Directorate.

- The accompanying Clinical Audit Policy to the Strategy was tabled at Policy Scrutiny Committee on 17th November 2022, and will be subject to final approval at Senior Management Team.

- This policy along with the development of documented standard operating procedures will finalise the one outstanding internal audit recommendation from the 2016/2017 report.

- Focussed clinical lead engagement has been on-going across Directorates to both identify the areas where audit programmes are working well and those where improvement is required to enable increased clinical engagement.

- An increased audit network of lead clinicians alongside the corporate clinical audit team will be required to ensure an adequately staffed and trained team can facilitate and support the Trust's annual programmes going forward.

Southern Health and Social Care Trust

Quality Care - for you, with you

NHS England Quality Accounts List 2022 - 23 :
NHSE-QA-List-2022-23 (HQIP.org.uk)
SHSCT planned participation — Appendix 1a

Division	National Clinical Audit & Clinical Outcome Review Programme	Host Organisation	Will SHSCT be participating?
Anaesthetics, theatre & intensive care unit	Case mix programme (CMP) - ICNARC	Intensive Care National Audit and Research Centre	Yes
Cardiology	Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust	Yes
	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Barts Health NHS Trust	Yes
	National Audit of Cardiac Rhythm Management (CRM)	Barts Health NHS Trust	Yes
Respiratory	Adult Respiratory Support Audit	British Thoracic Society	Yes
	Smoking Cessation Audit- Maternity and Mental Health Services	British Thoracic Society	Yes
Emergency department	Pain in Children (care in Emergency Departments)	Royal College of Emergency Medicine	Yes
	Assessing for Cognitive Impairment in Older People	Royal College of Emergency Medicine	Yes
	Mental Health (self-harm)	Royal College of Emergency Medicine	Yes
Integrated maternal & women's health	Maternal, newborn and infant clinical outcome review programme	University of Oxford / MBRRACE-UK collaborative	Yes
	National Perinatal Mortality Review Tool	University of Oxford / MBRRACE-UK collaborative	Yes
Nephrology	UK Renal Registry Chronic Kidney	UK Kidney Association	Yes
MHLD	Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and	Yes

		Homicide in Mental Health (NCISH)	
	Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists (RCPsych)	Yes
Stroke services	Sentinel Stroke National Audit programme (SSNAP)	King's College London	Yes
Trauma & orthopaedics	National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Yes
	Falls and Fragility Fracture Audit Programme (FFFAP) - National Hip Fracture Database	Royal College of Physicians	Yes
Urology	Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)	British Association of Urological Surgeons (BAUS)	Yes
Cross speciality	Medical and Surgical Clinical Outcome Review Programme: 1. Community acquired pneumonia	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes
	Medical and Surgical Clinical Outcome Review Programme: 2. Crohn's disease	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes
	Medical and Surgical Clinical Outcome Review Programme: 3. End of life care	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes
	Medical and Surgical Clinical Outcome Review Programme: 4. Endometriosis	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes

	Child Health Clinical Outcome Review Programme – 1. Transition from child to adult health services	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes
	Child Health Clinical Outcome Review Programme -2. Testicular Torsion	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes
	National Audit of Care at the End of Life (NACEL) Round 4	NHS Benchmarking Network	Yes
	Falls and Fragility Fracture Audit Programme (FFFAP) - Fracture Liaison Service Database	Royal College of Physicians (RCP)	Yes
	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Serious Hazards of Transfusion (SHOT)	Yes
	UK Parkinson's Audit	Parkinson's UK	Yes

Southern Health and Social Care Trust

Quality Care - for you, with you

SHSCT Clinical audit work programme (Oct 2021 – Oct 2022) (audits registered with the central clinical audit directory)

Appendix 1b

Directorate / Division	Division	Audit type	Audit Level	Audit title
Acute, SEC	T&O	National	1	Getting it Right First Time (GIRFT) Specialty Input Study
Acute, OPPC	Older People	National	1	Parkinson's UK audit
Acute, Cross Specialty	Cross Specialty	National	2	Seeking excellence in end of life care: A service evaluation of care provided to people dying in hospitals in Great Britain & Ireland (SEECare)
Acute, IMWH	IMWH	National	2	Cross sectional Survey to explore the process of care during induction of labour in a sample of units in the UK
Acute, Pharmacy	Pharmacy	SHSCT	2	Quarantine project (Quantifying change in Antibiotic Resistance, Antibiotic use and Infection control during COVID-19 Epidemics (QUARANTINE)
Acute, Pharmacy	Pharmacy	SHSCT	2	Clinical Outcomes in Gentamicin Prescribing and Monitoring in UK Hospitals: A National Audit Co gent
Acute, SEC	Breast Surgery	National	2	Local recurrence after breast conservation (LRAB), Association Breast Surgeons
Acute, SEC	General Surgery	National	2	Cardiovascular outcomes after major abdominal surgery
Acute, OPPC	Older People	National	2	NHS benchmarking network: Bespoke Frailty Service
Acute, Cross Specialty	Cross Specialty	Regional	2	Northern Ireland Transfusion Committee-O negative audit
Acute, IMWH	IMWH	SHSCT	2	Maternity outcomes during the Covid 19 pandemic based on vaccination status and covid status.
Community, CYP	Dental	SHSCT	2	Community Dental Service Image Quality Radiographic Audit January 2022-June 20222
CYP / Acute	Cross Specialty	Regional	2	Paediatric IV Fluid Audit Improvement Tool (PIVFAIT)
Acute, MUSC	Cardiology	Regional	3	Coronary re-access in TAVI patients

Acute, SEC	General Surgery	Regional	3	Cost effectiveness of routine group and save in patients booked for Lap/open appendectomies
Acute, ATICS	ATICS	SHSCT	3	Audit into the management of intracranial bleeds
Acute, IMWH	IMWH	SHSCT	3	Oasis in DHH
Acute, IMWH	IMWH	SHSCT	3	Induction of labour methods in women aiming vaginal birth after caesarean (VBAC)
Acute, IMWH	IMWH	SHSCT	3	Emergency c/s rates from Foley induction
Acute, MUSC	General Medicine	SHSCT	3	HIV Audit AMU/MAU
Acute, MUSC	General Medicine	SHSCT	3	Audit of staff induction in the direct assessment unit at Daisy Hill hospital
Acute, MUSC	General Medicine	SHSCT	3	Are Patients Diagnosed with Spontaneous Bacterial Peritonitis Discharged on Appropriate Prophylactic Antibiotics?
Acute, MUSC	Neurology	SHSCT	3	Immunoglobulin Levels during Ocrelizumab treatment
Acute, SEC	ENT	SHSCT	3	Urodynamics Practice against Guidelines
Acute, SEC	General Surgery	SHSCT	3	Strong Opioid use among surgical patients
Acute, SEC	General Surgery	SHSCT	3	General Surgery Kardex Audit
Acute, SEC	T&O	SHSCT	3	Does our management of open fractures conform to national BOAST guidelines?
Acute, SEC	T&O	SHSCT	3	Complex arthroplasty audit
Acute, SEC	Urology	SHSCT	3	Postponed flexible cystoscopies when urinalysis suggests presence of infection
Acute, SEC	Urology	SHSCT	3	Audit of all prostate biopsies in SHSCT from Jan 2018 to current
Acute, SEC	Urology	SHSCT	3	Nephrostomy Audit
Acute, SEC	Urology	SHSCT	3	Review of stent mobility associated with prolonged waiting lists secondary to covid
CYP / Acute	Cross Specialty	SHSCT	3	Comprehensive Annual Surveillance Audit NG29 (CASA 29)

Acute, IMWH	IMWH	SHSCT	4	The impact of covid 19 on accessing gynaecology service for the management of post-menopausal bleeding
Acute, SEC	General Surgery	SHSCT	4	Timeline of definitive management in acute gall stone pancreatitis patient
Acute, SEC	General Surgery	SHSCT	4	Timeline of imaging in acute pancreatitis patient
Acute, SEC	General Surgery	SHSCT	4	STAR note keeping
Acute, SEC	General Surgery	SHSCT	4	Ward round improvement
Acute, SEC	General Surgery	SHSCT	4	Group and Holds in appendectomy
Acute, SEC	General Surgery	SHSCT	4	Endoscopy validation
Acute, SEC	General Surgery	SHSCT	4	DHH NELA data
Acute, SEC	General Surgery	SHSCT	4	Understanding knowledge of Surgical glycaemic control amongst foundation year doctors.
Acute, SEC	General Surgery	SHSCT	4	Antibiotic usage
Acute, SEC	T&O	SHSCT	4	KIWI project
Acute, SEC	T&O	SHSCT	4	Do we document tourniquet use in accordance with BOAST guidance?
Acute, SEC	T&O	SHSCT	4	Blunt Cerebrovascular Injury and CT angio
Acute, SEC	Urology	SHSCT	4	Rate of UTI's post cystoscopy
Acute, SEC	Urology	SHSCT	4	Local Anaesthetic urology procedures
CYP	Neonatal	SHSCT	4	Post-natal Huddle- a service evaluation initiative
OPPC	Elderly Care	SHSCT	4	QIP Hyponatraemia

Southern Health and Social Care Trust

Quality Care - for you, with you

NHS England Quality Accounts List 2022 - 23
SHSCT non participation and rationale — Appendix 2

	Division	National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Will SHSCT be participating?	Rationale
Non participation	Cross Directorate	Falls and Fragility Fracture Audit Programme (FFFAP) - National Audit of Inpatient Falls	Royal College of Physicians (RCP)	**No**	PARIS system dataset not compatible
		National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK	**No**	GDPR / data sharing
	ATICS	Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists	**No**	not commissioned and data sharing
	Cardiology	National Audit of Cardiac Rehabilitation (limited data input available) Regional HSCB / QUB Review	University of York	**No**	Participation impacted due to C19. Data sharing now an issue
	Gastroenterology	Inflammatory bowel disease programme / IBD Registry	Inflammatory Bowel Disease Registry	**No**	Explicit consent process would be required to permit data sharing
	Medical	Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	**No**	Unable to participate due to staff availability
	T&0	Trauma Audit & Research Network (TARN)	The Trauma Audit & Research Network (TARN)/University of Manchester	**No**	N/A to SHSCT trauma services

Southern Health and Social Care Trust

Quality Care - for you, with you

NHS England Quality Accounts List 2022-23(1)
SHSCT non participation and rationale Appendix 3

	National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Will SHSCT be participating?	Rationale
Non participation	Breast and Cosmetic Implant Registry	NHS Digital	Not eligible	Service not provided by SHSCT
	UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	Participation in local QUB registry	
	Cleft Registry and Audit Network Database	Royal College of Surgeons - Clinical Effectiveness Unit	Not eligible	Service not provided by SHSCT
	National Bariatric Surgery Register	British Obesity and Metabolic Surgery Society	Not eligible	Service not provided by SHSCT
	National Cardiac Audit Programme: National Congenital Heart Disease	Barts Health NHS Trust	Not eligible	Service not provided by SHSCT
	National Cardiac Audit Programme: National Adult Cardiac Surgery Audit	Barts Health NHS Trust	Not eligible	Service not provided by SHSCT
	National Cardiac Audit Programme: National Heart Failure Audit	Barts Health NHS Trust	Not eligible	Data collection England &Wales
	National Ophthalmology Database Audit (NOD)	Royal College of Ophthalmologists	Not eligible	Service not provided by SHSCT
	National Prostate Cancer Audit (NPCA)	Royal College of Surgeons of England	Not eligible	Not Commissioned via cancer registries
	National Vascular Registry	Royal College of Surgeons of England	Not eligible	Not Commissioned
	Neurosurgical National Audit Programme	Society of British Neurological Surgeons	Not eligible	Service not provided by SHSCT
	Paediatric Intensive Care Audit Network (PICANet)	Universities of Leeds and Leicester	Not eligible	Service not provided by SHSCT
	Renal Audits - National Acute Kidney Injury Audit	UK Kidney Association	Not eligible	Data Collection England

Southern Health and Social Care Trust

Quality Care - for you, with you

	National Adult Diabetes Audit (NDA) - National Diabetes Core Audit	NHS Digital	Not eligible	Data Collection England & Wales
	National Adult Diabetes Audit (NDA) - National Diabetes Foot care Audit	NHS Digital	Not eligible	Data Collection England & Wales
	National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Safety Audit	NHS Digital	Not eligible	Data Collection England & Wales
	National Adult Diabetes Audit (NDA) - National Pregnancy in Diabetes Audit	NHS Digital	Not eligible	Data Collection England & Wales
	National Asthma and COPD Audit Programme (NACAP) - Adult Asthma Secondary Care	Royal College of Physicians	Not eligible	Data collection England &Wales
	National Asthma and COPD Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians	Not eligible	Data collection England &Wales
	National Asthma and COPD Audit Programme (NACAP) - Paediatric Asthma Secondary Care	Royal College of Physicians	Not eligible	Data collection England &Wales
	National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation Organisational and Clinical Audit	Royal College of Physicians	Not eligible	Data collection England &Wales
	National Audit of Breast Cancer in Older Patients	Royal College of Surgeons	Not eligible	Data collection England &Wales
	National Audit of Cardiovascular Disease Prevention	NHS Benchmarking Network	Not eligible	Primary care
	National Audit of Dementia	Royal College of Psychiatrists	Not eligible	Data collection England &Wales
Non participation	National Audit of Pulmonary Hypertension	NHS Digital	Not eligible	Data Collection England & Scotland
	Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	Not eligible	Data collection England &Wales
	Gastro-intestinal Cancer Audit Programme (GICAP) National Bowel Cancer Audit	NHS Digital	Not eligible	Data Collection England & Wales

	Gastro-intestinal Cancer Audit Programme (GICAP) National Oesophago-gastric Cancer Audit	NHS Digital	Not eligible	Data Collection England & Wales
	National Child Mortality Database	University of Bristol	Not eligible	Data Collection England
	National Clinical Audit of Psychosis	Royal College of Psychiatrists	Not eligible	Data collection England &Wales
	National Early Inflammatory Arthritis Audit	British Society of Rheumatology	Not eligible	Data Collection England & Wales
	National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	Not eligible	Data Collection England & Wales
	National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology	Not eligible	Data Collection England, Scotland and Wales
	National Neonatal Audit Programme 1, 2	Royal College of Paediatrics and Child Health	Not eligible	Data Collection England, Scotland and Wales
	Out of hospital cardiac outcomes (OHCAO)	University of Warwick	Not eligible	NHS Ambulance Service

Southern Health and Social Care Trust

Quality Care - for you, with you

HQIP National Audit Published Reports November 2021 – November 2022 Dissemination Record

Appendix 3

HQIP Audit Report Title	Date Issued	Directorates disseminated to	Trust participation
HQIP National Emergency Laparotomy Audit	11/11/2021	ACUTE/OPPC	NO
HQIP National Paediatrics Diabetes Audit-Spotlight on Type 2 Diabetes	11/11/2021	ACUTE/CYP	NO
MBRRACE- Saving Lives, Improving Mothers' Care Report-Maternal, Newborn and Infant Clinical Outcome Review Programme	11/11/2021	ACUTE/MHLD/CYP	YES
HQIP National Audit of Inpatient Falls Annual Report 2021-The Falls and Fragility Fracture Audit Programme	11/11/2021	ACUTE/MHLD/OPPC	NO
HQIP National Hip Fracture Database Report 2020	11/11/2021	ACUTE/MHLD/OPPC	YES
HQIP National Maternity and Perinatal Audit	11/11/2021	ACUTE/CYP	NO
HQIP National Vascular Registry 2021 Annual Report	11/11/2021	ACUTE/OPPC	NO
HQIP National Oesophago-Gastric Audit Annual report 2021	10/12/2021	ACUTE	NO
HQIP Cardiovascular Disease Prevention First Annual Report	10/12/2021	ACUTE/OPPC	NO
Sentinel Stroke National Audit Programme Annual Report 2020/21	10/12/2021	ACUTE/OPPC	YES
SSNAP Post-Acute Organisational Audit Report	10/12/2021	ACUTE/ OPPC	YES
NCAP (National Clinical Audit of Psychosis)Employment Spotlight Audit Report 2021	10/12/2021	ACUTE/ MHLD	NO
HQIP National Joint Registry 2021	20/12/2021	ACUTE/ OPPC	YES
HQIP Paediatric Intensive Care Audit Annual report 2021	17/01/2022	ACUTE/CYP	NO
HQIP National Early Inflammatory Arthritis Audit-Short report on ethnicity published January 2022	17/01/2022	ACUTE	No
HQIP Variable resilience of FLS's during Covid-19 pandemic Annual Report-Published January 2022	17/01/2022	ACUTE/ OPPC	NO
HQIP Hospital and surgeon level volumes for rectal cancer surgery-Short Report-Published January 2022	17/01/2022	ACUTE	NO

HQIP National Lung Cancer Audit Annual Report-Published January 2022	17/01/2022	ACUTE	NO
HQIP National Prostate Cancer Audit Annual Report 2021	17/01/2022	ACUTE	NO
HQIP National Bowel Cancer Audit National Report 2021	11/02/2022	ACUTE/OPPC (14/02/22)	NO
National Neonatal Audit Programme:2020 data	15/03/2022	ACUTE/CYP	YES
National Paediatric Diabetes Audit Annual report 2020-21	15/04/2022	ACUTE/CYP	NO
National Confidential Enquiry into Patient Outcome and Death: Review of Health Inequalities Short Report	15/04/2022	ACUTE/CYP/OPPC/ MHLD	YES
National Confidential Inquiry into Suicide and safety in Mental health Annual report 2022	15/04/2022	ACUTE/CYP/MHLD	YES
National Audit of Breast Cancer in Older Patients: Annual Report 2022	13/05/2022	ACUTE/OPPC	NO
National Diabetes Foot Care Audit	13/05/2022	ACUTE/OPPC	NO
NCEPOD "A Picture of Health"	13/05/2022	ACUTE/MHLD	NO
CVD Prevent Second Annual Report	22/06/2022	ACUTE/OPPC	NO
National Diabetes Audit 2020-21 Type 1 Diabetes	21/06/2022	ACUTE	NO
National Diabetes Audit 2017-2021 Adolescent and Young Adult Type 1 Diabetes	21/06/2022	ACUTE/CYP	NO
National Cardiac Audit Programme, Patients, carers & the Public	21/06/2022	ACUTE/OPPC	NO
National Asthma and COPD Audit Programme	21/06/2022	ACUTE/CYP	NO
Adult Asthma and COPD Organisational Audit	21/06/2022	ACUTE	NO
National Adult Cardiac Surgery Audit	21/06/2022	ACUTE	NO
National Audit of Cardiac Rhythm Management	21/06/2022	ACUTE	NO
National Heart Failure Audit	21/06/2022	ACUTE/OPPC	NO
National Audit of Percutaneous Coronary Intervention	21/06/2022	ACUTE	YES
National Congenital Heart Disease Audit	21/06/2022	ACUTE	NO
National Myocardial Ischaemia National Audit Report	21/06/2022	ACUTE	YES
SNNAP Acute Organisational Audit 2021	22/06/2022	ACUTE/OPPC	YES
SNNAP Mimic Audit	22/06/2022	ACUTE/OPPC	NO

National Maternity and Perinatal Audit	22/06/2022	ACUTE	NO
National Lung Cancer Audit	22/06/2022	ACUTE	NO
National Oesophago-gastric cancer audit 2022	15/08/2022	ACUTE	NO
National Audit of Dementia	15/08/2022	ACUTE/OPPC	NO
National Hip Fracture Database 2021	12/09/2022	ACUTE/OPPC/MHLD	YES
National Prostate Cancer Audit 2022	12/09/2022	ACUTE/OPPC	NO
National Paediatric Diabetes Annual report 2021	12/09/2022	ACUTE/CYP	NO
Perinatal Mortality Review Tool Annual Report 2022	18/10/2022	ACUTE/CYP	YES
Perinatal Mortality Surveillance Report 2020	18/10/2022	ACUTE/CYP	YES
National Early Inflammatory Arthritis: Year 4 Annual Report	18/10/2022	ACUTE/OPPC	NO
Sentinel Stroke National Audit Programme Annual Report 2022	14/11/2022	ACUTE/OPPC	YES
National Audit of Inpatient falls Annual Report 2022	14/11/2022	ACUTE/OPPC	NO
National Vascular Registry Annual Report 2022	14/11/2022	ACUTE/OPPC	NO
National Neonatal Audit Programme Annual Summary Report on 2021 Data	14/11/2022	ACUTE/CYP	YES
Maternal, Newborn and Infant Clinical Outcome Review Programme 2022	14/11/2022	ACUTE/CYP	YES

Southern Health and Social Care Trust

Quality Care - for you, with you

Process for Submitting NAAR Updates

Appendix 4

The following link includes documents relevant to the process of compiling the annual National Audit Assurance Report

Process for submitting NAAR updates

Stage 1 – Medical Director Memo Issued

Stage 2 – Clinical Lead Request by email with submission template

Stage 3 – Reminder email(s) – as required

References

1. NHS England Quality Accounts List 2022-23 NHSE-QA-List-2022-23-revisedMarch2022.pdf (hqip.org.uk)

2. NHS England Quality Accounts List 2021-22 nhs-england-quality-accounts-list-2021-22.pdf (hqip.org.uk)

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

Minutes of a meeting of the Governance Committee held on Thursday 5th December 2019, at 9.15 am in the Boardroom, Trust Headquarters

PRESENT:

Mrs S Rooney, Non-Executive Director (Chair)
Mrs H McCartan, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr M McDonald, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mr B Beattie, Acting Director of Older People and Primary Care
Dr T Boyce, Director of Pharmacy
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Interim Director of Acute Services
Dr M O'Kane, Medical Director
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing and Allied Health Professions
Mrs T Reid, Interim Assistant Director of Clinical and Social Care Governance
Mr J McEntee, Assistant Director of Disability Services *(for Mr McNeany)*
Ms F Leyden, Assistant Director of Social Work Governance *(for Mr Morgan)*
Mrs P Keenan, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary (Minutes)

1. WELCOME AND APOLOGIES

Mrs Rooney welcomed those present. Apologies were recorded from Ms E Mullan, Non-Executive Director, Ms G Donaghy, Non-Executive Director, Mrs P Leeson, Non-Executive Director, Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work, Mr B McNeany, Director of Mental Health and Disability Services and Mrs E Gishkori, Director of Acute Services. The Chair welcomed Mrs Paula Keenan, Boardroom

Apprentice, Mr John McEntee and Ms Francesca Leyden deputising for their respective Directors.

The Chair, on behalf of members, expressed condolences to Mr Morgan and his family on the Personal information redacted by USI Personal Information redacted by the USI.

The Chair congratulated Mrs H Trouton on her recent appointment as Executive Director of Nursing, Midwifery and AHPs.

2. PRESENTATION: OBSTETRICS AND GYNAECOLOGY

Dr O'Kane presented information on the CHKS Audit and Mortality and Morbidity process within Obstetrics and Gynaecology (O&G). She provided background and a high level summary of statistics including antepartum, C-section and post-partum indicators for CAH and DHH. Dr O'Kane noted her concern the elective C-section rate is higher than the national average and further added that 10% of C-sections were occurring out of hours, which she expected to be higher. The Chair posed a question regarding the possible correlation between increased induction, increased instrumental births and increase in emergency C-sections. It was agreed that C-Section rates will be further explored.

Action: Dr O'Kane / Mrs McClements / Mrs Trouton

Mr McDonald highlighted the difficulty in understanding the data presented in the presentation and reiterated the need for increased training for Non-Executive Directors to help an increased understanding in relation to Clinical and Social Care Governance data.

In responding to a question asked by Mrs McCartan as regards peer comparisons, the Chief Executive explained the data is not released as a league table, but is a learning tool for the Trust. Complaints were discussed. Dr O'Kane reported the top 4 complaint subjects correlate to the same pattern across other Directorates. Mrs Magwood pointed out an increase in complaints in MHLD and asked if there was a pattern emerging. Mrs Reid advised this quarterly comparison will be ongoing to establish if Directorate patters are emerging. In relation to Litigation, Dr O'Kane noted between 1999 and 2019, the Obstetrics

and Gynaecology division has received 178 claims, of which 140 remain open. Dr O'Kane informed members that a raising concerns process is underway in relation to a whistleblowing complaint. NIMDTA have commenced a review in response to concerns raised by Doctors in training. Dr O'Kane added management will be meeting with staff to gain a better understanding of the issues which will be carried out in a confidential setting with staff. Dr O'Kane proposed to the committee the trusts intention to request an Invited Service Review from the Royal College Obstetricians and Gynaecologists.

Mrs Reid guided members through the Morbidity and Mortality process within Obstetrics and Gynaecology and drew members' attention to the meeting structure. She reported on the number of outstanding perinatal and maternal deaths that are awaiting sign off.

The Chair thanked Dr O'Kane and Mrs Reid for an informative presentation.

3. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

4. CHAIR'S BUSINESS

None noted.

5. MINUTES OF MEETING HELD ON 5th SEPTEMBER 2019

The Minutes of the meeting held on 5th September 2019 were agreed as an accurate record and duly signed by the Chair.

6. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates from the relevant Directors.

Mrs McClements noted work is progressing in relation to Stroke Services. An update will be provided to Trust Board in January 2020.

7. CLINICAL AND SOCIAL CARE GOVERNANCE

i. Clinical and Social Care Governance Report

Mrs Reid presented the above named report which provides information on SAIs, catastrophic incidents, learning on patient safety initiatives, complaints and ombudsman cases.

Mrs Reid reported there has been a 6% increase in incident reporting which demonstrates openness from staff to report incidents. There has been a significant increase in reporting of incidents within the Older People and Primary Care Directorate, namely from the Independent Sector which members welcomed. Mrs Reid added 22% of incidents remain uncategorised on the DATIX system. Mrs McCartan enquired on the timescale to ensure these are completed. Mrs Reid stated categorisation onto the DATIX system will occur as the incident is being investigated and sign off depends on Directorate processes and can be by a Ward Sister / Charge Nurse or Head of Service.

Adverse incidents were discussed. Mrs Reid drew members' attention to the 14 catastrophic incidents recorded between July 2019 – September 2019. 12 of these incidents have also been notified to the HSCB as SAIs. In addition a further 12 SAIs were also reported to the HSCB, details of the 26 cases are included in the report. She noted the increase of incidents in regards to suicide.

The Chair referred to SAI number 15 of the report and asked for further information. Mrs McClements provided background to the incident and advised learning has been identified and shared.

Mrs Reid informed members the Trust currently has 72 SAI investigations in progress, 3 of which have been paused due to ongoing investigations by external bodies and 28% of the investigations remain within the HSCB timescale. She noted the contributory factors which influence the compliance of SAI reports within the timescales.

Mrs Reid commented that work continues to improve engagement with families. In responding to a question asked by Mr Wilkinson, Mrs Reid highlighted that efforts are made that contact and

communication occurs with families in relation to those SAIs exceeding their timescale.

Mrs McClements reported that the Acute Directorate is focusing on those outstanding SAI investigations to ensure they are signed off as a matter of urgency. Dr O'Kane advised there are dedicated teams responsible to undertake SAI investigations in England and felt this is the correct direction of travel, however emphasised the need for regional support to take this forward.

The top 5 incidents were discussed which showed abuse / behaviour as the top incident type.

Mrs Reid spoke of the NEWS bundle compliance and noted for Q1 2019/20 the overall compliance target was not achieved, however 5 out of the 6 elements of the bundle achieved compliance of 95% or above. Mrs Reid reminded members of the launch for NEWS 2 and advised the charts are currently being printed and will be distributed throughout clinical areas.

Mrs Reid referred to the ulcer pressure bundle compliance section. In Q1 2019/20 there were 7 avoidable pressure ulcers reported. Learning from these cases is fedback to Ward Managers, via Lead Nurses. In response to a question asked by Mr Wilkinson, Mrs Trouton explained the various routes hospital acquired ulcers can occur. She also highlighted the turnover of staff which is challenging; however this is an area that continues to be reviewed.

VTE Risk Assessment was discussed and Mrs Reid noted the overall bundle compliance target of 95% was not achieved. In Q1 2019/20 92% was achieved. Mrs McClements highlighted that a number of wards achieved compliance however a small number of wards decreased the overall rate and these areas will be focused on for improvements.

Complaints were discussed. Mrs Reid reported that for the current reporting timeframe, 206 complaints were received, an increase of 8% on the previous quarter. The 206 complaints contained 320 complaints subjects. In relation to communication, staff attitude and behaviour, Mrs Toal advised work is due to commence on the Trust Value 'working together'. She reminded members Customer Care

training is provided to staff. Dr O'Kane added she met with Professor Peter McBride and increased training on communication is planned.

Mrs Reid informed members that compliments data was not available for this quarter. BSO who host the compliment server expected to have their access arrangements for HSCTs set up and tested which is taking longer than expected; therefore the information was not available. Mrs Magwood agreed to follow this up.

Action: Mrs Magwood

ii. Management of Standards and Guidelines

Dr O'Kane presented the report on the Management of Trust Standards and Guidelines. She advised the report sets out the compliance and risk rating position for those Standards and Guidelines received into the Trust up to 30th September 2019.

Dr O'Kane noted from 1st July 2019 to 30th September 2019, 67 Standards and Guidelines have been received from external agencies, 5 were not applicable to the Trust. This brings the total number of Standards and Guidelines listed on register to 1924.

The backlog review of Standards and Guidelines was discussed. Dr O'Kane noted the review involves ensuring that each guideline has been effectively disseminated, implemented and monitored which is an ongoing challenge and a long process that continues to be outlined in the Directorate Risk Register. Mrs Reid commented the backlog is an extremely challenging process to work through, and would require additional resources to progress. She added that staff continue to focus on those recommendations from the Inquiry into Hyponatraemia Related Deaths report. Mr McDonald asked for further clarification on the historical Standards and Guidelines. Mrs Reid provided assurance that the operational teams are aware of their standards and guidelines. Actions plans are in place to progress recommendations of more recent standards and guidelines. Mrs McCartan recognised the extensive efforts that would be required to review the backlog.

iii. National Audit Assurance Report

Dr O'Kane presented the above named report which provides assurance on participation in the NHS England Quality Accounts List(1) 2018/19 national clinical audits, highlights compliance with key performance indicators, together with recommendations and actions to achieve further improvement and outlines the SHSCT 2019/20 Clinical Audit work programme, including the rationale for non-participation in selected national audit.

Mrs Reid spoke of the necessity for regional consensus on GDPR compliance regarding sharing of patient identifiable data with external organisations, for secondary use purposes. She added this limits benchmarking data and comparison to national data.

The Chair referred to page 63 of the report regarding Non Invasive Ventilation recommendations 10 and 11 and raised concern at the comment that 7 day cover is unavailable due to staffing levels. Dr O'Kane to explore this further.

Following discussions on the amount of clinical information included in reports to the Committee, the Chief Executive agreed to consider establishing a Clinical Audit Sub-Committee with the remit to review reports, highlight areas of concern and provide assurance to the Governance Committee.

The Chair thanked Dr O'Kane and the team for a comprehensive, informative document.

Action: Chief Executive

iv. Trust Mortality Report April 2018 – March 2019

Dr O'Kane presented the Trust Mortality Report and explained the Trust RAMI (Risk Adjusted Mortality Index) for the period April 2018 to March 2019 was 83.8, meaning there were 17.2% less deaths than were expected based on the case mix. The Trust RAMI score demonstrates that the Trust falls into the lower mid-range of the peer 'CHKS Top UK Hospitals' group.

The Chief Executive drew members' attention to the graph on page 11 which demonstrates the Trust position in relation to individual UK peer sites which compares well to other peer hospitals.

Dr O'Kane welcomed the Trusts position in relation to coding. The Trusts palliative coding rates are higher than the regional peer group.

Mr McDonald raised the previous limited Internal Audit report in this area and enquired on the progress of the recommendations. Ms O'Neill provided assurance that those outstanding recommendations are monitored by the Trust Internal Audit Forum.

v. Review of Clinical and Social Care Governance

The Chief Executive advised the Review of Clinical and Social Care Governance Report was still in draft form and not all recommendations have been discussed or accepted, however in the spirit of openness it was being shared with members at this stage for their information.

A discussion ensued on the focus of the review. The Chair felt that whilst the report was titled Clinical and Social Care Review, the content would be more suggestive of a Corporate Governance Review. Mr McDonald expressed the view that the content of the report had a huge focus on Board Committees and therefore appeared to be broader than Clinical and Social Care Governance.

The Chair referred to the statement on page 3 that the role of the Medical Director had been in a period of flux since 2011 and felt this was incorrect. She further noted under section 4.1.3 the Endowments and Gifts Committee has been omitted from the report as a sub-committee of Trust Board.

The Chief Executive noted the above comments and stated a detailed discussion is required at SMT to decide what recommendations will be accepted and if there are further actions needed to help build the governance structure within the Trust. He stated the report will be discussed at the Board Workshop in February 2020.

8. CORPORATE RISK REGISTER

The Chief Executive presented the Corporate Risk Register (CRR) and informed members there are currently 12 risks – 9 high and 3 medium level. He noted the CRR has been reviewed by SMT since the last meeting, mostly recently on 26th November 2019. The Chief Executive advised on the changes to the register. One risk was removed that of the lack of Data Controller / Data Processor Agreement as this is now in place. One risk was added - Volume of Locum Engagements (risk no.4). Furthermore it was agreed at SMT on 26th November 2019 to escalate to the CRR the compliance and implementation of the Mental Capacity Act (2016).

The Chief Executive advised that SMT have discussed industrial action and whether to include same on the Register. SMT agreed that industrial action was a corporate issue which was being managed daily with appropriate mitigations.

There was a detailed discussion on risk number 5: GP Out of Hours. Mr Beattie highlighted challenges to service delivery in light of reduced GP participation and spoke of actions taken to support continued service delivery.

Mr Beattie advised that proposals have been made to the HSCB in respect of requesting regional support to help address these pressures.

Following discussion, the Committee requested the Chief Executive with Mr Beattie write to the HSCB to highlight the need for a radical review and proposed regional approach to this issue.

Action: Chief Executive / Mr Beattie

9. LITIGATION: CLAIMS MANAGEMENT

Mrs Toal spoke to the above named report. The report provides an overview on the summary of litigation activity, claims, trends, coroner's inquests and medico-legal requests as at 30th September 2019.

Mrs Toal noted a slight decrease in the overall number of litigation claims for this quarter from 513 to 509. In response to a request from the previous meeting, members were advised that out of the 513 litigation cases last quarter, 97 claims relate to Obstetrics and Gynaecology and claims by site and incident type were included in the report.

The Chair pointed out that there are a number of pending cases in excess of £250,000 with an historical incident date and enquired on the reasoning behind these. Mrs Toal explained the claim could have been submitted a number of years after the incident occurred; however she will review those specific cases and provide an update at the next meeting.

Action: Mrs Toal

Medico-legal work was discussed. There were 942 requests received from 1st July 2019 to 30th September 2019. The compliance figures have risen from 46% to 53%, which members welcomed the improved position.

10. UPDATE ON SEE SOMETHING, SAY SOMETHING

Mrs Toal spoke to the above named report. She advised the report details the review workshop undertaken by the Trust following the first year since the launch of the Regional HSC Framework 'Your Right to Raise a Concern at Work – Whistleblowing' along with the Trust's policy and procedure. Mrs Toal advised that the first year saw a 156% increase in cases from the previous year with cases of fraud, theft and other financial concerns highlighted as the most common type of concern raised. Mrs Toal spoke of the learning identified through the workshop as outlined in the report. Next steps were discussed. She advised resources and capacity issues need to be reviewed to ensure there are enhanced resources to support both investigations and staff. An agreed communication plan will be developed on sharing positive outcomes across the Trust to ensure all staff are confident they will be supported when raising a concern.

Mrs Toal noted 8 concerns have been raised in the first 6 months of 2019/20. She noted how concerns have been raised and reported that 'anonymous' is the highest category. Mrs Toal added work is

underway to highlight to staff the benefit of submitting a concern openly. Mrs Toal drew members' attention to the concerns raised by Directorates. Ms O'Neill reported on the number of concerns raised within the Estates Department, therefore a number of half day workshops were set up. Trust policies were discussed among staff which reminded staff of their responsibility in relation to fraud. Ms O'Neill stated there was 100% attendance from staff, which members welcomed. Mrs Toal added that when concerns are raised anonymously it is difficult to feedback to staff on the progress and outcome of the investigation; therefore she welcomed Ms O'Neill's approach to include all staff in the workshop.

The Chair pointed out that the Mental Health and Learning Disability Directorate have no concerns in the first 6 months of 2019/20 having accounted for almost half of all complaints in 2018/19. Mrs Toal attributed this to the extensive work that has been undertaken with staff in the Directorate.

Mrs Toal referenced the work associated with the Family Intervention Team following the Whistleblowing letter and referred to the case study in the paper. Vacancies and workload remain an issue, however Ms Leyden advised workload has been spread amongst staff to assist with the situation. The input from Dr McGurk, Clinical Psychologist from Occupational Health has been beneficial to the team but that a full report from Dr McGurk would be presented following her intervention with the teams.

11. MEDICINES GOVERNANCE REPORT

Dr Boyce presented the Medicines Governance report which demonstrates that during the second quarter of 2019/20 there were 418 medication incidents reported within the Southern Trust. The average number of reported medication incidents each month was again 139, as the total number of incidents reported was exactly the same as the previous quarter.

Dr Boyce reminded members the Medicines Governance report will report lower figures than those in the Clinical and Social Care Governance Report as the screening process redirects those incidents that occurred outside the Trust e.g. community pharmacy,

GP practice, etc. and those that were adverse drug reactions, rather than medication incidents.

Dr Boyce noted there were no trends of specific concerns amongst the incident reports received. She added that the Older People and Primary Care Directorate reporting of incidents have increased which Dr Boyce welcomed.

During the quarter there were no catastrophic incidents and one major incident reported via Datix, which Dr Boyce provided background to and assured members a SAI review had commenced and learning was identified.

In regards to benchmarking data for medication incidents, Dr Boyce reported the Trust 'no harm' incidence had decreased to 64.6% which is below average for the Human Factors in Healthcare which recommends minimum standard of 70% of reported incidents should result in no harm to the patient as an indicator of a positive reporting culture.

Members noted the content of the Medication Safety Today newsletter issue 64. In response to a question asked by Mrs McCartan, Dr Boyce clarified that all Trusts contribute to the content of the newsletter and is circulated regionally including Primary Care.

The Drugs and Therapeutic Committee met on 12th September 2019 and noted the items that were discussed and approved, as outlined in members' papers.

Dr Boyce drew members' attention to the HSCB items noted in the report, particularly the Regional Medical Representatives Guidance for Trust adoption. Members asked that the document be circulated for their information. Dr Boyce agreed to undertake.

Action: Dr Boyce

12. HEALTH AND SAFETY REPORT

Ms O'Neill presented the above named report. The report provides assurance to the committee that the Trust is managing its health and safety risks and thereby complying with its statutory duties. The report also identifies a number of areas for improvement and the action taken to address the issues.

Ms O'Neill reminded members that Health and Safety at work is the responsibility of all staff and it is duty of managers to ensure this is communicated to staff and ensure that relevant training is up to date. She added a training pack for managers would be beneficial and Mrs Toal advised Human Resources could assist the Health and Safety team in producing this. Ms O'Neill to consider the production of a training pack.

13. INFORMATION GOVERNANCE

i. Cyber Security: Progress Update

Mrs Magwood spoke to the above named paper which demonstrates the Trust's position in relation to managing cyber security risks. She noted good cyber security governance is in place in the Trust, reporting to the Regional Cyber Security Programme Board and Governance Committee, however cyber continues to be a high risk and remains on the Corporate Risk Register.

In relation to audits, Mrs Magwood advised the Trust continues to work with the regional group as well as the internal task and finish group to progress recommendations from Internal Audit. The Chief Executive informed members that the E-Health Board has been reconstituted and has suggested that all Directors of Performance and Reform be part of the group.

ii. Freedom of Information, Environmental Information and Subject Access Requests: 1st July 2019 – 30th September 2019

Mrs Magwood presented the summary report for the period 1st July 2019 – 30th September 2019. In relation to Freedom of Information (FOI) and Information Regulation (EIR) requests, a total

of 114 requests were received and responded to in this period. Of these, 108 were processed within the 20 day deadline. Mrs Magwood reported the compliance with the 20 day deadline has significantly increased to 95% compared to 81% in the previous quarter. Members noted that the majority of requests were received from the public, businesses and the media. Details of the individual requests for information are included within the report.

Members noted 161 Subject Access Requests (SAR) were received during the period and of these, 140 responses were processed within the 30 day deadline. Mrs Magwood reported the compliance with the 30 day deadline has decreased to 83% compared to 87% in the previous quarter. The majority of Data Protection Act information requests were received from the public, insurance companies and family members.

Mr McDonald welcomed the detailed report particularly the appendices which outlines the content and complexity of FOI's requested.

iii. SIRO Information Governance Report

Mrs Magwood reported on the findings as detailed in the report and highlighted the Information Governance mandatory training rates have increased from 80% in 2018 to 82% in 2019. She added within the Trust there are 112 Information Asset Owners and of these 109 completed the Information Governance Framework Audit questionnaire.

14. LEADERSHIP WALKS

Members noted the above named report. During the timeframe April 2019 to September 2019 a total of 13 Leadership Walks were undertaken by Non-Executive Directors.

15. NON-EXECUTIVE DIRECTORS' VISITS TO CHILDREN'S HOMES REPORT: APRIL 2019 – SEPTEMBER 2019

A total of 11 Children's Home visits were undertaken during the period April 2019 and September 2019. Ms Leyden advised that the situation in Carrickore was now stable.

16. SCHEDULE OF REPORTING FOR 2020

Members discussed the Schedule of Reporting for 2020. The Chair made the point that Organ Donation is a regional service with activities overseen by Organ Donation Committee in each Trust. The NHS Blood and Transplant requested a number of years ago that a Trust Non Executive Director Chair this Committee and that annual reports are presented to Trust Board. It was agreed that this would be further discussed at the Committee Chair feedback meeting.

Members approved the Schedule of Reporting for 2020 subject to further discussion on Organ Donation as outlined above.

17. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.40 p.m.

Signed _____ ***Dated*** _____

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

Minutes of a virtual meeting of the Governance Committee held on Thursday 11th February 2021, at 9.10 am

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, Acting Director of Older People and Primary Care
Dr T Boyce, Director of Pharmacy
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Director of Acute Services
Mr B McNeany, Director of Mental Health and Learning Disability
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, Executive Director of Nursing, Midwifery and Allied Health Professions
Mrs V Toal, Director of Human Resources and Organisational Development
Mr S Wallace, Acting Assistant Director of Clinical and Social Care Governance
Mrs C Doyle, Acting Assistant Director of Clinical and Social Care Governance
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES

None

1. WELCOME AND APOLOGIES

The Chair welcomed those present. She informed members that a number of reports have been deferred and they will be presented at the Committee meeting on 13th May 2021. At this point she advised members regarding some aspects of virtual meeting etiquette.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

None noted.

4. MINUTES OF MEETING HELD ON 26th NOVEMBER 2020

The Minutes of the meeting held on 26th November 2020 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates from the relevant Directors.

Mr McNeany provided a verbal update on the progress of the judicial review in the Learning Disability Service. He noted that the Trust is awaiting a date for the judgement from the court and therefore at present there is no further update. The Chair felt it would be beneficial for the committee to receive an update on the progress of all judicial reviews undertaken throughout the Trust. The Chair and Chief Executive to further discuss how best to take this forward.

Action: Chair and Chief Executive

6. REPORT ON OBSTETRICS AND GYNAECOLOGY WHISTLEBLOWING INVESTIGATION

Mrs Toal presented a report outlining a number of key actions and learning from the investigation raised in respect of the Obstetrics and

Gynaecology Whistleblowing Investigation. She informed members that the report of the investigation, which commenced in January 2020, has still to be received and accepted in its entirety by the Trust's oversight group. This is being followed up by the Medical Director and the Executive Director of Nursing, Midwifery and AHPs to seek to bring to a satisfactory conclusion. Mrs Toal recognised that this has been a very difficult and protracted investigatory process which has been impacted by pressures of Covid-19.

Dr O'Kane spoke to the key concerns raised in the report and stated that the Investigating Team reported that it was satisfied that clinical competency both of Obstetricians and Midwives met the required standards. Specific cases referred to in the correspondence raising issues in relation patient safety / obstetric violence have been independently reviewed through case note reviews / interviews and no significant issues were evidenced. Dr O'Kane commented to ensure that safe maternal care is in place additional support has been put in place to support governance arrangements and the team has reviewed their processes for analysing Stillbirths / Neonatal Deaths and developed the Perinatal Mortality Review Tool (PMRT). This tool is being trialled and it is envisaged that the outcome will be presented at a future Governance Committee meeting.

Mrs McCartan thanked the Directors for their update on this issue and welcomed the positive initiatives being undertaken to address these matters. She asked if the issues were management related. Mrs McClements stated that a service improvement action plan had already been established to improve quality and patient experience prior to this Whistleblowing investigation and work is ongoing with positive impacts already noted. She did highlight that there were specific issues in relation to the Delivery Suite, and management undertook significant work to address these concerns. There may have been earlier opportunities to address some of these issues.

In response to a question asked by Mrs McCartan, Mrs McClements confirmed that performance appraisals are undertaken through 1:1 supervision built into staff practice.

Mr Wilkinson asked for further information on the process of undertaking factual accuracy of the report. Mrs Toal explained that

applicable extracts of the report had been shared with those individuals involved for their comments. She reported that there were numerous inaccuracies throughout the report and these have been fed back to the investigation team.

Ms Donaghy queried if patients were interviewed and complaints reviewed to inform the investigation. Mrs Toal advised that service user stories were included as part of the initial whistleblowing concern, however there were concerns on the source of this information. Mrs McClements added that patient experience has been captured from discharge questionnaires. In some instances, patients have indicated that they are aware of the demands on midwifery staff and the increasing staff shortages. She advised that a piece of work is ongoing to address how staff are perceived as busy to patients on the ward.

In responding to a question asked by Mr McDonald, Mrs Toal confirmed that the Trust has in place the HSC values and behaviours that all staff have signed up to. She noted that there have been shortfalls in these values highlighted by the investigation team and this is a piece of work that the teams are taking forward to improve across the division.

Members requested that the final report be presented at a future Governance Committee meeting when available.

Action: Dr O'Kane, Mrs Toal

Mrs Doyle joined the meeting at this point

7. CLINICAL AND SOCIAL CARE GOVERNANCE

i. Clinical and Social Care Governance Report

Dr O'Kane presented the above named report which provides information on SAIs, catastrophic incidents, learning on patient safety initiatives, complaints and ombudsman cases from 1st October to 31st December 2020, with the exception of Patient Safety & Quality measures which are for the previous quarter 1st July to 30th September 2020. She noted that in general the pandemic has

resulted in a more unstable reporting picture with more variation than previously observed.

Dr O'Kane reported that there has been an increase in incident reporting across the Acute and Mental Health directorates for this quarter. She advised the majority of incidents are categorised as 'insignificant'. 6% of Incidents have been categorised as a 'Moderate' severity rating.

Adverse incidents were discussed. Dr O'Kane drew members' attention to the 9 catastrophic incidents recorded between 1st October 2020 – 31st December 2020. 7 of these incidents have also been notified to the HSCB as SAIs. In addition, a further 13 SAIs were also reported to the HSCB, details of the cases are included in the report.

Members noted that there were a high number of incidents which had 'no immediate learning identified' recorded within the report and felt that this terminology is unsuitable. Following a discussion, members requested that this terminology be amended for future reports.

Action: Dr O'Kane

SAIs were discussed. Dr O'Kane informed members the Trust currently has 86 SAI investigations in progress, 1 of which has been paused due to ongoing investigations by external bodies and 22 of the investigations remain within the HSCB timescale. She noted the contributory factors which influence the compliance of SAI reports within the timescales as documented in the report.

Information on Early Alerts is now included in the report. A total of 68 early alerts were submitted to the DoH and the HSCB since 1st October to 31st December 2020. A breakdown of the Directorate and type of early alert was included in the report. Dr O'Kane reported on the volume of early alerts can be attributed to OPPC (GP Out of Hours Cover).

Dr O'Kane reported that the Trust Crash Call Rate for 2019/20 is stable: 0.46 per 1,000 Deaths & Discharges (10 crash calls) Based on the data there has been no significant change in crash call rates.

Dr O'Kane spoke to the data on Patient Falls. She noted that of the 27 Wards monitoring their Patient Falls/Falls Rate using the Falls Walking Stick 19 wards (70%) saw an increase in quarter one and quarter two 2020/21. The Rate of increase is more significant due to the decrease in Occupied Beds day in Q1& Q2 20/21 due to Covid-19.

In regards to Pressure Ulcers, Dr O'Kane reported that for Q1 and Q2 2020/21 there were 19 (14%) avoidable Pressure Ulcers and there are 6 cases Post Incident Reviews outstanding. For VTE the Trust compliance in Q2 20/21 was 93%, which equalled the same rate as Q1 20/21.

Complaints were discussed. Dr O'Kane reported that for the current reporting timeframe, 157 complaints were received, a decrease from 180 in the previous quarter. The 157 complaints contained 289 complaints subjects. The HCAT Tool information for 1st October – 30th December 2020 was included in appendix 1 of the report. Mr Wallace added that 9 months of data has been coded and will be included in the next report. In regards to Compliments, 1085 compliments were received into the Trust for the reporting timeframe 1st October 2020 to 31st December, which is a significant increase from the previous quarter of 459.

ii. Management of Trust Standards and Guidelines

Dr O'Kane presented the report on the Management of Trust Standards and Guidelines which sets out the Trusts' position on implementation and compliance to Standards and Guidelines up to the 31st December 2020.

Dr O'Kane guided members through the report and commented that the Trust's ability to manage and implement regionally endorsed standards and guidelines has been significantly impacted upon, with many of the normal processes being stood down to ensure Trusts could prioritise dealing with COVID-19. However, despite the challenges within the system, a concerted effort has been made to review new regionally issued circulars and ensure they are disseminated within the organisation and where possible, local level processes put in place to support guidance recommendations. In

addition, the Trust's Standards and Guidelines database has been used to track the dissemination of COVID related circulars within the organisation. From a trend analysis perspective this has resulted in a higher than normal number of circulars being recorded on the database for this 3 month time frame.

From 1st October 2020 to 31st December 2020, a total number of 82 circulars have been received by the Trust (1 of which was not applicable to the Trust). A further review of these 81 Trust wide applicable circulars identifies that 53 (65%) of them were COVID-19 related, a breakdown of these were included in Appendix 2 of the report. Two circulars related to the supply disruption in medication. The remaining 28 (36%) circulars are within the agreed scope of the standards and guidelines processes and have been managed accordingly. The report included hyperlinks to the guidance and the current risk rating / compliance position.

Dr O'Kane noted that the Trust has appointed a new Trust Standards and Guidelines lead post which will help co-ordinate all the information into one central point.

Mr Wallace highlighted the ongoing discussions with identifying a new IT solution for capturing and monitoring Standards and Guidelines and the difficulty in sourcing a bespoke system and discussions are continuing at a regional level of rectifying this.

Mrs McCartan asked on the definition of 'compliant'. Mr Wallace explained that the actions required differ from each circular and once all those actions are achieved then compliance has been reached.

Responding to a question asked by Mrs McCartan on removing those S&Gs that have been superseded from 2007, Mr Wallace welcomed this suggestion and commented that this is a task that the team have reviewed before, however he felt that this could entail a level of risk in removing these from the excel spreadsheet. The Chair added that a new IT bespoke system would address this.

Mr McDonald noted that the report demonstrated a number of S&Gs that have achieved partial compliance and asked what the external barriers were to achieve full compliance. Mr Wallace advised that this

information is not included in the report but will provide this breakdown of information for the next meeting and future reports.

Action: Dr O'Kane

In replying to a comment made by Mr Wilkinson, the Chief Executive asked Mrs McClements as an operational Director to explain the S&G process from a Directorate point of view. Mrs McClements spoke of the robust process under a governance mechanism where the team receives, reviews, circulates, monitors and implements S&Gs within the Acute Directorate.

In concluding Mrs Magwood advised that there is an opportunity to explore local solutions to address some of the external barriers

iii. Mortality Report

Dr O'Kane presented the Mortality Report which provides assurance on the safety of hospital care and assurance on Trust processes to measure and monitor hospital mortality. She explained that there are 3 different timeframes within report: CHKS: April 2019 – March 2020, Intensive Care Unit April 2019 – March 2020, VLADs April 2019 – March 2020 and Contextual SHMI January – December 2019). For the reporting period of April 2019 – March 2020, there were 1,101 deaths.

It was noted that risk adjusted measures such as RAMI are not designed for pandemic activity such as that observed during 2020. It is anticipated that at least 12 months full year activity will be required for sufficient data to be available to begin considering the development of risk adjusted mortality relating to Covid-19. As a result, the present RAMI measure cannot accurately calculate an expected deaths figure for records with Covid-19 coding using the present methodology. Risk adjusted reporting in this report therefore excludes any activity with Covid-19 diagnoses codes.

Dr O'Kane noted that the Trust crude mortality rate showed no significant change and generated no alerts (1.03% compared to 1.04% for the 2018/19 period). The rate is below the regional and national peer mean. The RAMI 2018 score for the 2019/20 period

was 75.81 compared to 83.95 2018/19. This is a decrease of 9%. The rate is below the regional and national peer mean and generated no alerts. For the 12 month reporting period April 2019 to March 2020 the overall RAMI index score is 75.81, meaning there were 24.19% less deaths than were expected based on the case-mix.

Dr O'Kane reported the overall data quality index score for the Trust for the overall data quality index score for the trust for the April 2019 - March 2020 period was 92.95. This compared favourably to the NI peer of 92.98.

Mr Wallace commented that work is still ongoing to further develop the qualitative triangulation data regarding M&M meeting notes and SAI outcomes.

The Chair and Chief Executive welcomed the very informative graphical report and noted their thanks to Dr O'Kane and her team on producing a document that was easy to understand the complex data. The Chief Executive added that the report provided a high level of assurance.

8. RISK MANAGEMENT

i. Corporate Risk Register

The Chief Executive presented a working draft paper summarising the key activities related to a new Corporate Risk Register since it was last reported to the Committee In November 2020. He explained that in the context of the current operational demands facing the Trust, the SMT had agreed six principal corporate risks that it would manage and monitor on a monthly basis. He welcomed members' feedback on the document.

The Chair acknowledged that this was a fluid process and asked what role this document played in the last 8 weeks during wave three of the Covid-19 Pandemic. The Chief Executive stated that wave three focused SMT's thinking on the major issues and risks the Trust was experiencing and the document is now more closely aligned to the daily business of the Trust. The Trust Surge Plans also mirror the content of the Corporate Risk Register.

The access to services risk was discussed in which Ms Donaghy asked if this covered the quality and experience of services. Mrs Magwood stated that access to services is a key requirement of how the Trust is performing as an organisation and SMT will further consider the impact on patient experience. Mrs McClements stated that the quality of services is impacted by the current workforce challenges.

Members welcomed the work undertaken by the SMT to date and were content that the document is reflective of the organisation's key risks at a corporate level. It was recognised that the building of a new more agile Risk Register is a work in progress and more detail is to be included in terms of mitigating controls, identified risk owners etc.

As previously agreed, Risk Appetite and Risk Management will be the focus of a Board Workshop in 2021.

Mrs McCartan stated that the recent Internal Audit satisfactory assurance report on Risk Management had been discussed by the Audit Committee. It was agreed that this report would be shared with Governance Committee members.

Corporate Risk Register was approved

9. MEDICINES GOVERNANCE

i. Medicines Governance Report

Dr Boyce presented the Medicines Governance report which demonstrates that during the third quarter of 2020/21 there were 261 medication incidents reported within the Southern Trust. The average number of reported medication incidents each month was 87, a slight decrease from the previous quarter of 91 per month. The fall in the number of reports over the last number of quarters can be attributed to the rapid reduction of Acute inpatients from the end of February. There was also a reduction in reports from the other Directorates. Due to the second and third surge reporting has remained at a lower level than previously reported.

Dr Boyce noted there were no trends of specific concerns amongst the incident reports received. During the quarter there was one major

incident, 4 moderate incidents but no catastrophic incidents reported via Datix. Dr Boyce provided background to the major incident. The top 5 medicines involved in medication incidents were discussed with insulin remaining as the number one incident type. Dr O'Kane added that a Trust wide patient safety group to improve incidents around insulin has been established.

In regards to benchmarking data for medication incidents, Dr Boyce reported the Trust 'no harm' incidence had decreased to 61.7% which is below average for the Human Factors in Healthcare which recommends minimum standard of 70% of reported incidents should result in no harm to the patient as an indicator of a positive reporting culture. Dr Boyce added that staff were reminded on the importance of reporting 'no harm' incidents.

The MedSafe newsletter issue 23 was included in members' papers. The Drugs and Therapeutic Committee was due to meet on Tuesday 20th October 2020 via Zoom, however due to the competing pressures related to the pandemic response the meeting was postponed and a number of items were dealt with via email discussion amongst the membership in the following weeks. The next meeting is due on 16th February 2021.

An update on EU Exit plans for the supply of medicines was included in the report. Dr Boyce reminded members of the background to the situation and from 1st January 2021 the transition period ended and the Northern Ireland Protocol came into effect. Some of the EU legislation will still apply in Northern Ireland but not in GB. This means that Northern Ireland will have a dual system of compliance for medicines and medical devices whereas GB will have to comply with the Medicines and Healthcare products Regulatory Authority (MHRA) regulations. Dr Boyce spoke of the 3 main issues facing the Pharmaceutical Industry to address.

As at 31st January 2021, the EU granted a 12 month derogation on 9th November 2020 which allows current rules for medicines to continue and Trusts and the Pharma Industries until 31st December 2021 to address these issues. Dr Boyce reported that as at January 2021 there have been no major issues in relation to medicines supply to Northern Ireland Trusts.

ii. Report From The Accountable Officer Responsible for Controlled Drugs

Members welcomed the above named report. For the 12 month period January – December 2020, the Accountable Officer submitted 4 Occurrence Reports to the Northern Ireland Local Intelligence Network (LIN) in line with the legislation. These reports contained 3 concerns, details of which are documented within Appendix A of the report. These were discussed in detail by the Committee.

10. HYPONATRAEMIA UPDATE

Mrs Trouton presented the Hyponatraemia update which monitors and progresses the implementation of the recommendations on the Report on Hyponatraemia Related Deaths. She reported that the Trust Oversight Group met on 13th January 2021, via Zoom. A review of progress against objectives was undertaken and a Trust wide 'Stocktake' of progress against recommendations was proposed for March 2021. The Stocktake event will review progress against all recommendations and additional Hyponatraemia requirements will be reviewed and outstanding outputs discussed, addressed and actioned.

Mrs Trouton guided members through the report. She referred to the hyponatraemia training figures for nursing staff across the Acute Directorate, as at 12th January 2021. Mrs Trouton reported on the difficulty in staff accessing the 3 yearly face to face component of Hyponatraemia training which is run by the Clinical Education Centre. Furthermore there isn't as yet a face to face programme suitable for midwives; however this is currently being devised at the Trust's request. She added that the Lead Nurse within Paediatrics has developed a training programme for facilitators to train staff through the case study element of the training. Mrs Trouton noted the training figures for Obstetrics and Gynaecology wards to which Mrs McClements stated that this is being addressed.

In relation to Medical training, Dr O'Kane noted that since January 2020 medical staff have been required to confirm their training status regarding the Children's Hyponatraemia BMJ module completion. Consultant and SAS grade doctors are required to complete training

or pending agreement of their Associate Medical Director obtain a desist notice confirming they will not prescribe fluids until they have completed the necessary training. All junior rotational doctors are required to complete Children's Hyponatraemia BMJ module as part of core training. The figures for training were included in the report.

Mrs McCartan referred to recommendation 70 where it states that '*effective measures should be taken to ensure that minutes of board and committee meetings are preserved'*. She informed the committee that Internal Audit undertook an audit on the retention of these records and a satisfactory assurance was provided. This was reported to the Audit Committee on 4th February 2021. Mrs Trouton welcomed this update and advised she will amend this recommendation that is has been completed.

In responding to a question asked by Mrs McCartan, Mr Wallace advised that the SAI Framework is an internal piece of work that is being progressed in parallel with the Hyponatraemia recommendations.

Members welcomed the Stocktake event planned for March 2021 and the next report will provide the detail the outcome of this event. Mr Wallace advised this event will give the Trust the opportunity to review what has been achieved to date and what areas of work needs progressed and focused on within the next 9-12 months to provide assurance and close this piece of work off.

Ms Donaghy is the Non-Executive Representative for the Duty of Candour work stream and provided an update on the progress of their work. She advised that the group have met and the draft consultation document has been submitted to the Minister for approval to proceed with consultation. Ms Donaghy did note the issue around a number of agencies that have been excluded from the criminality and legal sanctions and advised that this will be discussed further with the group.

11. INFORMATION GOVERNANCE

i. Freedom of Information, Environmental Information and Subject Access Requests: 1st October 2020 – 31st December 2020.

Mrs Magwood presented the summary report for the period 1st October 2020 – 31st December 2020.

In relation to Freedom of Information (FOI) and Environmental Information Regulation (EIR) requests, a total of 74 requests were received and responded to in this period. Of these, 65 (88%) were processed within the 20 day deadline. 31% of responses were provided by the Acute Services Directorate and 48% of requests came from members of the public.

Mrs Magwood provided information on FOI trends; requests decreased by 31% on the same period last year, requests decreased by 22% on the previous quarter, compliance with timescales decreased by 4% compared to the same quarter last year and compliance increased by 3% on the previous quarter.

Members noted 144 Subject Access Requests (SAR) were received during the period and of these, 95 (66%) responses were processed within the 30 day deadline. Members noted that the majority of requests were received from the public, businesses and the media. Details of the individual requests for information are included within the report. In relation to trends, Mrs Magwood reported a decrease of 18% on the same quarter in the previous year and an increase overall of 8% on the previous quarter.

Mrs Magwood reported that for Q4 2020 period the Trust reported 1 data breach incident to the Information Commissioner Office (ICO) and the detail was included in members' papers. She provided assurance that recommendations from the ICO have been shared and taken forward within the relevant directorate and no further action is being taken by the ICO.

The Chair spoke of her recommendation that the Trust website has a FOI section that includes all this information in the hope that this will reduce the pressure on teams receiving FOI requests. Mrs Magwood advised that work has commenced on this area with a view to have a database of all FOI made available for staff and public view.

Mrs Leeson pointed out the two requests on abortion services and given that this is a high profile matter in the media she asked how the

Trust plans to address this. Mrs Magwood reminded members that this issue and associated legislation is the responsibility of the NI Executive and the Trust is monitoring this issue closely.

12. ANNUAL REPORTS 2019/20

i. Functional Support Services Report

Mrs McClements presented the Functional Support Services Report for 2019/20 for assurance. The Functional Support Services (FSS) Annual Report normally includes updates relating to all the services provided by the Division, however in light of the Covid-19 Pandemic this report only provides updates on Food Hygiene and Safety, Environmental Cleanliness, Decontamination of Reusable Medical Devices and Security Management to meet the requirements of the four Controls Assurance Standards.

Mrs McClements guided members through the annual report highlighting key achievements for each of the four areas noted above. She spoke of the excellent work and dedication undertaken by FSS staff particularly during the Covid-19 pandemic and how hard each staff member worked to ensure the safety of patients and staff across each hospital site. Mrs McClements noted that from March 2020 when Covid-19 situation escalated the Catering, Security, Domestic and Decontamination services were involved in reviewing escalation plans and preparing for the surge in demand for each of their service, which is outlined in the report.

Members commented that this service is critical to the day to day running of the Trust and paid tribute to the staff involved.

In response to a question asked by Mr McDonald, the Chief Executive explained that there have been ongoing discussions on the best directorate to align the Functional Support Services to. He felt that it should be aligned corporately however conversations were paused to deal with the Covid-19 pandemic. The Chief Executive and Mrs McClements advised that this is an area for further discussion.

Mrs McCartan noted the numbers of replacement equipment required. Mrs McClements acknowledged this and spoke of the

workarounds that are currently in place but highlighted the need for investment in this area and these have been submitted for capital investment consideration corporately.

Mrs Leeson left the meeting at this point

ii. Health and Safety Report

Ms O'Neill presented the Health and Safety Report for 2019/20 for assurance purposes. The report sets out key health and safety systems in place in order to demonstrate the Trust's approach to minimising the risk and ensuring the health and safety of its employees, service users and visitors. Ms O'Neill reminded members that Health and Safety at work is the responsibility of all staff and it is duty of managers to ensure this is communicated to staff and ensure that relevant training is up to date. In relation to Controls Assurance Standards, Ms O'Neill reported that the Health and Safety standard received a green RAG rating.

Ms O'Neill informed members that during 2019/20 there was an opportunity to conduct a review of the overall structure which resulted in the Health and Safety Department now being aligned to the Head of Specialist Estate Services. She spent time guiding members through the report highlighting Health and Safety activities, performance and training and development. The report also identifies a number of areas for improvement and the action taken to address the issues. Ms O'Neill added that the annual report has a significant Covid-19 focus and this will also be the same for the 2020/21 annual report. The report also noted some invaluable learning.

The Chair welcomed the detailed report and noted the amount of work that the Health and Safety team carry out and noted her thanks to the whole team. She asked if learning for Health and Safety will be delivered virtually in the future. Ms O'Neill noted the benefits to delivering training virtually as the attendance is higher than face to face and next year report will highlight this.

Mr McDonald referred to the decreasing incident rate across the Trust and stated that his reflects the quality and outputs of the work of the team and provides a level of assurance.

The Chair commented that all staff will benefit from having access to all Trust Annual Reports and added that this is an area she would like to incorporate into SharePoint/website as previously discussed under the FOI report.

13. COMMITTEE TERMS OF REFERENCE

Members reviewed and endorsed the revised Terms of Reference for Trust Board approval.

14. ANY OTHER BUSINESS

The Chair noted that this was Mr McNeany's last Governance Committee meeting as he would be retiring from the Trust at the end of March 2021. On behalf of the Committee, the Chair thanked him for his contribution to the work of the Committee and wished him well in his future retirement.

The Chief Executive informed members of the current position in regards to [redacted]. Mr Beattie provided background to the situation and the difficulties experienced in securing GP cover. He reminded members that the Trust has managed the practice since 2017 and that currently the Trust is working in partnership with the HSCB and DoH to secure a long term solution to ensure that the patients of [redacted] continue to have access to the full range of services expected in a General Practice. In the interim, while work is undertaken to identify an alternative service provider, the Trust continues to work to provide safe care for the practice population.

The meeting concluded at 12.20p.m.

Signed _____ *Dated*_____

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

Minutes of a virtual meeting of the Governance Committee held on Thursday 13th May 2021, at 9.00 am

PRESENT:

Ms E Mullan, Trust Board Chair (Chair of meeting)
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, Acting Director of Older People and Primary Care
Dr T Boyce, Director of Pharmacy
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Director of Acute Services
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Dr M O'Kane, Medical Director / Interim Director of Mental Health and Learning Disability
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professions
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs C Doyle, Acting Assistant Director of Clinical and Social Care Governance
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES

None

1. WELCOME AND APOLOGIES

The Chair welcomed those present, no apologies were noted. At this point she advised members regarding some aspects of virtual meeting etiquette.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

The Chair drew members' attention for noting the Letter from Corporate Management Directorate, Department of Health, to ALBs dated 23rd March 2021 re Covid-19 Pause to Sponsorship and Governance Activities Update.

4. MINUTES OF MEETING HELD ON 11TH FEBRUARY 2021

The Minutes of the meeting held on 11th February 2021 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates from the relevant Directors.

- Judicial Reviews - the Chief Executive informed members that these will be captured within the Litigation report to the Committee going forward.

- O&G Whistleblowing Investigation – members were advised that a summary report on the investigation was being finalised and would be issued for discussion at their next meeting with the Chief Executive on 17th May 2021.

6. PERINATAL MORTALITY REVIEW TOOL

The Chair welcomed Dr Nicola-Ann Henderson, Consultant Obstetrician and Ms Wendy Clarke, Head of Service for Midwifery

and Gynaecology to the meeting to present information on the Perinatal Mortality Review Tool (PMRT).

Dr Henderson guided members through the presentation presenting information on: the purpose of reviews, tools for review, examples of outcomes, how the process has evolved, parent engagement and future developments. Data on the number of stillbirths and neonatal deaths in the Trust since 2018 were included in the presentation.

Dr Henderson spoke of the Perinatal Review Group established in the Craigavon Unit which includes representatives from areas such as medical, midwifery, management, bereavement and governance. In relation to patient engagement, Dr Henderson stated that patient information leaflets and a dedicated email address have been developed. Members raised the importance of ensuring that parents are looked after during the process. Dr Henderson spoke of the support in place such as bereavement midwives and the establishment of postnatal debrief clinics. For those families from the BAME community, Dr Henderson advised that a clinic has been set up in the Dungannon area with an interpreter for mothers from East Timor and Eastern European region.

Ms Clarke spoke of a number of steps that have been undertaken in the past 6 months within the unit to ensure that processes and learning is identified, shared and implemented.

In concluding, Dr Henderson spoke of the importance in cross site working between Craigavon and Daisy Hill Hospitals in particular with the elective C-Section lists.

Ms Donaghy enquired on comparative data against other Trusts and asked where this information is presented to. Dr Henderson stated that in regards to stillbirths and neonatal deaths the Trust is lower compared to regional Trusts, however there has been an increase with the stillbirth rate in DHH and work is underway to address this. She informed members that all the statistics are collated and presented to the Annual Perinatal Meeting for discussion and identify learning. Dr Henderson provided assurance that these cases are also presented to the Integrated Maternity and Women's Health Mortality and Morbidity meetings on a monthly basis.

Mr McDonald highlighted the need to build in time for report writing. The Chief Executive stated that he would discuss this further with Mrs McClements as well as the extension of the pilot to Daisy Hill Hospital.

The Chair thanked Dr Henderson and Ms Clarke for the presentation.

7. INFORMATION GOVERNANCE

i. Freedom of Information, Environmental Information and Subject Access Requests: 1st January 2021 – 31st March 2021.

Mrs Magwood presented the summary report for the period 1st January 2021 – 31st March 2021.

In relation to Freedom of Information (FOI) and Environmental Information Regulation (EIR) requests, a total of 114 requests were received and responded to in this period, an increase from 74 on the previous quarter. Of these, 104 (88%) were processed within the 20 day deadline. 31% of responses were provided by the Acute Services Directorate and 62% of requests came from members of the public.

Mrs Magwood provided information on FOI trends; requests decreased by 39% on the same period last year, requests increased by 58% on the previous quarter, compliance with timescales increased by 3.5% compared to the same quarter last year and compliance remained the same on the previous quarter.

Members noted 136 Subject Access Requests (SAR) were received during the period and of these, 101 (74%) responses were processed within the 30 day deadline. Members noted that the majority of requests were received from the public, businesses and the media. Details of the individual requests for information are included within the report.

In relation to trends, Mrs Magwood reported an increase of 67% on the same quarter in the previous year and an increase overall of 6% on the previous quarter.

Mrs Magwood reported that for Q1 2021 period the Trust reported 2 data breach incidents to the Information Commissioner Office (ICO) and the detail was included in members' papers. She provided assurance that recommendations from the ICO have been shared and taken forward within the relevant directorate.

Members requested further information on FOI/00000318 in relation to Covid-19 deaths. Mrs Magwood advised she will review and feedback at the next meeting.

Action: Mrs Magwood

ii. Third Party Cyber Incidents

Mrs Magwood presented a report on Third Party Cyber Incidents. She provided background to the report and advised that over the last two months a series of Cyber Attacks on organisations which the Southern Trust shares data with have been reported. She stated that in all cases the initial response by the Trust and Business Services Organisation (BSO) was to sever any links that the HSC have with these organisations including email communication or direct access to systems. Mrs Magwood informed members that to date these organisations have not confirmed that any personal data has been compromised, but due to the nature of these attacks the risk of data being compromised is high. She reported that following assessment of the information flows between the Trust and these organisations, it has been determined that all of these organisations are Data Controllers in their own right and are therefore responsible for reporting these incidents and any data loss to the Information Commissioners office. In all cases this has been confirmed.

In regards to local actions, Mrs Magwood advised that the Cyber Security IT and Information Governance teams have been heavily involved in the response to these Cyber incidents which included restricting access and preventing further exchanges of data; identifying what information is shared with each of these organisations and what contractual arrangements for the sharing of information are in place and collating an inventory of information shared and to assess risks with current processes.

The Chief Executive spoke of the importance of having contract arrangements in place with 3rd party companies who have access to the Trust's data and information. In response to a question asked by Mr Wilkinson, Mrs Magwood noted the challenges faced by the Trust as the data controller who is ultimately held accountable. She added as the Trust SIRO, she is responsible for this risk and confirmed that a full risk assessment is being completed.

The Chair asked for an update to be provided at the next meeting to which Mrs Magwood agreed to undertake.

Action: Mrs Magwood

iii. Information Governance Annual Report 2020/21

Mrs Magwood presented the Information Governance Annual report for 2020/21. She guided members through the report and drew their attention to the section on key facts and figures for the year. Mrs Magwood reported on the challenges faced by the team and in particular the year on year increase in requests for information and space for storage of paper records.

Mrs McCartan noted that 509 Subject Access Requests (SARs) were received from the public and 2485 Subject Access Requests were received from Solicitors for 2020/21 and asked if sufficient resources are in place to deal with this volume of requests. Mrs Magwood replied that additional resources are required to meet this demand and this alongside other increasing demands on both service and corporate support teams continues to be considered by SMT and how best to address as part of wider risk management discussions. She added resources have recently been put in place to support the process of redacting notes in both HR and operational directorates however the impact of this is not yet evidenced in the Trusts performance reporting against statutory timelines. It is anticipated committee will see the impact of this going forward.

8. MEDICINES GOVERNANCE

i. Medicines Governance Report

Dr Boyce presented the Medicines Governance report which demonstrates that during the fourth quarter of 2020/21, there were 299 medication incidents reported within the Southern Trust. The average number of reported medication incidents each month was 100, a slight increase from the previous quarter of 87 per month. Due to the second and third surge, reporting has remained at a lower level than previously reported, but now does appear to be recovering.

Dr Boyce noted there were no trends of specific concerns amongst the incident reports received. She advised of an amendment to the report and confirmed that there were no major medication incidents and will amend the report to reflect this. Dr Boyce advised of 3 moderate incidents but no catastrophic incidents reported via Datix and background to the incidents was outlined within the report.

The top 5 medicines involved in medication incidents were discussed. Dr Boyce advised that 'Covid vaccines' was the number one incident type with insulin the second highest incident type. She clarified that the Covid vaccine incidents includes a variety of reasons that require to be logged e.g. dropped vials.

In regards to benchmarking data for medication incidents, Dr Boyce reported the Trust 'no harm' incidence had decreased to 73.6% which is above average for the Human Factors in Healthcare which recommends minimum standard of 70% of reported incidents should result in no harm to the patient as an indicator of a positive reporting culture.

The MedSafe newsletter issue 23 was included in members' papers. The Drugs and Therapeutic Committee have not met since February 2021; however a number of items were dealt with via email amongst the membership in the following weeks. The next meeting is due on 12th May 2021.

An update on EU Exit plans for the supply of medicines was included in the report. Dr Boyce reminded members of the background to the situation and reported that as at April 2021 there have been no major issues in relation to medicines supply to Northern Ireland Trusts. A regional procurement pharmacist workshop is planned for late May 2021 to update Trust leads on progress with negotiations and

MHRA's plans to date. Dr Boyce informed members that at the end of April the Chief Pharmacist asked Trust Directors of Pharmacy to add EU Exit medicines supply chains to their Trust risk register and she confirmed that this is in process. She added that solutions are being tested which include: pairing NI with similar EU countries and using them as an import route, use of batch testing on arrival in NI, and licensed pharmaceutical warehousing for Trusts.

9. LITIGATION

i. Claims Management

Mrs Toal spoke to the above named report. The report provides an overview on the summary of litigation activity, claims, trends, coroner's inquests and medico-legal requests as at 31st March 2021.

Mrs Toal noted a decrease in the overall number of litigation claims for this quarter from 504 to 491. The costs related to litigation have reduced significantly in the financial year 2020/21 compared to the previous year. Mrs Toal reported that overall payments totalled £2.8m in 2020/21 compared to £6.3m in 2019/20. There were, however, less claims settled in this financial year compared to the last financial year.

High Value claims were discussed. Mrs Toal reported that there are 26 potentially high value claims and details of those cases were included in appendix one of the report.

Mrs Toal commented on the litigation discount rate and advised that a decision has been taken to bring forward secondary legislation to change the discount rate under the current framework to 1.75% (from its current 2.5%). It is an 'interim' rate which is planned to be implemented from 31 May 2021. The interim rate, when introduced, will have a significant financial impact on claims.

Medico-legal work was discussed. The compliance figures in relation to the statutory timeframes set by GDPR legislation has increased from 27% to 49%. There has been an increase in Subject Access Requests (SAR) from 688 during the previous quarter to 697 this quarter. The number of requests received is steadily rising month on

month. Mrs Toal reported that as at the end of March 2021 the team was dealing with an active caseload of Subject Access Requests totalling 813. She advised that the team continues to face a number of difficulties with regards vacancies and unexpected absences that impact on the capacity to deal with requests.
Coroner activity was included within the report with no Inquest Hearings taking place during this quarter.

Mrs McCartan informed members that the Statement of Losses report was presented to the Audit Committee on 6th May 2021 and stated that £4.78m was attributed to Clinical Negligence and payments in excess of £250k were made in 3 clinical negligence cases. She added that the report will be presented to Trust Board on 17th June for approval.

ii. Raising Concerns (Whistleblowing)

Mrs Toal spoke to the above named report. She advised the report focuses on 3 areas: case themes and trends (April 2020 to March 2021) to provide a year-end update during the first year of the Covid-19 pandemic; lessons learned from cases and case review on the Laboratory Service.

17 cases were reported for 2021/21 and the overall number of concerns raised is slightly down on the last 2 years. Mrs Toal reported an increase of concerns that are reported openly, which members welcomed. She reported that concerns about patient services and patient safety were higher this year than last year with most of those concerns relating to the Covid 19 pandemic.

Mrs Toal reported that fraud and financial concerns are the highest category of concern. She added that the Trust continues to highlight the need for ongoing promotion and training for this area. Ms O'Neill stated that internal discussions have taken place to provide training and skill up finance staff into the fraud team which would help with the potential increase of workload following the publication on awareness of fraud.

Mrs Toal discussed how the lessons from these cases are shared. She spoke of the staff newsletter which has been published and is

now being shared across the Trust. She noted that the team expect the publication of this newsletter to further highlight the raising concerns campaign and it was important to manage this during a period when resources and priorities are pointed in other directions. Four manager on-line clinics have been established for June 2021 which provides a forum for managers to hear the lessons from whistleblowing cases. Furthermore, work is underway to recruit a dedicated band 7 resource for managing the raising concerns campaign and whistleblowing cases.

In relation to the case review, Mrs Toal provided background within the Laboratory Services. She provided assurance that following a full investigation into the concerns, the Trust's Oversight Group accepted the findings and recommendations of the case investigators at a meeting on 25 March 2021. As a result of this case, a number of prompt questions have been shared with Directors for discussion with their teams, and will be shared for wider learning as part of the manager clinics. In response to a question asked by the Chair, Mrs Toal confirmed that regular check in's with the whistle-blower do take place. In responding to a question by Mr McDonald, Mrs Toal explained that the concern concentrated in one particular area of the laboratory and provided assurance that working patterns have been reviewed to ensure that they meet the needs of the service.

Mr Wilkinson expressed his concern that with the publication of the newsletter, the potential increase in cases submitted against the lack of resources could significantly impact the timeframe to investigate the claims and have a major impact on the team and asked if the additional band 7 post would suffice. Mrs Toal spoke of the capacity gaps and felt there were not enough resources to manage the potential demand of increased cases. She advised that discussions are underway nationally with Trusts on how they manage their whistleblowing cases and the freedom to speak up guardian role. Mrs Toal added that SMT support the need for additional resources in this area.

Ms Donaghy noted that 30% of cases were upheld and asked how this particular information will be circulated to staff. Mrs Toal responded that this will be included in the staff newsletter which will be included on the Trust Southern-i global emails. She further added

that the newsletter will focus on financial fraud and learning from cases. Mrs Toal envisaged that the newsletter will be circulated on a 6 monthly basis.

10. CLINICAL AND SOCIAL CARE GOVERNANCE

i. Clinical and Social Care Governance Report

Dr O'Kane presented the above named report which provides information on SAIs, catastrophic incidents, learning on patient safety initiatives, complaints and ombudsman cases from 1st January 2021 to 31st March 2021, with the exception of Patient Safety & Quality measures which are for the previous quarter 1st October 2020 to 31st December 2021.

Never events were noted with two cases reported within Acute Services and the detail of each was outlined in the report. Dr O'Kane provided assurance that both cases are being investigated through the SAI process. The Chair noted her concern that both cases occurred on the DHH site and raised the fact that incidents have increased in DHH. Dr O'Kane clarified that two never events are non-related and she attributed the increase in incidents on the DHH site to awareness raising in incident reporting.

Dr O'Kane reported that there has been an increase in incident reporting across the Acute and OPPC directorates for this quarter and a decrease in MHD and CYP. She advised the majority (53%) of incidents are categorised as 'insignificant' and 5.7% of Incidents have been categorised as a 'Moderate' severity rating.

The Chief Executive drew members' attention to page 6 of the report on the total number of incidents recorded on Datix. He pointed out that from April 2019 there has been a significant increase in incidents reported and explained that for every incident recorded a review process is carried out. The Chief Executive noted his concern that the resources to undertake these processes are not aligned with this increased shift and added that this has a significant demand on staff. He advised that discussions are underway with SMT on how best to address the lack of resources in the area to meet the demand.

Ms O'Neill referred to page 7 of the report and noted that within the Acute Directorate there has been an increase in reports of abuse from patients to staff and security incidents due to the significant number of patients with alcohol withdrawal and delirium. She queried if this will be a trend going forward as sufficient resources will be required to address this. Mrs McClements stated that there is significant demand on staff to provide care to these patients who require 1:1 support which has an impact on the wards and units. Dr O'Kane advised that this is an area that will be monitored closely.

Adverse incidents were discussed. Dr O'Kane drew members' attention to the 21 catastrophic incidents recorded between 1st January 2021 - 31st March 2021. 8 of these incidents have also been notified to the HSCB as SAIs. In addition, a further 10 SAIs were also reported to the HSCB, details of the cases are included in the report.

Mrs Leeson pointed out the high number of suspected service user suicides and asked what support was available to staff. Dr O'Kane commented that the team are closely monitoring the number of suicides particularly during the past year through the pandemic. She added that the Royal College of Psychiatrists have not identified a significant increase in the number of suicides nationally, however she noted the increase in the number of people presenting to Mental Health services following the pandemic. In regards to support for staff, Dr O'Kane spoke of the comprehensive debrief process. She added that the Clinical and Social Care Governance Co-ordinator for Mental Health is progressing recruitment into the family liaison system that will be responsible for providing support to staff.

SAIs were discussed. Dr O'Kane informed members the Trust currently has 83 SAI investigations in progress, 2 of which have been paused due to ongoing investigations by external bodies and 18 of the investigations remain within the HSCB timescale. She noted the contributory factors which influence the compliance of SAI reports within the timescales as documented in the report. Ms Donaghy asked if future reporting can include a table on the number of SAIs for each Directorate and their level which Mrs Doyle agreed to include.

In responding to a question by Mr McDonald in relation to SAI Personal information redacted by USI, Dr O'Kane assured members that this case has been

discussed in depth at the Weekly Governance meeting and learning has been identified around communication. She added that she has approached the Belfast Trust to establish an inter-Trust oversight group for patients transferring across the system. Mrs McClements highlighted an error on the date within the descriptor for this case. Mrs Doyle advised she will amend for the final version.

Dr O'Kane reported that a total of 33 early alerts were submitted to the DoH and the HSCB between 1st January 2021 and 31st March 2021. A breakdown of the Directorate and type of early alert was included in the report.

Dr O'Kane referred to the Trust crash call rate which remained stable for 2019/20. In relation to patient falls, Dr O'Kane stated that of the 27 Wards monitoring their Patient Falls/Falls Rate using the Falls Walking Stick, 21 wards (78%) saw an increase from quarter one and quarter three 2020/21. She added that there has been no significant change in the falls rate, however there has been significant improvement in compliance with Falls Bundle B.

In regards to Pressure Ulcers, Dr O'Kane reported that for quarter 1 to quarter 3 2020/21 there were 27 (13%) avoidable Pressure Ulcers and there is 1 case Post Incident Review outstanding. For VTE the Trust compliance in quarter 3 20/21 was 94%, which was a slight increase from quarter 2 20/21.

Complaints were discussed. Dr O'Kane stated that for the current reporting timeframe, 138 complaints were received, a decrease from 157 in the previous quarter. The 138 complaints contained 275 complaints subjects. She reported that communication/information and staff behaviour/attitude are the top 2 complaint types. Dr O'Kane noted that Health Care Complaint Analysis Tool data was included in appendix A of the report. Furthermore she noted that 1105 compliments have been received into the Trust for this quarter.

ii. Management of Trust Standards and Guidelines

Mrs Doyle presented the report on the Management of Trust Standards and Guidelines which sets out the Trusts' position on

implementation and compliance to Standards and Guidelines up to the 31st March 2021.

Mrs Doyle guided members through the report and highlighted that it includes a section on Quality Improvement which illustrates some of the work that has been undertaken by the MDT over the last 3 months to implement key recommendations within a number of regionally endorsed guidance documents. She added that the report also outlines the work that has been undertaken across the Trust to provide the HSCB with an assurance that the recommendations within the relevant guidance has been reviewed by the relevant clinical teams with action plans established to drive forward any improvement in practice.

From 1st January 2021 to 31st March 2021, a total number of 102 circulars have been received by the Trust (1 of which was not applicable to the Trust). A further review of these 101 Trust wide applicable circulars identifies that 38 of them were COVID-19 related, a breakdown of these was included in Appendix 1a of the report. The remaining 63 circulars are within the agreed scope of the Trust's Standards and Guidelines processes and have been managed accordingly. The only exception to this is in relation NICE COVID-19 Rapid Guidance and the COVID related SQR letter which has been included in the scope. The document included hyperlinks to the guidance and the current risk rating / compliance position.

Mrs Doyle noted that despite the long standing challenges, one notable development has been the appointment of a Senior Manager for Risk and Learning to the Medical Directorate team (secondment for initially 3 months) in February 2021. The role aims to provide a corporate oversight of the effective dissemination and implementation of regionally endorsed standards and guidelines within the Trust, ensure any associated risk is appropriately managed and that key learning messages are shared within the organisation to enhance patient safety and quality of care. Whilst the post is in its early stages of development, a number of key actions have been prioritised and these are being driven forward over the next few months. Mr Wilkinson noted how important this role is and asked if there is potential for it to be extended. Dr O'Kane commented that this role

has made a significant impact; therefore discussions will take place with SMT on the possibility of an extension.

The Chief Executive stated that SMT are committed to ensuring that there is sufficient investment into Standards and Guidelines.

iii. Mortality Report

Dr O'Kane presented the Mortality Report which provides assurance on the safety of hospital care and assurance on Trust processes to measure and monitor hospital mortality. She explained that there are 3 different timeframes within the report: CHKS: April 2019 – June 2020, Intensive Care Unit April 2019 – September 2020 and VLADs July 2019 – June 2020. For the reporting period of July 2019 – June 2020, there were 1,059 deaths.

Dr O'Kane noted that the Trust crude mortality rate showed no significant change and generated no alerts (1.12% compared to 1.06% for the 2018/19 period). The rate is below the regional and national peer mean.

The RAMI 2019 score for the 2019/20 period was 78.83 compared to 86.82 2018/19 meaning there were 21.17% less deaths than were expected based on the casemix. This is a decrease of 9%. The rate is below the regional and national peer mean and generated no alerts. It is worth noting that this is the first time that the RAMI 2019 score has been used so the results will differ from those in previous reports which referred to the RAMI 2018 score.

Dr O'Kane reported the overall data quality index score for the Trust for July 2019 - June 2020 period was 93.54. This compared favourably to the NI peer of 92.97.

The impact of Covid-19 was discussed. Dr O'Kane advised that patients have been presenting to their GPs or hospital late which has an impact on the indicators and a greater pressure on the clinical teams to ensure care is provided in a timely manner.

The Chief Executive stated that the report provides a high level of assurance and informed members that Dr Mark Haynes undertook a

piece of work through the Mortality and Morbidity meetings to review those elective deaths for any learning and trends.

11. RISK MANAGEMENT

i. Corporate Risk Register

The Chief Executive presented the Corporate Risk Register (CRR). He reminded members that following a full review of the CRR by SMT, six principal risks to the achievement of the Trust's corporate objectives were agreed. Each risk is underpinned and informed by risk triggers overseen at an operational level within Directorates. The Chief Executive advised that the document includes a 'deep dive' into the People risk which was included in members' papers under Appendix A.

Mrs Toal drew members' attention to appendix A on the People risk and guided members through the controls and additional actions planned to mitigate and possibly reduce the rating of this risk to a medium level.

Mr Morgan advised that he was looking at the vacancy rates in social work with HR and Mrs Trouton was doing likewise with AHPs.

Mrs Toal referred to the high volume of medical locum engagements. She advised that a paper has been agreed regionally which sets out a proposal for consistency in locum rates to the Department of Health for consideration of new circular / instruction to Trusts to ensure that there is equity across the region for the availability of locum doctors.

In regards to agency use, Mrs Toal stated that work is ongoing to identify hotspot areas of high agency use and try to understand the reasoning behind this and to implement actions to drive down this usage. She advised that within Midwifery, the same process will be undertaken to identify those areas with capacity gaps and high agency usage. Mrs Toal added that the Psychology vacancy gap within Occupational Health is being addressed with funding requested from Endowments and Gifts Committee to ensure that staff continue to be supported.

Mrs McCartan asked if the timeframe of 3 months for priority actions is achievable, to which Mrs Toal advised that work is progressing steadily and noted that a paper has been shared with the Medical Director and the Human Resources team to progress the actions for within the Medical sub risk and will be shared with the Department of Health to take forward. She felt that this would be achievable by July 2021. Mrs Toal assured members that an update on the progress will be included in the CRR.

Mr McDonald asked what the Trust is doing in regards to the age profile of the workforce. Mrs Toal commented that there have been a number of staff who has retired recently or left the Trust and work is underway on the retention of staff and succession planning.

The Chief Executive stated that the risks will be re-assessed after 3 months to ensure they are progressing and if not what actions are needed to address this which will be highlighted in the CRR.

Corporate Risk Register was approved

The Chair requested item 19 be taken at this point

19. FEEDBACK FROM AUDIT COMMITTEE

i. Internal Audit Report on Adult Safeguarding – Limited

The Chair welcomed Ms Deborah Hanlon, Head of Service for Adult Safeguarding to the meeting. Mr Morgan advised that Internal Audit undertook an invited audit on Adult Safeguarding and a limited assurance was provided. The report was presented to the Audit Committee on 6th May 2021 and it was requested the report and a briefing paper be presented to the Governance Committee.

Mr Morgan informed members that the Trust established a Blueprint Project Board to oversee the implementation of the new regional Adult Safeguarding Policy and Operational Procedures in 2016/7. Since 2017 there has been significant regional learning regarding adult safeguarding practice reflected in the Home Truths report, Muckamore Abbey leadership and governance report and more recently in the Consultancy Network in Social Care (CPEA) Whole

Systems review into Adult Safeguarding commissioned by the Department of Health. The Internal Audit report summaries 19 recommendations over 6 key areas which are outlined within the report. Mr Morgan added that the briefing paper indicates the work that has been progressed internally since 2019 in conjunction with the Mental Health and Learning Disability Directorate.

Mrs Leeson welcomed that the report was presented to the Governance Committee as she does not sit on Audit Committee. She reiterated that Adult Safeguarding is the responsibility of everyone.

A discussion ensued on under which Directorate Adult Safeguarding should sit. The Chief Executive stated that this is part of discussions included in the review of structures which SMT are actively taking forward. Mrs Hanlon pointed out that a key finding from the Internal Audit report stated that the designated lead social worker within OPPC does not have line management responsibility for any of the Designated Adult Protection Officers (DAPO) or Investigating Officers (IO) therefore there is a disconnect in structures and it is more difficult to co-ordinate and manage overall Adult Safeguarding services. Mr Beattie informed members that recruitment is underway within the OPPC directorate for a lead Social Worker who will have responsibility for adult safeguarding. Furthermore, Ms Hanlon commented that the Acute Directorate had identified within their Directorate Scorecard an objective to nominate a number of champions, however with the pressure of the pandemic, the roll out was not achieved. She suggested that this will support accountability and reporting structures within Acute.

In responding to a question by Mrs McCartan, Mr Morgan advised that a meeting is due to take place in June 2021 to discuss the recommencement of the Project Board. The purpose of the meeting is to review the composition of the Project Board and introduce scorecards, to provide greater assurance.

Members suggested that the Clinical and Social Care Governance report to the Committee is expanded to include a wider range of social care information such as adult safeguarding.

Mr Morgan recorded his thanks to Ms Hanlon who has led and driven Adult Safeguarding for the past number of years especially through the past year during the pandemic with the workforce pressures across the system.

Mr Morgan advised that an action plan will be developed to address the key findings and recommendations which will be presented at a future Governance Committee.

Action: Mr Morgan

12. HYPONATRAEMIA UPDATE

Mrs Trouton presented the Hyponatraemia update which provides an overview of the work that has been undertaken in relation to the 96 recommendations arising from the Report into Hyponatraemia Related Deaths and summarises their current status. The report also provides details of the percentage of Nursing and Medical staff trained in Hyponatraemia BMJ e-learning and the percentage of Nursing staff that availed of CEC and PHA Hyponatraemia training and provides an update on the audit findings on Fluid Management in Children.

Mrs Trouton advised that the Trust Oversight Group met on 3rd March 2021 and a Stocktake event was held via Zoom on 14th April 2021. The aim of the event was to review the current position in relation to the 96 recommendations and that a shared understanding of what was required to take forward. She confirmed that all 96 recommendations were discussed and the agreed status following discussion was: 59 recommendations were transferred to nominated leads to progress, 10 await outcome of public consultation/await outcome of regional system procurement/RQIA lead, 25 remain on the Oversight Group agenda, 9 require further clarification and 2 are compliant.

The Chair asked how the Trust is comparing with the implementation of the recommendations against other Trusts. Mrs Trouton explained that there is no comparative data; however she felt that through regional discussions all Trusts were in a similar position.

The Chair reminded the Non-Executive Directors that the dates for the public consultation on a statutory Duty of Candour in NI were circulated on 13th May.

13. RQIA REVIEW OF THE IMPLEMENTATION OF NICE CG 174 – IV FLUID THERAPY IN ADULTS IN HOSPITALS IN NI

Dr O'Kane presented the above named item and advised that the Department of Health requested RQIA to review the implementation of Clinical Guideline 174, to include a focus on the governance and oversight arrangements and ongoing assurance mechanisms in place across the Health and Social Care system. The review commenced in December 2017 and concluded in May 2018 and the report was published on 25 September 2020 with a number of recommendations made.

Dr O'Kane commented that in response to the RQIA report, a SHSCT Multi-disciplinary team working group was established to collectively review each of the 9 recommendations outlined within the report and the inaugural meeting was held on 16 March 2021. A regional workshop was held on 14 April 2021 with representatives from the PHA, HSCB and all 5 HSCTs. It was agreed that there will be 3 regional task and finish groups established with SHSCT representatives on each: training and development, review of regional fluid balance chart and regional Audit Tool development.

Dr O'Kane informed members that work is ongoing with the Educational Fellows who have developed a simulation which will be rolled out for Junior Doctors, Physician Associates and Nursing staff. She felt that the success of this simulation will be adopted regionally by other Trusts.

In regards to IV Fluid balance sheets, Dr O'Kane reported that NEWS2 (National Early Warning Score) has been launched across the Trust. She noted her thanks to all those involved that undertook the significant work to release and inform all relevant areas and staff.

Mrs McCartan left the meeting at this point

14. LEARNING FROM EXPERIENCE FORUM – UPDATE REPORT

Dr O'Kane presented the updated report on the Learning from Experience forum and reported on the objectives that have been set for 2021/22.

Ms O'Neill referred to the membership of the forum and felt it would be beneficial for a representative from Estates and Health and Safety given the environmental issues be included in the membership. Dr O'Kane agreed and advised she will take this forward.

Mr McDonald noted that he would welcome the opportunity to re-join the forum which Dr O'Kane welcomed.

15. DRAFT GOVERNANCE STATEMENT 2020/21

The Chief Executive presented the Trust's draft Governance Statement for members' endorsement. He guided members through the document highlighting the key points. The Chair confirmed that this document had been reviewed separately by the Audit Committee on 6th May 2021 and will be presented to Trust Board on 17th June 2021 for approval, prior to submission with the Trust Accounts.

Members were content with the draft Governance Statement.

16. CONTROLS ASSURANCE REPORT 2020/21

Ms O'Neill presented the report on compliance against the Controls Assurance Standards for 2020/21. She stated that the lead assessors completed the self-assessment which demonstrated that 18 areas achieved a green rating and 4 achieved an amber rating. She assured members action plans are in place to address areas of control divergence.

17. DRAFT ANNUAL REPORT OF THE GOVERNANCE COMMITTEE 2020/21

The Chair presented the Governance Committee Annual Report for 2020/21. She stated that its purpose was to report on the work of the Committee for the financial year under review. Following Governance Committee endorsement, the report will be brought to Trust Board for approval. The Chair recorded thanks to the Board Assurance Manager for producing this informative report.

The Chair requested item 20 be taken at this point

20. NON-EXECUTIVE DIRECTORS' VISITS TO CHILDREN'S HOME REPORT

Mr Morgan reported that a total of 12 Children's Home visits were undertaken virtually during the period October 2020 – March 2021. He advised that the paper provides assurance on the quality of care provided to young people in residential care. It also focuses on key issues raised as a result of the Non-Executive Directors' visits and actions taken / proposed to address the issues.

Mr Morgan commented that discussions are underway with the Assistant Director of Corporate Parenting to reinstate face to face visits by the Non-Executive Director's whilst adhering to social distancing and IPC guidelines. Members welcomed this approach.

18. ANNUAL REPORTS

i. Research and Development Annual Report 2019/20 and 2020/21

The Chair welcomed Dr Peter Sharpe Associate Medical Director for Research and Development and Ms Irene Knox, Research and Development Manager to the meeting.

Dr O'Kane stated that these Research and Development Annual Reports have been prepared for the two years 2019/2020 and 2020/2021 due to the increased workload related to COVID-19.

Dr Sharpe guided members through the presentation and spoke of the achievements through the pandemic, namely the Trust's participation in nine priority Covid-19 studies accorded that status by the Chief Medical Officers of England, Scotland, Wales and Northern Ireland with recruitment of 1,337 participants. He added that the Trust was the first to open the SIREN Study for Healthcare staff and achieved the highest recruitment in Northern Ireland with 280 participants. Other Clinical Trials/Studies achievements were included in the report.

Dr Sharpe spent time discussing the recovery – priority Covid-19 trial which looked at the efficacy of candidate therapies for suspected or confirmed COVID-19 infection in hospitalised patients receiving usual care, with 310 participants recruited and was broadcast on BBC Newsline and also had extensive coverage in the local press. Dr Sharpe presented information on SIREN – priority Covid-19 trial which is the study of infection/immunity following natural infection and post vaccination in healthcare workers. The study included 280 participants and the team consisted of Clinical Research Nurses, Occupational Health Testing POD, Laboratory and Research Office staff. Dr Sharpe reported that the interim results at six months show 85% immunity post infection.

In concluding the presentation, Dr Sharpe spoke of a number of key priorities for 2021/22.

Mr Wilkinson welcomed the presentation and commented on the importance of Research and Development as it has contributed significantly to the production of the Covid-19 vaccine. In response to a question by Mr Wilkinson, Dr Sharpe advised that Consultants have requested additional protected time for Research and Development. The Chief Executive added that discussions are underway with Dr O'Kane and Mrs McClements to address this.

Ms Donaghy asked if EU Exit will have a negative impact on Research and Development. Dr Sharpe stated that the funding from the EU may decrease however the UK Government will provide the deficit.

Mrs Magwood advised that she has had discussions with ABC council on their Health Life Science Strategy in relation to Cardiology and spoke of the opportunities to look at innovation which may help future consideration of accommodation issue.

Miss Knox informed members that the discussions are underway with Queens University Belfast for a placement of a Clinical Academic Fellow into the Trust which was welcomed.

Dr O'Kane commented that the pandemic has provided an opportunity for staff outside of Research and Development to experiment into this field with great results and hoped Research and Development is promoted more throughout the Trust.

The Chief Executive thanked Dr Sharpe and Miss Knox for their dedication and commitment to Research and Development within the Trust.

ii. Emergency Planning Annual Report 2020/21

Dr O'Kane presented the Emergency Planning Annual Report which details the work undertaken within the organisation to respond to the wide variety of incidents and emergencies the Trust has faced in the last 12 months. From the outset, Dr O'Kane recorded her thanks to all staff within the Trust on their response to the global pandemic and other emergencies / incidents, as an initial Trust review identified considerable good practice in Co-ordination, Communication, Planning and Resource Allocation.

Dr O'Kane spoke of the challenges during 2020/21 and highlighted that the main challenge for Emergency Planning is to deliver on the training requirements identified as a result of this pandemic. She advised that a Training Needs Analysis has been completed and is being presented to SMT for endorsement and implementation.

The number of incidents reported between 1st April 2020 and 31st March 2021 and the lessons learned from each incident were outlined within the report.

In concluding, Dr O'Kane noted her thanks to Teresa Cunningham, Emergency Planning Manager and her team on the enormous work undertaken throughout the pandemic.

The Chair welcomed the informative report and emphasised the need for ongoing communication from the PSNI in relation to incident response. Dr O'Kane agreed and advised she would take this forward.

Action: Dr O'Kane

21. ANY OTHER BUSINESS

None noted.

The meeting concluded at 1.35p.m.

Signed _____ *Dated*_____

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

Minutes of a virtual meeting of the Governance Committee held on Thursday 9th September 2021, at 9.00 am

PRESENT:

Ms E Mullan, Trust Board Chair *(Chair of meeting)*
Ms G Donaghy, 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
Dr M O'Kane, Medical Director / Interim Director of Mental Health and Learning Disability
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs C Doyle, Acting Assistant Director of Clinical and Social Care Governance
Mr R Carroll, Assistant Director of Acute Services, Surgery and Elective Care and ATICS *(for Mrs McClements)*
Mrs J McConville, Assistant Director of Specialist Child Health & Disability *(for Mr Morgan)*
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES

Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Dr T Boyce, Director of Pharmacy
Mrs M McClements, Director of Acute Services
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professions
Mrs S Judt, Board Assurance Manager

1. WELCOME AND APOLOGIES

The Chair welcomed those present and noted the apologies. She welcomed Mrs Catherine Teggart to her first Governance Committee meeting and congratulated her on the recent appointment as the Director of Finance, Procurement and Estates.

At this point she advised members regarding some aspects of virtual meeting etiquette.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S REMARKS

The Chair advised that Mrs Trouton was an apology due to significant pressures on the wards and advised members that she will have a discussion with the Chief Executive on how committees will be managed going forward through the winter period.

Action: Ms Mullan

4. MINUTES OF MEETING HELD ON 13TH MAY 2021

The Minutes of the meeting held on 13th May 2021 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates from the relevant Directors.

In relation the Internal Audit report on Adult Safeguarding, the Chair requested that the action plan and an update be presented at a future Governance Committee.

Action: Mr McCafferty

6. REPORT ON THE QUALITY ASSURANCE VISIT TO THE SOUTHERN AREA BREAST SCREENING UNIT

The Chair welcomed Dr Linda Johnston, Director of Breast Screening and Lead for Breast Imaging in the Southern Area and Dr Adrian Mairs, Acting PHA Lead for Breast Screening to the meeting to present information on the above named item. The full report was included in members' papers. Mr Carroll introduced this item and advised that the visit was undertaken by the NI Young Person and Adult Screening Team on 3rd March 2020 and a positive assurance was provided to the Trust.

Dr Johnston guided members through the presentation and stated that the aim of the quality assurance (QA) in Breast Screening Programme (BSP) is to maintain minimum standards and continuously improve the performance of all aspects of breast screening. She spoke of the 3 quality standards on how effective the BSP is in meeting the needs of its users: uptake, round length and invasive/small invasive cancer detection rate. Dr Johnston noted that the minimum uptake standard is ≥70% and the Trust's average overall uptake rate for the three year period 2015/16 to 2017/18 was 76.1%. An active programme is in place to promote informed choice with support from health promotion within the Trust.

In relation to Round Length, the UK minimum standard is ≥90% and Dr Johnston reported that the Southern Breast Screening Unit has had a consistently high round length in 2015/16 to 2017/18; with figures of 99.0%, 99.2% and 98.8% respectively. She continued to present data on invasive and small invasive detection rates with both prevalent and incident screen above target. Furthermore, areas of good practice and key areas for quality improvement were presented.

Dr Johnston raised the mammography equipment in Craigavon Area Hospital as a significant area of concern. She advised that out of the two machines which are over 9 years old, one has been replaced in July 2021. She also raised the fact that the Director of Breast Screening requires protected time to undertake the management of the breast screening programme with 1 PA devoted to this and advised that the job plan is under review.

In concluding, Dr Johnston spoke of the challenges faced by the unit, namely the difficulty in recruiting Consultant Breast Radiologists which may have potential implications for the future sustainability of the Unit and the pausing of the NHS BSP in April 2020 due to pandemic.

Members noted the positive QA visit with excellent engagement from Unit staff and management.

Dr Mairs reported that progress has been made on the recommendations but did note the importance of the job plan for Dr Johnston to take priority to include 1 PA. He spoke of the good engagement with the Unit and credited the team for their remarkable work. Dr Mairs highlighted the significant issue with regard to the availability of theatre time to undertake surgery and the possibility of pausing the screening programme. Ms Donaghy queried this and asked how this will affect the waiting lists for treatment. Dr Mairs spoke of the different types of treatment available, the assessment targets and how this can impact the waiting lists. He added that there is significant resistance to pausing the screening programme as this would not be in the best interests for patients.

Mr Carroll spoke of the challenges across all elective surgery specialities, especially through the pandemic when elective theatre lists were reduced and staff redeployed to other areas.

The Chief Executive queried the difficulty in recruiting Consultant Radiologists to which Dr Johnston replied that this issue is regionally and nationally recognised. She added that the Clinical Director and Associate Medical Director have previously tried to recruit these roles with limited candidates applying.

The Chair thanked Dr Johnston and Dr Mairs for their informative presentation.

7. RISK MANAGEMENT

i. Corporate Risk Register

The Chief Executive presented the Corporate Risk Register (CRR). He reminded members that following a full review of the CRR by

SMT, six principal risks to the achievement of the Trust's corporate objectives were agreed. Each risk is underpinned and informed by risk triggers. The Chief Executive reported on the changes to the CRR: new risk added – 'risk to the ongoing supply of medicines due to EU Exit/NI Protocol grace period ending on 31.12.2021' and the removal of 'risk to service delivery disruption due to the deterioration of exposed concrete on Daisy Hill Hospital building exterior' which will now be managed at Directorate Risk Register level.

The Chief Executive informed members of a potential addition to the CRR for the next quarter - supply of domiciliary care staff. A discussion is required at SMT on where best on the CRR it belongs - people or access to services. The Chief Executive gave a brief overview of each risk and noted that work and focus has to be progressed further in relation to Infection Control. He stated he was content with the progress on the other 5 areas.

In response to a question asked by Mr McDonald in relation to Estates and Infrastructure, the Chief Executive explained that this remains a high risk and Mrs Magwood has re-presented the ongoing submission to DoH to influence 10 Year Capital Strategy.

The Chair requested that Estates and Infrastructure be the focus for a deep dive at the next meeting.

Corporate Risk Register was approved

8. CLINICAL AND SOCIAL CARE GOVERNANCE

i. Clinical and Social Care Governance Report

Mrs Doyle presented the above named report which provides information on SAIs, catastrophic incidents, learning on patient safety initiatives, complaints and ombudsman cases from 1st April 2021 to 30th June 2021, with the exception of Patient Safety & Quality measures which are for the previous quarter 1st January 2021 to 31st March 2021.

Mrs Doyle guided members through the report and commented on the areas of improvement which included a reduction in the number of incidents relating to staff shortages due to Covid-19, as well as a reduction in the number of re-opened complaint cases. For those

areas of concern, she advised that the number of outstanding cases on the DATIX system has increased and the number of SAI notifications to the Health and Social Care Board has increased. She added that in relation to the DATIX system, there were 5971 incidents logged for this quarter and attributed a significant number of these to violence and aggression.

Mrs Doyle informed members that a violence and aggression forum has been established. The group will undertake a review these cases, discuss the cause, actions required, role of the Portering and Security staff and the involvement of PSNI. She advised that all incidents involving security staff have to be reported via DATIX and felt that reporting and awareness has improved in this area. In response to a question asked by Ms Donaghy, Mrs Doyle advised that a significant number of violence and aggression incidents were towards staff. She added that the violence and aggression forum will consider how to improve security and engage with the PSNI for their assistance. Mrs Doyle advised that a PSNI representative will be requested to join the forum. She reminded members that the Trust has implemented a Zero Tolerance Policy and the importance of reminding patients and visitors of this. Mrs Toal spoke of the revised regional violence and aggression policy framework that is nearing completion. She added that the Minister of Health has written to each Trust seeking an update on how the Trust manages violence and aggression and Mrs Toal felt that this was a great opportunity to feedback to the Minister any concerns the Trust may have in this area.

In response to a question asked by Mr Wilkinson, Dr O'Kane spoke of the significant increase in the number of patients presenting to the hospital with alcohol related issues. She noted that these cases significantly contribute to the number of violence and aggression incidents.

The Chair noted her concern on this issue and advised that she will liaise with regional Trust Chairs to discuss their processes and actions on addressing the increase in incidents for violence and aggression.

Action: Chair

Mrs Doyle presented information on incident severity and noted that 53% of incidents were categorised as insignificant. She added that 16% of the minor incidents remain uncategorised and in relation to moderate incidents, 36% of incidents remain uncategorised. Mrs Doyle provided assurance that the cases have been reviewed but not themed and work is underway to address this.

Major incidents were discussed and Mrs Doyle advised that these have increased significantly with an upper confidence limit breach in June 2021 and there has been 8 consecutive data points above the mean. She advised that 36% remain uncategorised and 23% relate to Infection Prevention Control. Mrs Doyle reported on the catastrophic incidents and between 1st April to 30th June 2021, 11 catastrophic incidents were recorded. 8 of these incidents have also been notified to the HSCB as SAI's. In addition a further 19 SAI's were also reported to the HSCB the detail of which was included in the report.

SAIs were discussed. Mrs Doyle informed members the Trust currently has 88 SAI investigations in progress, 2 of which have been paused due to ongoing investigations by external bodies and 33 of the investigations remain within the HSCB timescale. She noted the contributory factors which influence the compliance of SAI reports within the timescales as documented in the report.

Mrs Doyle drew members' attention to figure 7 of the report for unapproved incidents and explained that the 7 incidents relating to the Chair and Chief Executive's office that these were test items added to the DATIX system and confirmed that these have now been removed. A number of other incidents have been removed following discussions and assurances with relevant Directors.

Mr McDonald asked for further clarification on the process of the Structure Judgement Review (SJR). Dr O'Kane explained the background of the SJR process which is embedded in hospitals across England. She advised that Dr John Simpson has undertaken a pilot of SJR on a number of SAI cases to seek a better understanding if an SJR process would be more beneficial than undertaking an SAI. Dr O'Kane stated that the outcomes of the pilot suggest that undertaking an SJR on level one and two SAI is at least as valuable than an SAI. She added that engagement with clinicians when using the SJR process has improved and produces additional data and

learning. Dr O'Kane advised that the Trust has approached PHA and RQIA to ask if this process could be adopted regionally.

Mrs Doyle presented information on Patient Safety areas.

In relation to the Trust Crash Calls the rate for 2020/21 is 0.66 per 1,000 Deaths & Discharges (30 crash calls) and based on the data there has been no significant change in crash call rates.

Pressure ulcers were discussed and Mrs Doyle advised of an amendment to the report on page 33 that there has been no significant change in bundle compliance in Q4 20/21; however there is a change above the mean for ten data points. She advised the report will be amended to reflect this. In 2020/21 11% of stage 3 and above avoidable Pressure Ulcers were noted, compared to 12% in 2019/20. Themes / shared learning arising out of avoidable Post Incident Reviews are fed back to Ward Managers, via Lead Nurses. For VTE the Trust compliance in quarter 4 2020/21 was 94%, which was the same as quarter 3 2020/21.

In relation to patient falls, Mrs Doyle stated that of the 27 Wards monitoring their Patient Falls/Falls Rate using the Falls Walking Stick, 21 wards (78%) saw an increase from in 2020/21 compared to the same period in 2019/20quarter one and quarter three 2020/21. She added that there has been no significant change in the falls rate, however there has been significant improvement in compliance with Falls Bundle B with 1 upper confidence limit breaches in Q4

Mrs Doyle reported on Ombudsman Cases and advised for April 2021 to June 2021, the Trust received 7 requests for information from the Ombudsman's Office. 6 of these cases are currently pending and 1 has been opened. At present there are 12 open Ombudsman cases and 14 pending cases.

Complaints were discussed. Mrs Doyle stated that for the current reporting timeframe, 175 complaints were received, an increase from 138 in the previous quarter. The 175 complaints contained 352 complaints subjects. She reported that communication/information and quality treatment and care are the top 2 complaint types. She reported that although it appears there has been an increase in the number of complaints received this quarter, numbers are returning to

the same levels as pre Covid-19 pandemic. Mrs Doyle noted that Health Care Complaints Analysis Tool data was included in appendix A of the report. She added that work is ongoing to use this tool to drill down further into the complaints data to analyse and learn from complaints. Mrs Doyle stated that the DoH is still deliberating whether to implement the HCAT regionally and it is for further discussion regionally over the next few months. Mrs Doyle noted that 991 compliments have been received into the Trust for this quarter which is a decrease from the previous quarter.

Mr McDonald noted that 28% of all complaints for this quarter related to communication and asked what measures are in place for the Trust to address this. Mrs Doyle acknowledged this and noted that whilst this figure is high, in turn the number of communication compliments is also significantly high. She stated that the operational directors are responsible for the development of an action plan to address the concerns raised. Mrs Magwood reminded members of the Quality Improvement initiative that asked frontline staff to participate in identifying areas of improvement for communication within their area of work. She advised that this was successful with 15 projects taken forward and a number of areas identified for better communication which were implemented.

Mrs Doyle informed members that the HCAT tool is able to identify where in the patient's pathway the complaint on communication was submitted and felt that this was valuable to identify quick solutions and learning.

Members requested that a further breakdown of complaints in relation to communication be included in the next report.

Action: Mrs Doyle / Dr O'Kane

ii. Management of Trust Standards and Guidelines

Mrs Doyle presented the report on the Management of Trust Standards and Guidelines (S&G) which sets out the Trusts' position on implementation and compliance to Standards and Guidelines up to the 30th June 2021.

Mrs Doyle guided members through the report and highlighted that it includes a section on Quality Improvement which illustrates some of the work that has been undertaken by the MDT over the last 3 months to implement key recommendations within a number of regionally endorsed guidance documents. She added that the report also outlines the work that has been undertaken across the Trust to provide the HSCB with an assurance that the recommendations within the relevant guidance has been reviewed by the relevant clinical teams with action plans established to drive forward any improvement in practice.

From 1st April 2021 to 31st June 2021, a total number of 60 circulars have been received by the Trust (3 of which were not applicable to the Trust). A further review of these 57 Trust wide applicable circulars identifies that 19 of them were Covid 19 related and 2 were related to the regional supply disruption alerts, a breakdown of these were included in Appendix 1a of the report. The remaining 36 circulars are within the agreed scope of the Trust's Standards and Guidelines processes and have been managed accordingly. The document included hyperlinks to the guidance and the current risk rating / compliance position.

Mrs Doyle noted that the temporary role for the Standards and Guidelines manager has progressed to the advertisement for a permanent manager, which members welcomed.

In relation to the S&G excel spreadsheet database, Mrs Doyle reminded members of the need for significant investment for a system to maintain the S&G database. She advised that within the DATIX system it does have a safety alert module embedded into it which will fit the purpose for monitoring S&G information. Mrs Doyle added that she has met with the HSCB on this and felt that this system was the way forward and the need for a level of investment for purchasing this package. Mrs Doyle advised that this will be pursued further.

Mrs Doyle spoke of the recent establishment of the SHSCT Governance Officers S&G forum. She informed members that this forum will review the risks and ensure that the learning identified is disseminated across all relevant directorates.

Members welcomed the assurance provided that investment in additional resources and an appropriate system to capture and monitor S&G has been taken forward.

The Chief Executive reminded members of the three areas for improvements; SAIs, Complaints and Standards and Guidelines. He stated that the investment in these areas are now coming to the forefront and provide an assurance of control. The Chief Executive recorded his thanks to the team for their hard work.

iii. Mortality Report

Dr O'Kane presented the Mortality Report which provides assurance on the safety of hospital care and assurance on Trust processes to measure and monitor hospital mortality. She explained that there are 3 different timeframes within the report: CHKS: October 2019 – September 2020, Intensive Care Unit April 2020 – March 2021 and SHMI and VLADs October 2019 – September 2020. For the reporting period of October 2019 – September 2020, there were 1,038 deaths.

The RAMI 2019 score for the 2019/20 period was 79.45 compared to 84.09 2018/19. This is a decrease of 5.67%. In comparison with the UK peer (94.4%), the Trust RAMI score of 79.45 falls into the lower range of the peer meaning there were 21.55% fewer deaths than were expected based on the case mix.

The Trust crude mortality rate showed no significant change and generated no alerts (1.21% compared to 1.02% for the 2018/19 period). The rate is below the regional and national peer mean. Whilst the overall crude mortality rate did not increase there was a significant increase in mortality for April 2020 and May 2020 which was reflected in deaths from Covid 19. This was in line with the regional peer and below the national peer.

Dr O'Kane reported the overall data quality index score for the Trust for October 2019 - September 2020 period was 94.18. This compared favourably to the NI peer of 92.83.

Dr O'Kane noted her concern on the Variable Life Adjusted Displays (VLADs) with two higher and one lower limit control breach, the lower limit breach was relating to patients with secondary malignancy,

however she did add that the data is 10 months old, but she attributed this potentially to the recognised regional reduction in patients presenting to hospital for concerns during Covid-19.

The Chief Executive also noted his concern on this issue of excess deaths due to patients not requesting healthcare throughout the pandemic and felt it would be beneficial for this information to be included in a future report, when the data becomes available. Dr O'Kane agreed to bring this back to the committee.

Action: Dr O'Kane

iv. RQIA Review of the Implementation of NICE CG 174 – IV Fluid Therapy in Adults in Hospitals in NI

Dr O'Kane presented the above named item and advised that the Department of Health requested RQIA to review the implementation of Clinical Guideline 174, to include a focus on the governance and oversight arrangements and ongoing assurance mechanisms in place across the Health and Social Care system. She reminded members of the 3 regional task and finish groups established with SHSCT representatives on each: training and development, review of regional fluid balance chart and regional Audit Tool development. Dr O'Kane stated that in order to support these regional work streams, similar local MDT groups have also been established to ensure expedient sharing of information, to include review and comment relating to any resource development.

Dr O'Kane guided members through the summary update and highlighted the key outcomes that have been achieved by the project team from April to June 2021, as detailed in the report.

The report included an appendix of the SHSCT Governance Structure for IV Fluid Management in Adults in Hospital, Communication Plan and a SHSCT Resource bid to HSCB.

Mr McDonald commented that the report states that the Trust does not have a suitable electronic data collection tool that will ensure efficient and effective data collection with ability to present 'live' outcomes and if the project is to be successful there is a need to invest in nursing champions and felt that this may be challenging

given the current staffing gaps and pressures. He asked on the timelines of each for implementation. Dr O'Kane commented that Dr Gormley is currently reviewing the capacity and limitations of the IT system in this regard and IT is in the process of exploring potential options. In regards to the nurse champions, Dr O'Kane advised that Multi-disciplinary teams have undertaken training together through simulation and champions should emerge from this work.

9. INFORMATION GOVERNANCE

i. Freedom of Information, Environmental Information and Subject Access Requests: 1st April 2021 – 30th June 2021

Mrs Magwood presented the summary report for the period 1st April 2021 – 30th June 2021.

In relation to Freedom of Information (FOI) and Environmental Information Regulation (EIR) requests, a total of 93 requests were received and responded to in this period, a decrease from 117 on the previous quarter. Of these, 78 (84%) were processed within the 20 day deadline. 29% of responses were provided by the Acute Services Directorate and 62% of requests came from members of the public.

Mrs Magwood provided information on FOI trends; requests increased by 45% on the same period last year, requests decreased by 21% on the previous quarter, compliance with timescales remained the same compared to the same quarter last year and a decrease of 5% in compliance with timescales from the previous quarter.

Members noted 180 Subject Access Requests (SAR) were received during the period and of these, 135 (75%) responses were processed within the 30 day deadline. Members noted that the majority of requests were received from the public, businesses and the media. Details of the individual requests for information are included within the report. She added that the Acute Services dealt with the highest number of requests in this period - 77%.

Mrs Magwood reported that for Q2 2021 period the Trust reported 2 data breach incidents to the Information Commissioner Office (ICO) and the detail was included in members' papers. She advised that in

both cases, the ICO were satisfied with the actions taken by the Trust and have indicated no further action is required.

Mrs Donaghy noted that requests seeking Covid information are now passed to the PHA to respond. She sought clarification on FOI 454 and Mrs Magwood agreed to review and feedback at the next meeting.

Mr McDonald asked if any appeals have been submitted in response to an FOI request, particularly those that have been rejected. Mrs Magwood advised she will review and feedback at the next meeting.

Action: Mrs Magwood

ii. Good Management, Good Records (GMGR)

Mrs Magwood presented the above paper which outlines the approval (though the NI Assembly) of the new Retention and Disposal Schedule for all records created and maintained by Health and Social Care organisations. The number of differences between to the new Retention and Disposal Schedule were included within the paper.

Mrs Magwood added that whilst the new Retention and Disposal Schedule outlines minimum retention periods, many of the Trust's Service User records are currently under embargos in terms of destruction due to a number of ongoing Public and Department of Health Inquiries. She stated that this problematic for storage issues and that SMT have sought legal advice on scanning records and work is ongoing to address this.

10. MEDICINES GOVERNANCE

i. Medicines Governance Report

The Chair advised that the Director of Pharmacy was on annual leave for this meeting. The paper was noted with the request that members email through any questions they have directly to the Director.

11. LITIGATION

i. Claims Management

Mrs Toal spoke to the above named report. The report provides an overview on the summary of litigation activity, claims, trends, coroner's inquests and medico-legal requests as at 30th June 2021. Mrs Toal noted a slight decrease in the overall number of litigation claims for this quarter from 491 to 490. The costs related to litigation have reduced significantly this quarter compared to the previous quarter.

High Value claims were discussed. Mrs Toal reported that there are 26 potentially high value claims and details of those cases were included in appendix one of the report.

Medico-legal work was discussed. There were a total of 735 subject access requests opened this quarter. The largest volume of requests received this quarter (88%) relates to the Acute Services Directorate. The number of Subject Access Requests received this quarter has increased by 38 when compared to the number of requests received in the previous quarter (697).

Mrs Toal reported that as at the end of June 2021, the team were dealing with an active caseload of Subject Access Requests totalling 817 which is a slight increase from 813 in the previous quarter. During this quarter, the team have continued to face a number of difficulties with staffing levels that impact on the capacity to deal with requests and as at the end of June 2021, the backlog which was in excess of 90 days equalled 247 requests. Mrs Toal drew members' attention to the updated information in the report and as at 22nd August; the overall active caseload has been reduced to 674 and the back-log (i.e. over 90 days) currently stands at 227. The Medico Legal Team is actively working with each of the Directorates to address this backlog as a matter of urgency given that the Trust is not complying with statutory requirements and an updated position is forwarded to the Director of Human Resources on a fortnightly basis. Mrs Toal informed members that dedicated support for the Medico-legal team has been put in place temporarily at Assistant Manager level to focus on assisting the team to address the back-log. With effect from 23rd August 2021, all funded vacancies within Medico-legal have been filled.

Mr Wilkinson enquired if there are penalties to the Trust for not meeting the statutory 90 day target. Mrs Toal explained that monetary penalty can be given to the Trust by the Information Commissioner's Office and also a reputational risk to the Trust. Mrs Magwood stated that this is a financial risk which has been raised with the local commissioning group and Mrs Toal added that this is an area that is largely unfunded. The Chief Executive commented that this issue has been raised with the DoH previously and felt it would be important to highlight to the Permanent Secretary the risk to the Trust in relation to the lack of resources and meeting the 90 day target for Subject Access Requests. The Chair and Chief Executive agreed to take this forward.

Action: Chair / Chief Executive

In concluding the report, Mrs Toal advised that in relation to Coroner activity there has been three Inquest Hearings taking place during this quarter and the detail of each was included within the report.

Judicial Review applications were highlighted and it was noted that as at July 2021, one Judicial Review case remains open and the detail was included within the report.

12. HYPONATRAEMIA UPDATE

Dr O'Kane presented the Hyponatraemia update which provides an overview of the work that has been undertaken in relation to the 96 recommendations arising from the Report into Hyponatraemia Related Deaths and summarises their current status. The report also provides details of the percentage of Nursing and Medical staff trained in Hyponatraemia BMJ e-learning and the percentage of Nursing staff that availed of CEC and PHA Hyponatraemia training and provides an update on the audit findings on Fluid Management in Children.

Dr O'Kane advised that the Trust Oversight Group met on 4th August 2021 where a review of progress against objectives and information on the outstanding and completed recommendations. She provided assurance that all 96 recommendations were discussed which amounted to 105 individual recommendations as 1 of the recommendations has 9 parts. An analysis of the recommendations

was included within the report. Dr O'Kane drew members' attention to the information on medical and nursing training figures and the 9 point Paediatric IV Fluid Audit Improvement Tool (PIVFAIT) audit results. Ms Donaghy spoke of the report into Hyponatraemia Related Deaths and asked for assurance that those children who are admitted to an adult ward that robust checks and monitoring is adhered to. Mr Carroll explained that those young people admitted to an adult ward are mainly surgical patients who require IV Fluids in theatre and assured these patients are robustly monitored before and after their surgery. Mrs McConville advised that the age threshold to be admitted to a paediatric ward since the report was published has been increased to children up to their 16th birthday. She commented that patients are under the care of a Paediatrician and they liaise closely with surgical clinicians for those children requiring surgery. Mrs McConville added that work continues to monitor and review this cohort of patients to ensure the safe management of IVFs.

13. ANNUAL REPORTS

i. Organ Donation Annual Report 2020/21

Mr Carroll presented for assurance the Organ Donation Annual Report for 2020/21. The full and summary reports were included in members' papers.

Mr Carroll provided background to the report and stated that the NHS's goal is that every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service. He reported that there were 10 consented donors and the Trust facilitated 9 actual solid organ donors resulting in 20 patients receiving a life-saving or life-changing transplant. In addition to the 9 proceeding donors there was one consented donor that did not proceed. He provided assurance that a Specialist Nurse for Organ Donation (SNOD) was present for discussions with families during 2020/21. There were no occasions where a SNOD was not present.

The Chair welcomed the report and thanked all the staff involved for their hard work and dedication to promote this service, while noting the sensitivity and difficult time for the families.

Responding to a question asked by the Chair, Mr Carroll advised that during the 1st wave of the pandemic the organ donation unit remained opened and protected. Dr O'Kane spoke of the good news story that the unit in Belfast carried out a record number of kidney transplants during 2020/21 which members noted was a significant achievement.

14. PROPOSED MEETING DATES 2022

Members approved the meeting dates for 2022.

15. ANY OTHER BUSINESS

None noted.

The meeting concluded at 11.40 p.m.

Signed _____ *Dated*_____

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

Minutes of a virtual meeting of the Governance Committee held on Tuesday 16th November 2021, at 2.40 p.m.

PRESENT:

Ms E Mullan, Trust Board Chair *(Chair of meeting)*
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
Dr T Boyce, Director of Pharmacy
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Director of Acute Services
Mr C McCafferty, Interim Director of Children and Young People's Services / Executive Director of Social Work
Dr M O'Kane, Medical Director / Interim Director of Mental Health and Learning Disability
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, Midwifery and Allied Health Professions
Mrs C Doyle, Acting Assistant Director of Clinical and Social Care Governance
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES

None noted.

1. WELCOME AND APOLOGIES

The Chair welcomed those present. She welcomed Mr McCafferty to his first Governance Committee meeting and congratulated him on

the recent appointment as the Interim Director of Children and Young People's Services / Executive Director of Social Work.

At this point, she advised members regarding some aspects of virtual meeting etiquette.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S REMARKS

None noted.

4. MINUTES OF MEETING HELD ON 9TH SEPTEMBER 2021

The Minutes of the meeting held on 9th September 2021 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates from the relevant Directors.

In relation to the increase in incidents for violence and aggression towards staff, the Chair advised that an open letter has been raised with the Minister of Health from the Chair's Forum on the importance of zero tolerance towards staff and to thank staff for their continued commitment. She noted that the Minister has agreed to take this forward.

In relation to the Internal Audit report on Adult Safeguarding, the Chair requested that specific timeframes be added to the action plan and asked that the updated progress report be provided for the next meeting.

Action: Mr McCafferty

6. HYPONATRAEMIA UPDATE

Mrs Trouton presented the Hyponatraemia update which provides an overview of the work that has been undertaken in relation to the 96 recommendations arising from the Report into Hyponatraemia Related Deaths and summarises their current status. The report also provides details of the percentage of Nursing and Medical staff trained in Hyponatraemia BMJ e-learning and the percentage of Nursing staff that availed of CEC and PHA Hyponatraemia training and provides an update on the audit findings on Fluid Management in Children.

Mrs Trouton advised that the Trust Oversight Group met on 1st September 2021 where a review of progress against objectives was undertaken. She informed members that in order to provide assurance regarding the current position, a planned audit was undertaken week beginning 13th September 2021. This audit covered clinical recommendations only across a number of areas within CAH and DHH

Mrs Trouton explained that during the pandemic a number of wards were changed to accommodate covid wards and it was established that a number of Gynae patients were admitted to other wards. As 4 North has potential for an under 16 to be admitted with Gynae concerns a baseline audit of 4 North is planned to take place within the next few weeks.

In relation to the 84 recommendations which are specific to Trusts, Mrs Trouton referred members to the attached spreadsheet which demonstrates the RAG rating for each. She confirmed that 6% out of the 84 recommendations have a red RAG rating and work continues to sign these off.

Training figures were discussed. Mrs Trouton noted her concern that in certain areas/wards nurse training figures remain in red. She added that work is progressing to improve this through face to face, e-learning and case studies. Medical training is low; however she explained that the figures related to all medical staff throughout the Trust. She advised that the next report will only include medical staff that work directly with Children to provide a better overview.

Mrs Trouton spoke of regional work streams and reminded members that of the 9 regional work streams, 8 were paused from March 2020 with Duty of Candour continuing. The Department of Health have indicated that they are planning to resume at least an additional three work streams by September 2021, however this has not been achieved to date.

Mrs McCartan appreciated the ongoing work within the Trust to address the recommendations and recorded her disappointment that 8 of the 9 regional workstreams have been paused. She sought clarification in relation to recommendation 10 which noted that policies have been developed and awaiting final confirmation from SMT on one out of the three. Mrs Trouton advised that one policy is awaiting approval from the Trust's Scrutiny Committee; however she will seek out the reasoning for delay and feedback at the next meeting.

Action: Mrs Trouton

In response to a question asked by Mrs McCartan, Mrs Trouton advised that the transfer form which accompanies patients during transfer from one hospital to another is currently being modified for regional use. Mrs McCartan suggested it would be beneficial from time to time to undertake a 'deep dive' into some of the recommendations at Governance Committee.

7. MEDICINES GOVERNANCE

i. Medicines Governance Report

Dr Boyce presented the Medicines Governance report which demonstrates that during the second quarter of 2021/22, there were 278 medication incidents reported within the Southern Trust. The average number of reported medication incidents each month was 93, a decrease from the previous quarter of 117 per month.

Dr Boyce noted there were no trends of specific concerns amongst the incident reports received. She advised of 1 catastrophic incident and 5 moderate incidents reported via Datix and background to the incidents was outlined within the report.

The top 5 medicines involved in medication incidents were discussed. Dr Boyce advised that 'Anticoagulants' was the number one incident type with insulin the second highest incident type.

In regards to benchmarking data for medication incidents, Dr Boyce reported the Trust 'no harm' incidence had increased to 75.5% which is above average for the Human Factors in Healthcare which recommends minimum standard of 70% of reported incidents should result in no harm to the patient as an indicator of a positive reporting culture.

The MedSafe newsletter issue 26 was included in members' papers which focused on the timing of pre-mixed insulin. The Drugs and Therapeutic Committee met on 26th August and the next meeting is due on 9th December 2021.

An update on EU Exit plans for the supply of medicines was included in the report. Dr Boyce reminded members of the background to the situation and reported that as at 31st October 2021 there have been no major issues in relation to medicines supply to Northern Ireland Trusts. There have been a few minor supply problems, mainly as a result of the supplier not understanding the derogation in place. These have been quickly resolved with the help of the Department of Health's EU Exit team. Dr Boyce informed members that the transition period for medicines has been extended to allow for further discussion and negotiation about medicines supply to Northern Ireland under the Protocol. The Board has asked each Trust to release a band 7 pharmacist for the period 1st December 2021 to 31st March 2022, to work alongside its EU Exit team and the MHRA. This group of pharmacists will work on the risk assessment of every product that may be a risk in the future, identifying and developing alternative options for each item. An IPT has been completed and retuned to HSCB for this post and are awaiting the commissioning letter to allow an Expression of Interest process to commence.

In concluding, Dr Boyce advised that the EU Exit medicines supply risk has been added to the Trust Corporate Risk Register.

8. INFORMATION GOVERNANCE

i. Freedom of Information, Environmental Information and Subject Access Requests:

Mrs Magwood presented the summary report for the period 1st July 2021 – 30th September 2021.

In relation to Freedom of Information (FOI) and Environmental Information Regulation (EIR) requests, a total of 124 requests were received and responded to in this period, an increase from 93 on the previous quarter. Of these, 86 (69%) were processed within the 20 day deadline. 40% of responses were provided by the Acute Services Directorate and 60% of requests came from members of the public.

Members noted 197 Subject Access Requests (SAR) were received during the period and of these, 171 (87%) responses were processed within the 30 day deadline. Members noted that the majority of requests were received from the public, businesses and the media. Details of the individual requests for information are included within the report. She added that the Acute Services dealt with the highest number of requests in this period - 75%.

Mrs Magwood reported that for Q3 2021 period the Trust reported 2 data breach incidents to the Information Commissioner Office (ICO) and the detail was included in members' papers. She advised that in one case, the ICO were satisfied with the actions taken by the Trust and the other case a response is awaited from the ICO.

The Chair asked for further clarity and information on FOI/00000621 'Charity funding issued by the Southern Trust 2020 & 2021'. Mrs Magwood agreed to take this forward and feedback at the next meeting.

Action: Mrs Magwood

ii. Information Governance Framework: Personal Identifiable Data (PID) and Personal Sensitive Data (PSD) Audit Report

Mrs Magwood reported on the findings as detailed in the report and highlighted the Information Governance (IG) mandatory training rates

are currently at 86% which is an increase from 72% in quarter 2. She noted a reduction in Directorate Performance in securing IG Framework Audits, Risk Assessments with the completion rate down from 100% to 95% and down from 100% to 94% for the updated Information Asset Registers.

Mrs Magwood suggested that this report will be incorporated into the Information Governance Annual Report which is presented to Governance Committee in May each year.

9. LITIGATION

i. Claims Management

Mrs Toal spoke to the above named report. The report provides an overview on the summary of litigation activity, claims, trends, coroner's inquests and medico-legal requests as at 30th September 2021. Mrs Toal noted a slight increase in the overall number of litigation claims for this quarter from 490 to 497. The costs related to litigation have reduced significantly this quarter compared to the previous quarter.

High Value claims were discussed. Mrs Toal reported that there are 24 high value claims and details of those cases were included in appendix one of the report.

Medico-legal work was discussed. There were a total of 671 subject access requests opened this quarter. The largest volume of requests received this quarter (90%) relates to the Acute Services Directorate. The number of Subject Access Requests received this quarter has decreased by 64 when compared to the number of requests received in the previous quarter (735).

Mrs Toal reported that as at the end of September 2021, the team were dealing with an active caseload of Subject Access Requests totalling 659 which is a decrease from 817 in the previous quarter. Following the reduction in staffing since September 2021, Mrs Toal noted the difficulty in obtaining staff cover within the team. This is reflected in the figures whereby the backlog of cases in excess of 90 days as at 31st October 2021 equals 24 which is a concern for the

Trust. However, during the period when there was full staffing, the team completed more requests than were received during this quarter (by 118). Mrs Toal advised that with effect from 1st November 2021, part time additional photocopying resources have been provided to the team through an external contractor and the impact of which will be kept under review.

In concluding the report, Mrs Toal advised that in relation to Coroner activity, there has been three Inquest Hearings taking place during this quarter and the detail of each was included within the report.

Judicial Review applications were highlighted. Mrs Toal drew members' attention to the updates on the reviews provided by DLS and detail of each was included within the report.

Mrs Toal referred to the pending claim on page 4 within the Chief Executive's Office and clarified that all 5 Chief Executive's across the region received the same correspondence and that this was in relation to the vaccination programme.

Mrs McClements drew members' attention to the claim on page 7 and provided assurance that the Rapid Chest Clinic is well managed and within expectation. Mrs Toal added that a Locum Oversight Group is in place; learning has been identified and implemented. Mrs Magwood commented that the performance of rapid chest access clinic is fed into performance reporting.

In responding to a request by Ms Donaghy, Mrs Toal agreed to include a summary of the most recent claims in the next report.

Action: Mrs Toal

10. RAISING CONCERNS

i. Raising Concerns Report

Mrs Toal spoke to the above named report. She advised the report focuses on 3 areas: case themes and trends (April 2021 to September 2021) lessons learned from cases and case review on the Microbiology Service / Court LAC. Also included was a sample template Job Description from NHS England for a National Freedom

to Speak Up Guardian. This is a model which the Trust would like to introduce.

Mrs Toal advised that the mid-year update indicates that the number of concerns raised so far is consistent with the previous two years. Mrs Toal reported that 10 cases have been reported to date; 8 were reported anonymously, 1 confidential and 1 open. Current trends indicate that the number of concerns raised relating to the Covid-19 pandemic are decreasing with 2 out of the 10 concerns relating to this and the detail of both cases were included within the report. Mrs Toal noted that out of the 10 concerns raised so far this year, 5 have concluded and 5 are ongoing. Mr Wilkinson reminded members that he is the Non-Executive Director lead for Raising Concerns and he has reviewed each case with the team. He felt that the 10 concerns raised were below the number expected to date.

Mrs Toal spoke of the new Whistleblowing staff newsletter. The newsletter is a tool for reminding managers and staff about the importance of raising concerns and to share some of the lessons from cases over the past number of years. The Chair welcomed this and asked that the newsletter be circulated to members and include this in future reporting. Mrs Toal agreed to take this forward.

Action: Mrs Toal

An update on the review case within Microbiology was included in the report. Mrs Toal spoke of the disciplinary proceedings for those affected staff and the outcomes of the hearings. She provided assurances that work is ongoing with Payroll Shared Services to begin the recoupment of overpayment of salary.

In relation to the LAC whistleblowing case, Mr McCafferty drew members' attention to the update on the outcome of the case, however he felt that process from the professional body to undertake the investigation was extensively long and noted the impact this has on staff.

Mrs Toal drew members' attention to the job description from NHS England for a National Freedom to Speak Up Guardian role that was included in their papers. She explained that this is a role that the Trust would like to introduce and she provided background and the

purpose of the role. She felt that having these roles in place across the Trust would provide a better opportunity for staff to raise their concerns at an earlier stage. Mr Wilkinson agreed and commented that this role will encourage staff to come forward and speak up in a less formal way. Mr McDonald added that the People Plan has an important role to play in highlighting to staff the significance of Raising Concerns and to show staff that management do take their concerns seriously. Ms Donaghy noted her concern that this role may be misused by staff to highlight low level issues and not use the role for the purpose for which it was intended. She felt that the title of the role should be amended to include the word 'advocate' and reminded members of the importance of having an open and honest organisation culture from senior management down. The Chief Executive spoke of the Francis Report and the importance of staff being able to speak up and to highlight issues while being supported to do so. He added that there are over 530 Guardians in the NHS and he welcomed this role. The Chair stated that this was a step forward in the right direction and would support the introduction of this new role.

In concluding, the Chair felt it would be beneficial for a deep dive into one raising concern case to provide members with a complete overview on the process. Mrs Toal agreed to present this at a future meeting.

Action: Mrs Toal

11. RISK MANAGEMENT

i. Corporate Risk Register

The Chief Executive presented the Corporate Risk Register (CRR). Since the last Governance Committee meeting in September 2021, the Corporate Risk Register was reviewed and updated by SMT most recently on 9th November 2021. SMT agreed the addition of 4 risks namely: Risk No.1.5 'Risk to the management of the Trust's statutory responsibilities under the Mental Health (NI) Order 1986 due to insufficient numbers of Approved Social Workers to provide a robust rota covering emergency assessments for detention; Risk No. 2.4 i) 'Risk to the supply of clean linen due to the age and condition of existing equipment' and ii) Risk to the Trust due to overdue servicing

of medical equipment as highlighted in Internal Audit of Management of Medical Equipment 21/22 and Risk 3.6 'Risk to the provision of food for patients and staff due to Supplier difficulties sourcing and supplying some food produce'. The Chief Executive added that a 'deep dive' into the Technology Enablement risk was undertaken by SMT on 26th October 2021. He further added that the Urology Lookback into the volume of potential patients that may be impacted from the Inquiry and the Trust being in a position to review them will be added to the Corporate Risk Register, which members welcomed.

Action: Chief Executive

The Chair welcomed Mr Mark Bloomer, Assistant Director of Estates to the meeting. Ms Teggart presented a deep dive into Estates and Infrastructure. She provided members with 3 documents at month 7 position; an update on Capital Reporting, general capital and ring fenced capital. The general and ring fenced appendices provided a summary of all the projects to date and their costings. She advised that there has been £21m of schemes undertaken this year. Ms Teggart provided assurance that she liaises with the Estates team on a weekly basis. Mr Bloomer spoke of the ongoing restructuring of the Estates Team over the last number of years, recruitment of vacant posts along with a further drive for efficiencies and higher productivity and the capacity to deliver the Estates team has been increased. He added that the Trust is utilising the established NHS frameworks which have allowed Estates to operate more efficiently, quicker and apply more resources to react to the demands and needs of the trust in delivering capital schemes.

Mrs Leeson enquired if the materials for construction are more expensive to which Mr Bloomer responded that costs has increased across the region, however additional funding will be available from the October monetary round which will cover this additional cost.

In response to a question asked by Mrs McCartan, Mr Bloomer explained it is planned that all capital allocation will be spent by the year end and no allocation will be returned.

In relation to the backlog of maintenance, Mr Bloomer advised that funding was allocated in April 2021 to address this. Those backlogs

have been scoped out, quotations received and work is progressing to clear these.

Mrs McCartan enquired if the project allocation can be received earlier in the year than September as she felt that the Trust was at a disadvantage starting works mid-year. Mrs Magwood explained that the Trust has not received the reinvestment and redevelopment capital funding and therefore additional funding has been received to address minor works throughout the year to ensure that the estate is maintained and improved in the meantime. Mrs Magwood spoke of the steps required to start works on site which includes obtaining approval from the Department for design fees before funding is released and noted the challenges of this. She spoke of the impending 3 year settlement programme which will provide more effective planning for the future. Ms Teggart agreed that realistically the funding would be needed a year in advance.

In response to a question asked by Ms Donaghy, Mr Bloomer explained that the GP works in Dungannon are to facilitate a small project to provide additional space. Mrs Magwood reminded members that the Trust is not responsible for GP services, however the Trust will facilitate the Department of Health and GP's to undertake estates works.

Members approved the Corporate Risk Register.

Mr Bloomer left the meeting at this point

12. CLINICAL AND SOCIAL CARE GOVERNANCE

i. Clinical and Social Care Governance Report

Due to time constraints, the Chair took the report as read and members asked a number of questions.

Mr Wilkinson noted the number of Hospital acquired covid SAIs and asked how the Trust is managing these cases. Dr O'Kane noted the challenges in containing covid on wards. She advised that there is regular communication with the HSCB and DoH with a joint meeting with the PHA on a daily basis. Dr O'Kane spoke of the mitigations in place to help reduce the spread of covid; PPE, staff testing and advice to patients. She noted that there is no concern with infection

from staff to patients, however she felt there was an issue was long waiting times in Emergency Department with reduced capacity for social distancing. Following discussions with the PHA, it was suggested that the Trust encourage increased testing through PCR and LFT tests. Dr O'Kane commented that the IPC and Estates team are doing all that they can to ensure a safe environment is provided for both staff and patients.

The Chair asked for an update on the SAI process following the introduction of a pool of SAI chairs. Dr O'Kane advised that the number of chairs has increased and reported an increase in incident reporting, however she noted that the pressures of covid and staff shortages have affected the ability to undertake Sai reviews. She added that Structured Judgement Reviews (SJR) are being reviewed in parallel with SAIs to establish if a SJR would be more effective. The outcome of this report from RQIA is awaited.

The Chair referred to SAI [Irrelevant redacted by the USI] in relation to medication stock issues and asked for further information and assurances. Dr O'Kane provided background to the case and Mr Beattie explained that the GP Federation is responsible for medications at Covid centres. Dr Boyce added that locked cabinets and alarms were provided by the Trust. An independent chair has been agreed to take the SAI forward.

ii. Management of Trust Standards and Guidelines

Dr O'Kane presented the report on the Management of Trust Standards and Guidelines (S&G) which sets out the Trusts' position on implementation and compliance to Standards and Guidelines up to the 30th September 2021.

The report detailed that from 1st July 2021 to 30th September 2021, a total number of 110 circulars have been received by the Trust (2 of which were not applicable to the Trust and 3 circulars have been superseded). A further review of these 105 Trust wide applicable circulars identifies that 30 of them were Covid 19 related and 3 were related to the regional supply disruption alerts, a breakdown of these were included in Appendix 1a of the report. The remaining 72 circulars are within the agreed scope of the Trust's Standards and Guidelines processes and have been managed accordingly.

Dr O'Kane informed members that a permanent manager for Standards and Guidelines has now been recruited. Since this post has been made permanent, a number of key actions have been progressed. She advised that a new Standards and Guidelines SharePoint site has been established which will ensure information is held in in one place, is accessible by all of the governance teams and ensures consistency in approach. Furthermore, the Trust was exploring the option of using the Datix Safety Alerts system and following further discussions / system demonstrations with the *Datix* team it has been agreed that the functionality of this system will deliver the key needs of the service. It is envisaged that by the end of December 2021 the changes and initial pilot of the system will be achieved.

iii. Mortality Report

Dr O'Kane presented the Mortality Report which provides assurance on the safety of hospital care and assurance on Trust processes to measure and monitor hospital mortality. She explained that there are 4 different sources and timeframes within the report: CHKS: January 2020 – December 2020, Intensive Care Unit 1st April 2020 – 31st March 2021 and SHMI and VLADs January 2020 – December 2020, Data Quality Assurance: January 2020 – December 2020. For the reporting period of January 2020 – December 2020, there were 1,091 deaths within the Southern Trust.

Dr O'Kane reminded members that risk adjusted measures such as RAMI are not designed for pandemic activity such as that observed during 2020. It is anticipated that at least 12 months full year activity will be required for sufficient data to be available to begin considering the development of risk adjusted mortality relating to Covid-19. As a result, the present RAMI measure cannot accurately calculate an expected deaths figure for records with Covid-19 coding using the present methodology.

The overall RAMI index score for the Trust over the period January 2018 to December 2020 is 84.52. For the 12 month reporting period January 2020 to December 2020 the overall RAMI index score is 81.12, meaning there were 18.88% less deaths than were expected based on the casemix.

The Trust crude mortality rate showed a marked increase but generated no alerts (1.43% compared to 1.01% for the 2019 period). Whilst this is a marked increase, the Trust is in line with the UK peer and Regional Peer. There was a significant increase in mortality for April 2020 before reducing in May and returning to within control limits for June 2020. The Mortality rate also increased again in November/December 2020 above control limits

Dr O'Kane reported the overall data quality index score for the Trust for January 2020 – December 2020 period was 95. This compared favourably to the NI peer of 91.99.

Variable Life Adjusted Displays [VLADs] was discussed and of the 15 available one higher and one lower limit control breach, the lower limit breach was relating to a patient with secondary malignancy.

Members discussed the amount of information, statistics and the length of the Mortality report. The Chief Executive stated that the cover sheet provided high level information for members to concentrate on.

iv. RQIA Review of the Implementation of NICE CG 174 – IV Fluid Therapy in Adults in Hospitals in NI

Dr O'Kane presented the above named item and advised that the Department of Health requested RQIA to review the implementation of Clinical Guideline 174, to include a focus on the governance and oversight arrangements and ongoing assurance mechanisms in place across the Health and Social Care system.

She highlighted the challenge of the implementation of the 3 regional task and finish groups established with SHSCT as they were all established at the same time given their co-dependent relationship. However until the regional fluid balance chart is finalised, the audit tool cannot be fully tested and the training model / curriculum cannot be agreed. It is likely the timescales will extend for at least 18 - 24 months, with the need for ongoing monitoring a key requirement.

Ms Donaghy stated that the current guidelines are dated 2013 and sought assurance that these have been implemented. Dr O'Kane

advised that they have been implemented across relevant areas and work continues on a rolling basis to ensure staff are trained and refreshed on the guidelines. Mrs Doyle reminded members that all guidelines received into the Trust are disseminated, action plans developed and assurances fed back to HSCB.

v. National Audit Assurance Report

Dr O'Kane spoke to the above named annual report. It provides assurance on the Trust's participation in the NHS England Quality Accounts List, an updated SHSCT position on the progression of recommendations arising from participation in national audits, including those from previous years, a composite SHSCT clinical audit work programme 2020/21, together with the rationale for non-participation in some NHS England Quality Accounts List national audits and an updated position on the Trust's Clinical Audit Strategy.

The Chair welcomed the internal and external assurance that the report provides. The Chief Executive stated that the rigor with clinical audit will generate learning which Dr O'Kane agreed that this is the way forward to establishing significant learning which will be disseminated across relevant areas across the Trust. Mrs McCartan enquired on the reporting of action plans for each audit undertaken. The Chief Executive advised that updates on action plans are discussed at relevant clinical governance forums.

13. LEARNING FROM EXPERIENCE FORUM

i. Update Report

Dr O'Kane presented the updated report on the Learning from Experience forum. Since the last update to the committee in May 2021, the forum has met on two occasions.

Dr O'Kane guided members through the report which provided information on the challenges and pathways of sharing learning from experience. She advised that Learning from Experience is being developed in conjunction with Standards and Guidelines and Clinical Audit which will provide triangulated learning.

14. FEEDBACK FROM AUDIT COMMITTEE 14TH OCTOBER 2021

i. Internal Audit Report - Management of Medical Equipment 2021/22

Mrs McCartan as the Chair of the Audit Committee advised members that the above Internal Audit Report which received a limited assurance was presented and discussed at the Audit Committee on 14th October 2021. It was recommended that the report be shared with Governance Committee for further assurance.

Mrs McCartan explained that a limited assurance was provided on the basis that medical devices governance and reporting structures needed strengthened. There is a backlog of servicing and maintenance of medical devices and a number of devices recorded on Backtraq system could not be located at their ward/department.

Ms Teggart informed members that the Medical Device Equipment Group will take forward and monitor the recommendations. She advised that the Terms of Reference of this group will be updated to reflect how Trust Board will receive appropriate assurance in relation to the management of medical devices. Coding on the location of medical devices on the Backtraq system is underway.

In relation to Controls Assurance, the Chair asked for further clarity on the level of assurance that was submitted. Mrs McCartan explained that the RAG scoring of amber is difficult to assess how close the overall assurance is to red or green. Internal Audit has requested that only those actions that are completed can be assessed as green.

In responding to a question asked by Mrs McCartan, Ms Teggart advised that over 2000 new medical devices were purchased during Covid-19 and she provided assurance that they have all be logged onto the system with their service details.

Ms Teggart commented that Internal Audit recommendations will be monitored through the working group and through Audit Committee. The Chair requested an update on the progress of implementation of recommendations be provided for the next meeting.

Action: Ms Teggart

15. ANNUAL REPORTS

i. Health and Safety Annual Report 2020/21

Ms Teggart presented the Health and Safety Report for 2020/21 for assurance purposes. The report sets out key health and safety systems in place in order to demonstrate the Trust's approach to minimising the risk and ensuring the health and safety of its employees, service users and visitors. In relation to Controls Assurance Standards, Ms Teggart reported that the Health and Safety standard received a green RAG rating.

Ms Teggart drew members' attention to the cover template which highlights the significant pressure on services due to the pandemic, workforce resilience and flexibility during a very challenging period to process over 12,000 Face Fit testing sessions and provides Health & Safety training and development to staff. She further reported on the challenge of maintaining staffing levels with the Health and Safety Department to provide the necessary resource to ensure the fulfilment of the Trust's statutory health and safety obligations.

Mrs McCartan noted her concern on the number of physical and verbal incidents involving staff. The Chair agreed stated these incidents are unacceptable and spoke of the zero tolerance policy and the importance of implementing this.

ii. Functional Support Services Annual Report 2020/21

Mrs McClements presented the Functional Support Services (FSS) Report for 2020/21 for assurance. The purpose of the report is to give a summary of the activities within the FSS division that took place 2020/21. The report also meets the requirements of the controls assurances standards that pertain to the division.

Mrs McClements drew members' attention to the areas of improvement / achievement which includes workforce resilience and flexibility during a very challenging period and work within the catering department on allergens and dysphagia. She was pleased to report that the Craigavon Area Hospital Catering Team were finalists

in the prestigious Public Sector Catering Awards 2021 and were shortlisted in the 'Team of the Year' category for their outstanding commitment and contribution in response to the Covid-19 pandemic.

In regards to areas of concern, the aging laundry and decontamination equipment was highlighted. Mrs McClements reported that some investment has already been received and procurement is underway with all items listed for capital investment and papers are prepared to demonstrate this need. It was also noted that suppliers are having difficulties sourcing and supplying food as a result of supplier contracts in relation to EU Exit.

Mrs McCartan commented that the Trust is dependent on this division and thanked all the staff for their hard work and dedication.

The Chief Executive advised that a detailed presentation on Functional Support Services will be presented to Trust Board in January 2022.

Action: Mrs McClements

16. NON-EXECUTIVE DIRECTOR'S VISITS TO CHILDREN'S HOMES REPORT

Mr McCafferty reported that a total of 7 Children's Home visits were undertaken virtually during the period April 2021 to September 2021. He advised that the paper provides assurance on the quality of care provided to young people in residential care. It also focuses on key issues raised as a result of the Non-Executive Directors' visits and actions taken / proposed to address the issues.

The Chair raised the issue of fire incidents at Bocombra and the importance of maintaining a safe environment for the Young People and staff.

Mrs Leeson welcomed the commitment from all staff across the facilities that provide compassionate care to the Young People.

17. SCHEDULE OF REPORTING FOR 2022

Members discussed the Schedule of Reporting for 2022. The Chair advised that the Governance Committee agendas require further review with the possibility of some reports being presented by exception. Members approved the Schedule of Reporting and this will be kept under review during the year.

18. ANY OTHER BUSINESS

The Chair noted that this was Dr Boyce's last Governance Committee meeting as she would be retiring from the Trust in the New Year. On behalf of the Committee, the Chair thanked her for her contribution to the work of the Committee over the years and wished her well in her future retirement.

The meeting concluded at 5.30 p.m.

Signed _____ *Dated*_____

Stinson, Emma M

From: Mullan, Eileen <[redacted]>
Sent: 20 May 2019 20:05
To: Brownlee, Roberta; Rooney, SiobhanNED; Donaghy, Geraldine; McDonald, Martin; Leeson, Pauline; Wilkinson, John; McCartan, Hilary
Cc: Comac, Jennifer; Wright, Elaine; Devlin, Shane
Subject: NED Meeting Tuesday 21st May
Attachments: Eileen Mullan comments for NED Meeting on the 21st May 2019.pdf

Dear all

Sorry I am not able to join you tomorrow for the NED meeting scheduled for 1:00pm. I have pulled together some comments from my perspective in line with the agenda shared on the 15th May.

I have asked Jennifer (in separate email) to print copies for you to have at the meeting as I appreciate this is a very heavy Southern Trust week and it is the night before.

Best wishes

Eileen

Southern Health and Social Care Trust

Quality Care - for you, with you

Eileen Mullan Non-Executive – comments for NED meeting 21st May 2019

1. Welcome and Apologies
   - Please accept my apologies.
   - Would appreciate update on discussions with Shane when at Trust Board on Thursday

2. Notes of Previous Meeting held on 29th November 2018
   - Fine

3. Matters Arising
   - Leadership Walks – I remain supportive of having a joint NED/ED Leadership Walk. Happy to try same and report back to colleagues. I don't see this as an either-or process, and welcome the opportunity to at the very least test and explore rather than to rule out.

4. Topics/issues from Non-Executive Directors which require discussion.

5. Non-Executive Directors' Visits – Statutory/Non-Statutory
   - 3 x Children's Home Visits
   - Leadership Walks – one completed and two scheduled

6. NED Sub-Committee Membership/Other Interested Areas/Roles and Responsibilities:

I had hoped that the Board Effectiveness Review Internal Audit report would have been available so a fully informed conversation could occur. As it is coming to a workshop in June – perhaps the discussion should be deferred until then.

If it does proceed at this meeting, then here are some thoughts in my absence.

My view is that there needs to be wider conversation on what Committees are needed for current work and for the future – this should include purpose and membership both for Non-Executive and Executive members.

Roberta you had shared with me at our meeting on the 07th March your intention to change the configuration of the Governance Committee. This decision might sit well in the wider discussions and context of the Board Effectiveness Review.

I think alternative configurations should be considered to maximise skills we have in the most effective way and enable NEDs to have sufficient time to undertake the various roles and activities requested from us.

I think committees could function with fewer NEDS eg. 2 x Non-Executives and 2 x Executive (collective responsibility) then you have members dedicated to a single committee which frees up time for other activities. Endowments and Gifts operates in a similar way currently (with 3 x Non-Execs and 2 x Executive Directors). When members are committed across 3 Committees, they have less availability to carry out the additional activities.

I have shared before that is it important that we maximise the skills we have in the most effective way. Each one of us have been appointed based on the skills we have and indeed Roberta if I recall you very clearly sought specific skills to replace those you were losing with your previous board at the time of appointing Hilary, John and I. However, this is not to say that NEDs should not be offered the opportunity to develop skills in particular areas to support succession planning.

Committees I am on:

- Governance (Chair)
- Audit
- Patient and Client Experience

Whilst Hilary and I sit on each committee – I do wonder on occasions whether the audit and governance are too closely linked. Is there a need for a degree of separation?

With Patient Client Experience Committee – I know John has spent a great deal of time to bring clarity to the purpose of the Committee. I see its worth and value – but it does not command the same level of commitment and attention as others – why is this?

Where we can, we need to ensure also that no Non-Executive is carrying too much – this is really important when you consider the range of delegated functions members are asked to undertake. I know several colleagues have been able to do more at short notice than I at times. The question for me is, whether Non-Executives are needed to attend all the current commitments – we need to consider what value/contribution do we bring?

From a personal perspective, the IHRD implementation of recommendations group that I sit on is very clinical and operationally focused. I have wondered from the start actually what value am I adding to the discussions. The number of meetings which I have been able to attend this year are few as these have often coincided with our Trust Board/Committee meetings. We do have a number of staff on that – which means the Trust is represented and informing. I am on the Trust oversight group as Chair of the Governance Committee – so am kept abreast through that.

Other roles assigned to me:

- Trust Hypo Oversight group
- Undergraduate/Postgraduate Meetings
- Independent Inquiry into Hyponatraemia-related deaths Implementation of Recommendations
- Trust Hyponatraemia Inquiry Oversight Group (Trust)
- NICON HSC Governance ECHO
- Bocombra Children's Home

All NEDS:

- HR – Maintaining High Professional Standards (MHPS)
- Excellence Awards Committee
- Recruitment Panels

The above are my views and thoughts, I am sure colleagues will have their own. I trust that we can have wider discussions in the context of the Board Effectiveness Review with Executive Colleagues and the Board Assurance Manager to ensure that future committees and their configurations best meet the needs of the Trust into the future and maximise skills and time across the full Trust Board compliment.

7. E-Learning

8. Any Other Business

Date of next Non-Executive Directors Meeting: To be confirmed

Stinson, Emma M

From: Mullan, Eileen <Personal Information redacted by the USI>
Sent: 28 October 2018 17:42
To: Brownlee, Roberta; Wilkinson, John; McDonald, Martin; McCartan, Hilary; Donaghy, Geraldine; Rooney, SiobhanNED; pauline.lesson Personal Information redacted by the USI
Cc: Comac, Jennifer; Judt, Sandra
Subject: RE: CX performance targets 17/18 and 18/19 years

Roberta

Thanks for opportunity to input to the thinking on this. I have noted my thoughts below.

1: Culture - to create and articulate the expected culture in line with vision, mission and values
2: Executive Director Performance - review and hold to account Executive Directors on Directorate performance
3: Trust Performance - substantive improvement on Trust performance
4: Trust in the Trust - improve the Trusts reputation following recent events (last three years)
5: Use what we get wisely - achieve break even, use allocation effectively to deliver services 'value for money and value are different' . We need to ensure that we spend the money in the right way that benefits are citizens.
6: SMT - strengthen and build the Executive Director Team - to be a high performance team

Thanks

Eileen

-----Original Message-----
From: Brownlee, Roberta
Sent: 25 October 2018 22:22
To: Wilkinson, John; McDonald, Martin; McCartan, Hilary; Donaghy, Geraldine; Mullan, Eileen; Rooney, SiobhanNED; pauline.lesson Personal Information redacted by the USI
Cc: Comac, Jennifer; Judt, Sandra
Subject: CX performance targets 17/18 and 18/19 years

NEDS

Further to our discussion today please like me have your thoughts on what CX targets should be by Tuesday 30/10 am.

I have planned to meet CX mid Nov to finalise and then present to Rem Committee.

When I get all your thoughts back I will ask to meet with Hilary and Martin (on behalf of all NEDS) to bring these together prior to my meeting with CX.

Jennifer was to forward CX job description to you.
One of the objectives must be on performance.

I await hearing from you all. Meantime could Hilary and Martin let me know when they would NOT be available during the weeks of the 29/10: 5/11: and 12/11 so I can arrange to meet once to discuss.

Roberta

Sent from my iPad

Stinson, Emma M

From: Devlin, Shane <[redacted]>
Sent: 01 February 2019 10:37
To: Brownlee, Roberta; Mullan, Eileen
Cc: Comac, Jennifer; Judt, Sandra; Wright, Elaine; OKane, Maria
Subject: RE: Govern mtg/papers

Hi Roberta / Eileen

This is an issue that we discussed at SMT this week when reviewing the papers. I have asked for a line by line explanation for each one that was over 10 days. This will be discussed at the Governance committee as I am not content with this area.

Thanks

Shane

From: Brownlee, Roberta
Sent: 01 February 2019 09:35
To: Mullan, Eileen; Devlin, Shane
Cc: Comac, Jennifer; Judt, Sandra; Wright, Elaine
Subject: Govern mtg/papers

Eileen/Shane

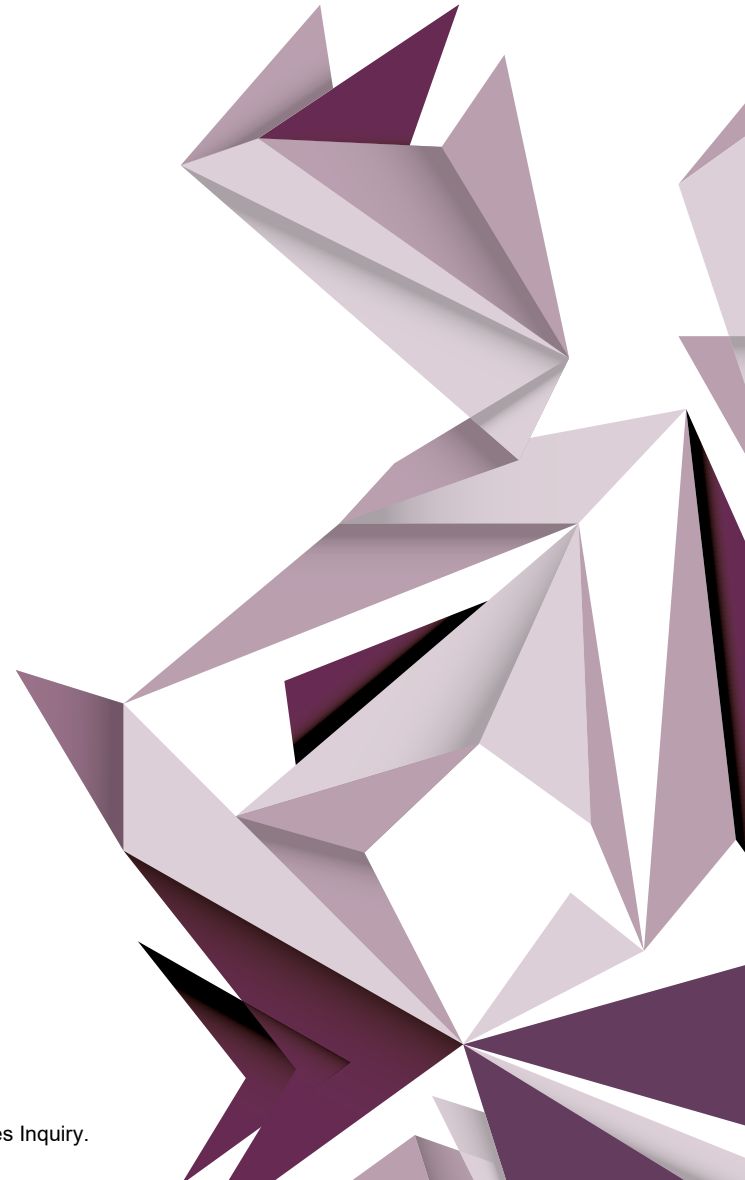
Just working through the Govern papers for meeting next week. You probably have noted, as I have mentioned before, under litigation the number listed under Maternity & Women's health. If I recall previous papers referenced this as well.
Also noting the SAIs reported between 1/1/18 and 31/12/18 that the high graph "blue" shows 10 - 60 days or more. I appreciate this area is under discussion. At a tragic maternal death, before Shane came into post, you will recall Eileen, TB especially NEDs concern the length of time for reporting same and who and how escalated to CX (in Stephen's time as CX). This created a lot of debate then. Has the reporting mechanism improved since that TB meeting?

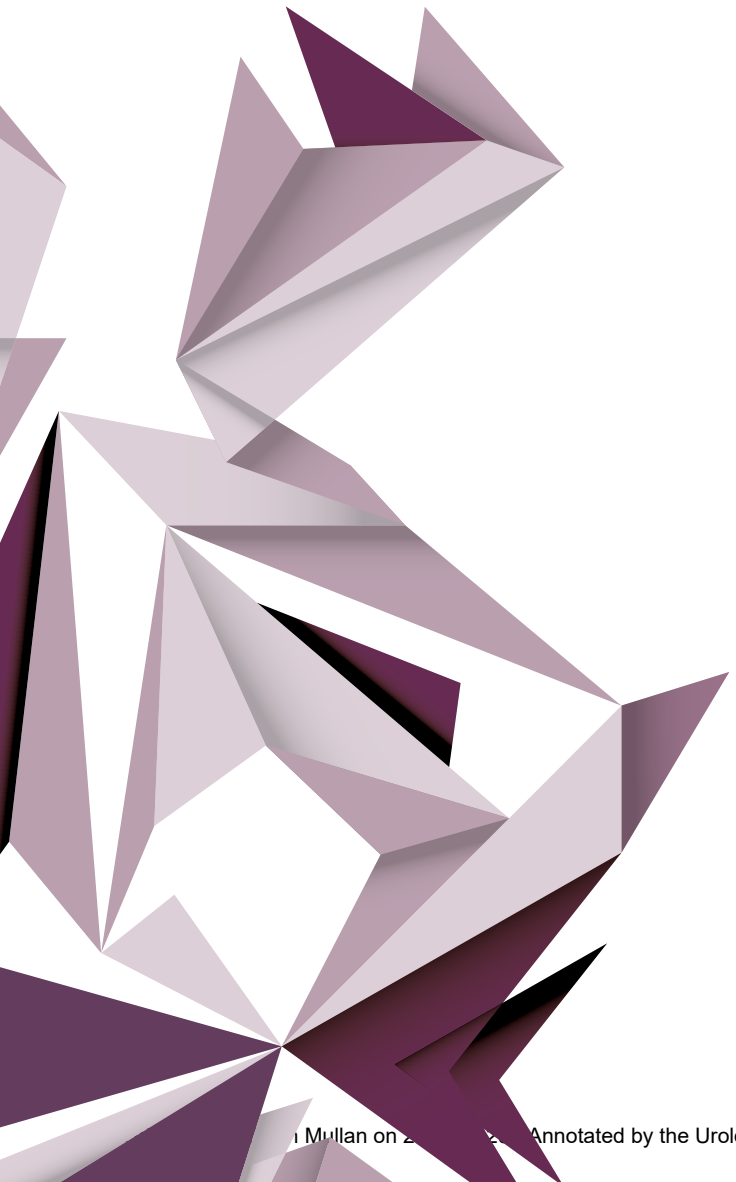
Roberta

N I A O
Northern Ireland Audit Office

Conflicts of Interest

A Good Practice Guide

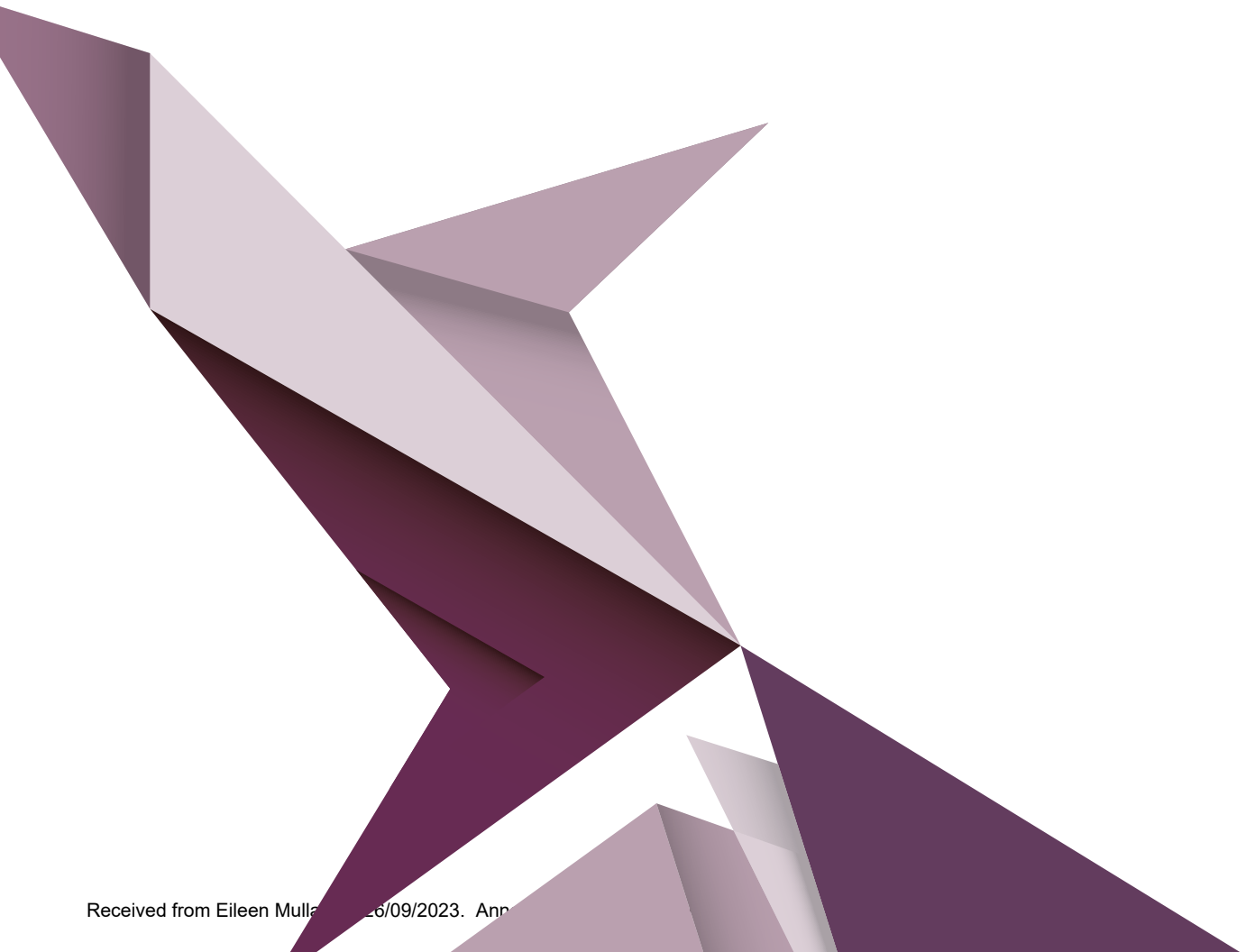




Northern Ireland Audit Office

Conflicts of Interest
A Good Practice Guide

Published March 2015



This report has been prepared under Article 8 of the Audit (Northern Ireland) Order 1987 for presentation to the Northern Ireland Assembly in accordance with Article 11 of the Act.

K J Donnelly
Comptroller and Auditor General

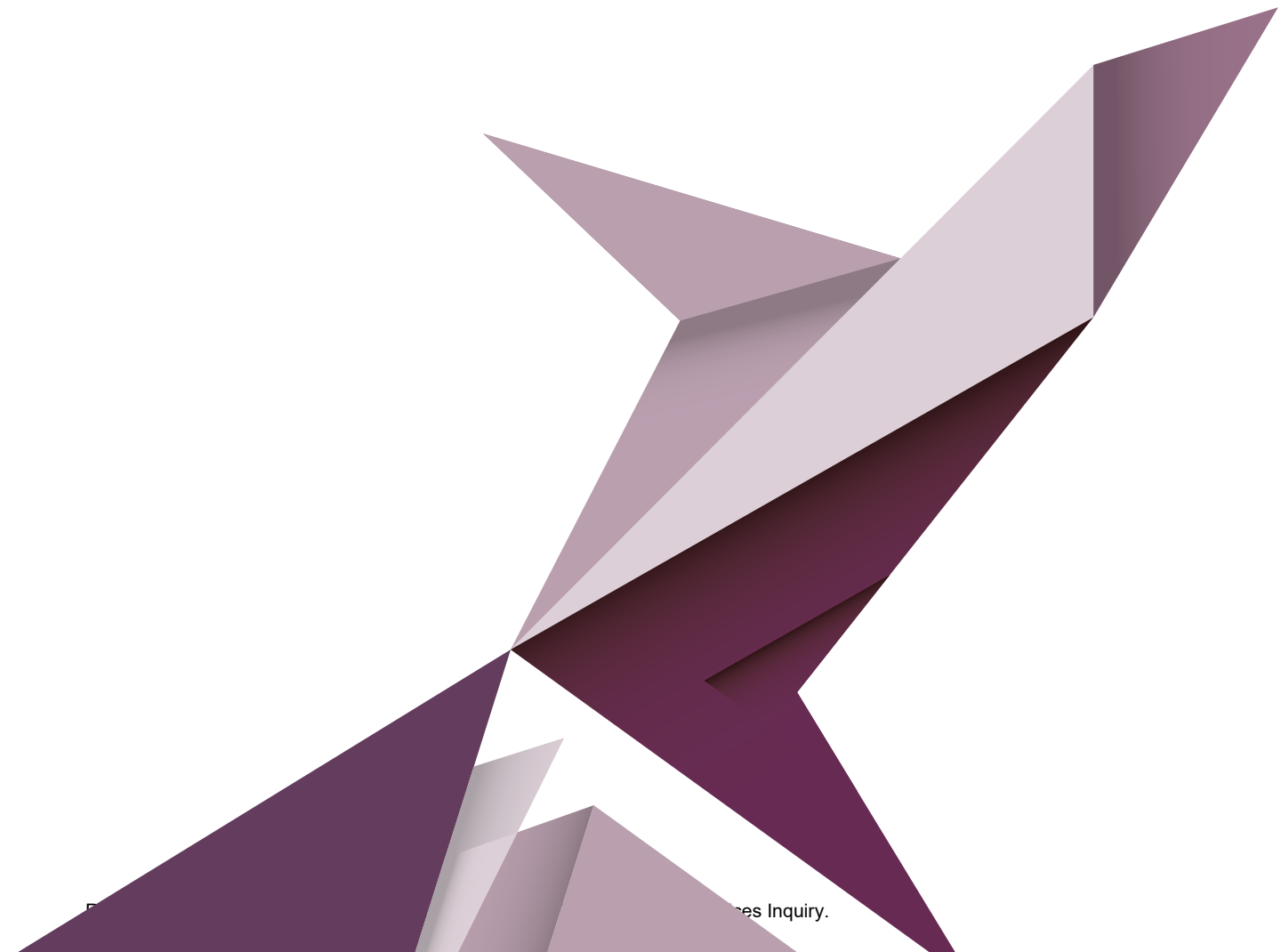
Northern Ireland Audit Office
March 2015

The Comptroller and Auditor General is the head of the Northern Ireland Audit Office employing some 145 staff. He, and the Northern Ireland Audit Office are totally independent of Government. He certifies the accounts of all Government Departments and a wide range of other public sector bodies; and he has statutory authority to report to the Assembly on the economy, efficiency and effectiveness with which departments and other bodies have used their resources.

For further information about the Northern Ireland Audit Office please contact:

Northern Ireland Audit Office
106 University Street
BELFAST
BT7 1EU

Tel: 028 9025 1100
email: info@niauditoffice.gov.uk
website: **www.niauditoffice.gov.uk**



Contents

Contents

Part One:

Introduction

Part One: Introduction

1.1 The primary responsibility of public bodies is to serve the public interest. Staff and Board members of public bodies must discharge their duties in a manner that is seen to be honest, fair and unbiased. In an age where all sectors of society are increasingly well-informed, there is growing pressure for more transparent and unbiased public decision-making. Consequently, public bodies must ensure that conflicts of interest are identified and managed in a way that safeguards the integrity of staff and Board members and maximises public confidence in the organisation's ability to deliver public services properly. Many public bodies have policies and codes of conduct for staff and Board members on recognising situations where conflicts may arise, and the action to take where this is the case.

1.2 This Guide seeks to provide clear and simple advice, which is relevant throughout the public sector in Northern Ireland, for staff drafting and implementing conflict of interest policies. It should also help Board members and staff in key positions to recognise when they have a conflict of interest and how they should act when such a situation arises. The Guide includes examples of good practice, as well as case illustrations of all types of conflicts of interests with the associated problems and possible solutions.

1.3 The main aim of the guide is to promote high standards in public life and especially to follow the key characteristics of propriety as defined in the 'Seven Principles of Public Life'[1] known as the Nolan Principles. These seven principles underpinning public life are: Selflessness; Integrity; Objectivity; Accountability; Openness; Honesty; and Leadership. A key observation in the tenth report by the Committee on Standards in Public Life states 'the Registration and Declaration of Interests by public office holders that may constitute or may be perceived to constitute a conflict of interest is one of the cornerstones of probity in public life. The resolution of such conflicts of interest brings together all the aspects of the Seven Principles of Public Life'[2].

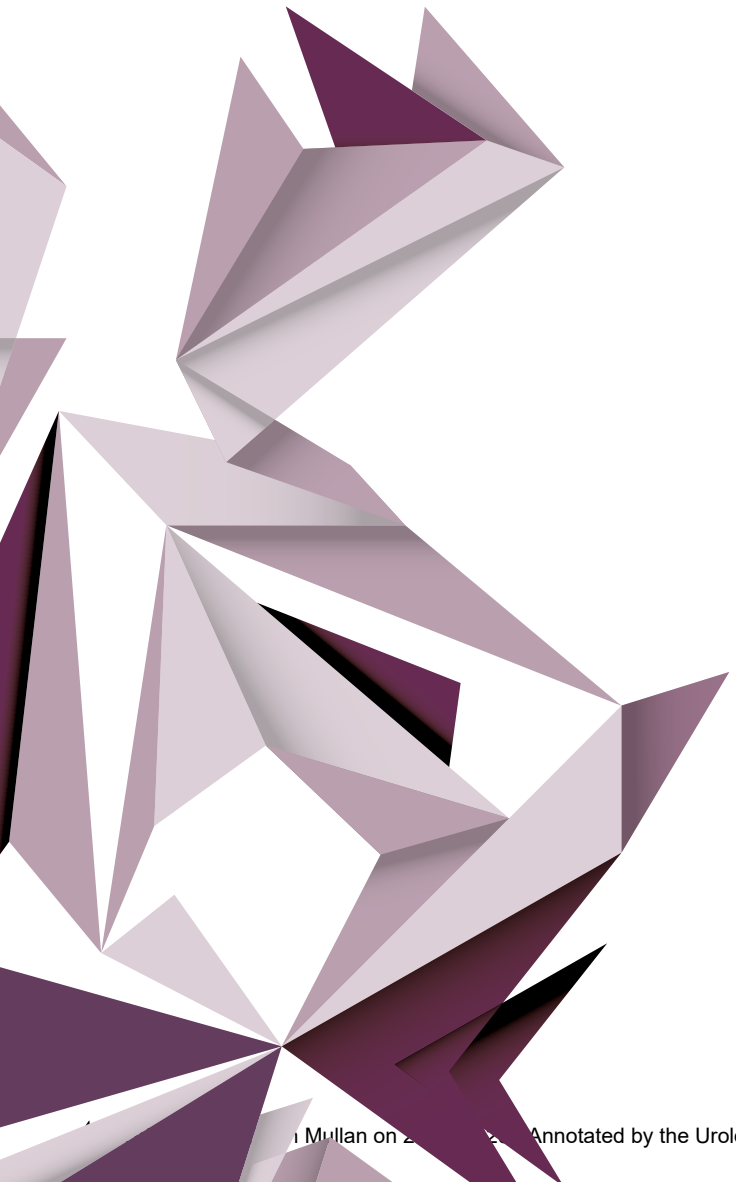
1.4 The Guide will also help to avoid any potential reputational damage to public bodies and individuals and to educate organisations on how to manage the interests of staff and Board members. This is essential as new instances of issues surrounding conflicts of interests in organisations are being identified all the time, in both the public and private sector.

1 The Nolan Principles- The 'Seven Principles of Public Life' by the Committee on Standards in Public Life, published 31 May 1995

2 Getting the Balance Right – Implementing Standards of Conduct in Public Life, the Committee on Standards in Public Life, January 2005

What this guide covers

- recognising a conflict of interest;
- types of conflicts of interest; and
- dealing with conflicts of interest.



Part Two:

Recognising a Conflict of Interest

Part Two: Recognising a Conflict of Interest

Definition of a conflict of interest

2.1 At its most basic, a conflict of interest arises when an individual has two different interests that overlap. This Guide uses a broad definition[3] that is applicable across the public sector and is relevant to public officials and Board members alike:

> ***"A conflict of interest involves a conflict between the public duty and the private interest of a public official in which the official's private-capacity interest could improperly influence the performance of his/her official duties and responsibilities."***

2.2 A conflict of interest can also be perceived.

2.3 A **perceived** conflict of interest exists where it could be perceived, or appears, that private-capacity interests could improperly influence the performance of a public official or Board member's official duties and responsibilities. It may pose no actual risk to the conduct of public business, but it requires proper management in order to minimise the risk of reputational damage both to the organisation and the individual(s) concerned.

2.4 A perception of a conflict of interest can be just as significant as an actual conflict of interest. The key issue is whether there is a risk that a fair-minded outside observer, acting reasonably, would conclude that there is a real possibility of bias.

Whose interest?

2.5 The interest in question need not be that of the public official or Board member themselves. It can also include the interests of close relatives or friends and associates who have the potential to influence the public official or Board member's behaviour.

2.6 As a benchmark a 'close relative' would usually refer to the individual's spouse or partner, children (adult and minor) , parent, brother, sister, in-laws and the personal partners of any of these . For other relatives it is dependent upon the closeness of the relationship and degree to which the decisions or activity of the public entity could directly or significantly affect them. Where an individual has to declare interests of this nature they may wish to seek advice from a senior public official or the Board Chairman to ensure all potential conflicts are identified.

2.7 A 'friend or associate' should be considered as someone with whom the individual has a longstanding and/or close relationship, socialises with regularly or has had dealings with which may create a conflict of interest.

---

3 Managing Conflict of Interest in the Public Sector – A toolkit, Organisation for Economic Co-operation and Development, September 2005

Is a conflict of interest always wrong?

2.8 In many cases a conflict of interest will be neither wrong nor unethical. The main concern is that the conflict is identified early and any risks are managed appropriately. The best way of dealing with conflicts of interest is to prevent them from arising in the first place, but if they do occur it is important to declare them and then handle them suitably and efficiently (see Part 4).

What are the risks to an organisation?

2.9 Actual, potential or perceived conflicts of interest can lead to doubt about the integrity of a public official or Board member and can impact on the reputation of the organisation itself. A conflict of interest that is concealed, even if unintentionally through ignorance of proper procedure, or managed poorly, creates at best a risk of allegations or perceptions of misconduct. It could potentially result in more serious consequences, such as disciplinary action against the employee or litigation against the organisation. A high-profile conflict of interest could ultimately result in severe reputational damage to an organisation and could result in individuals losing their jobs.

2.10 A major conflict of interest violation can also breach other rules, for example appointment procedures and procurement policies. This can have major consequences for the organisation. The Nolan Principles[4], which underpin public life, are also at risk of being breached if a conflict of interest is not identified and managed correctly.

How do I recognise a conflict of interest?

2.11 The checklist at Figure 1 can be used to help in determining if an actual, potential or perceived conflict of interest exists.

4 The Nolan Principles- The 'Seven Principles of Public Life' by the Committee on Standards in Public Life, published 31 May 1995

Part Two:
Recognising a Conflict of Interest

Figure 1: Checklist for public officials and Board members

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

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

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

Part Three:

Types of Conflicts of Interest

Part Three:
Types of Conflicts of Interest

3.1 This section includes case examples which demonstrate some of the most common types of interests that can give rise to a conflict. Some conflicts of interest are relatively easy to identify and manage, others are more difficult and complicated. In areas where conflicts of interest are more common, extra controls should be in place.

3.2 It should be noted that these are not actual examples but illustrations of the type of conflicts that may arise.

Direct financial gain or benefit to the individual, a relative or close friend

3.3 A conflict of interest can occur when an individual has the opportunity to use their position for personal financial gain.

3.4 As outlined at paragraph 2.5, the interest in question need not be that of the public official themselves. It can also be that of close relatives or friends and associates who have the potential to influence the public official or Board member's behaviour, as illustrated in the following two case examples.

Involvement in a decision that could lead to the appointment of a relative or friend

Part Three:
Types of Conflicts of Interest

Involvement in, or influencing, the award of a contract or grant where the individual is connected to an applicant

3.5 A conflict of interest can arise where a public official has private business interests and can use their public position to benefit their private business interests. The following two case examples illustrate extremely serious conflicts of interest where individuals in public office exploited their positions to advance their own private business interests.

Carrying out business on behalf of the organisation with their own or a relative's company

Owning shares in or working for another business or organisation, that has dealings with the public body

Case 5:

A newly appointed Board Chairman of an NDPB had a majority share holding in a construction firm which had been successful in the award for the construction of the organisation's new headquarter building.

What is the problem?

As this was a significant project for the NDPB, the Board had many discussions regarding the progress, monitoring and success of the construction project. The

Part Three:
Types of Conflicts of Interest

Gifts, hospitality or other benefits received

3.6 A conflict of interest can arise where public officials accept the offer of gifts, hospitality or other benefits, for example from potential contractors/suppliers, as the next case example describes.

3.7 Good practice guidance on some of the above risks is at **Appendix 1**.

Part Four:

Dealing with Conflicts of Interest

Part Four: Dealing with Conflicts of Interest

4.1 Conflicts of interest must be declared by public officials and Board members and managed effectively by public sector organisations to prevent them undermining the proper conduct of public business and adversely affecting an organisation's reputation. This section of the guide covers the policies that an organisation should have in place to manage conflicts of interest.

The need for a conflicts of interest policy

4.2 An organisation's code of conduct for staff and Board members should include a section on conflicts of interest. However, there is merit in having a separate policy which underlines the importance of managing the risk of conflicts of interest properly and provides more detailed guidance for dealing with a range of scenarios. This is particularly useful if the organisation's business exposes it to particular conflict of interest risks.

4.3 A conflicts of interest policy will serve a dual purpose. It will:

- clearly set out an organisation's commitment to the effective management of conflicts of interest; and
- provide a framework for dealing with such conflicts in a consistent and transparent manner.

4.4 However, policies cannot anticipate every situation that may arise and consequently need to retain a degree of flexibility in order to allow for the exercise of judgement in individual cases. This is particularly relevant in novel or serious circumstances where a straightforward remedy may not be applicable.

4.5 An effective policy needs to strike a balance between the public interest, i.e. protecting the integrity of public decisions, and the private interests of public officials. Conflicts of interest need to be properly identified, managed and resolved in an appropriate, transparent and timely way.

4.6 Some conflicts of interest are relatively easy to identify and manage. In such cases, a policy can set out clear rules to prevent conflicts from arising in the first place, by prohibiting public officials and Board members from:

- involvement in any decision that could lead to financial gain or benefit to the individual, a relative or close friend;

- involvement in any decision that could lead to the appointment of a relative or friend;
- involvement in, or influencing, the award of a contract or grant where the public official or Board member is connected to any of the tenderers or applicants;
- carrying out business on behalf of the organisation with their own or a relative's company;
- owning shares in, or working for, organisations that have dealings with the public body; and
- accepting gifts and hospitality in connection with their official role.

4.7 Parent departments should issue guidance on conflicts of interest to organisations for which they are responsible, to ensure consistency and transparency. However, the principles underlying effective management of conflicts of interest are generic so it is important for each organisation to tailor its policy according to its structure, function, activities and the environment in which it operates.

4.8 It is important that all public officials and Board members are aware of their responsibility for avoiding the risk of a conflict of interest or, where this is not possible, for ensuring that it is declared and managed properly. The conflicts of interest policy must be understood and applied by all public officials and Board members. Regular induction and awareness training is essential.

4.9 The public body must review its conflicts of interest policy annually. The policy should also be considered by the Audit and Risk Assurance Committee in its role of reviewing governance arrangements generally.

Policy contents

4.10 An effective conflicts of interest policy should:

- provide a definition of conflicts of interest;
- state the organisation's commitment to addressing the issue of conflicts of interest;

Part Four:
Dealing with Conflicts of Interest

4.11 Policies should clearly define who each section applies to: some sections may apply mostly or entirely to Board members; others to officials or to specific groups of staff. Where particular types of contractors or consultants are employed, it should be clear which sections of the policy also apply to them. The Department of Regional Development has two conflicts of interest policies for all staff, one that applies to all staff and one that specifically deals with the personal/private interests of those staff involved with contracts[6].

4.12 The policy should require all public officials and Board members to complete a declaration of interests form **annually**. This will allow the organisation to identify when a conflict may arise and plan how to manage it. Regularly completing the declaration reminds public officials and Board members that they must guard against conflicts that may arise as a consequence of their outside interests.

4.13 The following checklist is for organisations to help them ensure that their conflicts of interest policy and register of interests are in line with good practice.

6 Department of Regional Development Office Memorandum 2/12 & 3/12, issued 13 August 2012

Checklist for Organisations - Policy

- Is there a conflicts of interest policy in place?
- Is this policy up to date?
- Is the policy adapted to the organisation's structure, function, activities and operating environment?
- Are staff aware of the policy and do they understand it?
- Are declarations received from all employees and Board members on appointment?
- Are the declarations of all employees and Board members updated annually?
- Are all conflicts considered by management and actions to manage/ mitigate the risks recorded?
- Is an up to date Register of Interests in place for the whole organisation?
- Is the Register regularly monitored?
- Is the Register available for public inspection?
- Are staff aware of the consequences if the Conflicts of Interest policy is breached?

Part Four: Dealing with Conflicts of Interest

Register of interests

4.14 Declaration of interest forms (see paragraph 4.12) should be compiled into a 'Register of Interests'. The register enhances transparency within the organisation and is a useful tool to help individuals and managers identify conflicts at an early stage and take the necessary steps to manage them. The register should be kept up-to-date through an annual declaration of interests process. In addition, public bodies must ensure that staff and Board members understand the requirement to declare any changes to their interests as and when they arise.

4.15 A Register of Interests should record the following information for each conflict of interest:

- the individual concerned;
- the circumstances involved;
- an assessment of the situation;
- how the matter was resolved or how the risk was reduced/eliminated; and
- any action taken by the organisation.

Disclosing a conflict of interest

4.16 Public officials and Board members must be open and transparent about any overlap between their official role and private interests and must fully disclose any such conflict of interest to the organisation. This allows others with suitable expertise to determine whether an actual, potential or perceived conflict of interest exists, to assess its seriousness and to decide on any action needed to manage it.

4.17 In addition to the annual declaration of interests and notification of changes as they arise, conflicts of interest should also be declared where they arise in specific settings. For example, if during a Board meeting a matter arises which a Board member has an interest in, they should declare the interest before the matter is discussed, the declaration should be recorded in the minutes, and the Board should decide on the action, which may be withdrawal when the area of interest is considered or if it is a serious conflict it could lead to resignation from the Board.

4.18 A declaration of interests form should be completed as part of the appointment process for public officials and Board members. In the majority of NI Civil Service job application forms, a declaration of interests section is included, enabling the interview panel to review this information. This allows the conflict to be explored to determine how it might affect the

individual's ability to contribute effectively and impartially to the role and how the conflict may be handled following appointment. If the interview panel regards the conflict as so serious that impartiality and integrity could not be assured, the individual's application may be withdrawn.

4.19 In some cases, organisations seek a declaration of conflicts from Board members and public officials on appointment. The difficulty with this is that the onus for determining the conflict is then with the Board member or public official and potential conflicts of interest could be omitted.

Declaration of interest form

4.20 Just as an organisation's conflicts of interests policy should be tailored to the organisation (see paragraph 4.7), it is important for each body to tailor its declaration of interest form. The type of declaration will depend on the business of the organisation, for example, disclosure of land holdings would be required for those working in Land and Property Services and disclosure of financial or other interests in companies would be required for those working in Invest NI.

4.21 Organisations should ensure their declaration of interests form is detailed, clear and easily understood so that the register of interests is as accurate as possible. **Appendix 2** provides a good practice example of a declaration of interests form.

Managing conflicts of interest

4.22 When a conflict of interest has been identified, organisations must carefully consider what action, if any, needs to be taken to adequately avoid or mitigate the associated risks (see paragraph 2.9). The seriousness of the conflict, as well as the range of options available to handle, lessen or monitor it, must be assessed.

4.23 Policies and procedures cannot cover every type of situation which may occur and judgement needs to be exercised in individual cases (see paragraph 4.4). This is particularly important where the circumstances giving rise to the conflict of interest are novel or rare, or where the degree of seriousness needs to be taken into consideration.

4.24 While public officials or Board members are best placed to identify whether they have a conflict of interest, and are responsible for declaring it, public bodies should not rely solely on individuals. Line managers and senior personnel should always be alert for situations affecting officials or Board members that may create a conflict, particularly one that has not yet been declared.

Part Four:
Dealing with Conflicts of Interest

4.25 When an individual reports an interest, management must consider how it should be dealt with (see **Appendix 3**). Questions to be answered include:

Action taken to manage the conflict of interest

4.26 There are different options for managing conflicts of interest. The table below outlines possible management strategies and when they might best be used.[7]

7 Managing Conflicts of Interest in the Public Sector- toolkit, Independent Commission Against Corruption and Crime and Misconduct Commission (Queensland), Sydney and Brisbane, 2004 (terminology adapted for local use)

Management Strategy	When most suitable	When least suitable
Register Where details of the existence of a possible or potential conflict of interest are formally registered.	• For very low-risk and potential conflict of interest. • Where the act of transparency through recording the conflict of interest is sufficient.	• The conflict of interest is more significant or higher risk. • The potential or perceived effects of a conflict of interest on the proper performance of the public official/ Board member's duties require more proactive management.
Restrict Where restrictions are placed on the public official/Board member's involvement in the matter.	• The public official/Board member can be effectively separated from parts of the activity or process. • The conflict of interest is not likely to arise frequently.	• The conflict is likely to arise more frequently. • The public official/Board member is constantly unable to perform a number of their regular duties because of conflict of interest issues.
Recruit Where a disinterested third party is used to oversee part or all of the process that deals with the matter.	• It is not feasible or desirable for the public official/Board member to remove themselves from the decision-making process. • In small or isolated communities where the particular expertise of the public official/Board member is necessary and genuinely not easily replaced.	• The conflict is serious and ongoing, rendering ad hoc recruitment of others unworkable. • Recruitment of a third party is not appropriate for the proper handling of the matter. • A suitable third party is unable to be sourced.
Remove Where a public official/Board member chooses to be removed from the matter.	• For ongoing serious conflicts of interest where ad hoc restriction or recruitment of others is not appropriate.	• The conflict of interest and its perceived or potential effects are of low risk or low significance. • The public official/Board member is prepared to relinquish the relevant private interest rather than radically change their work responsibilities or environment.
Relinquish Where the public official/Board member relinquishes the private interest that is creating the conflict.	• The public official/Board member's commitment to public duty outweighs their attachment to their private interest.	• The public official/Board member is unable or unwilling, for various reasons, to relinquish the relevant private interest.
Resign Where the public official/Board member resigns from their position with the organisation.	• No other options are workable. • The public official/Board member cannot or will not relinquish their conflicting private interest and changes to their work responsibilities or environment are not feasible. • The public official/Board member prefers this course as a matter of personal principle.	• The conflict of interest and its potential or perceived effects are of low risk or low significance. • Other options exist that are workable for the public official/ Board member and the organisation.

Part Four:
Dealing with Conflicts of Interest

Breaching a conflicts of interest policy

4.27 A conflicts of interest policy must include details of the sanctions that will apply when a breach of the policy occurs. Sanctions should only be imposed when a full investigation has been completed which establishes that there has been a breach. The most severe sanctions should only be applied where there has been deliberate and repeated concealment or failure to disclose a conflict of interest.

4.28 When a breach occurs there are a range of consequences for both the individual concerned and their organisation:

Individual:

- Embarrassment
- Disciplinary action
- Being subject to an internal or external inquiry
- Loss of employment
- Criminal prosecution.

Organisation:

- Reputational damage
- Loss of public trust
- Being subject to an external inquiry
- Legal action.

Appendices:

Appendix 1: Good practice guidance

(see paragraph 3.7)

NI Civil Service conflict of interest guidelines relating to additional employment

The Northern Ireland Civil Service Staff Handbook provides guidance on conflicts of interest. The following extract deals with mitigating the conflict of *'being an employee, director, partner of another business or organisation, or pursuing a business opportunity'*:

"If a Civil Servant wishes to undertake any work (paid or unpaid) with another Government department or other public body they must first obtain permission from their Establishment/Personnel Officer.

No remunerative private work of the following description may be undertaken:

a. work which would occupy your time or attention or render you unavailable for duty during normal official hours;

b. work identified in any way with the activities of a political party, group or organisation;

c. work of an educational, literary or scientific nature involving the use of information acquired by you in your official capacity or from official sources, except where it has previously been published, unless you have received the permission of your employing department to undertake such work;

d. work of a nature conflicting with your duty to your employing department or the Government generally or as a member of the Civil Service;

e. work which may ultimately have to be reviewed by you or any member of the Civil Service acting in an official capacity;

f. work, related to your function, which a Civil Servant might otherwise justifiably undertake, but which is of such a scale as to involve unfair competition with persons wholly dependent on such work for a livelihood;

g. work which would involve the use of the property, tools, equipment or materials of departments; and

h. work which is, or might be, inconsistent with your position as a public servant and may expose you or your department to public criticism." [8]

8 Northern Ireland Civil Service Staff Handbook, Section 6.01, paragraph 6.1 and 6.2

Department of Finance and Personnel (DFP) - Gifts and Hospitality Policy

Acceptance of gifts and hospitality has the potential to cause a conflict of interest. Where an organisation has a detailed code of conduct for staff and Board members, it should have a section on gifts and hospitality. It should also have a stand-alone policy which provides more detailed guidance and instructions. In Northern Ireland, DFP has issued guidance on the acceptance of gifts and hospitality which applies to all NI Civil Service departments.

DAO (DFP) 10/06 states that, ***"The general principle is that all gifts offered should be refused. However, seasonal, promotional or trivial gifts.....having a value of less than £50, may be accepted by individuals without the need for these to be reported or approved in advance... More expensive or substantial items, valued at £50 or more and gifts of lottery tickets, cash, gift vouchers or gift cheques, cannot on any account be accepted. All gifts offered, even if they are declined/returned, need to be recorded in the register... The acceptance of what would be accepted as conventional hospitality, for example working lunches, should, in the main, cause no problem, especially if there is some official means of reciprocity and provided that it is limited to isolated occasions and its acceptance is in the interests of the department/agency."***

Appendix 2: (see paragraph 4.21) Example of Declaration of Interest Form - Invest NI

Register of Interests:

Declaration by Member of Staff

Period: 1 January 20XX to 1 January 20XX

Invest Northern Ireland
Building Locally
Competing Globally

Surname	
Forename	
Title	
Department	
Job Title	
Date of Appointment to Current Position	
Date of Appointment to Invest NI (if different)	

Please include dates and role

1. **Company Interests –** any relationship with a company or commercial organisation; Directorships, paid employment, consultancy; close family connection.

2. **Self employment**

3. **Land or Property Holdings –** (see page 6 of the Guidelines on Conflicts of Interest and Representation on Outside Bodies).

4. **Charities –** trusteeships, governorships or employment with any charities or voluntary organisations.

5. **Public Appointments –** remunerated or unremunerated.

6. **Memberships –** including membership of professional or external bodies, trade or other associations.

7. **Close Family Links –** specific close family interest in any of the above.

8. **Other Interests –** any other interests held by you or your close family

I confirm that the above declaration is complete and correct to the best of my knowledge and belief. The interests I have declared include both direct and indirect interests (i.e. those of a partner, spouse or close relative) and any specific financial interests are shown.

Signature: …… **Date**: ……

Print: ……

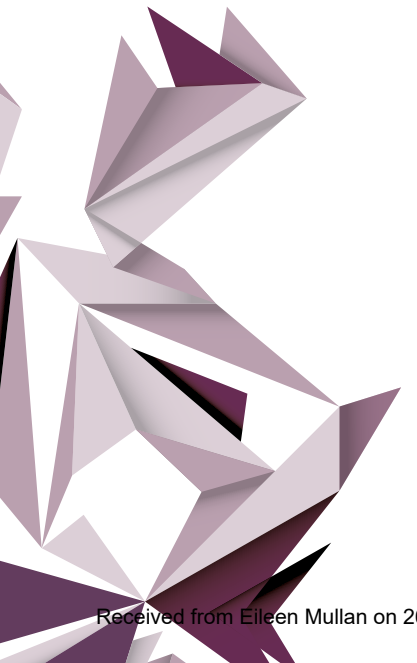
Appendix 3: Dealing with a Conflict of Interest

(see paragraph 4.25)

- Conflict of interest is identified and reported to management
- Conflict is considered and action is decided
- Action is recorded and carried out (if necessary)
- Declaration of interest form and register of interests are updated

Published and printed by CDS

CDS 129409



Toal, Vivienne

From: Brownlee, Roberta [redacted]
Sent: 09 January 2017 18:06
To: Wilkinson, John
Cc: Comac, Jennifer; Toal, Vivienne
Subject: RE: CONFIDENTIAL: Designated NED under MHPS

Thanks John will call you. Will let Vivienne know.
Also would you be free next 16th after 11am or Tuesday 17th afternoon. I would like you to meet with the Director and I who has expressed an interest to act up during [redacted].

Roberta

From: Wilkinson, John
Sent: 09 January 2017 16:16
To: Brownlee, Roberta
Subject: Re: CONFIDENTIAL: Designated NED under MHPS

Hi Roberta
No issue.
We would need to chat.
Let me know when or ring me on my mobile.
John

Sent from my iPad

On 6 Jan 2017, at 20:14, Brownlee, Roberta [redacted] > wrote:

> John
>
> Hope you had a quiet and lovely family Christmas. Happy New Year.
> Would you do this for me? I would want to explain re Mr A O'Brien can you let me know and then can we chat first. Roberta
>
> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** "Toal, Vivienne" <[redacted]>
> **Date:** 6 January 2017 at 16:41:22 GMT
> **To:** "Brownlee, Roberta" [redacted]>
> **Cc:** "Rice, Francis" [redacted]>, "Wright, Richard" <[redacted]>
> **Subject: CONFIDENTIAL: Designated NED under MHPS**
>
> Roberta
>
> I am aware that Dr Wright has spoken to you regarding the immediate exclusion under MHPS of Mr A O'Brien and the need for a formal investigation.

I would be grateful if a recently MHPS trained NED could be identified as soon as possible to enable this to be communicated to Mr O'Brien in accordance with the framework.

I will then arrange to meet with the designated NED to brief them on the case.

Many thanks

Vivienne

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

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

Stinson, Emma M

From: Brownlee, Roberta [redacted] >
Sent: 07 September 2020 09:05
To: Mullan, Eileen; Devlin, Shane
Cc: Comac, Jennifer; Wright, Elaine; Judt, Sandra; Donaghy, Geraldine; Leeson, Pauline; McCartan, Hilary; McDonald, Martin; Wilkinson, John
Subject: Govern Meeting

Eileen

I plan to attend Govern meeting (most of) Thursday am. Hope this acceptable.

Roberta

Mrs Roberta Brownlee
Chair
Southern Health and Social Care Trust

Changed My Number

Tel: [redacted] **(External);** [redacted] **(Internal)**
Email: [redacted]

'You can follow us on Facebook and Twitter'

smoke free
Southern Trust will be Smoke Free from 9 March 2016

Stinson, Emma M

From: Roberta Brownlee [redacted] >
Sent: 08 September 2020 18:41
To: Mullan, Eileen
Cc: Judt, Sandra
Subject: Re: Govern meeting

Eileen

Message noted.
I Could not address my comments in 5 mins as Chair of the Board. Several serious matters. Will ensure each of my points Is highlighted And asked to be addressed / actioned in the full agenda.

Roberta

Sent from my iPhone

> On 8 Sep 2020, at 15:51, Mullan, Eileen <[redacted]> wrote:
>
> Roberta
>
> RE: Governance Committee Thursday 10th September
>
> As you will be aware, I am not having a confidential section on Thursday and will run the meeting in a fully open way from 0845.
>
> As discussed yesterday, we have a very hefty agenda for the Governance Committee and starting on time is extremely important to facilitate everyone.
>
> Happy to give you a few minutes once I open the meeting, but will need to move immediately to Covid-19 outbreak. I would really appreciate it if you could keep your remarks to no more than 5 mins. It is really important that we have the Covid-19 discussion and update without be rushed. Then I will move us all on to the other important parts of our agenda and focus for Thursday.
>
> Hope this is ok with you.
>
> Thanks
>
> Eileen
>
> -----Original Message-----
> From: Roberta Brownlee [mailto[redacted]]
> Sent: 08 September 2020 08:55
> To: Judt, Sandra; Mullan, Eileen
> Subject: Govern meeting
>
> Elaine

> At the beginning of confidential section when all members present may I please speak to the Board on a few areas.
> As Chair, and after you do the welcome, i need to speak.
>
> Roberta
>
> Sent from my iPhone
>

Stinson, Emma M

From: Brownlee, Roberta <[redacted]>
Sent: 09 September 2020 20:25
To: Mullan, Eileen
Cc: Devlin, Shane; Judt, Sandra
Subject: Re: Your phone call this am

Eileen

Thanks for getting in touch. Sorry I had a busy day with mostly no phone.

The CX and and I will be updating tomorrow's meeting on issues all well known to Trust Board members at this present time. I'm happy to discuss them under each item as they arise tomorrow.
I do not wish to delay the start time of the meeting as you have asked with such a busy agenda. But it's very important they are discussed as time allows.
All Trust Board Members have been kept up to date on CAH Covid 19 outbreak on a daily basis/ at times hourly by the CX with his emails and updates. Thats why I asked for this Covid 19 outbreak to be put on the agenda as a first item.

The Board learning (and the report) on Muckamore Abbey, members all have a copy, must be noted at a first Govern meeting since report was issued. The CX and I have discussed how this report will need to be reviewed as we all take time to read and hopefully in the next month will come to Trust Board or Governance? To be decided. There is much learning in this Muckamore Abbey report for a Trust Board.

The CX and I also need to update all Trust Board Members on the latest Virtual meeting with Minister and his senior team regarding the Covid 19 outbreak.

The CX made me aware that Dr Maria was on holiday and her deputy Dr Gorman is attending who will fulfil her role at Govern meeting. I'm sure Paul has a deputy as well attending.

I do not need see the need for an emergency Trust Board meeting as all Trust Board members will be present for Confidential Section (excluding those on holidays and the absence of one NED). However happy to discuss this when we meet in the morning.

Thank you.

Roberta

Sent from my iPad

> On 9 Sep 2020, at 15:23, Mullan, Eileen <[redacted]> wrote:
>
> Roberta
>
> Thanks for letting me know.
>
> I picked up your email this morning, so was touching base in relation to that.

>
> If you have several serious matters you wish to share as Chair of the Trust Board, it might be prudent for you to hold an Emergency Trust Board Meeting. That would mean that all Non Exec and Exec Directors would be in attendance. Dr Maria O'Kane and Paul Morgan are on leave this week. Governance Committee includes Dr Tracey Boyce, Dr Damien Gormley, Stephen Wallace and Marita Magennis.
>
> See you in the morning.
>
> Eileen
>
> -----Original Message-----
> From: Brownlee, Roberta
> Sent: 09 September 2020 14:01
> To: Mullan, Eileen
> Cc: Gribben, Laura; McCormick, Susan
> Subject: Your phone call this am
>
> Sorry Eileen I missed your call was away to work very early and did not have my phone with me where I am working today.
>
> Will see emails later. Roberta
>
> Sent from my iPad