Southern Health and Social Care Trust

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Maintaining High Professional Standards Formal Investigation

Case Manager Determination

Dr Ahmed Khan, Case Manager

1.0 Case Manager Determination following Formal Investigation under the Maintaining High Professional Standards Framework in respect of Mr Aiden O'Brien, Consultant Urologist

Following conclusion of the formal investigation, the Case Investigator's report has been shared with Mr O'Brien for comment on the factual accuracy of the report. I am in receipt of Mr O'Brien's comments and therefore the full and final documentation in respect of the investigation.

2.0 Responsibility of the Case Manager

In line with Section 1 Paragraph 38 of the MHPS Framework, as Case Manager I am responsible for making a decision on whether:

1. No further action is needed
2. Restrictions on practice or exclusion from work should be considered
3. There is a case of misconduct that should be put to a conduct panel
4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer
5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (re-named as Practitioner Performance Advice)
6. There are serious concerns that fall into the criteria for referral to the GMC or GDC
7. There are intractable problems and the matter should be put before a clinical performance panel.

3.0 Formal Investigation Terms of Reference

The terms of reference for the formal investigation were:

1. (a) To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.

   (b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.

(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.

(d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.

2. (a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.

   (b) To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.

   (c) To determine if any patient notes tracked to Mr O'Brien are missing.

3. (a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.

   (b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient clinics.

   (c) To determine if there have been delays in clinical management plans for these patients as a result.

4. To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.

5. To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

4.0 Investigation Findings

In answering each of the terms of reference of the investigation, the Case Investigator concluded:

1. (a) It was found that Mr O'Brien did not undertake non-red flag referral triage during 2015 and 2016 in line with the known and agreed process that was in place. In January 2017, it was found that 783 referrals were un-triaged by Mr O'Brien. Mr O'Brien accepts this fact.

(b) It was found that there was the potential for 783 patients to have been added to the incorrect waiting list. A look back exercise of all referrals by other Consultant Urologists determined that of the 783 un-triaged referrals, 24 would have been upgraded to red-flag status, meaning the timescales for assessment and implementation of their treatment plans was delayed. All un-triaged referrals were added to Trust waiting lists based on the GP referral assessment.

(c) It was found that all other Consultant Urologists undertook triage of all referrals in line with established practice.

(d) It was found that of the 24 upgraded patient referrals, 5 patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing appropriate treatment plans.

2. (a) It was found that in January 2017 Mr O'Brien returned 307 sets of patient notes which had been stored at his home. Mr O'Brien accepts that there were in excess of 260 patient notes returned from his home in January 2017.

   (b) The notes dated as far back as November 2014. It was found that Mr O'Brien returned patient notes as requested and he asserts therefore there was no impact on patient care.

   (c) It was found that there are 13 sets of patient notes missing. The Case Investigator was satisfied these notes were not lost by Mr O'Brien.

3. (a) It was found that there were 66 undictated clinics by Mr O'Brien during the period 2015 and 2016. Mr O'Brien's accepts this.

   (b) It was accepted by Mr O'Brien that he did not dictate at the end of every care contact but rather dictated at the end of the full care episode. This is not the practice of any other Consultant Urologist. The requirements of the GMC is that all notes / dictation are contemporaneous.

   (c) There are significant waiting list times for routine Urology patients. It is therefore unclear as to the impact of delay in dictation as the patients would have had a significant wait for treatment. The delay however meant that the actual waiting lists were not accurate and the look back exercise to ensure all patients had a clear management plan in place was done at significant additional cost and time to the Trust.

6. It has been found that Mr O'Brien scheduled 9 of his private patient's sooner and outside of clinical priority in 2015 and 2016.

7. Concerns about Mr O'Brien's practice were known to senior managers within the Trust in March 2016 when a letter was issued to Mr O'Brien regarding these concerns. The extent of the concerns was not known. No action plan was put in place to address the concerns. It was found that a range of managers, senior managers and Directors within the Acute Service Directorate were aware of concerns regarding Mr O'Brien's practice dating back a number of years. There was no evidence available of actions taken to address the concerns.

Other findings / context

Other important factors in coming to a decision in respect of the findings are:

Triage

1. Mr O'Brien provided a detailed context to the history of the Urology service and the workloads pressures he faced. Mr O'Brien noted that he agreed to the triage process but very quickly found that he was unable to complete all triage. Mr O'Brien noted that he had raised this fact with his colleagues on numerous occasions to no avail. Mr O'Brien accepts that he did not explicitly advise anyone within the Trust that he was not undertaking routine or urgent referral triage. Mr O'Brien did undertake red-flag triage.

2. It was known to a range of staff within the Directorate that they were not receiving triage back from Mr O'Brien. A default process was put in place to compensate for this whereby all patients were added to the waiting lists according to the GP catergorisation. This would have been known to Mr O'Brien.

3. Mr Young is the most appropriate comparator for Mr O'Brien as both have historical long review lists which the newer Consultants do not have. Mr Young managed triage alongside his other commitments. Mr Young undertook Mr O'Brien's triage for a period of time to ease pressures on him while he was involved in regional commitments.

Notes

1. There was no proper Trust transport and collection system for patient notes to the SWAH clinic in place.

2. There was no review of notes tracked out by individual to pick up a problem.

3. Notes were returned as requested by Mr O'Brien from his home.

4. It was known that Mr O'Brien stored notes at home by a range of staff within the Directorate.

Undictated clinics

1. Mr O'Brien's secretary did not flag that dictation was not coming back to her from clinics. Mr O'Brien's secretary was of the view that this was a known practice to managers within the Directorate.

2. Mr O'Brien indicated that he did not see the value of dictating after each care contact.

3. Mr O'Brien was not using digital dictation during the relevant period and therefore the extent of the problem was not evident.

5.0 Case Manager Determination

My determination about the appropriate next steps following conclusion of the formal MHPS investigation:

- There is no evidence of concern about Mr O'Brien's clinical ability with patients.

- There are clear issues of concern about Mr O'Brien's way of working, his administrative processes and his management of his workload. The resulting impact has been potential harm to a large number of patients (783) and actual harm to at least 5 patients.

- Mr O'Brien's reflection on his practice throughout the investigation process was of concern to the Case Investigator and in particular in respect of the 5 patients diagnosed with cancer.

- As a senior member of staff within the Trust Mr O'Brien had a clear obligation to ensure managers within the Trust were fully and explicitly aware that he was not undertaking routine and urgent triage as was expected. Mr O'Brien did not adhere to the known and agreed Trust practices regarding triage and did not advise any manager of this fact.

- There has been significant impact on the Trust in terms of its ability to properly manage patients, manage waiting lists and the extensive look back

exercise which was required to address the deficiencies in Mr O'Brien's practice.

- Mr O'Brien did not adhere to the requirements of the GMC's Good Medical Practice specifically in terms of recording his work clearly and accurately, recording clinical events at the same time of occurrence or as soon as possible afterwards.

- Mr O'Brien has advantaged his own private patients over HSC patients on 9 known occasions.

- The issues of concern were known to some extent for some time by a range of managers and no proper action was taken to address and manage the concerns.

This determination is completed without the findings from the Trust's SAI process which is not yet complete.

Advice Sought

Before coming to a conclusion in this case, I discussed the investigation findings with the Trust's Chief Executive, the Director of Human Resources & Organisational Development and I also sought advice from Practitioner Performance Advice (formerly NCAS).

My determination:

1. No further action is needed

Given the findings of the formal investigation, this is not an appropriate outcome.

2. Restrictions on practice or exclusion from work should be considered

There are 2 elements of this option to be considered:

a. A restriction on practice

At the outset of the formal investigation process, Mr O'Brien returned to work following a period of immediate exclusion working to an agreed action plan from

February 2017. The purpose of this action plan was to ensure risks to patients were mitigated and his practice was monitored during the course of the formal investigation process. Mr O'Brien worked successfully to the action plan during this period.

It is my view that in order to ensure the Trust continues to have an assurance about Mr O'Brien's administrative practice/s and management of his workload, an action plan should be put in place with the input of Practitioner Performance Advice (NCAS), the Trust and Mr O'Brien for a period of time agreed by the parties.

The action plan should be reviewed and monitored by Mr O'Brien's Clinical Director (CD) and operational Assistant Director (AD) within Acute Services, with escalation to the Associate Medical Director (AMD) and operational Director should any concerns arise. The CD and operational AD must provide the Trust with the necessary assurances about Mr O'Brien's practice on a regular basis. The action plan must address any issues with regards to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme.

b. An exclusion from work

There was no decision taken to exclude Mr O'Brien at the outset of the formal investigation process rather a decision was taken to implement and monitor an action plan in order to mitigate any risk to patients. Mr O'Brien has successfully worked to the agreed action plan during the course of the formal investigation. I therefore do not consider exclusion from work to be a necessary action now.

3. There is a case of misconduct that should be put to a conduct panel

The formal investigation has concluded there have been failures on the part of Mr O'Brien to adhere to known and agreed Trust practices and that there have also been failures by Mr O'Brien in respect of 'Good Medical Practice' as set out by the GMC.

Whilst I accept there are some wider, systemic failings that must be addressed by the Trust, I am of the view that this does not detract from Mr O'Brien's own individual professional responsibilities.

During te MHPS investigation it was found that potential and actual harm occurred to patients. It is clear from the report that this has been a consequence of Mr O'Brien's conduct rather than his clinical ability. I have sought advice from Practitioner

Performance Advice (NCAS) as part of this determination. At this point, I have determined that there is no requirement for formal consideration by Practitioner Performance Advice or referral to GMC. The Trust should conclude its own processes.

The conduct concerns by Mr O'Brien include:

- Failing to undertake non red flag triage, which was known to Mr O'Brien to be an agreed practice and expectation of the Trust. Therefore putting patients at potential harm. A separate SAI process is underway to consider the impact on patients.

- Failing to properly make it known to his line manager/s that he was not undertaking all triage. Mr O'Brien as a senior clinician had an obligation to ensure, this was properly known and understood by his line manager/s.

- Knowingly advantaging his private patients over HSC patients.

- Failing to undertake contemporaneous dictation of his clinical contacts with patients in line with GMC 'Good Medical Practice'.

- Failing to ensure the Trust had a full and clear understanding of the extent of his waiting lists, by ensuring all patients were properly added to waiting lists in chronological order.

Given the issues above, I have concluded that Mr O'Brien's failings must be put to a conduct panel hearing.

4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer.

There are no evident concerns about Mr O'Brien's health. I do not consider this to be an appropriate option.

5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (now Practitioner Performance Advice)

Before coming to a conclusion in this regard, I sought advice from Practitioner Performance Advice.

The formal investigation report does not highlight any concerns about Mr O'Brien's clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'Brien's administrative practices. The report highlights the impact of Mr O'Brien's failings in respect of his administrative practices which had the potential to cause harm to patients and which caused actual harm in 5 instances.

I am satisfied, taking into consideration advice from Practitioner Performance Advice (NCAS), that this option is not required.

6. There are serious concerns that fall into the criteria for referral to the GMC or GDC

I refer to my conclusion above. I am satisfied that the concerns do not require referral to the GMC at this time. Trust processes should conclude prior to any decision regarding referral to GMC.

7. There are intractable problems and the matter should be put before a clinical performance panel.

I refer to my conclusion under option 6. I am satisfied there are no concerns highlighted about Mr O'Brien's clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'Brien. The investigation report presented to me focused centrally on the specific terms of reference set for the investigation. Within the report, as outlined above, there have been failings identified on the part of Mr O'Brien which require to be addressed by the Trust, through a Trust conduct panel and a formal action plan.

The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.

Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien.

In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes

with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings.

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Medical and Dental Oversight Group

Terms of Reference
2020

Summary & Purpose

The Purpose of the Medical and Dental Oversight Group is to support the Responsible Officer / Medical Director in the discharge of statutory responsibilities by ensuring there is;

- a process for review of all cases where a practitioners practice, conduct, health gives cause for concern,
- regular review of all cases where a practitioner is subject to procedures under Maintaining High Professional Standards in a Modern HPSS (MHPS),
- regular review of all cases where a practitioner is subject to Fitness to Practice procedure (or restriction to practice or similar sanction) of the GMC, GDC or any national professional regulatory body of another sovereign state,
- no undue delays in addressing practitioner performance issues.
- Adequate support, guidance for clinical managers and individual practitioners
- Consistency in approach and decision making where appropriate across the organisation

Terms of Reference

The panel will review the case files of all medical and dental practitioners employed in the Trust, or engaged via Agency for whom there concerns have been raised about their professional practice. This applies to any medical or dental practitioner registered with the GMC and/or GDC who is currently employed or was employed at the time concerns arose. Termination of employment, for whatever reason, does not necessarily end Trust responsibility in terms of MHPS or regulatory Fitness to Practice procedures.

Concerns about professional practice shall include;

- all Fitness to Practice procedures with regulatory agencies,
- all practitioners subject to procedures under MHPS (or equivalent procedures for doctors in training),
- restrictions, undertakings, suspensions or other sanctions imposed by a regulatory agency,
- all cases where NCAS have provided advice or assessment,
- all practitioners subject to a remediation process,
- practitioners whose performance has been called into question through appraisal and/or governance systems (as determined by the Responsible Officer),
- and all doctors for whom a recommendation to revalidate could not be provided at the time requested by GMC.

The Oversight Panel shall regularly review each case file with the Medical/Dental manager for the practitioner.

The Oversight Group shall ensure that any investigations taken under the management of performance comply with relevant guidance and occur in a timely manner.

The Oversight Group will at all times have due regard for ensuring patient safety.

The Oversight Group is required to provide additional assurance to the Trust that procedures under MHPS are undertaken in a fair and proportionate manner

All procedures under MHPS will be undertaken in accordance with this guidance and **SHALL NOT** be delayed until the next meeting of the Panel.

MEMBERSHIP

The members of the Medical and Dental Oversight Group will comprise:

- Responsible Officer / Medical Director (Chair)
- Senior Manager MD Office
- Director of HR / Deputy Director of HR
- Head of Medical HR
- Associate Medical Director and/or Relevant representation from the Service (as set out below)*

*The Director or a nominated deputy.

The Oversight Panel may request additional members (including a legal representative) to provide expertise in particular areas. In the event of a member being unable to attend meetings an alternative professional representative may attend on his/her behalf.

ROLES AND RESPONSIBILITIES

To be discussed and completed here after further discussions with AMD's

The oversight panel shall consider each case and may give direction on further actions required. If the practitioner is a doctor in training then the Director of Medical Education and/or a representative of NIMDTA shall attend.

All meetings will be attended by a minute taker. Detailed minutes will be recorded of each meeting and retained.

All meetings will be chaired by the chairperson or in his/her absence, by a member nominated by the chairperson.

It is best practice that AMD's discussing cases at the Oversight Panel should ensure individual doctors are aware of the above process and that their case may be discussed as part of the Trust's process for handling concerns.

QUORUM

The Panel will not normally meet unless 2 members are present and meetings can only take place if the chairman (The Medical Director) is present or a nominated deputy.(Deputy Medical Director)

FREQUENCY OF MEETINGS

Meetings shall be held monthly

REPORTING ARRANGEMENTS

Minutes of the meetings of the Panel will be formally recorded and action notes distributed to Panel members and a full copy retained on the Medical Directors file.

REVIEW OF TERMS OF REFERENCE

The Terms of Reference will be reviewed at the first meeting of the Forum and thereafter annually. Any amendments to the Terms of Reference will be approved by the Medical Director; in the event of significant changes to the Terms of Reference these shall be presented to SMT for approval.

Southern Health and Social Care Trust

REPORT SUMMARY SHEET

Meeting: Date:	Senior Management Team 9th November 2021
Title:	Medical Leadership Development Update
Lead Director:	Dr Maria O'Kane, Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	Discussion / Approval

Overview:

Update on previously presented proposal (March 2021) on strengthening the Trust Medical and Collective Leadership Model which commenced with reconfiguration of the roles Associate Medical Directors and Corporate Associate Medical Directors. This paper includes details and costings associated with the Proposed Clinical Director structure.

Key Issues / Risks for SMT Consideration:

- Consideration of current medical leadership structures and previously funded medical leadership roles
- Approval of reconfigured Clinical Director role template and provision of funds required to move to position appointments.

Outcome of SMT Discussion:

Background and Context

1. The most important determinant of the development and maintenance of an organisation's culture is current and future leadership. Every interaction by every leader at every level shapes the emerging culture of an organisation[1].

2. Leadership is a key part of doctors' professional work regardless of specialty and setting. It is already a requirement of all doctors as laid out in the General Medical Council's (GMC) publications Good Medical Practice and also Management for Doctors.

3. While the primary focus for doctors is on their professional practice, all doctors work in systems and within organisations. It is a vitally important fact that doctors have a direct and far-reaching impact on patient experience and outcomes.

4. Doctors have a legal duty broader than any other health professional and therefore have a key leadership role within healthcare services. They have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction.

5. Learning from the Paterson Inquiry and expected themes from the Belfast Health and Social Care Trust Neurology Inquiry highlight the requirements for robust medical management structures to quality assure, professionally manage and provide safe effective care and services for our patients and service users. The Trust's upcoming Trust Public Inquiry regarding a Trust Urology Consultant will likely consider Trust Medical Professional and Clinical governance arrangements.

6. In 2019 the Trust Medical Director commissioned a review of the Medical Leadership with a view to a stronger collective leadership model to aid the creation of a Trust integrated, collective network of leaders distributed throughout the organisation who embody shared values and practices.

7. The report entitled "Medical Leadership Review" identified key medical leadership positions that are required to develop medical and collective leadership within the organisation. To date two Deputy Medical Directors and eight Divisional Medical Directors have been appointed.

[1] *Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base (2011)*

8. As the next stage of this process, the Trust Medical Director has now reviewed the Clinical Director role and revised the responsibilities of this role (Role description found in Appendix 2)

9. Each of these posts will have a clearly defined medical lead responsibility within the Division on the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance activity in partnership with operational managers.

10. The posts as configured will attract a 2 PA allocation as opposed to the 1 PA currently assigned. This is in recognition for the additional time required that by and large is undertaken in a supernumerary fashion by current post holders.

Rationale for Change of Clinical Director Posts

Expansion of Role and Responsibilities of the Clinical Director

11. The role and responsibilities of Clinical Directors has significantly expanded over the last decade. The modern Clinical Director role is now formally two-fold entailing a broad range of general management and leadership activities combined with the responsibility to deliver on clinical governance and patient safety within their divisional areas.

12. These duties have grown in excess of the 1 PA that was historically allocated. To full itemised range of responsibilities for modern Clinical Directors is set out in the role specification below:

- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance within their areas of responsibility including:

- *Professional Medical Governance*
  - *Staffing and Staff Management*
  - *Professional Performance Management including Job Planning*
  - *Appraisal and Revalidation*
- *Adverse and Serious Adverse Incident Management*
- *Litigation and Claims Management*
- *Coronial Matters*
- *Complaints*
- *Morbidity and Mortality*
- *Patient Safety (Including Infection Prevention and Control)*
- *Medications management*
- *Risk Management / Mitigation and Reduction*
- *Learning from Experience*
- *Medical Workforce development*
- *Quality Improvement*
- *Clinical Audit*
- *Education, Training and Continuing Professional Development*
- *Ensuring Delivery of Effective Evidence-Based Care*
- *Patient and Carer Experience and Involvement*
- *Medical leadership in delivery of MCA and Safeguarding*

Expansion of the Trust Medical Workforce

13. Over the last decade the Trust has experienced a significant expansion in medical staffing compliment while Clinical Director numbers have remained static. Since the inception of the SHSCT in 2007 to 2019/20. The table below illustrates this growth in substantive medical staff complement (excluding trainees, LATs, Long Term Locums, and Clinical Fellows).

Grade	2009	2021
Consultant	152	265
SAS / Staff Grade	64	110
Total	**216**	**375**

14. The table below provides information relating to the growth in the number of training grades from 2013 to 2021.

Grade	2013	2021
Training Grades	240	294

15. The increase in substantive medical staff complement is a 74% increase from 2007 to 2021 and an increase of 23% in trainee grades from 2013 to 2021. Despite this significant expansion in medical staffing the clinical director cohort and associated PA allocation has remained largely static.

16. In addition to the above increases the Trust has commenced the roll out of a physical associate model. The Trust is currently growing the number of Physician Associates across specialities; to date there 10 Physician Associates employed within the Trust with plans to further expand this. The positions are also overseen and managed by the Clinical Director.

Increased Role of Medical Leaders in Professional Governance

17. The Professional Governance responsibilities on the medical workforce have increased significantly over the last number of years. Notably, since December 2012 the General Medical Council have required medical doctors to revalidate on a 5 yearly cycle. Medical Revalidation is a regulatory process and is intended to complement clinical governance, with the one strengthened by the other.

18. Clinical Directors are central to the local oversight of clinical governance for individual doctors. This clinical governance information both informs and assures Medical Appraisal and Revalidation processes. This change in the levels of responsibility for Clinical Directors has not been formally recognised through the time allocation allotted to the Clinical Director role.

Increased Use of Medical Locums

19. Medical locum usage has also increased significantly over the last number of years. As of 27th September 2021 there are 113 Long Term Locums within the Southern Trust. 60.18% (68 Locums) of Long Term Locums are engaged within Medicine and Unscheduled Care.

20. The General Medical Council states that '*some locums practice on the fringes of governance systems*' due to the nature of the locum role[2]. Oversight and management of locum positions presents significant challenges especially when it comes to delivering on professional and clinical governance activities.

21. Clinical Directors, particularly those in divisions that experience high volume of locum usage will require significant investment to ensure that a similar level of assurance that is sought from substantive post holders can be achieved for locum post holders.

[2] General Medical Council 2018 – What Our Data Tells Us About Locum Doctors 2018_04_11_locumDoctors_JG (gmc-uk.org)

Number of Doctors Managed Per Clinical Director

22. There is significant variance in the number of doctors per Clinical Director in the Trust. Although a formal evidence base is not available for the ratio of Medical Staff per Clinical Manager by way of example in Craigavon Area Hospital Medicine and Unscheduled Care a single Clinical Director is responsible for the management and oversight of 59 doctors across a range of specialities.

23. In order to rationalise the number of medical staff each doctor is responsible for it is proposed that no clinical director is responsible for managing more than 30 substantive doctors. This number may be less dependent on a number of factors including speciality type and physical location of staff.

Clinical Director Proposal

24. The following three proposals are provided for SMT consideration:

1. **SMT agree the new Clinical Director role**
2. **SMT agree investment in 6 New Clinical Director Posts**
    - **2 Medicine,**
    - **1Unscheduled Care**
    - **1 Cardiology**
    - **1 Mental Health**
    - **1 Older Persons**
3. **SMT agrees the increase PA allocation for Clinical Directors to 2 PA from the existing 1 PA allocation and the associated costs**

25. An updated table on Medical Leadership Structures is provided below.

Appendix 1 – Updated Proposed Divisional Medical Leadership Structures

Domain	Role	PA Required	PA Currently Funded	Investment Required	Post Currently Filled	Comment
Medical Executive Leaders	Deputy Medical Director – Workforce	6	6	0	*Yes*	
	Deputy Medical Director – Quality and Safety	6	6	0	*Yes*	
	Deputy Medical Director – Appraisal and Revalidation (24 months)	6	6*	0	*In progress*	**PI funding (24 months)*
	Director of Medical Education	4	4	0	*In progress*	*Currently covered by DMD Workforce*
Operational Divisional Medical Director Posts	DMD Surgery and Elective Care (Except Urology)	3	3	0	*In Progress*	*Being advertised currently via EOI process*
	DMD Urology Services	3	3*	0	*Yes*	**PI funding (24 months)*
	DMD ATICS	3	3	0	*Yes*	*Appointed*
	DMD Medicine and Unscheduled Care - Workforce	4	0	4	*Yes*	*Post realigned – Workforce and Governance split*
	DMD Medicine and Unscheduled Care - Governance	4	4	0	*Yes*	*Post realigned – Workforce and Governance split*
	DMD Integrated Maternity and Women's Health	3	3	0	*Yes*	
	DMD Cancer and Clinical Services	3	3	0	*In progress*	
	DMD Emergency Medicine & Unscheduled Care	3	3	0	*Yes*	
	DMD Children's and Young Peoples Services	3	3	0	*Yes*	
	DMD Mental Health and Learning Disability	3	2	1	*In progress*	
	DMD Older People	3	3	0	*Yes*	*Being met with OPPC funds*
Corporate Services	AMD Primary Care	4	4	0	*Yes*	*Two posts*
	AMD Infection Prevention and Control	3	3	0	*No*	*Previously Funded Position*
	AMD Research and Development	2	2	0	*Yes*	

Domain	Role		PA Required	PA Currently Funded	Investment Required	Post Currently Filled	Comment
	Medical Lead for Coroner Services		0.5	0	0.5	*No*	*New Post currently unfunded*
	Medical Lead for Standards and Guidelines		1	1	0	*No*	*Previously Funded Position*
	Medical Lead for Litigation		0.5	0	0.5	*No*	*New Post currently unfunded*
	Medical Lead for Locums		4	0	4	*No*	*New Post currently unfunded*
	Medical Lead Complaints		1	0	1	*No*	*New Post currently unfunded*
	Medical Lead Wellbeing		1	0	1	*No*	*New Post currently unfunded*
Clinical Director Structure	Surgery and Elective Care	CD General Surgery CAH	2	1	1	*Yes*	*CD Leaving Post*
		CD General Surgery DHH	2	1	1	*No*	
		CD T&O	2	1	1	Yes	
		CD Urology, ENT and Orthodontics	2	1	1	*Yes*	
	Emergency Medicine	CD CAH	2	1	1	*Yes*	
		CD DHH	2	1	1	*In progress*	*Incumbent now DMD*
		CD Unscheduled Care	2	0	2	*No*	
	ATICS	CD CAH	2	1	1	*Yes*	
		CD DHH	2	1	1	*Yes*	
		CD ICU	2	1	1	*Yes*	
	Medicine	CD (3 Posts)	6	3	3	*1/3*	*Split governance and workforce roles cross sites*
		CD Cardiology	2	0	2	*Yes*	

Domain	Role		PA Required	PA Currently Funded	Investment Required	Post Currently Filled	Comment
	IMWH	CD CAH	2	1	1	*Yes*	
		CD DHH	2	1	1	*Yes*	
	CYPS	CD CAH	2	1	1	*Yes*	
		CD DHH	2	1	1	*Yes*	
		CD Comm Paeds	2	1	1	*Yes*	
		CD CAMHS	2	1	1	*In progress*	*CD Appointed DMD*
	MHLD	CD Phys & Learning	2	1	1	*Yes*	
		CD Mental Health	2	1	1	*Yes*	
		CD Psychiatry Old Age	2	2	0	*In progress*	*To be funded by MHLD*
	Cancer Services	CD Radiology	2	1	1	*Yes*	
		CD Laboratory	2	1	1	*Yes*	
		CD Cancer Services	2	1	1	*Yes*	
	Older People	CD Older People Community	2	1	1	*No*	
		CD Older People Stroke and Acute Care	2	0	2	*No*	
Appraisal and Revalidation Support	Medical Lead Corporate Appraisal & Revalidation		2	1	1	*Yes*	
	Medical Lead Consultant Appraisal & Revalidation		2	1	1	*Yes*	
	Lead SAS Doctors Appraisal and Revalidation		2	1	1	*No*	*One post funded*
	Lead Medical Performance Management		2	0	2	*No*	
	Appraiser Allocation (0.25PA per 8 appraisals per annum)		5	0	5	*In progress*	*Agreed as per LNC discussions 2019*

Domain	Role	PA Required	PA Currently Funded	Investment Required	Post Currently Filled	Comment
Patient Safety	M&M Chairs, 20 posts	13.5	6	7.5	*In progress*	*Six posts Trustwide (7.5 new PA to include sub speciality and increase in support for CAH Medical M&M meetings)*
	Divisional Patient Safety Leads (0.5 PA proposed per 50 doctors in division)	8	0	8	*In progress*	
	Clinical Audit Leads (0.5 PA proposed per 50 doctors in division)	8	0	8	*In progress*	
Total		**172.5**	**97**	**75.5**		

Costing Table (Total Costs)

Element	Number	Unit Cost	Total Cost
Total Required New PA Allocation Required (All Posts)	75.5	£9,200*	£694,600
Management Allowance(For New CD Posts)	6	£7,200)	£43,200
Total Cost			**£737,800**

**Midpoint of scale*

Appendix 2 Clinical Director Job Description

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Clinical Director – XXXXXXXXXXXXX

DIRECTORATE: XXXXXXXXXX

RESPONSIBLE TO: Divisional Medical Director XXXXXXXXXXXX

ACCOUNTABLE TO: Medical Director

COMMITMENT: X PAs

LOCATION: XXXXXXXXXX

Context:

The Clinical Director (CD) on behalf of the Divisional Medical Director (DivMD) will be a leader in Divisional Management Team. The CD will report to the DivMD and will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The CD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The CD will have delegated responsibility on behalf of the DivMD within their areas Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Specialties / Areas Responsible For

- Specialty / Area 1 *e.g. Neurology*
- Specialty / Area 2 *e.g. Gastroenterology*

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.
- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance within their areas of responsibility including:

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management including Job Planning – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Risk Management / Mitigation and Reduction • Learning from Experience • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

- X
- X
- X
- X

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within their areas of responsibility
- To promote quality improvement and to grow and embed a culture of Collective Leadership within their areas of responsibility
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within

clinical and social care governance structures and culture.

- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
  (a) delivery of safe, high quality and effective person-centred care
  (b) secures activity and performance
  (c) maintains ongoing financial viability
  (d) is aligned to corporate goals
- The Divisional Medical Director with the Assistant Director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

Appraisal and Revalidation

To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes including undertaking at least 8 appraisals annually, equating to 0.25SPA of CD allocation.

Job Planning

- Provide leadership and support for Job planning process within their areas of responsibility for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and

behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

   - Smoke Free policy
   - IT Security Policy and Code of Conduct

5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

Admin Review Processes

Introduction

This review of administrative processes followed a formal investigation into concerns about an individual Consultant under the Maintaining High Professional Standards Framework (MHPS). The main concerns highlighted concern over the Consultant's way of working, their administrative processes and their management of workloads.

The MHPS Case Manager made a number of recommendations one of which was a recommendation that in order for the Trust to understand fully the failings in the case, the Trust should *'carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. It recommended that the review should look at the full system wide problems to understand and learn from the findings'.*

The formal MHPS investigation focused on four main areas of concern::

1. Non-triage of GP and other consultant referrals
2. Non-dictation on patients who had attended outpatient clinics
3. Hospital notes being stored off Trust premises, namely the Consultant's home
4. The Consultant was found to have scheduled his private patient's sooner and outside of clinical priority.

The table below:

- highlights and describes the issues of concern
- identifies the gaps that led to the concerns raised
- advises on the policies and processes now in place
- describes the ongoing risks/ flaws
- explains the escalation process for non-adherence

.

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
1. Triage	Pre 2014 Due to the delayed triage of referrals, the decision was taken to add to the OP waiting list the referral at the clinical priority that the GP had assigned. .	2014-2017 For routine and Urgent GP referrals, non-adherence and non-enforcement of the IEAP, resulted in referrals not being returned within the appropriate timeframe, which then resulted in a lost opportunity to either upgrade or downgrade urgent/routine referrals	2017-current The introduction of e-Triage on 27/3/17 enabled referrals to be monitored with respect to the triage process. The revised triage process (draft) detailed in the word document below is based on the current IEAP also addresses these issues of timely and appropriate triaging TRIAGE PROCESS April 21.docx	Current Consultant-to-Consultant referrals (including outside of Trust) are not currently manged through e-Triage so there is still a risk that these could be delayed. Remaining specialties that still do not use e-Triage are being addressed	Consultant to Consultant referrals to be added to e-Triage and the PDF SOP to be updated Consultant to Consultant Referrals. Remaining specialties to be added to e-Triage The triage process continues to be monitored weekly and needs to be complied to and enforced where necessary	After 7 days Non- triage of urgent and routine referrals is escalated by the Referral & Booking Centre to the Operational Support Lead for the Clinical Area After 21 days OSL to escalate to Lead Clinician and HOS and copy Assistant Director of Functional & Support Services After 28 days HOS escalates to AD & AMD to address. After 35 days AD & AMD escalates to Director of Acute

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
2. Undictated Clinics	Some patients not having a letter dictated following an outpatient consultation resulting in no outcome recorded on PAS.	There is no system or process that provides assurance that each outpatient consultation generates an outpatient outcome letter	All Medical staff must understand that a letter is required for every outpatient attendance.	A limitation with the G2 system is that it simply records speech and generates a letter. However G2 is unable to correlate the letter dictated against the outpatient attendance.	The Trust has been working on the G2/PAS interface. This major piece of work required integration with the help of BSO. It is now in 'live' mode and is being piloted by one consultant with positive feedback. This will provide the Trust with more assurance around the dictation of outpatient clinics. A policy and guidance document needs to be developed and circulated to all Medical Staff to reiterate that a letter must be done for all outpatient attendance including for patients who do not attend. Update typing SOP to highlight that when a letters is not dictated for a patient that the secretary raises with	When the secretary is typing the clinics she must escalate to the Consultant by e mail and cc their service administrator if there are any letters missing on Digital Dictation. <u>If no response After 7 days</u> This is escalated to the Service Administrator. <u>After 14 days</u> Service Administrator to escalate to Lead Clinician and HOS <u>After 21 days</u> HOS escalates to AD & AMD to address.

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
2. Undictated Clinics					the consultant and line manager in the first instance. Secretaries need to do a check and balance after every clinic checking that every patient has a letter dictated. Secretaries to stipulate on their backlog reports if they know of any undictated clinics/letters Monthly typing reports require to be produced and shared throughout all divisions At Junior doctor changeover inductions, the importance of timely and accurate dictating of all outpatients they have reviewed must be highlighted to them.	<u>After 28 days</u> AD & AMD escalates to Director of Acute

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
3. Hospital Notes	Patient's hospital records electronically casenote tracked to a consultant and a location.	When patients hospital records were required same not in the tracked location At a time health records did complete IR1 forms but were advised to stop , by the Director at that time.	Current tracking system is a function on Patient Administrative System (PAS) Missing Charts are investigated and an IR1 form is completed if not found	There is currently no system which identifies that a chart is not where it is tracked to other than manual searches.	Any missing notes need to have an IR1 raised to highlight the problem. These should be reported to the respective areas. All staff managing patient notes should be reminded of the need for accuracy on PAS when tracking notes and patient records should be returned to file as soon as possible. All consultants need to be reminded regularly that all charts are tracked in their name and that it is their responsibility to ensure the notes are kept in the location that the notes are tracked to. Business Case for IFit which is an electronic	Service Administrators to do spot-checks of offices and highlight any issues of charts being stored beyond a reasonable time period IR1's to be monitored by the Head of health records and to escalate to the AD FSS Division for repeat 'Borrower' missing notes and any concerns over a particular consultant should be escalated to Clinical Director/AMD and

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
					tracking system using barcode technology (as used in other Trusts in NI) to be considered for funding until the NI Electronic Patient Record replaces paper records under the Encompass Project This had been previously submitted and approved but no funding identified.	AD
4. Private Patients	Patients who had been initially reviewed privately were added to the waiting list in a non-chronological manner	No monitoring of patients seen privately where they are entered onto the waiting list	This is governed by the Private Patient policy	It relies on the integrity of the consultant to comply with the private patient policy.	Revise the policy for paying patients in the Trust and share with all clinical teams. Guide-to-Paying-Patients-Southern-Trust- Data Quality Release notice for recording of	Secretaries have been given the codes to use to add private patients to the waiting list. A report is now on business objects for private patients added to waiting lists the private patient officer reconciles and chases up missing forms . After 7 days the

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
					private patient activity on PAS to be shared amongst clinical teams.	<u>private patient officer</u> If forms haven't been received by Private Patient Office this is escalated to the HOS/CD. <u>After 14 days</u> HOS escalates to AD & AMD to address. <u>After 21 days</u> AD & AMD escalates to Medical Director

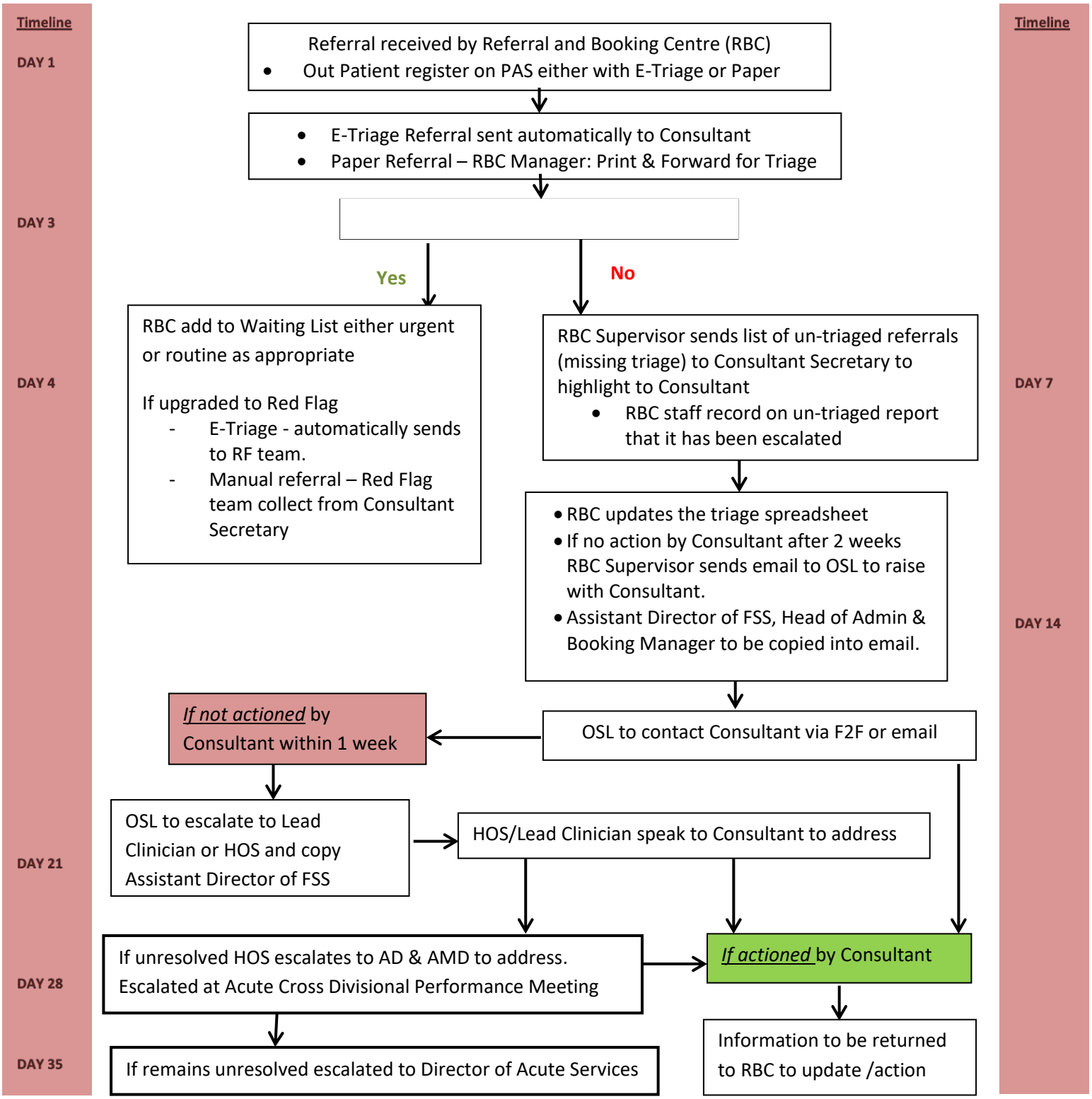
TRIAGE PROCESS

This process is developed by the Region under the IEAP (Integrated Elective Access Protocol) Referrals should be returned within 72 hrs but the Southern Trust have agreed 1 week to assist Clinicians as a more reasonable approach.

- **Red Flag referrals should be returned from Triage within 24hrs**
- **Urgent referrals should be returned from Triage within 72hrs**
- **Routine referrals should be returned from Triage within week.**

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It directs the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
- The Consultant can return referrals with advice and no outpatient attendance where appropriate.



Note: This process will incur a minimum of 5 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.
It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above.

Southern Health and Social Care Trust

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ADMINISTRATIVE & CLERICAL Standard Operating Procedure

Title	Consultant to Consultant Referrals	
S.O.P. Section	Referral and Booking Centre	
Version Number	v1.0	**Supersedes:** v0.1
Author	Katherine Robinson	
Page Count	3	
Date of Implementation	January 2011	
Date of Review	January 2012	**To be Reviewed by:** Admin and Clerical Manager's Group
Approved by	Admin and Clerical Manager's Group	

Standard Operating Procedure (S.O.P)
Referral and Booking Centre Procedures

Introduction

This SOP outlines the procedures followed by the Referral and Booking Centre to recognise a referral is in place from one consultant to another.

Implementation

This procedure is already effective and in operation in the Referral and Booking Centre.

Consultant to Consultant Referrals

The secretary for the consultant referring the patient should OP REG the patient on PAS with the OP REG date being the date the decision to refer was made (eg the clinic date)

This is done by using the Function:
DWA – ORE.

The name of the *referring consultant* should be entered into the comment field NOT the name of the consultant being referred to. Referrals should then be directed to the Referral and Booking Centre not to the secretary.

This will ensure that the patient now appears on a PTL and that the booking clerks will know who referred the patient and when.

When doing this the **Referral Source should be OC** (Other Consultant) **and NOT CON.**

Patients registered with a referral source as 'Con' do not appear on a PTL and can be missed.

Although all referrals are date stamped when they are received into the Referral and Booking centre **–** the original referral date will remain and will not be amended.

Southern Health and Social Care Trust

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A GUIDE TO PAYING PATIENTS

V.2 [11th February 2016]

DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Guide to Paying Patients Version: 2
Supersedes	Supersedes: Guidelines for Management of Private Patients
Originator	Name of Author: Anne Brennan Title: Senior Manager Medical Directorate
Approval	Referred for approval by: Anne Brennan Date of Referral: 27th March 2014 to: • Trust Senior Management Team • Trust LNC
Circulation	Issue Date: 16th October 2014 Circulated By: Medical Directorate Issued To: As per circulation List: All Medical Staff
Review	Review Date: February 2017 Responsibility of (Name): Norma Thompson Title: Senior Manager Medical Directorate

CONTENTS

1. INTRODUCTION

1.1 The Trust came into existence on 1 April 2007 and is responsible for providing acute care across three sites namely:-

- Craigavon Area Hospital, Portadown
- Daisy Hill Hospital, Newry
- South Tyrone Hospital, Dungannon

1.2 The Trust welcomes additional income that can be generated from the following sources:-

- Private Patients
- Fee Paying Services
- Overseas Visitors

1.3 All income generated from these sources is deemed to make a valued contribution to the running costs of the Trust and will be reinvested to improve our facilities to benefit NHS and private patients alike.

1.4 All policies and procedures in relation to these areas will be carried out in accordance with Trust guidelines.

1.5 For further information please do not hesitate to contact the Paying Patient Office. [email: Irrelevant redacted by the USI
http://www.southerndocs.hscni.net/paying-patients/

2. OBJECTIVES

2.1 The purpose of this guideline is to:

- Standardise the manner in which all paying patient practice is conducted in the organisation.
- Raise awareness of the duties and responsibilities within the health service of medical staff engaging in private practice and fee paying services within the Trust.
- Raise awareness of the duties and responsibilities of all Trust staff, clinical and non-clinical in relation to the treatment of paying patients and fee paying services within the Trust.
- Ensure fairness to both NHS patients and fee paying patients at all times.
- Clarify for relevant staff the arrangements pertaining to paying patients and to give guidance relating to
  - record keeping
  - charging

- procedures and
- responsibilities for paying patient attendances, admissions and fee paying services.

- Clarify charging arrangements when consultants undertake fee paying services within the Trust.

3. CATEGORIES OF WORK COVERED BY THIS GUIDE

3.1 Fee Paying Services

3.1.1 Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

3.2 Private Professional Services *(also referred to as 'private practice')*

3.2.1 The diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions.

3.2.2 Work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

3.3 Overseas Visitors

3.3.1 The National Health Service provides healthcare free of charge to people who are a permanent resident in the UK/NI. A person does not become an ordinarily resident simply by having British Nationality; holding a British Passport; being registered with a GP, or having an NHS number. People who do not permanently live in NI/UK are not automatically entitled to use the NHS free of charge.

3.3.2 **RESIDENCY** is therefore the main qualifying criterion.

4. POLICY STATEMENT

4.1 Medical consultant staff have the right to undertake Private Practice and Fee paying services within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review and with the approval of the Medical Director.

4.2 This Trust provides the same care to all patients, regardless of whether the cost of their treatment is paid for by HSC Organisations, Private Medical Insurance companies or by the patient.

4.3 Private Practice and Fee Paying services at the Trust will be carried out in accordance with:

- The Code of Conduct for private practice, the recommended standard of practice for NHS consultants as agreed between the BMA and the DHSSPS (Appendix 2).
- Schedule 9 of the Terms and Conditions of the Consultant contract which sets out the provisions governing the relationship between HPSS work and private practice (Appendix 8).
- The receipt of additional fees for Fee Paying services as defined in Schedule 10 of the Terms and Conditions of the Consultant Contract (Appendix 1).
- The principles set out in Schedule 11 of the above contract (Appendix 5).

4.4 All patients treated within the Trust, whether private or NHS should, where possible:

- be allocated a unique hospital identifier
- be recorded on the Patient Administration System and
- have a Southern Health & Social Care Trust chart.

4.5 The Trust shall determine the prices to be charged in respect of all income to which it is entitled as a result of private practice or other fee paying services which take place within the Trust.

5. CONSULTANT MEDICAL STAFF RESPONSIBILITIES

5.1 Private Practice

5.1.1 While Medical consultant staff have the right to undertake Private Practice within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review, it is the responsibility of consultants, prior to the provision of any diagnostic tests or treatment to:

- ensure that their private patients (whether In, Day or Out) are identified and notified to the Paying Patients Officer.

- ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.
- ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, Pathologist, hospital charges. Leaflets can be obtained from the Paying Patients Officer or the Paying Patients section of Southern Docs website – click here.
- obtain prior to admission and at each outpatient attendance a signed, witnessed Undertaking to Pay form (Appendix 3) which must then be sent to the Paying Patient Officer for the relevant hospital at least three weeks before the admission date. This document must contain details of all diagnostic tests and treatments prescribed.
- Establish the method of payment at the consultation stage and obtain details of insured patients' private medical insurance policy information. The Trust requires this information to be forwarded to the Paying Patient Officer **prior to admission** so that patients' entitlement to insurance cover can be established. This should be recorded on the Undertaking to Pay form [Appendix 3].
- Ensure that all patients, where appropriate, are referred by the appropriate channels, i.e. GP/other consultant.
- Ensure that private patient services that involve the use of NHS staff or facilities are not undertaken except in emergencies, unless an undertaking to pay for treatment has been obtained from (or on behalf of) the patient, in accordance with the Trust's procedures.
- Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.

5.2 Fee Paying Services - *see Appendix 1 for examples*

5.2.1 The Consultant job plan review will cover the provision of fee paying services within the Trust. Consultants are required to declare their intention to undertake Fee Paying Services work by forwarding the Paying Patient Declaration form to the Medical Director's office.

5.2.2 A price list for fee paying services is available from the Paying Patients Office or the Paying Patients section of Southern Docs website – click here. It is the responsibility of the Consultant to ensure that the Trust is reimbursed for all costs incurred while facilitating fee paying services work undertaken. These costs could include:

- use of Trust accommodation;
- tests or other diagnostic procedures performed;
- radiological scans.

5.2.3 Consultants who engage in fee paying activities within the Trust are required to remit to the Trust on a quarterly basis the income due.

1.2.4 Consultants should retain details of all patients seen for medical legal purposes. These should be submitted by the consultant on a quarterly basis along with the corresponding payment. See Section 11 for further details.

5.3 Additional Programmed Activities

5.3.1 Consultants should agree to accept an extra paid programmed activity in the Trust, if offered, before doing private work. The following points should be borne in mind:

- If Consultants are already working 11 Programmed Activities (PAs) (or equivalent) there is no requirement to undertake any more work.
- A Consultant could decline an offer of an extra PA and still work privately, but with risk to their pay progression for the year in question.
- Any additional PAs offered must be offered equitably between all Consultants in that specialty; if a colleague takes up those sessions there would be no detriment to pay progression for the other Consultants.

5.3.2 Consultant Medical Staff are governed by The Code of Conduct for Private Practice 2003 (at Appendix 2).

6. RESTRICTIONS ON PRIVATE PRACTICE FOR CONSULTANT MEDICAL STAFF

6.1 New Consultants

6.1.1 Newly appointed consultants (including those who have held consultant posts elsewhere in the NHS, or equivalent posts outside the NHS) may not undertake private practice within the Trust or use the Trusts facilities or equipment for private work, until the arrangements for this have been agreed in writing with the Trust Medical Director. A job plan must also have been agreed. An application to undertake private practice should be made in writing to the Medical Director through completion of the Paying Patient Declaration. New consultants permitted to undertake private work must make themselves known to the Paying Patients Officer.

6.2 Locum Consultants

6.2.1 Locum consultants may not engage in Private Practice within the first three months of appointment and then not until the detailed Job Plan has been agreed with the relevant Clinical Manager and approval has been granted by the Medical Director. This is subject to the agreement of the patient/insurer.

6.3 Non Consultant Grade Medical Staff

6.3.1 Non-consultant medical staff practitioners such as Associate Specialists may undertake Category 2 or private outpatient work, with the approval of the

Medical Director following confirmation that the practitioner undertakes such work outside his/her programmed activities as per their agreed job plan.

6.3.2 Other than in the circumstances described above, staff are required to assist the consultant to whom they are responsible with the treatment of their private patients in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of the hospital treatment including that of all associated staff.

7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

7.1 Treatment Episode

7.1.1 A patient who sees a consultant privately shall continue to have private status throughout the entire treatment episode.

7.2 Single Status

7.2.1 An outpatient cannot be both a Private and an NHS patient for the treatment of the one condition during a single visit to an NHS hospital.

7.3 Outpatient Transfer

7.3.1 However a private outpatient at an NHS hospital is legally entitled to change his/her status for any a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking he/she has made to pay charges.

7.4 Waiting List

7.4.1 A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient.

7.5 Inpatient Transfer

7.5.1 A private inpatient has a similar legal entitlement to change his/her status. This entitlement can only be exercised when a significant and unforeseen change in circumstances arises e.g. when they enter hospital for a minor operation and they are found to be suffering from a different more serious complaint. He/she remains liable to charges for the period during which he/she was a private patient.

7.6 During Procedure

7.6.1 A patient may request a change of status during a procedure where there has been an unpredictable or unforeseen complexity to the procedure. This can be tested by the range of consent required for the procedure.

7.7 Clinical Priority

7.7.1 A change of status from Private to NHS must be accompanied by an assessment of the patient's clinical priority for treatment as an NHS patient.

7.8 Change of Status Form

7.8.1 Where a change of status is required a 'Change of Status' Form (Appendix 4) must be completed and sent to the Paying Patients Officer. This includes the reason for the change of status which will be subject to audit and must be signed by both the consultant and Paying Patients Officer. The Paying Patients Officer will ensure that the Medical Director approves the 'Change of Status' request.

7.8.2 It is important to note that until the Change of Status form has been approved by the Medical Director the patient's status will remain private and they may well be liable for charges.

8. TRUST STAFF RESPONSIBILITIES RELATING TO PRIVATE PATIENTS AND FEE PAYING SERVICES

8.1 A private patient is one who formally undertakes to pay charges for healthcare services regardless of whether they self-pay or are covered by insurance and all private patients must sign a form to that effect (Undertaking to Pay form at Appendix 3) prior to the provision of any diagnostic tests or treatments. Trust staff are required to have an awareness of this obligation.

8.2 The charge which private patients pay to the Trust covers the total cost of the hospital treatment excluding consultant fees. Trust staff are required to perform their duties in relation to all patients to the same standard. No payment should be made to or accepted by any non-consultant member of Trust staff for carrying out normal duties in relation to any patients of the Trust.

9. OPERATIONAL ARRANGEMENTS

9.1 Each hospital within the Trust has a named officer [Paying Patients Officer] who should be notified in advance of all private patient admissions and day cases. The Paying Patient Officer is responsible for ensuring that the Trust recovers all income due to the Trust arising from the treatment of private patients.

9.2 The Paying Patients Officer, having received the signed and witnessed Undertaking to Pay **Form at least three weeks** before the planned procedure will identify the costs associated with the private patient stay, will confirm entitlement to insurance cover where relevant and will raise invoices on a timely basis. [See Flow Chart 1]

9.3 The Medical Director will advise the Paying Patients Officer when a consultant has been granted approval to undertaken private practice. The Paying Patients Officer will advise the consultant of the procedures involved in undertaking private practice in the Trust.

9.4 Clinical governance is defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

9.5 This framework applies to all patients seen within this Trust. It is therefore a fundamental requirement of Clinical Governance that all patients treated within the Trust must be examined or treated in an appropriate clinical setting.

9.6 Any fee or emolument etc. which may be received by an employee in the course of his or her clinical duties shall, unless the Trust otherwise directs, be surrendered to the Trust. For further information please see Southern Trust Gifts and Hospitality Standards of Conduct policy.

9.7 Record Keeping Systems and Private Patients

9.7.1 All patients regardless of their status should, where possible, be recorded on Hospital Systems and their status classified appropriately. These systems include for example:

- Patient Administration System (PAS)
- Northern Ireland Maternity System (NIMATS)
- Laboratory System
- Radiology System(e.g. Sectra, PACS, NIRADS, RIS etc)

9.8 Health Records of Private Patients

9.8.1 All hospital health records shall remain the property of the Trust and should only be taken outside the Trust to assist treatment elsewhere:

- when this is essential for the safe treatment of the patient
- when an electronic record of the destination of the notes is made using the case note tracking system
- when arrangements can be guaranteed that such notes will be kept securely
- provided that nothing is removed from the notes

9.8.2 Consultants who may have access to notes for private treatment of patients must agree to return the notes without delay. Either originals or copies of the patient's private notes should be held with their NHS notes. Patients' notes should not be removed from Trust premises. Requests for notes for medico-legal purposes should be requested by plaintiff's solicitor through the normal channels.

9.8.3 Since the Trust does not have a right of access to patient notes held in non NHS facilities, when patients are seen privately outside the Trust their first appointment within the Trust, unless with the same consultant, will be treated as a 'new appointment' rather than a 'review appointment'.

9.8.4 In the event of a 'Serious Adverse Incident' or legal proceedings the Trust may require access to private patient medical records which should be held in accordance with GMC Good Record Keeping Guidance.

9.9 Booking Arrangements for Admissions and Appointments

9.9.1 A record of attendance should be maintained, where possible, for all patients seen in the Trust. All private in, day and out patients should as far as possible be pre-booked on to the hospital information systems. Directorates are responsible for ensuring that all relevant information is captured and 'booking in' procedures are followed. Each department should ensure that all such patients are recorded on PAS etc. within an agreed timescale which should not extend beyond month end.

9.10 Walk Ins

9.10.1 A private patient who appears at a clinic and has no record on PAS should be treated for record keeping purposes in exactly the same manner as an NHS patient (walk in) i.e. relevant details should be taken, registry contacted for a number and processed in the usual fashion. A record should be kept of this patient and the Paying Patient Officer informed.

9.11 Radiology

9.11.1 All patients seen in Radiology should be given a Southern Health and Social Care hospital number.

9.12 Private Patient Records

9.12.1 All records associated with the treatment of private patients should be maintained in the same way as for NHS patients. This includes all files, charts, and correspondence with General Practitioners.

9.12.2 Accurate record keeping assists in the collection of income from paying patients.

9.12.3 It should be noted that

- any work associated with private patients who are not treated within this Trust or consultants private diary work and correspondence associated with patients seen elsewhere should not be carried out within staff time which is paid for by the Trust.

9.13 Tests Investigations or Prescriptions for Private Patients

9.13.1 The consultant must ensure that the requests for all laboratory work, ie. radiology, prescriptions, dietetics, physiotherapy etc. are clearly marked as Private.

9.13.2 Consultants should not arrange services, tests investigations or prescriptions until the person has signed an Undertaking to Pay form which will cover the episode of care [Appendix 3]. This must be submitted three weeks before any planned procedure.

9.14 Medical Reports

9.14.1 In certain circumstances Insurance Companies will request a medical report from the consultant. It is the consultant's responsibility to ensure that this report is completed in the timeframe required by the insurance company otherwise the Trust's invoice may remain unpaid in whole or in part until the report has been received and assessed.

10. FINANCIAL ARRANGEMENTS - PRIVATE PATIENTS

10.1 Charges to Patients

10.1.1 Where patients, who are private to a consultant, are admitted to the hospital, or are seen as outpatients, charges for investigations/diagnostics will be levied by the hospital. A full list of charges is available from the Paying Patient Office on request. Patients should be provided with an estimate of the total fee that they will incur **before** the start of their treatment.

10.1.2 Prices are reviewed regularly to ensure that all costs are covered. A calendar of pricing updates will be agreed.

10.2 Charges for Use of Trust Facilities for Outpatients

10.2.1 It is the responsibility of the Doctor to recover the cost from the patient and reimburse the Trust, on a quarterly basis, for any outpatients which have been seen in Trust facilities. [See Flow Chart 2]

10.2.2 A per patient cost for the use of Trust facilities for outpatients is available. This will be reviewed annually.

10.2.3 It is responsibility of the doctor to maintain accurate records of outpatient attendances. It is an audit requirement that the Trust verifies that all income associated with use of Trust facilities for outpatients has been identified and collected. Accordingly, Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees as outlined above.

10.2.4 A Undertaking to Pay form will only be required if investigations/diagnostics are required.

10.3 Basis of Pricing

10.3.1 Charges are based on an accommodation charge, cost of procedure, including any prosthesis, and on a cost per item basis for all diagnostic tests and treatments e.g. physiotherapy, laboratory and radiology tests, ECGs etc. They do not include consultants' professional fees. Some package prices may be agreed.

10.4 Uninsured Patients – Payment Upfront

10.4.1 Full payment prior to admission is required from uninsured patients. Consultants should advise patients that this is the case. The patient should be advised to contact the Paying Patients Officer regarding estimated cost of treatment. [See Flow Chart 4]

10.5 Insured Patients

10.5.1 The Undertaking to Pay Form also requires details of the patient's insurance policy. The Paying Patients Officer will raise invoices direct to the insurance company where relevant, in accordance with the agreements with individual insurance companies.

10.5.2 Consultants, as the first port of contact and the person in control of the treatment provided, should advise the patient to obtain their insurance company's permission for the specified treatment to take place within the specified timescale. [See Flow Chart 4]

10.6 Billing and Payment

10.6.1 The Paying Patients Officer co-ordinates the collation of financial information relating to patients' treatment, ensures that uninsured patients pay deposits and that invoices are raised accordingly. The financial accounts department will ensure all invoices raised are paid and will advise the Private Patient Officer in the event of a bad debt.

10.7 Audit

10.7.1 The Trust's financial accounts are subject to annual audit and an annual report is issued to the Trust Board, which highlights any area of weakness in control. Adherence to the Paying Patient Policy will form part of the Trust's Audit Plan. Consultants are reminded that they are responsible for the identification and recording of paying patient information. Failure to follow the procedures will result in investigation by Audit and if necessary, disciplinary action under Trust and General Medical Council regulations.

11. FINANCIAL ARRANGEMENTS FOR FEE PAYING SERVICES

11.1 Consultants may see patients privately or for fee paying services within the Trust only with the explicit agreement of the Medical Director, in accordance with their Job Plan. Management will decide to what extent, if any, Trust facilities, staff and equipment may be used for private patient or fee paying services and will ensure that any such services do not interfere with the organisation's obligations to NHS patients. This applies whether private services are undertaken in the consultant's own time, in annual or unpaid leave. [See Flow Chart 3]

11.2 In line with the Code of Conduct standards, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients.

11.3 Fee Paying Services Policy (Category 2)

11.3.1 Fee Paying Services (Category 2) work is distinct from private practice, however it is still non NHS work as outlined in the 'Terms and Conditions for Hospital Medical and Dental Staff'. Refer to schedules 10 and 11 (Appendices 1 & 5 respectively) for further details.

11.3.2 There are a number of occasions when a Category 2 report will be requested, and they will usually be commissioned by, employers, courts, solicitors, Department of Work and Pensions etc. the report may include radiological opinion, blood tests or other diagnostic procedures

11.3.3 It is the responsibility of the Doctor to ensure that the Trust is reimbursed for all costs incurred in undertaking Category 2 work, this not only includes the use of the room but also the cost of any tests undertaken.

11.3.4 In order to comply with the Trusts financial governance controls it is essential that all Fee Paying services are identified and the costs recovered. It is not the responsibility of the Trust to invoice third parties for Category 2 work.

11.3.5 It is the responsibility of the Doctor to recover the cost from the third party and reimburse the Trust, on a quarterly basis, for any Category 2 services they have undertaken, including the cost of any treatments/tests provided.

11.3.6 The Category 2 (room only) charge per session will be reviewed annually.

11.3.7 A per patient rate may be available subject to agreement with the Paying Patient Manager

11.3.8 It is responsibility of the doctor to maintain accurate records of Category 2 attendances. It is an audit requirement that the Trust verifies that all income associated with Category 2 has been identified and collected.

11.3.9 Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees of Category 2 work as outlined above and should be submitted no later than ten days after the quarter end.

11.3.10 In order to comply with Data Protection requirements, Doctors must therefore inform their Category 2 clients that this information is required by the Trust and obtain their consent. Consultants should make a note of this consent.

11.3.11 Compliance to this policy will be monitored by the Paying Patient Manager and the Medical Director's Office.

11.3.12 The Consultant is responsible to HM Revenue and Customs to declare for tax purposes all Category 2 income earned. The Trust has no obligation in this respect.

11.3.13 Any Category 2 work undertaken for consultants by medical secretaries must be completed outside of their normal NHS hours. Consultants should be aware of their duty to inform their secretaries that receipt of such income is subject to taxation and must be declared to HM Revenue and Customs. It is recommended that Consultants keep accurate records of income and payment.

12. RENUNCIATION OF PRIVATE FEES

12.1 In some departments, consultants may choose to forego their private fees for private practice or for fee paying services in favour of a Charitable Fund managed by the Trust that could be drawn upon at a later stage for, by way of example, Continuous Professional Development / Study Leave.

12.2 For income tax purposes all income earned must be treated as taxable earnings. The only way in which this income can be treated as non taxable earnings of the consultant concerned is if the consultant signs a 'Voluntary Advance Renunciation of Earnings form' (Appendix 7) and declares that the earnings from a particular activity will belong to a named charitable fund and that the earnings will not be received by the consultant. In addition a consultant should never accept a cheque made out to him or her personally. To do so attracts taxation on that income and it cannot be subsequently renounced. Therefore all such income renounced in advance should be paid directly into the relevant fund. Income can only be renounced if it has not been paid to the individual and a Register of these will be maintained by the Charitable Funds Officer.

12.3 The Trust will be required to demonstrate that income renounced in favour of a Charitable Fund is not retained for the use of the individual who renounces it. Thus, in the event of any such consultant subsequently drawing on that fund, any such expenditure approval must be countersigned by another signatory on the fund.

13. OVERSEAS VISITORS - NON UK PATIENTS

(Republic of Ireland, EEA, Foreign Nationals)

PLEASE NOTE THIS IS ONLY A BRIEF GUIDE FOR FURTHER INFORMATION PLEASE CONTACT THE PAYING PATIENT OFFICE

13.1 The NHS provides healthcare free of charge to people who are 'ordinarily resident' in the UK. People who do not permanently live in the UK lawfully are not automatically entitled to use the NHS free of charge.

13.2 **RESIDENCY** is the therefore the main qualifying criterion, applicable regardless of nationality, being registered with a GP or having been issued a HC/NHS number, or whether the person holds a British Passport, or lived and paid taxes or national insurance contributions in the UK in the past.

13.3 Any patient attending the Trust who cannot establish that they are an ordinary resident and have lawfully lived in the UK permanently for the last 12 months preceding treatment are not entitled to free non ED hospital treatment whether they are registered with a GP or not. A GP referral letter cannot be accepted solely as proof of a patient's permanent residency and therefore entitlement to treatment.

13.4 For all new patients attending the Trust, residency must be established. All patients will be asked to complete a declaration to confirm residency, (regardless of race/ethnic origin). If not the Trust could be accused of discrimination.

13.5 Where there is an element of doubt as to whether the patient is an 'ordinary resident' eg no GP/ H&C number or non UK contact details, the Paying Patients Officer must be alerted immediately.

13.6 Emergency Department

13.6.1 Treatment given in an Emergency Department, Walk in Clinic or Minor Inuries Unit is free of charge if it is deemed to be immediate and necessary.

13.6.2 The Trust should always provide immediate and necessary treatment whether or not the patient has been informed of or agreed to pay charges .There is no exemption from charges for 'emergency' treatment other than that given in the accident and emergency department. Once an overseas patient is transferred out of Emergency Department their treatment becomes chargeable.

13.6.3 All patients admitted from Emergency Department must be asked to complete declaration of residency status.

13.6.4 This question is essential in trying to establish whether the patient is an overseas patient or not and hence liable to pay for any subsequent care provided.

13.6.5 If the patient is not an ordinary resident or there is an element of doubt eg no GP/ no H&C Number, the patient should be referred to Paying Patients Office to determine their eligibility.

13.6.6 If the person has indicated that they are a visitor to Northern Ireland, the overseas address must be entered as the permanent address on the correct Patient Administrative System and the Paying Patients Office should be notified immediately.

13.7 Outpatient Appointments

13.7.1 In all cases where the patient has not lived in Northern Ireland for 12 months or relevant patient data is missing such as H&C number, GP Details etc the patient must be referred to the Paying Patients Office to establish the patient's entitlement to free NHS treatment. This must be established before an appointment is given.

13.8 Review Appointments

13.8.1 Where possible follow up treatment should be carried out at the patient's local hospital, however if they are reviewed at the Trust they must be informed that they will be liable for charges.

13.8.2 If a consultant considers it appropriate to review a patient then they must sign a statement to this effect waiving the charges that would have been due to the Trust.

13.9 Elective Admission

13.9.1 A patient should not be placed onto a waiting list until their entitlement to free NHS Treatment has been established. Where the Patient is chargeable, the Trust should not initiate a treatment process until a deposit equivalent to the estimated full cost of treatment has been obtained.

13.10 Referral from other NHS Trusts

13.10.1 When a Consultant accepts a referral from another Trust the patients' status should, where possible, be established prior to admission. However, absence of this information should not delay urgent treatment.

13.10.2 The Trust will operate a policy of 'Stabilise and Transfer'.

14. AMENITY BED PATIENTS

14.1 Within the Trust's Maternity Service, a number of beds are assigned Amenity Beds. It is permissible for NHS patients who require surgical delivery and an overnight stay to pay for any bed assigned as an Amenity Bed. This payment has no effect on the NHS status of the patient. All patients identified as amenity will be recorded on PAS as APG and an Undertaking to Pay for an Amenity Bed form (Appendix 6) should be completed ideally before obtaining the amenity facilities.

15. GLOSSARY

Undertaking to Pay Form

Private Patients may fund their treatment, or they may have private medical insurance. In all cases Private Patients must sign an 'Undertaking to Pay' form (Appendix 3). This is a legally binding document which, when signed prior to treatment, confirms the patient as personally liable for costs incurred while at hospital and confirms the Patient's Private status. ALL private patients, whether insured or not are obliged to complete and sign an 'Undertaking to Pay' form, prior to commencement of treatment. Consultants therefore, as the first point of contact should ensure that the Paying Patients Officer is advised to ensure completion of the 'Undertaking to Pay' form.

Fee Paying Services
Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

Private Professional Services *(Also referred to as 'private practice')*

- the diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions (Appendix 1).

- work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

Non UK patients
A person who does not meet the 'ordinarily resident' test.

Job Plan
A work programme which shows the time and place of the consultant's weekly fixed commitments.

16. APPENDIX 1: SPECIFIC EXAMPLES OF FEE PAYING SERVICES - SCHEDULE 10

1. Fee Paying Services are services that are not part of Contractual or Consequential Services and not reasonably incidental to them. Fee Paying Services include:

   a. work on a person referred by a Medical Adviser of the Department of Social Development, or by an Adjudicating Medical Authority or a Medical Appeal Tribunal, in connection with any benefits administered by an Agency of the Department of Social Development;

   b. work for the Criminal Injuries Compensation Board, when a special examination is required or an appreciable amount of work is involved in making extracts from case notes;

   c. work required by a patient or interested third party to serve the interests of the person, his or her employer or other third party, in such nonclinical contexts as insurance, pension arrangements, foreign travel, emigration, or sport and recreation. (This includes the issue of certificates confirming that inoculations necessary for foreign travel have been carried out, but excludes the inoculations themselves. It also excludes examinations in respect of the diagnosis and treatment of injuries or accidents);

   d. work required for life insurance purposes;

   e. work on prospective emigrants including X-ray examinations and blood tests;

   f. work on persons in connection with legal actions other than reports which are incidental to the consultant's Contractual and Consequential Duties, or where the consultant is giving evidence on the consultant's own behalf or on the employing organisation's behalf in connection with a case in which the consultant is professionally concerned;

   g. work for coroners, as well as attendance at coroners' courts as medical witnesses;

   h. work requested by the courts on the medical condition of an offender or defendant and attendance at court hearings as medical witnesses, otherwise than in the circumstances referred to above;

   i. work on a person referred by a medical examiner of HM Armed Forces Recruiting Organisation;

   j. work in connection with the routine screening of workers to protect them or the public from specific health risks, whether such screening is a statutory obligation laid on the employing organisation by specific regulation or a voluntary undertaking by the employing organisation in pursuance of its general liability to protect the health of its workforce;

   k. occupational health services provided under contract to other HPSS, independent or public sector employers;

   l. work on a person referred by a medical referee appointed under the Workmen's Compensation (Supplementation) Act (Northern Ireland) 1966; work on prospective students of universities or other institutions of further education, provided that they are not covered by Contractual and Consequential Services. Such examinations may include chest radiographs;

m. Appropriate examinations and recommendations under Parts II and IV of the Mental Health (Northern Ireland) Order 1986 and fees payable to medical members of Mental Health Review Tribunals;

n. services performed by members of hospital medical staffs for government departments as members of medical boards;

o. work undertaken on behalf of the Employment Medical Advisory Service in connection with research/survey work, i.e. the medical examination of employees intended primarily to increase the understanding of the cause, other than to protect the health of people immediately at risk (except where such work falls within Contractual and Consequential Services);

p. completion of Form B (Certificate of Medical Attendant) and Form C (Confirmatory Medical Certificate) of the cremation certificates;

q. examinations and reports including visits to prison required by the Prison Service which do not fall within the consultant's Contractual and Consequential Services and which are not covered by separate contractual arrangements with the Prison Service;

r. examination of blind or partially-sighted persons for the completion of form A655, except where the information is required for social security purposes, or by an Agency of the Department of Social Development, or the Employment Service, or the patient's employer, unless a special examination is required, or the information is not readily available from knowledge of the case, or an appreciable amount of work is required to extract medically correct information from case notes;

s. work as a medical referee (or deputy) to a cremation authority and signing confirmatory cremation certificates;

t. medical examination in relation to staff health schemes of local authorities and fire and police authorities;

u. delivering lectures;

v. medical advice in a specialised field of communicable disease control;

w. attendance as a witness in court;

x. medical examinations and reports for commercial purposes, e.g. certificates of hygiene on goods to be exported or reports for insurance companies;

y. advice to organisations on matters on which the consultant is acknowledged to be an expert.

17. APPENDIX 2 - A CODE OF CONDUCT FOR PRIVATE PRACTICE

November 2003

Recommended Standards of Practice for NHS Consultants

An agreement between the BMA's Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland.

A CODE OF CONDUCT FOR PRIVATE PRACTICE: RECOMMENDED STANDARDS FOR NHS CONSULTANTS, 2003

Contents

Part I: Introduction

Scope of Code

1.1 This document sets out recommended standards of best practice for NHS consultants in England about their conduct in relation to private practice . The standards are designed to apply equally to honorary contract holders in respect of their work for the NHS. The Code covers all private work, whether undertaken in non-NHS or NHS facilities.

1.2 Adherence to the standards in the Code will form part of the eligibility criteria for clinical excellence awards.

1.3 This Code should be used at the annual job plan review as the basis for reviewing the relationship between NHS duties and any private practice.

Key Principles

1.4 The Code is based on the following key principles:

- NHS consultants and NHS employing organisations should work on a partnership basis to prevent any conflict of interest between private practice and NHS work. It is also important that NHS consultants and NHS organisations minimise the risk of any perceived conflicts of interest; although no consultant should suffer any penalty (under the code) simply
- because of a perception;
- The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services;
- With the exception of the need to provide emergency care, agreed NHS commitments should take precedence over private work; and
- NHS facilities, staff and services may only be used for private practice with the prior agreement of the NHS employer.

Part II: Standards of Best Practice

Disclosure of Information about Private Practice

1.2 Consultants should declare any private practice, which may give rise to any actual or perceived conflict of interest, or which is otherwise relevant to the practitioner's proper performance of his/her contractual duties. As part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work and out of hours cover.

2.2 Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser.

Scheduling of Work and On-Call Duties

2.3 In circumstances where there is or could be a conflict of interest, programmed NHS commitments should take precedence over private work. Consultants should ensure that, except in emergencies, private commitments do not conflict with NHS activities included in their NHS job plan.

2.4 Consultants should ensure in particular that:

- private commitments, including on-call duties, are not scheduled during times at which they are scheduled to be working for the NHS (subject to paragraph 2.8 below);
- there are clear arrangements to prevent any significant risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late or to be cancelled;

- private commitments are rearranged where there is regular disruption of this kind to NHS work; and private commitments do not prevent them from being able to attend a NHS emergency while they are on call for the NHS, including any emergency cover that they agree to provide for NHS colleagues. In particular, private commitments that prevent an immediate response should not be undertaken at these times.

2.5 Effective job planning should minimise the potential for conflicts of interests between different commitments. Regular private commitments should be noted in a consultant's job plan, to ensure that planning is as effective as possible.

2.6 There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments.

2.7 Where there is a proposed change to the scheduling of NHS work, the employer should allow a reasonable period for consultants to rearrange any private sessions, taking into account any binding commitments entered into (e.g. leases).

Provision of Private Services alongside NHS Duties

2.8 In some circumstances NHS employers may at their discretion allow some private practice to be undertaken alongside a consultant's scheduled NHS duties, provided that they are satisfied that there will be no disruption to NHS services. In these circumstances, the consultants should ensure that any private services are provided with the explicit knowledge and agreement of the employer and that there is no detriment to the quality or timeliness of services for NHS patients.

Information for NHS Patients about Private Treatment

2.9 In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf.

2.10 Where a NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, consultants should ensure that any information provided by them, is accurate and up-to-date and conforms with any local guidelines.

2.11 Except where immediate care is justified on clinical grounds, consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

Referral of Private Patients to NHS Lists

2.12 Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.

2.13 Where a patient wishes to change from private to NHS status, consultants should help ensure that the following principles apply:

- a patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation;
- any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient;
- any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status;
- patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients; and
- should a patient be admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.

Promoting Improved Patient Access to NHS Care and Increasing NHS Capacity

2.14 Subject to clinical considerations, consultants should be expected to contribute as fully as possible to maintaining a high quality service to patients, including reducing waiting times and improving access and choice for NHS patients. This should include co-operating to make sure that patients are given the opportunity to be treated by other NHS colleagues or by other providers where this will maintain or improve their quality of care, such as by reducing their waiting time.

2.15 Consultants should make all reasonable efforts to support initiatives to increase NHS capacity, including appointment of additional medical staff.

Part III – Managing Private Patients in NHS Facilities

3.1 Consultants may only see patients privately within NHS facilities with the explicit agreement of the responsible NHS organisation. It is for NHS organisations to decide to what extent, if any, their facilities, staff and equipment may be used for private patient services and to ensure that any such services do not interfere with the organisation's obligations to NHS patients.

3.2 Consultants who practise privately within NHS facilities must comply with the responsible NHS organisation's policies and procedures for private practice. The NHS organisation should consult with all consultants or their representatives, when adopting or reviewing such policies.

Use of NHS Facilities

3.3 NHS consultants may not use NHS facilities for the provision of private services without the agreement of their NHS employer. This applies whether private services are carried out in their own time, in annual or unpaid leave, or – subject to the criteria in paragraph 2.8 - alongside NHS duties.

3.4 Where the employer has agreed that a consultant may use NHS facilities for the provision of private services:

- the employer will determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable;

- any charge will be collected by the employer, either from the patient or a relevant third party; and

- a charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used.

3.5 Except in emergencies, consultants should not initiate private patient services that involve the use of NHS staff or facilities unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient, in accordance with the NHS body's procedures.

3.6 In line with the standards in Part II, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients. Only in unforeseen and clinically justified circumstances should an NHS patient's treatment be cancelled as a consequence of, or to enable, the treatment of a private patient.

Use of NHS Staff

3.7 NHS consultants may not use NHS staff for the provision of private services without the agreement of their NHS employer.

3.8 The consultant responsible for admitting a private patient to NHS facilities must ensure, in accordance with local procedures, that the responsible manager and any other staff assisting in providing services are aware of the patient's private status.

18. APPENDIX 3 - PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

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

PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

Private Patient: Yes ☐ No ☐ **Non-Ordinarily Resident in UK:** Yes ☐ No ☐

Name of Patient:			
Address:			
Postcode:	Telephone No:		
Date of Birth:			
H&C Number:			
Name of Insurer:		**Self Funding**	☐
Insurer Policy No:			

I have been seeing this person as a private patient. They are to be admitted / referred to _____ Hospital on _____ as an _____

Inpatient Referral	☐	**Obstetrics** ☐ Estimated Duration of Stay	**Medical** ☐ Estimated Duration of Stay	**Surgical** ☐ Estimated Duration of Stay	**T & O** ☐ Estimated Duration of Stay
Day Case Referral	☐				
Diagnostics (Inpatient or Outpatient)	☐	**Laboratory** ☐ [please detail]	**Radiology** [pleas ☐ detail]	**Other** [e.g. ☐ Pharmacy]	

Undertaking to Pay Confirmation To be completed by Consultant			
I have advised the patient named above of the estimated hospital charges and of my fees			
Signed Consultant		**Date**	
Undertaking to Pay To be completed by the person who will pay the account			
I understand and agreed to pay Southern Health and Social Care Trust all charges[1] associated with this episode of care[2] .Where the Consultant may deem further procedures/investigations necessary which will incur additional charges, I understand that this may result in a different cost from that quoted to me and I undertake to pay the full costs incurred.			
Signed Patient		**Date**	

RETURN TO PAYING PATIENTS OFFICE CRAIGAVON AREA HOSPITAL/DAISY HILL HOSPITAL [redacted]

[1] A list of Tariffs is available from the Private Patients office

[2] Episode of Care – The total treatment of either an inpatient or day case patient from diagnosis through to discharge

Southern Health and Social Care Trust - A Guide to Paying Patients

19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

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

APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
H&C Number:	
Name of Consultant	
Date of Last Private Consultation	

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

		Clinical Priority
Inpatient Referral	☐	
Outpatient Referral	☐	
Day Case Referral	☐	

Signed Consultant	
Effective Date	

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

PLEASE FORWARD TO PAYING PATIENTS OFFICE [[redacted] Irrelevant redacted by the USI

20. APPENDIX 5 PRINCIPLES GOVERNING RECEIPT OF ADDITIONAL FEES – SCHEDULE 11

Principles Governing Receipt of Additional Fees - Schedule 11

1. In the case of the following services, the consultant will not be paid an additional fee, or - if paid a fee - the consultant must remit the fee to the employing organisation:

- any work in relation to the consultant's Contractual and Consequential Services;
- duties which are included in the consultant's Job Plan, including any additional Programmed Activities which have been agreed with the employing organisation;
- fee paying work for other organisations carried out during the consultant's Programmed Activities, unless the work involves minimal disruption and the employing organisation agrees that the work can be done in HPSS time without the employer collecting the fee;
- domiciliary consultations carried out during the consultant's Programmed Activities;
- lectures and teaching delivered during the course of the consultant's clinical duties;
- delivering lectures and teaching that are not part of the consultant's clinical duties, but are undertaken during the consultant's Programmed Activities.
- Consultants may wish to take annual leave [having given the required 6 week notice period] to undertake fee paying work [e.g. court attendance] in this instance the consultant would not be required to remit fees to the Trust.

This list is not exhaustive and as a general principle, work undertaken during Programmed Activities will not attract additional fees.

2. Services for which the consultant can retain any fee that is paid:

- Fee Paying Services carried out in the consultant's own time, or during annual or unpaid leave;
- Fee Paying Services carried out during the consultant's Programmed Activities that involve minimal disruption to HPSS work and which the employing organisation agrees can be done in HPSS time without the employer collecting the fee;
- Domiciliary consultations undertaken in the consultant's own time, though it is expected that such consultations will normally be scheduled as part of Programmed Activities1;
- Private Professional Services undertaken in the employing organisation's facilities and with the employing organisation's agreement during the consultant's own time or during annual or unpaid leave;
- Private Professional Services undertaken in other facilities during the consultant's own time, or during annual or unpaid leave;
- Lectures and teaching that are not part of the consultant's clinical duties and are undertaken in the consultant's own time or during annual or unpaid leave;

- Preparation of lectures or teaching undertaken during the consultant's own time irrespective of when the lecture or teaching is delivered.

This list is not exhaustive but as a general principle the consultant is entitled to the fees for work done in his or her own time, or during annual or unpaid leave.

And only for a visit to the patient's home at the request of a general practitioner and normally in his or her company to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital.

21. APPENDIX 6 - UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

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

UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
Hospital Number:	

Site: Craigavon ☐ Daisy Hill ☐

I was allocated an amenity bed on (date): _____ **(time)**

Ward: _____ **Consultant:** _____

I undertake to pay the Southern Health Social Care Trust £39 per night for an amenity bed, which has been provided for me at my request.

Number of days Amenity Bed required: _____

I understand that if I am required to stay in hospital more days than anticipated, the midwifery staff will ask me if I wish to continue and pay for the amenity bed, or if I wish to be transferred to the open ward.

Patient's Signature: _____ **Date:** _____

Midwife's Signature: _____ **Date:** _____

To be completed by WARD CLERK OR MIDWIFE when patient is being transferred /discharged from an amenity bed.

Date transferred / discharged from amenity bed _____

Signed by midwife / ward clerk when transferred / discharged _____

22. APPENDIX 7 – AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

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

AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

I *(name)* _____

Request that any monies due to me from patients in relation to fees from
(description of activity)

_____

_____

_____

_____

_____

_____

_____

Shall be transferred to *(Charity title and reference)* _____

For its sole use in the advancement of its aims in accordance with the Trust Deed until directed otherwise by me in writing.

This request is to take effect from (date*):* _____

Signed, sealed and delivered by: _____
(Full name in BLOCK CAPITALS)

Date: _____

In the presence of: _____

Date: _____

Address:: _____

_____

_____

_____ **Postcode:** _____

_____

23. APPENDIX 8 - PROVISIONS GOVERNING THE RELATIONSHIP BETWEEN HPSS WORK AND PRIVATE PRACTICE - SCHEDULE 9

1. This Schedule should be read in conjunction with the 'Code of Conduct for Private Practice', which sets out standards of best practice governing the relationship between HPSS work and private practice.

2. The consultant is responsible for ensuring that their provision of Private Professional Services for other organisations does not:

   - result in detriment to HPSS patients;
   - diminish the public resources that are available for the HPSS.

Disclosure of information about Private Commitments

3. The consultant will inform his or her clinical manager of any regular commitments in respect of Private Professional Services or Fee Paying Services. This information will include the planned location, timing and broad type of work involved.

4. The consultant will disclose this information at least annually as part of the Job Plan Review. The consultant will provide information in advance about any significant changes to this information.

Scheduling of Work and Job Planning

5. Where a conflict of interest arises or is liable to arise, HPSS commitments must take precedence over private work. Subject to paragraphs 10 and 11below, the consultant is responsible for ensuring that private commitments do not conflict with Programmed Activities.

6. Regular private commitments must be noted in the Job Plan.

7. Circumstances may also arise in which a consultant needs to provide emergency treatment for private patients during time when he or she is scheduled to be undertaking Programmed Activities. The consultant will make alternative arrangements to provide cover if emergency work of this kind regularly impacts on the delivery of Programmed Activities.

8. The consultant should ensure that there are arrangements in place, such that there can be no significant risk of private commitments disrupting HPSS commitments, e.g. by causing HPSS activities to begin late or to be cancelled. In particular where a consultant is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of Programmed Activities for such emergency work to be carried out.

9. Where the employing authority has proposed a change to the scheduling of a consultant's HPSS work, it will allow the consultant a reasonable period in line with Schedule 6, paragraph 2 to rearrange any private commitments. The employing organisation will take into account any binding commitments that the consultant may have entered into (e.g. leases). Should a consultant wish to reschedule private commitments to a time that would conflict with Programmed Activities, he or she should raise the matter with the clinical manager at the earliest opportunity.

Scheduling Private Commitments Whilst On-Call

10. The consultant will comply with the provisions in Schedule 8, paragraph 5 of these Terms and Conditions. In addition, where a consultant is asked to provide emergency cover for a colleague at short notice and the consultant has previously arranged private commitments at the same time, the consultant should only agree to provide such emergency cover if those private commitments would not prevent him Or her returning to the relevant HPSS site at short notice to attend an emergency. If the consultant is unable to provide cover at short notice it will be the employing organisation's responsibility to make alternative arrangements and the consultant will suffer no detriment in terms of pay progression as a result.

Use of HPSS Facilities and Staff

11. Where a consultant wishes to provide Private Professional Services at an HPSS facility he or she must obtain the employing organisation's prior agreement, before using either HPSS facilities or staff.

12. The employing organisation has discretion to allow the use of its facilities and will make it clear which facilities a consultant is permitted to use for private purposes and to what extent.

13. Should a consultant, with the employing organisation's permission, undertake Private Professional Services in any of the employing organisation's facilities, the consultant should observe the relevant provisions in the 'Code of Conduct for Private Practice'.

14. Where a patient pays privately for a procedure that takes place in the employing organisation's facilities, such procedures should occur only where the patient has given a signed undertaking to pay any charges (or an undertaking has been given on the patient's behalf) in accordance with the employing organisation's procedures.

15. Private patients should normally be seen separately from scheduled HPSS patients. Only in unforeseen and clinically justified circumstances should a consultant cancel or delay an HPSS patient's treatment to make way for his or her private patient.

16. Where the employing organisation agrees that HPSS staff may assist a consultant in providing Private Professional Services, or provide private services on the consultant's behalf, it is the consultant's responsibility to ensure that these staff are aware that the patient has private status.

17. The consultant has an obligation to ensure, in accordance with the employing organisation's procedures, that any patient whom the consultant admits to the employing organisation's facilities is identified as private and that the responsible manager is aware of that patient's status.

18. The consultant will comply with the employing organisation's policies and procedures for private practice

Patient Enquiries about Private Treatment

19. Where, in the course of his or her duties, a consultant is approached by a patient and asked about the provision of Private Professional Services, the consultant may provide only such standard advice as has been agreed between the employing organisation and appropriate local consultant representatives for such circumstances.

20. The consultant will not during the course of his or her Programmed Activities make arrangements to provide Private Professional Services, nor ask any other member of staff to make such arrangements on his or her behalf, unless the patient is to be treated as a private patient of the employing organisation.

21. In the course of his/her Programmed Activities, a consultant should not initiate discussions about providing Private Professional Services for HPSS patients, nor should the consultant ask other staff to initiate such discussions on his or her behalf.

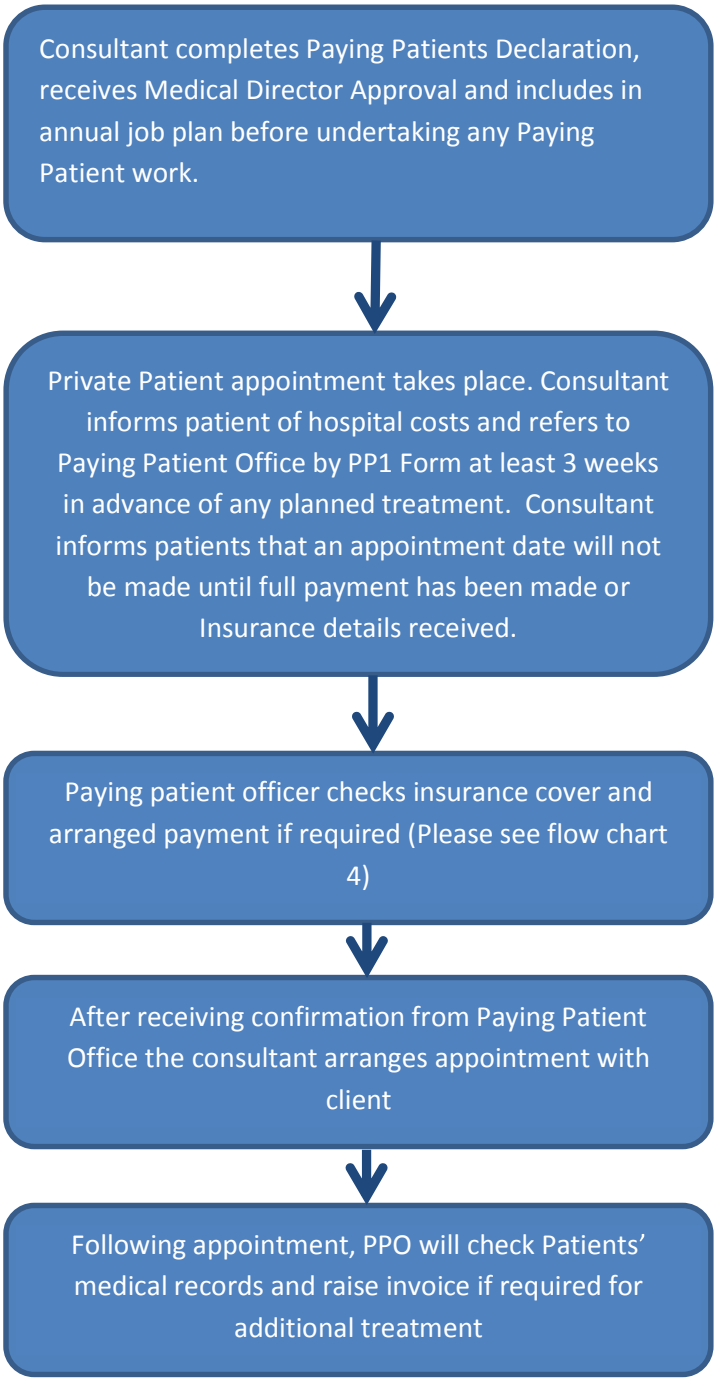
22. Where an HPSS patient seeks information about the availability of, or waiting times for, HPSS services and/or Private Professional Services, the consultant is responsible for ensuring that any information he or she provides, or arranges for other staff to provide on his or her behalf, is accurate and up-to-date.

Promoting Improved Patient Access to HPSS Care

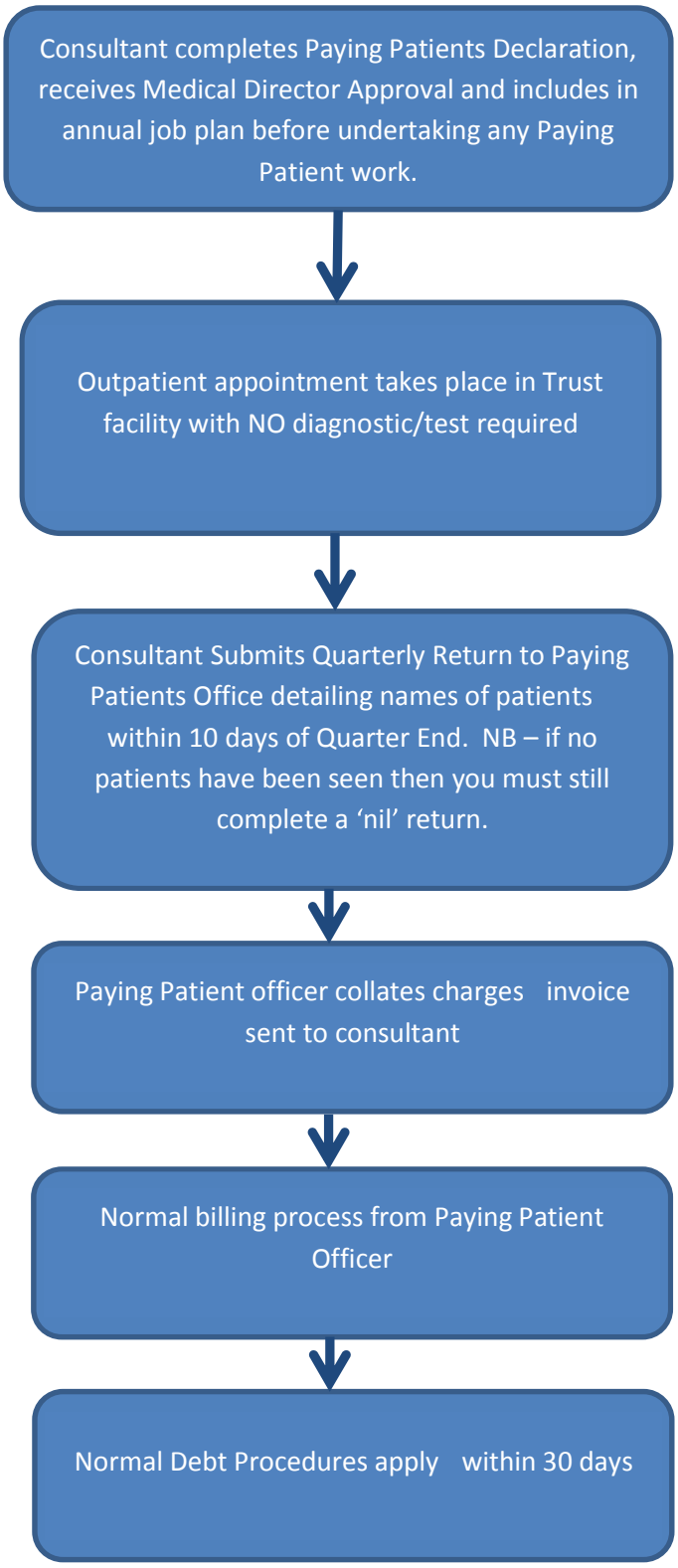
23. Subject to clinical considerations, the consultant is expected to contribute as fully as possible to reducing waiting times and improving access and choice for HPSS patients. This should include ensuring that, as far as is practicable, patients are given the opportunity to be treated by other HPSS colleagues or by other providers where this will reduce their waiting time and facilitate the transfer of such patients.

24. The consultant will make all reasonable efforts to support initiatives to increase HPSS capacity, including appointment of additional medical staff and changes to ways of working.

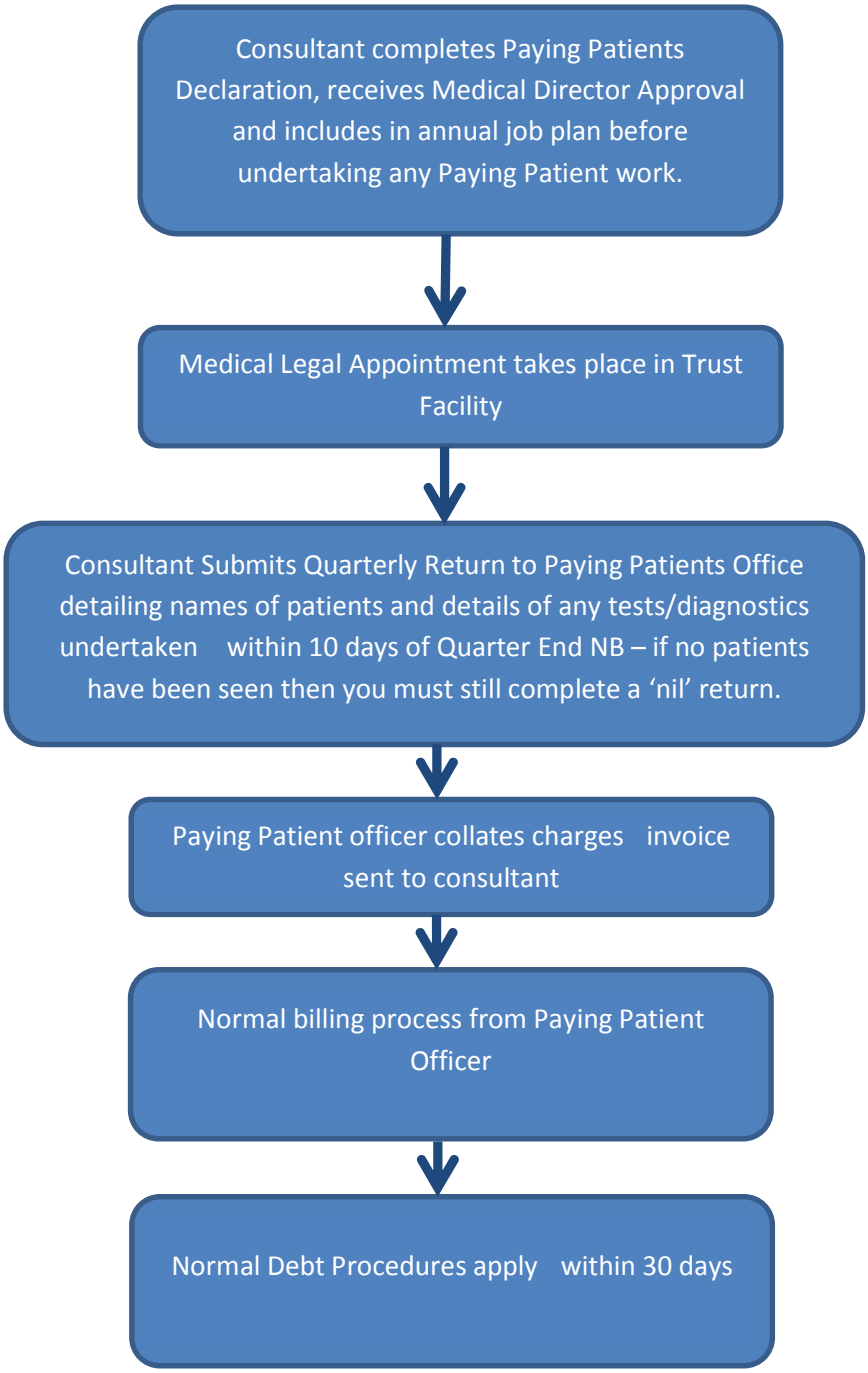
24. FLOW CHART 1 - PAYING PATIENTS [Inpatients]



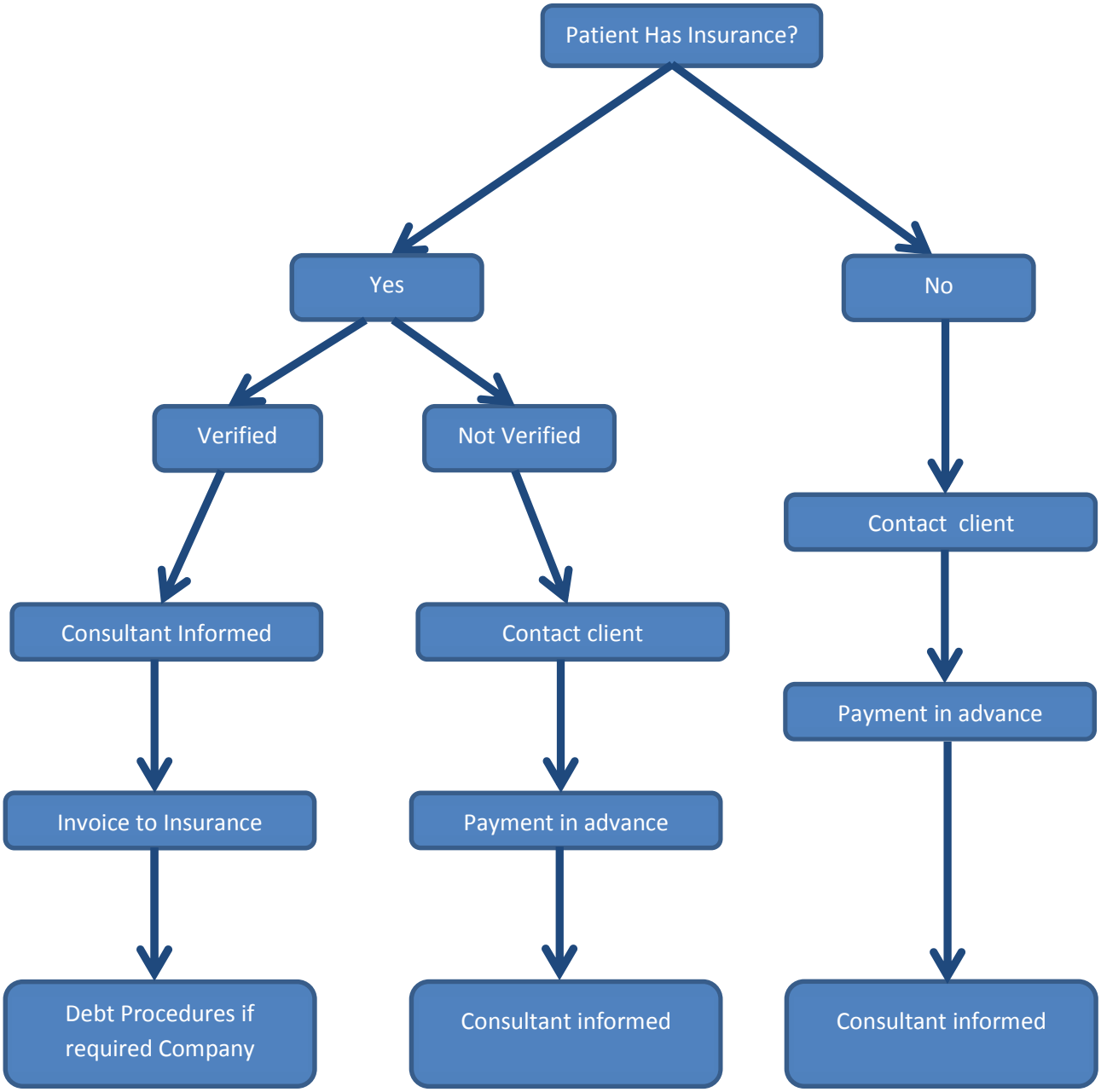
25. FLOW CHART 2 - PAYING PATIENTS [Outpatients]



26. FLOW CHART 3 - PAYING PATIENTS [Fee Paying Services]



27. FLOW CHART 4 – PATIENT INSURANCE



Services not using e-triage	
ORTHOPAEDIC GERIATRICS	Planned e-triage commencement Jan/Feb 2021
HAEMATOLOGY	Planned implementation postpone due to service pressures
NEPHROLOGY	Currently taking a break from e-triage, will relook at recommencing early 2021
GENERAL MEDICINE	Minimal referrals to this service but working with service looking towards implementation early 2021
BREAST SURGERY	Consultants not currently keen on e-triage – reengaged with service
GERIATRIC MEDICINE	Currently engaging with service

Health and Social Care Board

0023/18

Query Request Form

Requires Immediate Response: Yes

Reason for Immediate Response: Required as an action following Internal Audit review of management of private patients

---

☐	**Data Definition**	X	**Recording Issue**
X	**Technical Guidance**	☐	**Other**

Name: Roberta Gibney **Date:** 8th August 2018

Organisation: BHSCT **Contact Number:** Personal Information redacted by the USI

Subject Heading: PAS OP Referral Source Code – Private to NHS

a) Issue: ***Please provide as much detail as possible in order for the query to be considered and resolved as quickly as possible. This query form will be published on SharePoint when resolved.***

Belfast Trust requests a Referral Source Code on PAS for outpatients who change status from Private to NHS. Currently there is no guidance for identifying such patients.

Patient who attends Trust as a private patient has category recorded as PPG. When treatment completed OP registration should be closed with Discharge Reason – Treatment Completed, however if during their treatment the patient decides to change status to NHS the OP registration should be closed with Discharge Reason – Transfer to NHS and a new OP registration opened:
PAS with referral source PTN (Private to NHS) (suggested code), mapped to Internal Value (2) and CMDS Value (11) on Referral Source Masterfile and category as NHS.

This will ensure that the original category of PPG is not overwritten to NHS and the information recorded as per the Draft Technical Guidance on Private and Overseas Patients is not lost.

Belfast Trust request that the above is adopted as regional PAS Technical Guidance.

b) Response:

When a patient transfers from Private to NHS during their treatment period the OP registration should be closed using:

Discharge Reason code: TNHS – Transfer from Private to NHS

A new OP registration should be opened using:

Referral Source code: PTN – Private to NHS

Approved by: Acute Hospital Information Group

Date: 11/09/2018 **Response Published:** Yes / ~~No~~

Email: *HSCDataStandards@hscni.net*
HSC Data Standards Helpdesk: *(028) 9536 2832*

These forms are available on the Information Standards & Data Quality SharePoint Site at *http://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Helpdesk.aspx*

Clinical and Social Care Governance Review

Final Draft Report

November 2019

Report Compiled by: **Mrs J Champion, Associate HSC Leadership Centre**

Contents

Executive Summary

In April 2019 the Southern Health and Social Care Trust (the Trust) requested that the Health and Social Care (HSC) Leadership Centre undertake an independent review of clinical and social care governance within the Trust, including governance arrangements within the Medical Directorate and the wider organisation.

The independent review (the Review) was undertaken during the period from mid-May to end August 2019. A total of 15 days were allocated for the Review. The Review was undertaken using standard methodology; review and analysis of documentation and stakeholder meetings (Section 2).

During the course of the Review senior stakeholders provided the context to the development of integrated governance arrangements from the Trust's inception in April 2007 and from recommendations arising from an internal Clinical and Social Care Governance Review undertaken during 2010 and implemented in 2013 and a subsequent revisit of the 2010 Review in April 2015. Senior stakeholders identified that there had been many changes within Trust Board and the senior management team over a number of years which had had a destabilising impact upon the organisation. They cited the number of individuals who had held the Accountable Officer/Chief Executive in Interim and Acting roles as having the most significant impact and welcomed the appointment of the Chief Executive in March 2018. It was also noted that the role of Medical Director had also been in a period of flux since 2011.

The Report provides analysis (and recommendations) throughout Section 4 on what constitutes a good governance structure. Good governance is based on robust systems and processes by which the organisation directs and controls their functions in order to achieve organisational objectives. As a legal entity the Trust has in place the required elements of a good governance framework; Standing Orders, Standing Financial Instructions and a Scheme of Delegation. There is a well-defined high level Board governance structure (Board Committees Section 4.1.3) and terms of reference. The Trust Board sub-committee structure is less well defined and requires revision (Section 4.1.9). Senior stakeholders identified a lack of connectivity across the existing Governance Structure and a lack of a robust assurance and accountability framework which added to the perception that the core elements of integrated governance were being delivered in silos with various reporting lines (corporate, directorate, professional and expert/advisory committee). The proposed revised good governance structure will provide the Trust with an assurance and accountability framework which will also address the concerns expressed in respect of existing accountability/ reporting lines to Trust Board.

The Trust Board is responsible for ensuring that the Trust has effective systems in place for governance which are essential for the achievement of organisational objectives. It is also responsible for ensuring that the Trust consistently follows the principles of good governance applicable to HSC organisations and should work actively to promote and demonstrate the values and behaviours which underpin effective integrated governance. The revised assurance and accountability framework will improve connectivity by bringing together the full range of corporate,

clinical, social care, information and research governance activities into an integrated governance assurance and accountability framework through a single point of first level assurance, the Senior Management Team, to Trust Board.

There were many areas of good practice outlined during interviews with senior stakeholders; leadership walk rounds conducted by members of Trust Board, a Controls Assurance Group to continue to focus on maintaining sound systems of internal control and patient and service user initiatives including a lessons learned video on patient engagement with a mother who was involved in a Serious Adverse Incident Review following the death of her child. The video has been shared as an example of best practice by the Department of Health Inquiry into Hyponatremia-related Deaths Implementation programme at stakeholder events.

The core elements that underpin a good governance framework, strategic and operational systems of internal control and processes, were evaluated against best practice guidance (Sections 4.2-4.23). They were also evaluated for clarity of accountability, roles and responsibilities. The analysis demonstrated that many of the building blocks for good governance are in place e.g. a Board Assurance Framework, Corporate Risk Register, Risk Management Strategy and operational policies e.g. adverse incident reporting, health and safety management, claims and complaints management. However, gaps in controls and assurances in these systems and processes have been identified and recommendations made. A number of the policies and procedures are dated and require revision and updating with extant guidance. There is variation from Directorate to Directorate the application of operational policies e.g. management of complaints. Senior stakeholders identified examples of best practice in some areas, as identified above, which have not necessarily been shared or applied across the organisation. There have been changes in the roles and responsibilities at Executive Director level and these will need to be defined in revised strategy and policy documents, this will clarify the lines of assurance and accountability which will underpin the Framework as above.

Stakeholders identified lack of resources (staff and information management systems) in integrated governance structures at both a corporate and directorate level. They also identified the ever increasing demand on the existing resource for example in the management of serious adverse incidents and complaints, clinical standards and guidelines and implementation of the Regional Morbidity and Mortality System. Analysis and recommendations have been made throughout Section 4. The Corporate Clinical & Social Care Governance structure has been benchmarked against a peer Trust corporate team who provide a similar function and support an assurance and accountability framework as above (Section 4.23).

In considering recommendations for the Trust the Reviewer took account of the Inquiry into Hyponatraemia-related Deaths (IHRD) Report and Recommendations and the ongoing work of the IHRD Implementation Group and Department of Health (DoH) Workstreams.

The Trust may wish to consider constituting a task and finish/director's oversight group to oversee the implementation of the action plan to implement the findings of this Review.

There are a total of 48 recommendations contained within Section 4 which are broadly categorised under the following themes;

- Corporate Good Governance (Trust Board including Board Committees and Sub-Committees;
- Culture of Being Open;
- Controls Assurance;
- Risk Management Strategy;
- Management of SAIs, Complaints and Legal Services;
- Health & Safety;
- Standards and guidelines;
- Clinical Audit;
- Morbidity & Mortality;
- Learning for Improvement;
- Governance Information Systems including Datix;
- Clinical and Social Care Good Governance Structures.

A summary of the Recommendations is provided in Appendix 1. The summary of Recommendations should be considered in line with the related analysis and narrative in Section 4.

1.0 Introduction

In April 2019 the Southern Health and Social Care Trust (the Trust) requested that the Health and Social Care (HSC) Leadership Centre undertake an independent review of clinical and social care governance within the Trust, including governance arrangements within the Medical Directorate and the wider organisation.

The independent review (the Review) was undertaken during the period from mid-May to end-August 2019. A total of 15 days were allocated for the Review. The Review was undertaken using standard methodology; review and analysis of documentation and stakeholder meetings (Section 2).

2.0 Scope of the Clinical and Social Care Governance Review

2.1 Terms of Reference

The purpose of the review is to ensure the Trust has a robust governance structure and arrangements in place which offers assurance on patient safety and that help people learn.

The following terms of reference were agreed with the Medical Director of the Southern Health and Social Care Trust (SHSCT):

Objectives

- The Trust is seeking to undertake a comprehensive review of the current governance structure including the formulation of recommendations on what a good structure should look like;
- The Review will consider existing governance processes and particularly governance assurance, moving the Trust towards a position where there is a whole governance approach to the organisation rather than in two reporting lines. It will include a review of both clinical and social care governance;

Specifically the work will include;

- *gaining an understanding of the current governance structure and processes in place;*
- *meeting stakeholders to identify what works well and areas for improvement;*
- *undertaking a benchmarking exercise to identify best practice;*
- *reviewing existing and draft documentation including a new Governance Assurance Strategy.*

The outcome will be a written report outlining key findings from the review and recommendations.

2.2 Limitations to Review

As defined within the terms of reference above, the review of integrated governance arrangements within the Trust excluded financial governance. Given the breadth of

the terms of reference and the timeframe allocated to complete, the review does not claim to provide an exhaustive or exclusive list of all potential gaps in controls or assurance across the organisation at local level which may have arisen during the period of fieldwork.

3.0 Methodology

For the purposes of the Governance Review a standard methodology was adopted which entailed the examination and analysis of documentary evidence and meetings with key stakeholders.

Key to the consideration and analysis of documentary evidence was the evaluation and benchmarking of the Trust's core governance systems and processes of internal control, which underpin a good governance structure, against extant national/regional and best practice guidance and policy. An evaluation of existing accountability/reporting lines was also considered in the review of documentary evidence and during stakeholder meetings and recommendations to improve the Trust's overarching governance structure and internal processes are outlined throughout Section 4 (Analysis and Findings).

3.1 Analysis of Documentary Evidence

A detailed examination and analysis of a large number of policy and supplementary evidence was undertaken as part of the fieldwork for this Review.

Regional Documents:

- The Inquiry into Hyponatraemia-related Deaths, Volume 3, January 2018;
- Procedure for the Reporting and Follow up of Serious Adverse Incidents, HSCB, November 2016.

Core SHSCT Documents/Evidence:

- Annual Report and Accounts 2017/18;
- Board Assurance Framework, May 2018 and June 2019;
- Clinical Audit Strategy, June 2018;
- Clinical Audit Workplan, June 2018;
- Clinical and Social Care Governance Assurance Strategy, March 2019 (Draft only);
- Clinical and Social Care Governance; Children and Young Peoples Service Directorate;
- Clinical and Social Care Governance Indicator Suite, March 2019 (Draft only);
- Controls Assurance Self-Assessments, February 2019 (Emergency Planning, Governance, Risk Management and Health & Safety);
- Corporate Plan 2017/18 and 2020/21;
- Corporate Risk Register, December 2018;
- Directorate Governance Meetings Sample Agendas;
- Directorate Risk Registers;
- Governance Committee Agendas and Minutes (May & December 2018);
- Governance Arrangements for Social Work & Social Care, SHSCT, February 2019;

- Health & Safety Policy, December 2014;
- Health & Safety Risk Assessment, Version 3, H & S Department, November 2019;
- Incident Management Procedure, October 2014:
- Integrated Governance Framework, September 2017;
- Internal Audit Report, Management of Standards and Guidelines, 2018/19;
- Internal Audit Report, Morbidity & Mortality 2018/19;
- Medical Leadership Review, June 2019;
- Patient Safety Programme SOP, January 2019;
- Policy for the Management of Litigation Claims, November 2018;
- Procedure for the Management of Complaints, November 2018;
- Risk Management Strategy, 2014;
- Risk Management Strategy 2019-2022 (Draft only);
- RQIA Review of Serious Adverse Incidents Process in NI Questionnaire (Draft only);
- Senior Management Team Minutes (Sample from March 2019);
- Social Workers & Social Care Workers: Accountability and Assurance Framework February 2019;
- Standards and Guidelines Monitoring Process – Change Leads;
- Terms of Reference;
    - Audit Committee, February 2018;
    - Governance Committee, February 2018;
    - Health & Safety Committee,
    - Lessons Learned Forum;
    - Quality Improvement Steering Group;
    - Senior Management Team;
- Trust Board Minutes September 2018 - January 2019;
- 'Your Right to Raise a Concern (Whistleblowing) Policy.

3.2 Meetings with internal stakeholders

The following key stakeholders were interviewed as part of this review:

- Chairman of Trust Board;
- Nominated Non-Executive Directors;[1]
- Chief Executive, Executive Directors and Directors and members of the Senior Management Team;
- Director of Pharmacy;
- Interim Assistant Director Clinical and Social Care Governance and key related staff including the Clinical Audit Management and Governance Coordinator;
- Board Assurance Manager;

[1] The Chairman of Trust Board nominated three Non-Executive Directors to participate in the Review. The nominated Non-Executive Directors included the Chair of the Governance Committee.

- Directorate Clinical and Social Care Co-Ordinators;
- Patient Safety & Quality Manger (Standards & Guidelines), Acute Services
- Project Manager, Medical Directorate.

4.0 Findings and Analysis

4.1 Governance Structures

4.1.1 Trust Board

The purpose of a Trust Board is to govern effectively and in doing so build patient, public and stakeholder confidence that their health and social care is in safe hands. Effective Boards demonstrate leadership by undertaking three key roles; formulating strategy, ensuring accountability by holding the organisation to account for the delivery of strategy by being accountable for ensuring the organisation operatives effectively and with openness and by seeking assurance that systems of control are robust and reliable.[2] The role of the SHSC Trust's Board is defined in a number of key documents which are outlined below.

The Trust has an extant approved Standing Orders, Standing Financial Instructions and Scheme of Delegation which in line with best practice is available to staff and the public via the Trust's website.

As defined in the Trust's Standing Orders (SOs), the Trust Board is required to have in place integrated governance structures and arrangements that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, social care, information and research governance activities. From 2006, HSC organisations have been encouraged to move away from silo governance and take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and organisational objectives.[3]

The Trust Board is responsible for ensuring that the objectives of the organisation are realised. The Trust has communicated its strategic purpose and corporate objectives in its Corporate Plan 2017/18 to 2020/21.

The Trust Board is responsible for ensuring that the Trust has effective systems in place for governance which are essential for the achievement of organisational objectives. It is also responsible for ensuring that the Trust consistently follows the principles of good governance applicable to HSC organisations and should work actively to promote and demonstrate the values and behaviours which underpin effective integrated governance.[4]

[2] NHS Leadership Academy '*The Healthy NHS Board: Principles for Good Governance'*. 2013.
[3] Department of Health '*Integrated Governance Handbook'* February 2006.
[4] SHSCT '*Draft Integrated Governance Framework'*, September 2017, Section 4.

4.1.2 Trust Board Meetings

In line with recommendations from the Francis Report,[5] and best practice, the agenda for Public Trust Board meetings includes an account of a service improvement or learning from a service user experience. Post-Francis, HSC Trust Boards were encouraged to put quality, safety and learning for improvement at the heart of the Board agenda. Learning from service user experience defines the Trust Board agenda, reminding Members of the organisation's vison and values and acts as a catalyst to continue to strive to improve the quality and safety of care provided.

The Board Assurance Framework, outlining the organisation's principal risks is required to be reviewed by Trust Board and tabled for discussion at public meetings on a six monthly basis (see Section 4.4 below). This is evidence that the organisation is committed to being open and transparent. It was noted that the Trust has a busy Board agenda and this may not allow for full discussion by the Board of Directors. It was noted however, that the Corporate Risk Register, is also reviewed at the Governance Committees of Trust Board and Senior Management Team meetings (see also Sections 4.2.2 and 4.9.2). Stakeholders indicated that the linkages between the Board Assurance Framework and the Corporate Risk Register could be strengthened (see Sections 4.4 and 4.8).

The Trust holds monthly Board Meetings (with the exception of July) which are held alternatively in public session and workshop format. Confidential sessions, when required are held immediately prior to the Board meeting. Senior stakeholders advised that Trust Board and Board Committee agendas are very busy and throughout the year there are a significant number of Board reports, covering a wide range of complex issues, which are presented for approval or assurance.

Trust Board workshops allow for detailed discussion on a range of strategic matters including detailed reports for example the Statutory Functions Report and service developments. The Workshops are essential for providing the Board of Directors the time and background information they require to make strategic decisions and fulfil their scrutiny and challenge function. This will be a particularly important in implementing the IHRD recommendations on the Board's Statutory Duty of Quality/Board Effectiveness which have highlighted the need for time for Board effectiveness, development and for understanding patient safety objectives.[6]

The Reviewer has noted that Internal Audit have provided the Trust with a 'Satisfactory Assurance' level for Board Effectiveness. Senior stakeholders advised that they would wish the Internal Audit Board Effectiveness Action Plan to be formally reported and reviewed by a Board Committee for assurance.

There is a time allocation for Trust Board Agenda items. It was noted from the minutes of those Trust Board meetings held in public session, that Patient and Client Safety and Quality of Care Reports are included in a standing agenda which also

[5] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* February 2013. HC 947 London. The Stationery Office.

[6] IHRD Recommendation 55 ~ '*Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objective'*.

includes Strategic and Operational Performance Reports thus demonstrating a balanced agenda. There is evidence of Non-Executive Director challenge in the area of patient and client safety and quality for example in relation to infection prevention and control training performance and complaints response performance targets. Given the proposal to constitute a Performance Management Trust Board Committee ***it is recommended that the Trust Board review the cycle of Trust Board Reports and the Board of Directors' public meeting agenda.***

The Reviewer can confirm that Trust Board agendas and minutes are readily available on the Trust's website from April 2009 to date.[7]

4.1.3 Trust Board Committees

The Trust Board exercises strategic control over the organisation through a system of good governance which includes Trust Board Committees:

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

It is recognised that Accounting Officers and Boards have many issues competing for their attention. One of the challenges they and their members face is knowing whether they are giving their attention to the right issues. Key to addressing this is 'assurance', defined as: "an evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework".[8]

Assurance draws attention to the aspects of risk management, governance and control that are functioning effectively and, just as importantly, the aspects which need to be given attention to improve them. An effective risk management framework and a risk-based approach to assurance helps an Accounting Officer and Board to judge whether or not its agenda is focussing on the issues that are most significant in relation to achieving the organisation's objectives and whether best use is being made of resources.

At the heart of a good governance structure is the constitution of Trust Board Committees and Sub-Committees. The Trust Board Committees, and in particular the Audit and Governance Committees, can help the Accounting Officer and Board to formulate their assurance needs, and then consider how well assurance received actually meets these needs by gauging the extent to which assurance on the management of risk is comprehensive and reliable. Assurance cannot be absolute so the Committees (and Trust Board sub-committees) will need to know that the organisation is making effective use of the finite assurance mechanisms at its

[7] IHRD Recommendation 70 ~ *'Effective measures should be taken to ensure that minutes of board and committee meetings are preserved'*. The Department of Health IHRD ALB Board Effectiveness Workstream are reviewing this recommendation and are also considering the ease of access to board and committee information.

[8] Department of Finance '*Audit & Risk Assurance Committee Handbook NI*' April 2018.

disposal, targeting these at areas of greatest risk. The Board Assurance Framework and Corporate Risk Registers and their functions in supporting a risk-based approach are considered in Section 4.9.

4.1.4 Audit Committee

The Audit Committee is the Trust's statutory committee which deals with all aspects of financial governance.[9] The Audit Committee has no executive powers, other than those specifically delegated within the Terms of Reference. The Audit Committee is a non- executive committee of Trust Board and the Director of Finance and representatives from Internal and External Audit will normally attend the meetings. In line with best practice, the Chief Executive is invited to attend at least twice annually to discuss the process for assurance that supports the annual Governance Statement. In addition, other directors are required to attend when the Audit Committee is discussing areas of risk that fall within their area of responsibility or accountability.

It was noted from stakeholder meetings that the non-financial risk-based Internal Audit Reports (e.g. Management of Standards and Guidelines) would be tabled at the Governance Committee (see below) for more detailed discussion. The Trust should consider revising the terms of reference for the Audit Committee to enable the Interim Assistant Director for Clinical and Social Care Governance to be in attendance to facilitate the triangulation of integrated governance information.

The Trust has an Internal Audit Forum chaired by the Executive Director of Finance and Procurement. The Internal Audit Forum has successfully significantly increased the number of Internal Audit Plan recommendations that have been follow-up by Management (90% actions were reported as 'undertaken' at the time of Review).

4.1.5 Governance Committee

The Governance Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in the Terms of Reference. The Committee is appointed by the Trust Board from amongst the non-executive directors following recommendation by the Trust Chair and is required to consist of no less than three members. The Trust Board Chair confirmed that she attends Governance Committee meetings when there is a particular item on the agenda that she wants to review in more detail. The following are currently invited to attend; the Chief Executive, Executive Directors (with the exception of the Director of Finance and Estates), members of the Senior Management Team and the Director of Pharmacy. The [Interim] Assistant Director of Clinical and Social Care Governance also attend the committee and provide papers. ***It is recommended that the Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director***.

[9] Financial governance is not included within the terms of reference for this Review, however, an understanding of the role of the Audit Committee was required to gain an insight into the overall management of integrated governance within the Trust.

The remit of the Committee is to ensure that there are effective and regularly reviewed structures in place to support the effective implementation and continue development of integrated governance and that timely reports are made to Trust Board. The Committee is also responsible for a number of assurance functions including; assessment of assurance systems for effective risk management, ensuring there is sufficient independent and objective assurance as to the robustness of key processes and for ensuring that principal risks and significant gaps in controls and assurance are considered by the Committee and escalated to Trust Board as required. The Chair of the Governance Committee provides an annual report on the undertakings of the Committee to Trust Board which is an example of best practice.

The Agenda for Governance Committee is approved by the Senior Management Team. ***It is recommended that the Chair of the Governance Committee is fully involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020***.[10]

The annual Governance Statement is brought to Governance Committee for review and approval. The Statement indicates that the Trust adopts an integrated approach to governance and risk management and has an Integrated Governance Framework in place which covers all domains of governance associated with the delivery of health and social care services (see Integrated Governance Section 4.4).

The Corporate Risk Register is presented to Governance Committee on a quarterly basis. From senior stakeholder meetings and review of minutes it is planned to review a small number of corporate risks on a rolling basis to enable a more detailed discussion and afford the Non-Executive Directors the opportunity for scrutiny and challenge is a secure environment (see also Risk Registers Section 4.9).

Regular reports on integrated governance functions are reviewed at Committee including Adverse Incidents, Morbidity and Mortality, Management of Serious Adverse Incidents (SAIs), Claims, Whistleblowing Cases. The Medical Director and Interim Assistant Director Clinical and Social Care Governance are reviewing the format and content of reports to provide high quality intelligence and not just hard data. The Interim Assistant Director has also developed a draft suite of key performance indicators for clinical and social care governance which will help 'triangulate' data with different information sources and should form a key component of future governance reports to Committee. It is recognised that the collation and analysis of this data is labour intensive and resource dependant and currently there is insufficient managerial and administrative support and ITC infrastructure to support this governance function (see also Sections 4.22 and 4.23). ***It is recommended that the clinical and social care key performance indicators are further developed and submitted for approval through the Senior Management Team.***

The Governance Committee also receives a report on Freedom of Information (FOI), Environmental Regulation and Subject Access Requests (SARs). The Report

[10] Senior stakeholders suggested that a three year plan should be developed.

contains information on performance against timescales for processing requests and information on the nature of the requests which is good practice and there is evidence within the minutes of discussion stimulated by Non-Executive Directors. [11]

The Chief Executive advised that the Trust are to constitute a Performance Management Trust Board Committee (see below). The Governance Committee should therefore review its Terms of Reference. There is a need to focus on the detail of the Board Assurance Framework as well as the Corporate Risk Register on at least an annual basis at either a Trust Board workshop or at Governance Committee.

In line with best practice, the Chairs of the Audit and Governance Committee should meet annually to ensure an integrated approach to governance within the Trust and no overlap with agenda items.

4.1.6 Patient and Client Experience Committee

The Patient and Client Experience Committee was established as a subcommittee of the Trust Board. It has no executive powers, other than those specifically delegated in the Terms of Reference. The role of the Committee is to provide assurance that the Trust's services, systems and processes provide effective measures of patient, client and carer experience and involvement and to identify gaps and areas of opportunity for development to ensure continuous, positive improvement to the patient, client and carer experience and to ensure that patient, client and carer experience improvement initiatives are in place to address identified shortcomings and that these are monitored.

The Chief Executive advised that the terms of reference were being considered in the short term, with a view to refocus the role and responsibility of this Committee.

4.1.7 Performance Management

It has been agreed that a new subcommittee of Trust Board will be constituted during 2019/20 to ensure a strategic focus on performance management.

4.1.8 Senior Management Team/Governance Management Board

The Trust has a Senior Management Team (SMT) that is accountable to the Chief Executive. The Terms of Reference stipulate that the SMT is responsible for the leadership, strategy and priorities of the Trust and to oversee all aspects of Operational activities to ensure that the Trust meets its Statutory Requirement and provides high quality and effective services.

The Terms of Reference provided to the Reviewer are not dated. The Terms of Reference stipulate that all members of the SMT are individually and collectively responsible for the leadership of the following; Strategy and Planning, Delivery and Performance, Communication and Engagement, Governance and Risk Management The Terms of Reference define a model agenda of standing items in Section 8

[11] This will assist the Trust by forming a basis for implementing IHRD Recommendation 72 ~ *'All Trust publications, media statements and press releases should comply with the requirements for candour and be monitored for accuracy by a nominated non-executive Director'.*

'Cycle of Business' do not include quality and safety with the exception of Infection Controls within Performance and Delivery. A review of sample agendas confirm that quality and safety is discussed.

The Terms of Reference stipulate that papers, reports and presentations for submission to the Board of Directors will be considered by the SMT at the meeting one week prior to the Board meeting which is standard practice. In respect of Trust Board papers, SOs stipulate that the 'Agenda will be sent to members at least 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency'.

For SMT meetings the Terms of Reference stipulate that the collation of the agenda, issuing papers/reports are required at least 24 hours in advance of the meeting. Senior stakeholders advised that on occasion there may be a requirement to table an agenda item for urgent consideration and approval after the deadline. The Reviewer recognises that this should be avoided wherever possible to ensure that SMT members have time to review the information, this should be balanced with potential loss of opportunity and the Terms of Reference should allow for an urgent provision. (See also Weekly Governance Meeting/Debrief Section 4.23.2).

It is recommended that the SMT Terms of Reference are reviewed, including providing a provision for tabling urgent papers for consideration after the deadline [in exceptional circumstances].

The Terms of Reference also stipulate that once a month the SMT will meet as a Governance Management Board with the staff from the Governance Department in attendance. Section 2 of the SMT Terms of Reference constitute the terms of reference for the Governance Board. Roles and responsibilities include; ensuring the governance framework is fully implemented, monitoring and reviewing the Trust Risk Register and identifying Corporate Risks, reviewing and updating the Board Assurance Framework, escalating risk management issues to Trust Board and approving and reviewing policies that need to go to Trust Board for approval. The SMT Governance Board is also required to monitor patient safety and ensure continuous improvement and receive and approve reports/action plans for presentation to the Governance Committee. ***It is recommended that the remit and responsibilities of the SMT Governance Board are reviewed and a separate Terms of Reference developed to include the purpose, membership and reporting lines to Trust Board via the Governance Committee of Trust Board see Sub Committee Structure proposals at Section 4.1.9). The role of the SMT Governance Board should also be clearly defined in the Integrated Governance Framework/Strategy.***

4.1.9 Good Governance Structure: Trust Board Sub Committees

The Integrated Governance Framework contains an organogram depicting the organisation's high level governance structure including Trust Board, Board

Committees, SMT and Directorate and Professional forum. [12] The Reviewer is unable to provide a definitive list of all subcommittee and advisory groups from the written evidence considered. However, from the evidence provided by stakeholders and the review of a range of policies and procedures a number of other integrated Governance Trust Committees, Steering Groups and Advisory Groups have been constituted e.g. Quality Improvement, Health and Safety, Outcomes Review and a Directors' Oversight Group for the implementation of the IHRD Recommendations (see also the Trust's Integrated Governance Framework Section 4.4 below).

Senior stakeholders advised that current arrangements appeared to lack connectivity. From the evidence it is difficult to clearly define the accountability linkages and reporting arrangements between and from the various sub groups and advisory committees to Trust Board via the Senior Management Team. Stakeholders identified a number of accountability/reporting lines including; operational and corporate directorates, professional and expert committee. Clear lines of accountability are crucial to provide the Board of Directors with the assurance that there are robust and transparent governance arrangements in place. Additionally, it is important that staff and stakeholders have clarity on the lines of accountability within the organisation's assurance framework model.

Key to a good governance framework (structure) is the establishment of a robust assurance and accountability framework underpinned by sound systems of internal control the structure which supports the Trust Board and its Committees. ***It is therefore recommended that the Trust's existing Governance Structures are reviewed as a matter of urgency and Trust Board Sub Committee/Steering Groups are constituted to which integrated governance steering groups and committees will report and provide the organisation with a robust assurance framework (see below and Appendix 2) and a single line of assurance reporting to Trust Board through SMT.***

A Quality Improvement Steering Group has recently been constituted which pulls together some of the integrated management functions. The remit of that Steering Group is defined in the draft Terms of Reference provided as being responsible for ensuring that the Quality Improvement Framework is developed and delivered by the SMT and Trust Board.

It is recommended that the constitution of Executive Directors/Directors oversight/ steering groups should be considered with the following remits:

- Clinical and Social Care Governance – Quality Improvement and Safety;
- Corporate Governance;
- Patient and Client Experience and Engagement.

This will effectively group many of the existing sub committees and specialist advisory groups that exist within the organisation and provide a single accountability/ reporting line through the Governance Board of SMT to the respective Trust Board

[12] Integrated Governance Framework 2017, Figure 2.

Committees. In considering this sub-committee structure the Trust should ensure that there is no duplication of functionality of groups, forums or advisory committees. The Steering Groups should review the terms of reference of the sub groups and advisory groups on an annual basis and should also provide oversight of progress of any action plans or work plans. (The list of functional areas, advisory and expert groups potentially providing reports to the Steering Groups in Appendix 2 are examples only and do not indicate the need to constitute additional sub groups). ***Terms of Reference and annual work plans/action plans, where applicable should be held centrally (See Role of Board Secretary Section 4.2)***.

In response to all stakeholders who believed that there was a gap in the current framework regarding shared learning the Chief Executive advised that the proposed Steering Groups should be required to report on learning within their Terms of Reference and this would be a vehicle to bring together all aspects of learning from across the integrated governance arrangements including user experience. Senior stakeholders also advised that the role and function of the Lessons Learned Forum should be reviewed as a matter of urgency (see Section 4.20).

It is also recommended that any short term Director's Oversight Groups are added to the Governance Structure for the duration of their remit as 'Task and Finish Groups' e.g. IHRD Directors Oversight Group. This will provide staff and other stakeholders with clarity about the governance assurance and accountability arrangements.

It is recognised that the development and maintenance of an improved governance structure and assurance framework will require the oversight/ input of someone with expertise in Board Governance and Assurance. Additional resources (administrative and ITC support) will also be required to implement this recommendations (see also Section 4.2 Role of Board Secretary, and Section 4.23 Clinical and Social Care Governance Structures).

4.1.10 Committee Terms of Reference

A range of terms of reference (ToR) were analysed during the Review. The Audit and Governance Committees use a common template which meet good practice standards. Minutes of Board meetings reflect that their terms of reference are reviewed annually. ***To ensure that all committees provide clarity in their terms of reference, delegated powers and reporting requirements the Trust should consider developing a standard template to define the terms of reference for all Board Sub Committees, Steering Groups and Advisory/Specialist Groups***.

The terms of reference as a minimum should include the following:

- Constitution;
- Membership (Including chair, deputies and administrative support);
- Remit or high level purpose;
- Frequency of meetings;
- Authority/Delegated Powers;
- Quorum;

- Duties and responsibilities;
- Reporting arrangements;
- Revision dates.

All terms of reference should be reviewed annually and submitted to the relevant overarching Committee for approval. Approved terms of reference should be submitted to the Corporate Clinical and Social Care Governance Department and held in a shared folder. It is recognised that this will be an additional function for the Corporate Clinical and Social Care Department whose resources are already stretched (See Section 4.23). This function could be overseen by the creation of a Board Secretary as described below.

4.2. Role of Board Secretary/Head of Office

The Trust should consider introducing the role of Board Secretary/Head of Office to support the Trust Board and the Assurance Framework (incorporating the integrated governance strategy Sections 4.1.9 and 4.4).[13] This individual would be required to have a high level understanding of board assurance and board governance and would have the responsibility for ensuring that all Trust Board committees and sub committees are fully serviced and functioning and that their terms of reference are annually reviewed. They should be fully informed of the activity of committees and assist in making decisions on which issues can be resolved at subcommittee level and which issues may represent a high level risk to the organisation and may need to be escalated to the Board for debate and decision.

The Board Secretary/Head of Office should work closely with the Chief Executive, the Chairman of Trust Board and the Non-Executive Directors. They should be a high level appointment with the skills to act at Board level and be an expert in discharging their functions. They should be conversant with the Trust's Standing Orders/Standing Financial Instructions and the Scheme of Delegation. The post holder would hold line management responsibility for the Administrative Team in Trust Headquarters.

4.3 Professional Executive Directors – roles and responsibilities

The Northern Ireland Audit Office (NIAO) Guidance[14] acknowledges that role ambiguity can effect the function and effectiveness of the Board of Directors. As described above, concerns were expressed about the multiple reporting lines to Trust Board. Staff and other stakeholders should be clear on the roles and responsibilities of Executive Directors. The description of Executive Director functions are, by nature, generic in SO/SFIs therefore it is important that the full range of their accountability and responsibility are adequately outlined in the Trust's strategy and policy documents e.g. the Integrated Governance Framework and Risk Management Strategy. The Chief Executive indicated that the Job Descriptions for the recently appointed Executive Directors (Medical Director and Interim Executive

[13] The role of Company Secretary is described in the DoH (2006) *op. cit* pages 68 and 69 . The evidence for the efficacy of the role were based on discussions that took place with FTSE 100 companies.
[14] NIAO 'Board Effectiveness ~ Best Practice Guidance', November 2106.

Director of Nursing) were strengthened in respect of their integrated governance functions.

The role of the Executive Director Social Work is detailed in a framework entitled 'Governance Arrangements for Social Work and Social Care' for the Trust, which includes clinical and social care governance arrangements in the Children and Young Peoples Services Directorate' dated February 2019 (Section 4.5). The framework sets out clearly the legislative context that underpins social work governance and the Accountability and Assurance Framework for social work and social care. Clarity of role function is particularly important where an executive director has a dual role and has also operational management accountability and responsibility.

The Medical Director is the Executive Director with responsibility for providing assurance to Trust Board that effecive systems and processes for good governance, including those arrangements to support good medical practice. The strategic role of the Executive Medical Director in respect of risk management and clinical and social care governance is considered in more detail below.

The [Interim] Executive Director of Nursing is the lead Director for Nursing and Allied Health Professionals Governance and has responsibility for the strategic leadership for patient and client experience. The Exectuive Director of Nursing provides an annual Professional Nursing and AHP report to Trust Board and also provides a report on Quality Indicators (Nursing) to the Governance Committee. During the Governance Review, she advised that she was developing her strategic vision for Nursing and Midwifery Governance Structures and will be reviewing the Terms of Reference for the Nursing and Midwifery Governance Forum.

4.4 Integrated Governance

The context for integrated governance in healthcare has its origins in 2004[15] when NHS organisations were urged to; move governance out of individual silos into a coherent and complementary set of challenges, require boards to focus on strategic objectives, but also to know when and how to drill down to critical areas of delivery, require the development of robust assurance and reporting of delegated clinical and operational decision making in line with well-developed controls and to be supported by board assurance products, which provide board members with a series of prompts with which to challenge their objectives and focus.

The Good Governance Institute 'Integrated Governance Handbook' recognised that in simple terms there is only one governance and that this is the primarily the business of the board. Apart from clinical practice at the point of patient care the board is the key place where all the aspects of governance (clinical, quality, cost, staffing, information etc.), come to play at the same time.[16] Effective governance requires that organisations do not dissipate the composite whole into fragments that never realign. In 2006, integrated governance was defined as the 'systems,

[15] NHS Confederation Conference Paper by Professor Michael Deighan [and others]: '*The development of integrated governance, NHS Confederation*', May 2004 as summarised by John Bullivant.
[16] *Ibid*.

processes and behaviours by which Trusts lead and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community and partner organisations'.[17] Key to delivering a good governance model and to delivering these systems, processes and behaviours is an Integrated Governance Strategy or Framework which clearly articulates the organisation's assurance and accountability framework.

The Trust's strategy for integrated governance is defined in the Integrated Governance Framework 2017/18 – 2020/2021 (the Framework) which is marked as 'Draft' however, during the Review, the Board Assurance Manager confirmed that the Framework was endorsed by the Governance Committee. The document is set out in a standard strategy format and details the organisation's governance arrangements to implement an integrated governance model that links financial governance, risk management and clinical and social care governance into one framework. The Framework describes the overarching governance structure, the accountability and responsibility arrangements for the management of governance including the role and function of Trust Board and Board Committees. The document clearly indicates that the Framework should be should be considered with other key Trust documents, in particular the Trust's Risk Management Strategy. It is less definitive about the integrated governance assurance and accountability arrangements (complaints, serious adverse incidents, findings of independent review/inquiries and case management reviews etc.) to Trust Board and the operational/directorate governance reporting arrangements through to the Senior Management Team and this may have added to the perception of dual reporting lines. The Framework should provide an electronic link to the key supporting strategic and policy documents, which have been reviewed and described below Sections 4.5 – 4.22.

The Governance Controls Assurance standard requires that there are clear accountability arrangements in place for governance throughout the organisation. The Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation provide an overview of Trust Board and Board Committees, however, as described above these documents by their nature only provide generic descriptions of roles and responsibilities of Executive Directors. The Reviewer acknowledges the challenges in maintaining a dynamic Integrated Governance [Framework] as roles and responsibilities of Committees and individuals evolve and change as a result of a number of factors. Senior managerial functions have changed since the Framework was developed in 2017, therefore the extant version does not accurately reflect the accountability or current roles and responsibilities of the Executive Directors.

It is recommended that the Strategy/ Framework is reviewed as a matter of urgency and provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Strategy/Framework provides electronic links to related /key corporate Trust Strategies and Policies and extant guidance where applicable.

[17] DoH 'Integrated Governance Handbook' 2006.

The review of the Strategy/Framework will have to take account of any revision of the Trust Board's governance structures which will underpin good governance through an improved assurance and accountability framework, as recommended above (Section 4.1.9). [18]

4.5 Social Care Governance

The Integrated Governance Strategy indicates that the Executive Director of Social Work has a dual role also holding operational responsibility for the Children and Young People's Directorate and is responsible to the Chief Executive for the Trust's social work/social care governance arrangements and for the delegation of statutory social care functions and corporate parenting responsibilities. Within the Trust' High Level Governance Structure (Integrated Governance Framework) the only current reference to a social care governance framework is a forum entitled 'Social Work and Social Care Governance Forum'.

In the early stages of the Governance Review the Executive Director Social Work shared a framework entitled 'Governance Arrangements for Social Work and Social Care' for the Trust which includes clinical and social care governance arrangements in the Children and Young Peoples Services Directorate' dated February 2019. The framework sets out clearly the legislative context that underpins social work governance and the Accountability and Assurance Framework. This Framework also identifies roles and functions within the Directorate and across the interfaces. This key document should be cross-referenced and electronically linked with the Integrated Governance Framework (see above).

A review of Trust Board agendas and minutes confirm that the Annual Delegated Statutory Functions Report is tabled at a public meeting of the Trust Board meetings prior to submission to the Health and Social Care Board. During the Review, the Trust Board Chair outlined the process for review by the Non-Executive Directors. Minutes also confirm that the Corporate Parenting Report is also tabled at public Trust Board meetings. The Executive Director also presents a report every two months to Trust Board which provides a summary of activity and developments. Also tabled is the Corporate Patenting Report.

Senior stakeholders expressed some concern regarding Adult Safeguarding arrangements. ***It is recommended that this area of concern is reviewed to identify any potential risks/gaps in control or assurance in this area.***

4.6 Being Open

As outlined in Section 4.1, the Trust Board play a key role in ensuring the organisation operates effectively and with openness and transparency. The National Patient Safety Agency (NPSA) first issued the 'Being Open Framework' national

[18] SHSCT '*Integrated Governance Framework'* Figure 2 page 23.

guidance in 2005.[19] In recognition of changing context in NHS organisations and the altered context, infrastructure and language of patient safety and quality improvement they revised the guidance in 2009. The revision was also based on a listening exercise with healthcare professionals and patient representatives on how organisations could strengthen the principles of being open.

The Trust does not have a current Being Open Policy but has researched existing policies and has established a working group to develop the guidance. The Chair of the IHRD DoH Being Open Sub Group is scheduled to attend the Trust to meet with Board members. The Trust has also participated in the IHRD Programme Duty of Candour/Being Open Stakeholder Events.

The NHS Leadership Academy indicate that effective boards shape a culture for the organisation which is caring, ambitious, self-directed, nimble, responsive, inclusive and encourages innovation. A commitment to openness, transparency and candour means that boards are more likely to give priority to the organisation's relationship and reputation with patients, the public and partners as the primary means by which it meets policy and/or regulatory requirements. As such the Board holds the interest of patients and communities at its heart.[20]

Sir Robert Francis defined openness, transparency and candour as follows:

- Openness: enabling concerns to be raised and disclosed freely without fear and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public;
- Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.[21]

Post-Francis, the Care Act 2014 introduced a Statutory Duty of Candour for health and social care providers in England i.e. an organisational Duty of Candour.[22] Duty of Candour was introduced by legislation for NHS Trusts in England and the IHRD Report 2018 calls for a Statutory Duty of Candour to be enacted in Northern Ireland (Recommendation 10). The DoH IHRD Duty of Candour Workstream and Being Open Sub Group have delivered a series of stakeholder events to build on the principles of 'being open'. They are also considering the implications of the proposed individual Statutory Duty of Candour. Recommendation 2 seeks for a sanction of "criminal liability" to be attached to a "*breach of this duty and criminal liability should attach to the obstruction of another [member of staff] in the performance of [his/her duty]*". The Duty of Candour is inextricably linked to the policy of 'being open'.

[19] On 1 June 2012, the key functions of the NPSA were transferred to the NHS Commissioning Board Special Health Authority.[5], later known as NHS England. In April 2016, the patient safety function was transferred from NHS England to the newly established NHS Improvement.
[20] Leadership op cit. Section 2 Roles of the Board – Ensure Accountability
[21] The Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Sir Robert Francis, February 2013
[22] The details of the duty were subsequently set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In respect of developing Trust policy on 'Being Open', the Reviewer is aware that the DoH IHRD Being Open Sub Group are currently developing regional 'Being Open' policy/guidance with an aim to publish within the current financial year. It is envisaged that this policy directive/guidance will deliver the spirit of the IHRD recommendations on openness and candour until such times that a statutory duty of candour is enacted. The Trust will also have to consider the implication of the implementation of Recommendation 69 (i) and ***it is recommended that the Trust consider the implications of implementing the Regional 'Being Open' framework which includes appointing and training an Executive Director with specific responsibility for 'Issues of Candour'***. [23] The Trust has Non-Executive representation on the ALB Board Effectiveness Sub Group where this matter is being considered.

4.7 Controls Assurance

The requirement to report annually on Controls Assurances standards ceased in April 2018 and the Trust was required to put in place internal assurance arrangements for each area previously covered by the former Controls Assurance Standards. The Chief Executive outlined the importance of continuing to monitor and review action plans and advised that a Controls Assurance Group had been constituted, he advised that 2018/19 would be a transition year. The Terms of Reference will be reviewed for 2019/20.

The Controls Assurance Group is currently a sub-group of the Senior Management Team and was initially chaired by the Chief Executive and is now chaired by the Director of Finance, Procurement & Estates. The remit of the Group is to drive an implementation plan in the Trust to deliver on the governance framework and assurance model in relation to Controls Assurance. The implementation plan is linked to the annual Governance Statement and Mid-Year Assurance Statement reporting cycles.

Stakeholders raised a concern about a potential gap in the management of medical devices and equipment at operational level. The Reviewer was advised that there were Equipment Controllers in Acute Services. ***It is recommended that the Trust undertakes an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation***.

It is the responsibility of the Controls Assurance Group to monitor compliance with best practice guidance, policies and legislation previously contained within the former Controls Assurance Standards regime and agree the process for ensuring assurance on this to the Chief Executive and the Board (and onwards to the Department of Health, where required). Therefore, it is a key component of the Trust's systems of internal control and the integrated governance and assurance framework.

[23] IHRD, Loc.cit. Recommendation 69(i). Volume 3, Page 93.

It is recommended that the Trust develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards.[24] This will offer additional assurance that core standards and related legislation and statutory duties are embedded across the organisation (see also Section 4.1 Health and Safety Management and Medical Equipment as above). This development would also underpin the Risk Management Strategy and the Medical Directorate should provide corporate oversight of this process.

4.8 Risk Management Strategy

Managing risk is a key component of good governance and is fundamental to how an organisation is managed at all levels. The Trust's extant Risk Management Strategy is dated January 2014, and the Strategy was based on extant guidance at the time. It is linked to the Corporate Objectives and Values. In line with the Controls Assurance Standard, it contains a Risk Management Policy statement and key definitions including a brief definition of risk appetite. Since 2013/14 there has been more guidance available on how risk appetite should be applied in HSC organisations (see Draft Risk Management Strategy below). As the Strategy was approved 2014, it does not accurately reflect the roles and responsibilities of Committees and Executive Directors within the current governance accountability arrangements. Analysis and evaluation of risk are based on the Regional Matrix including the Regional Impact Table 2013, however, the Regional Risk Matrix was revised in 2016.

At the commencement of the Governance Review 2019, the Reviewer was made aware of a Draft Risk Management Strategy for 2019 – 2022 developed by the Interim Assistant Director of Clinical and Social Care Governance. This version of the Strategy is pending completion of the Review before further consultation and submission to Trust Board for approval.

The Draft Strategy (2019-2022) is based on ISO 31000: 2018, current legislation, and regional and national guidance. It contains a narrative detailing the roles and responsibilities of staff and related processes associated with risk management, including the management of risk registers and the process for the escalation and de-escalation of risk. It defines the role of the Senior Management Team in respect of risk management, including the management of the Corporate Risk Register. The Draft Strategy also provides a clear description of the risk assessment process utilising the most recent version of the Regional Risk Matrix.

The Draft Strategy outlines the role of the Medical Director as the Executive Director with delegated responsibility for risk management and clinical and social care governance. The role encompasses:

- The effective co-ordination of clinical and social care risk and governance – specifically this relates to the functional areas of patient/service user safety,

[24] The Trust's Health and Safety team have developed a Health and Safety risk audit tool. Comprehensive risk audit and assessment tools have been developed by other HSC Trusts for example Risk Audit and Assessment Tool Northern Trust (RAANT).

patient/service user liaison, litigation, effectiveness and evaluation, risk management and multi-disciplinary research;
- The provision of risk management support to Trust Directors via the clinical and social care governance structures of the medical directorate;
- Clinical and social care governance support for clinicians, nursing staff, social workers and allied health professionals;
- Regional and national initiatives related to clinical and social care governance are addressed and brought to the attention of appropriate staff;
- Regular clinical and social care reports/information are brought to the Governance Committee (in line with the Governance reporting framework) and to Trust Board.

The Draft contains a detailed Risk Acceptance Framework which includes a Risk Appetite Matrix.[25] The Trust must take risks in order to achieve its aims and deliver beneficial outcomes to stakeholders. Risks should be taken in a considered and controlled manner and exposure to risks should be kept to a level deemed acceptable to the Board. The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to achieve its strategy over a given time frame. Risk Appetite levels should form the background to the discussion in relation to risk and are nationally considered under four headings; risk to patients, organisational risk, reputational risk and opportunistic risk. Nationally Trusts make an annual statement on risk appetite.

The Draft Risk Management Strategy should show clear links with the Integrated Governance Framework (which should also be revised and updated as outlined in Section 4.4).

It is recommended that the Draft Risk Management Strategy is submitted for approval as a matter of urgency.

It is recommended that the Trust Board consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register. This will enable risks throughout the organisation to be managed within the Trust's risk appetite or where this is exceeded, action taken to reduce the risk. This item is also addressed in the Trust's Board Assurance Framework at June 2019.

Some stakeholders identified a current gap in provision of risk management training, which stakeholders have also highlighted that this is in part as a result of the lack of the resources to provide training in-house. Therefore, ***it is also recommended that a risk management training programme should be developed and delivered to underpin the publication of the approved strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers*** (see Section 4.9 and 4.23 Corporate Clinical and Social Care Governance structures).

4.9 Risk Registers including Board Assurance Framework

[25] Good Governance Institute **Risk Appetite** for NHS Organisations: A **Matrix** to support better risk sensitivity in decision taking. January 2012.

The Trust is required to be aware of its risk profile and to identify the key areas for investment in risk treatment. The Risk Management Strategy defines the framework for risk registers that comprises both the Directorate and Corporate Risks which underpin the Board Assurance Framework. Well managed risk registers are dynamic documents which log, quantify and rank the risks that threaten the Trust's ability in achieving its aims and objectives.

Currently risk registers are based on Word and Excel documents. The Trust has recently purchased the Datix Risk Register Module which will facilitate risk register reporting at Directorate and Corporate levels.

4.9.1 Board Assurance Framework

In line with extant guidance the Trust has a Board Assurance Framework.[26] The purpose of the Framework is 'to ensure that the Board can be effective in the delivery of [the Trust's] objectives'. An Assurance Framework seeks to identify and map the main sources of assurance in the Trust and co-ordination them to best effect. The Board Assurance Framework articulates the principal risks to achieving the Trust's objectives and enables the Board to assure itself that all significant risks are being managed effectively and appropriate controls are in place and are place. The Board Assurance Framework should be reviewed by Trust Board on a six-monthly basis. Analysis of Trust Board agendas indicate that the Framework was tabled in June 2018. A review of the minutes does not reflect levels of discussion.

The Board Assurance Manager, on the delegated authority of the Chief Executive, is responsible for maintaining the Corporate Risk Register and Board Assurance Framework and for supporting the Governance Committee and Trust Board in ensuring the provision of regular risk reporting and monitoring information and assurances.[27]

The Board Assurance Framework provides an organisational context and makes a clear link with the delivery of corporate objectives and is underpinned by the Integrated Governance Framework, Risk Management Strategy, Corporate Risk Register and Controls Assurance processes. The figure in Section 5 of the Board Assurance Framework demonstrates the combined 'top down' and 'bottom up' approach to identifying principal risks.

The Board Assurance Framework contains a high level summary of the Corporate Risk Register, which is also reviewed by the Governance Committee of Trust Board (see below). The Revised Risk Management Strategy provides clarity on the relationship between the Board Assurance Framework and the Corporate Risk Register and in particular the decision-making process on how risks are escalated to the Board Assurance Framework. The format of the Board Assurance Framework has been revised and now includes information on levels of assurance and where independent assurance had been provided i.e. by and Internal Audit or externally by RQIA or Royal College visit etc.

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[26] DHSSPS *'An Assurance Framework: a Practical Guide for Boards of DHSSPS Arm's Length Bodies'.* March 2009. www.dhssps.gov.uk

[27] SHSCT *'Draft Risk Management Strategy'* April 2019.

An assessment of the effectiveness of each control measure, based on a RAG rating is included in the Framework.

4.9.2 Corporate Risk Register

The Trust's Corporate Risk Register is linked to the Corporate Objectives as identified within the Trust's Corporate Plan 2017/18 – 2120/21. The Corporate Risk Register is reviewed on a quarterly basis by the Governance Committee. It is the remit of the Senior Management Team to ensure that there is an effective risk register and that risks are escalated to the Board Assurance Framework as appropriate.

The Senior Management Team review the Corporate Risk Register on a six weekly basis and stakeholders advised that there was robust debate and challenge at these meetings. In addition, the Chief Executive advised that at a Directors workshop during 2018/19 members had undertaken an in-depth analysis of two risks (Infection Prevention and Control (HCAI) and Cyber Security) which had proven to be a useful exercise. It was agreed by the Governance Committee in May 2018 that the Committee would also consider one/two risks in detail on a rotational basis. The minutes of the Governance Committee (September 2018) demonstrate this new approach and capture discussion and challenge by the Non-Executive Directors.

The Chief Executive further advised that the Corporate Risk Register template had also been revised during 2018/19 and that the Senior Management Team continue to monitor the process and seek ways to improve the format e.g. defining the risk description. Senior stakeholders indicated that the revised format was more user friendly. It was noted however, that currently the recorded risk rating is the inherent risk and not the residual risk after the control measures have been applied.

The Register provides a useful summary table of Corporate Risks and in line with best practice the summary table contains trends on the movement of risk levels. It provides a summary of the Risk Assessment Matrix and does not currently contain the impact grid as reviewed by the HSCB in 2016 (see Risk Management Strategy Section 4.8). The Reviewer acknowledges that when the Corporate Risk Register is underpinned by Datix Risk Register software a further review of the risk register process will be required.

It is recommended that the management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy.

4.9.3 Directorate Risk Registers

Each Directorate maintains a risk register which is owned by the Director. The Directorates each have a forum in which these Risk Registers are monitored. The Directorate Risk Register is owned by the Director. The Directorate Risk Registers

form the basis of the 'bottom up' approach to identifying principal risks as outlined in the Board Assurance Framework.

Directorate Risk Registers are currently in different formats. ***It is recommended that a standardised Directorate risk register template is considered when Datix risk register module is implemented.***

4.10 Management of Adverse Incidents including Serious Adverse Incidents

4.10.1 Management of Adverse Incidents

The Trust Policy supplied to the Review is entitled 'Incident Management Procedure', a 'working draft' dated October 2014. The Procedure sets the context for the management of incident reporting as a fundamental element of the Trust's Risk Management Strategy and focuses on the need to monitor trends and learn from incidents and it does promote the Trust's corporate priorities and values including the need for staff to be open and honest and act with integrity. However, the Procedure does not accurately reflect the current roles and responsibilities of Trust Officers in respect of the management of adverse incidents. The Reviewer was advised that the 2014 Policy was not reviewed as work was ongoing to develop a Regional Adverse Incident Policy which is due to be issued during 2019/20.

The Procedure provides guidance on the risk assessment process which should be applied to all incidents at the time of occurrence to decide the level of investigation that is required. This links with the Procedure for the management of Serious Adverse Incidents outline below.

Adverse incident reports form a key component of the Clinical and Social Care Governance Report to the Trust's Governance Committee. The Governance Committee review incident reporting including serious adverse incidents on a quarterly basis. Senior stakeholders indicated that the report format had been revised during 2017/18. However, the Interim Assistant Director Clinical and Social Care Governance advised that she was currently reviewing and developing the content of reports to provide higher quality intelligence (not just data) that is high level but also allows for appropriate scrutiny and challenge by the Board of Directors.

The Trust mechanism for recording all incidents is Datix web using an electronic incident form. The Trust uses Datix Common Classification System (CCS) codes for the categorisation of incidents. During 2018/19 work was undertaken to align Datix systems and the use of Datix CCS codes across the Region as part of the 'Delivering Together Programme'.[28] The Datix alignment programme was completed by March 2019. Stakeholders advised that there were currently insufficient staff in the Corporate Clinical and Social Care Governance team (Medical Directorate) to quality assure adverse incident data (see Section 4.23.1). This is a function undertaken in the other HSC Trusts. The Reviewer was informed that there were a significant number of incidents in the category 'In Review' which needs to be addressed in the short term.

[28] Department of Health, "*Health and Wellbeing 2026: Delivering Together",* October 2016.

It is recommended that a Trust flow chart is developed that underpins the Regional Adverse Incident Reporting Policy/Procedure (when disseminated) which accurately reflects local/ Trust roles and responsibilities especially at Executive Director level.

It is recommended that the corporate oversight of the management of adverse incidents is strengthened to include a quality assurance component which will be dependent upon the resources and skills available within the Clinical and Social Care department (see Section 4.23.1)

4.10.2 Serious Adverse Incidents

The extant procedure for the management of Serious Adverse Incidents (SAIs) is the Health and Social Care Board (HSCB) Regional 'Procedure for the Reporting and Follow up of Serious Adverse Incidents'[29]. Stakeholders indicated that the Directorates have adopted local procedures for the management of SAIs and some concern was expressed about a lack of consistency in approach. Stakeholders also advised of a backlog in SAI Reports being submitted to the HSCB within the required timescales which requires urgent attention.

The Reviewer is aware that the Regional Procedure is subject to imminent review to take account of the recommendations of the IHRD Report in respect of the Management of SAIs. There is also a significant link with the work of the Being Open Workstream (see Section 4.6). Three of the DoH IHRD Implementation Workstreams are considering these recommendations which are summarised as follows;

- *Duty of Quality ALB Board Effectiveness and Quality Clinical and Social Care Subgroups* – learning and trends should form programmes of clinical audit (See Section 4.15), relevant reaching authorities should be informed if findings of investigations show inadequacies in current medical or nursing education programmes and information from investigations should be assessed for potential use in training and retraining, Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths are brought to the immediate attention of every Board member (see Section 4.23.1);
- *SAI Workstream* – family engagement, investigations should be subject to multi-disciplinary peer review, each Trust should publish Policy detailing how it will respond to and learn from SAI related patient deaths and each Trust should publish in its Annual Report details of every SAI related patient death.
- *Education and Training* – training in SAI investigation methods and procedures should be provided to those employed to investigate and clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours (see Section 4.21 Medical leadership);

[29] Health and Social Care Board '*Procedure for the Reporting and Follow up of Serious Adverse Incidents'*, November 2016.

- *Preparation for Inquest and Death Certification* – Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation (See Sections 4.15 and 4.21).

It is appreciated that for some of these recommendations there have been challenges in defining the objective or principle of the recommendation and for some a Regional approach is being sought, however there are some early indications of travel in terms of family engagement and scrutiny and challenge (see also Section 4.23 for resource implications).

To enable the Trust meets the action required, the following is recommended.

It is recommended that the Trust constitutes an SAI Review Group and/or SAI Rapid Review Group which should provide independent scrutiny and challenge to the SAI process including review of level of investigation, independence of review panel and approval of terms of reference when SAIs are initiated. In addition, the Review Group should oversee completed reports before submission to the HSCB. The Review Group should be chaired by the MD or his/her Deputy and report to a Trust Board Sub Committee. The Review Group should meet on a four weekly basis initially.

It is recommended that the Trust develops a database of SAI Review Panel Chairs who have undertaken SAI/Systems Analysis Training.

The Governance Coordinator highlighted the investment in a recent SAI training programme delivered by an external provider. She also advised that the training programme provided staff with a wide range of investigation tools, techniques and best practice guidance.[30] ***It is recommended that the Trust develops a SAI RCA/Systems Analysis toolkit based on the training provided by the external provider.***

Given the importance and focus on family/service user engagement, IHRD workstreams have been considering the role of an SAI Review Liaison Officer. Discussions during IHRD workstream meetings have highlighted some of the challenges for staff fulfilling this role (emotional resilience, communication skills and time commitment), in addition to existing work commitments. ***It is recommended that the Trust considers how the role of a Service User Liaison Officer [or similar] for engagement with families throughout the SAI process would be implemented.***

4.11 Health and Safety Management

The Trust has a Health and Safety at Work Policy dated December 2014 which was due for review by December 2016. The Policy indicates that the Chief Executive has delegated responsibility for establishing an monitoring the implementation of the Health and Safety at Work Policy to the Director of Human Resources and Organisational Development with support from the Assistant Director of Estates/Head of Health and Safety. More recently, the responsible was delegated to

[30] Training was provided by CLS Educate @ www.clseducate.com

the Director of Finance, Procurement and Estates and the Health and Safety Team are currently part of the Estate Risks and Sustainability Department and report to the Director of Finance and Estates.

The Team aim to maintain a high visibility and engagement in clinical, non-clinical and social care areas. System based on HSG65 (Health & Safety Executive Managing for Health and Safety) and is centred around: Plan, Do, Check and Act.

The Trust has a Joint Health and Safety Committee and the Chair rotates between the Lead Director and Trade Unions. The Terms of Reference for the Committee are included in Appendix 1 of the Health & Safety Policy and are therefore circa 2014. The membership is indicated as being made-up from Directorate Representatives and Representatives from Trade-Union/Professional Bodies within the Trust. The quorum is four members however, the Terms of Reference do not specify the requirement for an equal representation of staff and management. The current Terms of Reference do not indicate the reporting arrangements to Trust Board and the extant Governance Committee Structure (Integrated Governance Framework Figure 1) does not clearly indicate the reporting and assurance arrangements of this key statutory Committee (See Section 4.2.6). The Lead Director advised that a review of committee membership and agenda was planned. ***It is therefore recommended that the Health and Safety Committee review their Terms of Reference and submit to the relevant Board Sub Committee for approval.***

The Annual Health and Safety Report 2017/18 was provided in evidence to the Review. The 2017/18 Report was presented to the Governance Committee for noting and with a request for feedback on the content and structure of the report so that reports going forward can be reviewed and be as 'meaningful and informative' for the Committee as possible.

Stakeholders indicated that attendance at training remains a challenge and this was highlighted in the Annual Report. The 2017/18 Report indicates that Health & Safety audit activity was constrained due to a lack of resources from within the Committee.

The Health & Safety Team have developed a Health & Safety audit tool to evaluate Trust compliance with key areas of health and safety legislation including; accountability, risk assessment, Display Screen Equipment, Management of Violence and Aggression and Slips, Trips and Falls. The aim of the audit is to provide assurance to the Lead Director for Health and Safety. The audit tool is based on a three year cycle which aims to audit all areas of the Trust and cover 15 legislative areas. All audit results are presented to the relevant Director, the Health and Safety Committee and the Governance Committee.

The audit tool is emailed to all Heads of Service (100) within the Trust. The Heads of Service are then required to issue the question sets to their Departmental/Service/Team leads for completion and scoring. Responses are completed on the basis of full compliance, partial compliance or no compliance options for each question. The return rate for the audits at year end 2018 were 78%. Results are collated by Directorate, indicating that 22% of Heads of Service did not

submit a return. The Health and Safety Team complete verification audits of 10% of returned audit compliance levels.

From the interviews with stakeholders, the Reviewer found a limited knowledge of the purpose and use of this audit tool. The audit process was evaluated during 2018 using Survey Monkey. A total of 22 Heads of Service responded and some issues were identified including the challenges of competing priorities. This is a useful audit tool which ***could be further developed and used to form the basis of a more comprehensive risk audit and assessment tool as highlighted above (see Section 4.7).***

Senior stakeholders identified some concern regarding assurance of compliance with Health and Safety risk assessments across the organisation. In particular, it was believed that an assessment of compliance with the Control of Substances Hazardous to Health (COSHH) Regulations was required. ***It is recommended that an organisational COSHH audit is undertaken during 2019/20 to be completed before end March 2020.***

4.12 Management of Complaints

The Trust has a Policy for the Management of Complaints which was approved in July 2018. The Policy indicates that the Medical Director is responsible for ensuring that the complaints procedure and approach ensures that appropriate investigations and actions have been competed before a response sent following a formal investigation of a complaint. Further, the Policy indicates that the responsibility for managing the requirements of this policy is delegated to the Assistant Director of Clinical and Social Care Governance. However, the Policy clearly indicates that the Medical Director must maintain an overview of the issues raised in complaints and be assured that appropriate organisational learning has taken place and that action is taken. Stakeholders indicated that the line of corporate oversight by the Medical Director's Office was now less robust than the Policy envisaged and that this should be revisited.

The [Interim] Assistant Director for Clinical and Social Care Governance is required to work with the Trust's 'operational, executive and corporate Governance leads and support leads on the ongoing development of systems and procedures to monitor the implementation and effectiveness' of changing practice, taking regard of evidence based practice, lessons learned from reviews, complaints, incidents and public inquires and to provide recommendations and advice to SMT Governance on the Governance Action Plan and priorities for action.

The Corporate Clinical and Social Care Governance Team receive complaints and log them into the Datix Complaints module and they are then forwarded to the Operational Directors. The Policy indicates that the Corporate Complaints Officer (CCO) is responsible for screening service user contacts and determining if these are enquiries or complaints and should facilitate either resolution of the enquiry or complaint or facilitate the complainant in the use of the formal complaints procedure. ***It is recommended that the remit of this important role (CCO) is reviewed in line with the Trust's Complaints Management Policy and as part of the***

recommended Corporate Clinical and Social Care Governance Department restructure (this will include consideration of resources required to deliver this improvement, see also Section 4.23). The Policy also indicates that the CCO should alert the Directorate governance teams to significant issues. ***It is recommended that the process of screening of complaints is reviewed and parameters for alerts to be clearly defined to include alerts to professional Executive Directors***.

The Operational Directors are responsible and accountability for the proper management of accurate, effective and timely responses to complaints received in relation to the services they manage. There is some variation across the Directorates in approach to the management of complaints. At interview, senior stakeholders outlined continuing challenges in meeting response timescales and in particular within those areas where a larger volume of complaints are received e.g. Acute Services. It was also identified that some complaint responses remained outstanding for significant periods of time. Senior stakeholders also indicated that there was a significant variation in the quality of responses received for review by the Director, with many responses being returned for further consideration/amendment. This was cited as a particular challenge when a cross Directorate response was required or when an accurate oversight of complaints involving independent sector providers was required.

A recent NI Public Services Ombudsman Report confirmed the concerns expressed by internal stakeholders reiterating the importance of timeliness in responding and the requirement for clear cross directorate/sector linkages, accurate grading of complaints and corporate oversight to ensure that appropriate linkages are made with the Regional SAI process.

There are some good examples of complaints management for example, the CYPS governance team undertook an IHI Quality Improvement Personal Advisors programme which resulted in significant improvement the management of complaints within the Directorate. The improvement initiative included service user feedback on the complaints process from 353 complaints investigated and responded. The Directorate also undertook an audit from January 2017 to December 2018 from which learning has been identified. A process to improve the management of complaints should be replicated across the organisation to ensure equality in response to service users.

Directorate staff were positive about the use of the Healthcare Complaints Analysis Tool (HCAT) which was developed by the London School of Economics Report July 2018. HCATs is an analytical tool for codifying and assessing the problems highlighted by patients and their families of advocates in letters of complaints. The HCAT codes are considered by Trust staff to be more effective than the Datix CCS Codes and the Reviewer has been advised that it is possible to add an additional field to Datix to capture both sets of codes to facilitate data analysis.

As has been indicated in other key areas of governance (incidents, legal services and M&M), stakeholders indicated a gap in sharing lessons from this process and the need to create a more robust process (see also Section 4.20).

It is recommended that the Trust constitutes a Director's Oversight Complaints Review Group as a short term 'task and finish group' to focus on reviewing Policy and Procedure and improving the management of complaints and experience of the service user. Membership should include a Non-Executive Director and/or a Service User(s).

4.13 Litigation Management

The Policy and Procedure for the Management of Litigation Claims provided for the Review indicates that it is operational from November 2018 and due for review in 2021. The Policy does not indicate that it is in draft status however, the Reviewer has been informed that the draft Policy has been submitted to the Policy Scrutiny Committee for approval and subsequent circulation.[31] The Policy provided in evidence states that the Executive Medical Director is the designated officer with responsibility for Clinical Negligence claims and Coronial Services and the Director of Human (HR) and organisational Development (OD) is the designated Director with responsibility for Public and Employer Liability Claims. Each have the associated delegated financial authority accordance with the Trust's SFI and Authorisation and Approvals Framework. From a managerial perspective the Litigation Management Team/Department is the responsibility of the Director of HR and OD.

The Policy is a best practice document that clearly articulates the roles and responsibilities of key stakeholders, line managers and staff and in particular the Policy highlights the need for shared learning, being as honest and open with patients/service users and their relatives/carers and the need for staff support in the event of their being involved with a litigation process.

The Litigation team provide reports to the Governance Committee. The Litigation Manager attends Interface Meetings with the Directorates. Stakeholders advised that the opportunities for learning from claims and Inquests both internally across the organisation and externally with the wider health service could be improved.

The Head of Communications is notified of pending Coroner's Inquests and Preliminary Hearings. The system will readily allow for compliance with IHRD Recommendation 50 (*The Health and Social Care ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved),* when it is formally implemented through the IHRD Implementation Programme.

Senior stakeholders highlighted the proposal to appoint two Medical Leads for litigation management (see Sections 4.21). The paper outlining proposals for Medical Leadership was presented to SMT in June 2019. It is proposed that there will be a Medical Lead for Coroners Services who will work with the Legal Services Manager and Clinical Directors to provide professional and clinical input into the management of Coroner's cases. The role will include the following areas of responsibility; support in the process of obtaining statements from involved staff and advise on action to be taken, support in deciding from whom statements and reports

[31] Policy Checklist indicates that the November 2018 Policy Version supersedes the 'Policy for the Management of Litigation and Claims 2007'.

should be sought and review reports and provide a direct liaison and efficient communication with the Coroner's Office. In this respect, the Medical Lead and Legal Services Manager should follow IHRD Recommendation 51 (*Trust employees should not record or otherwise manage witness statements made by Trust Staff and submitted to the Coroner's Office*). As above, more definitive guidance on this Recommendation will be issued via the IHRD Implementation Programme.

The Medical Lead will also provide an extremely important role in supporting Trust staff who are to appear in the Coroner's Court which may mean attending that Court. The Reviewer, acknowledges the challenge that fulfilling this role will entail i.e. balance the Duty of Care to support staff during a stressful experience with any perception that such support could be viewed as unduly influencing staff. Therefore, clear rules of engagement should be developed.

A second Medical Lead for Litigation Services is also proposed. The area of responsibility is not defined in the Medical Leadership Review paper, however, it is understood that this Medical Lead will provide support for the management of professional negligence (clinical negligence) claims and provide a separate line of support and leadership within the Trust's Legal Services Management arrangements.

Stakeholders raised the issue of the management of legal services within the Trust being compliant with IHRD recommendation 36 ~ *Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation.* The Reviewer is aware that the IHRD Death Certification and Preparation for Inquest Workstream have debated this requirement and are currently considering how this recommendation should be implemented in practice. However, the proposed arrangement for appointment of two separate Medical Leadership Management posts is a model which is currently viewed as being reasonable.

Senior stakeholders advised that given the existing workload, delegated authorisation framework for clinical (professional) negligence and the proposed model of providing medical leadership that the Legal Services team would be best placed with the Corporate Clinical and Social Care Governance team, Medical Directorate.

It is therefore recommended that the management of Legal Services should be reviewed. This recommendation should be taken in the context of any DoH policy directive arising from the IHRD programme which may indicate a best practice model for the management of serious adverse incidents, clinical negligence and Trust Coronial Liaison Services.

4.14 Policies, Standards and Guidelines

4.14.1 Policy Scrutiny Committee

The Trust has a Policy Scrutiny Committee. Stakeholders involved in the Committee indicated the challenges in maintaining oversight of review and renewal dates given the sheer volume and diversity of Trust Policies and Procedures. Another challenge is that on occasion the Trust Policy has reached the review date and there is a delay as new legislation or regional guidance is pending and/or a regional policy is being developed. In these instances the Trust should consider amending the Policy Procedure Checklist to indicate an extension to review/revision date due to external factors. Some policy authors advised the Reviewer of delay in time from submission to date of approval and dissemination of policies, especially when external deadlines were a factor. During the Review it was noted that version control was not always robust indicating the potential for staff to be working from a dated or draft version of a policy or procedural document. ***It is recommended that the Trust consider options for an electronic policy and procedure management system that is accessible, easy to navigate, contain a search facility and includes the capacity for email notification of new/changed policy and automates a review/revise reminder.***

4.14.2 Management of Standards and Guidelines

Each HSC Trust is accountable and responsible for ensuring that clinical standards and guidelines are effectively managed so that the required recommendations are embedded within local health and social care practice.

The Trust has a process for the management of standards and guidelines which is reliant on both Corporate and Directorate based systems. Standards and guidelines are logged onto the Trust's database system centrally by the Corporate Governance Team and then forwarded on a weekly basis to Directorate Governance Co-Ordinators, Pharmacy Governance and the Medical Directors Office. Each Directorate have developed their own processes for the management of Standards and Guidelines. During the Review stakeholders expressed concern that were there was evidence that Standards and Guidelines were disseminated, however, there was a lack of assurance that they were being implemented as subsequent audit of practice had not always taken place (see Section 4.15). This concern was reiterated by the Chairman and Non-Executive Directors, who identified that this was an area that required focus.

Internal Audit carried out an audit of the Management of Standards and Guidelines during May 2015 when 'Satisfactory' assurance was provided. They audited the process again in September 2018 and provided a Limited level of assurance identifying that although the Trust had good controls to record corporately the receipt and subsequent dissemination of Standards and Guidelines to the directorates there is no corporate overview and reporting of the Trust's overall compliance against Standards and Guidelines.

The Internal Audit also identified weaknesses in relation to the completeness of data held on the Trust's Standards and Guidelines Register and limited ongoing audit/follow up of compliance (as above).

Stakeholders described the challenges in managing the large volume of standards and guidelines that are received from external agencies. During 2017/18, a total of 230 guidelines were received from external agencies, 23 were not applicable to the Trust of the remaining 207 there were 39 that were not applicable to Acute Services. Senior stakeholders identified the challenges in managing standards and guidelines which have cross directorate applicability.

In April 2012, the Trust established a Corporate Standards and Guidelines Risk and Prioritisation group. The aim of this group was to provide a corporate forum to ensure that the Trust has in place a systematic and integrated approach for the implementation, monitoring and assurance of clinical standards and guidelines across all of its care directorates. The Reviewer understands that the Group was stood down in January 2017 to be replaced by monthly meetings between the Corporate Assistant Director Clinical and Social Care and Directorate Governance leads.

All of the Directorates have systems in place for the management of Standards and Guidelines. Acute Services have a robust system in place for the dissemination of Standards and Guidelines which represents a best practice model. The system was developed and is managed by a Patient Safety and Quality Manager (Standards & Guidelines) who is a NICE Scholar and a member of the Acute Services Clinical and Social Care Governance Team. The system includes a Standards and Guidelines Operational Procedures Manual, a reporting schedule, process maps including a process map for clinical change leads and an Accountability Reporting system for Acute Services. The downside of this system is that it is person dependent. The Patient Safety and Quality Manager also identified that the lack of clinical audit in providing assurance that standards and guidelines had been implemented was a systems issue.

Other challenges include identifying a clinical/managerial lead for guidelines – as there is an apprehension surrounding taking on the responsibility/accountability for change lead role.

Positive assurance statements go directly back to HSCB via the Corporate Clinical and Social Care Governance team. Previously they would have been approved by SMT prior to issue. ***It is recommended that a level of corporate oversight is reinstated (in line with the Assurance & Accountability framework S4.1).***

An 'Accountability Report' of the Trust's compliance with Standards and Guidelines had previously been reported to the Governance Committee on a twice yearly basis. ***It is recommended that the Accountability (Compliance) reporting arrangement is reinstated***.

The Trust will be required to comply with IHRD Recommendation 78 ~ *Implementation of clinical guidelines should be documented and routinely audited*. The challenges in respect of clinical audit are outlined in Section 4.15. It is anticipated that as part of the final stage of the IHRD Implementation Programme Assurance Framework HSC organisations will be required to provide independent

assurance of compliance with policies and procedures arising from the recommendations (see also Section 4.15 and 4.23).

The Trust, as a matter of urgency, should review the overarching corporate arrangements and resources to provide assurance regarding the effective management of Standards and Guidelines and to facilitate a risk based approach from the triangulation of data from incidents, complaints, claims, service reviews, Morbidity and Mortality reviews and Clinical Audit.

It is recommended that the Trust take the Standards and Guidelines model developed within Acute Services and provide a central management system within the Corporate Clinical and Social Care Team under the leadership of the Medical Director. The Reviewer understands that the IT system currently used within Acute Services may not have the capacity to deal with Trust-wide information.

4.15 Clinical Audit

The Trust's Clinical Audit Strategy was presented to the SMT on 20 June 2018 and was then presented to the Governance Committee on 6 September 2018. The Strategy defined clinical audit as 'a quality improvement cycle that involves the measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes'. Clinical audit is an integral part of the good governance framework.

Senior stakeholders advised that Internal Audit had provided Clinical Audit with a 'Limited' assurance level. The Clinical Audit Strategy outlined the strategy and structure for overseeing clinical audit processes to provide an assurance to SMT and Trust Board that clinical audit activity would be appropriately managed and delivered. The paper clearly outlined the key issues and challenges for the organisation which include; ensuring that clinical audit is delivered consistently across all operational directorates, in line with national guidance and ensuring that there is a sufficient number of staff in the corporate clinical audit team and in the operational Directorates to support the delivery of the approved clinical audit programme. The Strategy also describes the prioritisation of clinical audit in line with Healthcare Quality Improvement Partnership (HQIP) proposals that clinical audit programmes are categorised into 4 distinct elements with 'external must do' audits being assigned the highest priority as Level 1 projects.

Clinical Audit will have an increasing and key function in providing corporate assurance that IHRD Recommendations have been implemented. Clinical Audit and the Morbidity and Mortality Process are intrinsically linked (see Section 4.16). Clinical Audit will be required to provide assurance that clinical standards and guidelines have been implemented (IHRD Recommendation 78 as outlined in Section 4.14). Also Recommendation 76 ~*Clinical standards of care, such as patients might reasonably expect should be published and made subject to regular audit*. Clinical audit will also be required to provide assurance of organisational compliance with clinical standards in IHRD Paediatric Clinical (Recommendations 10-30) for example, patient transfer, on-call rotas and clinical record keeping.

Stakeholders described the dilution of the clinical audit function over a period of time, this experience is similar to that of other HSC Trusts. The Clinical Audit Strategy 2018, identified that the current [administrative] staffing levels in the corporate Clinical Audit and M&M team and operational directorates as insufficient to support and deliver the clinical audit work programme. The Reviewer would concur with this statement and would add that the demand on this governance function is set to increase significantly as described above. This is covered in more detail in Section 4.23. Clinical and Social Care Governance Structures.

The Medical Director has also identified resource issues in the paper entitled 'Medical Leadership Review submitted to SMT in June 2019 (see Section 4.21). The appointment of a Clinical Standards and Audit Lead who will lead the coordination and monitoring of systems and processes to ensure maximum compliance with clinical standards as endorsed or mandated by regional or professional bodies is key.

Stakeholders advised that there was a need to demonstrate more robust linkages between clinical audit and quality improvement and the management of serious adverse incidents. ***It is recommended that the integration between quality improvement and the integrated governance function is reviewed to ensure optimum connectivity.***

The 2018 Clinical Audit Strategy and Action Plan should be reviewed and updated.

It is also recommended that the Clinical Audit Committee is reinstated and the reporting arrangements considered in the review of the Trust Board Committee Structure (Assurance & Accountability Framework Section 4.2.6 and Appendix 2.

Given the potential increase in focus and demand on clinical audit as outlined above ***it is recommended that the resource implications are reviewed, see Section 4.21 Medical Leadership and Section 4. 23.1 Corporate Clinical and Social Care Governance Department).***

4.16 Clinical Outcomes - Morbidity and Mortality (see also 4.21 Medical Leadership)

Morbidity and Mortality (M&M) reviews are primarily a tool for identifying opportunities for system level improvement. There was a focus during the IHRD Inquiry into the rationale and mechanics of M&M Review and the significant role this process has in improving outcomes through learning. In November 2016, the DoH issued guidance on a Regional Mortality and Morbidity Review (RM&MR) process. The aim of the guidance was to provide specific direction for M&M leads and a regional approach as to how M & M meetings should be established, structured managed and assured. RM&MR is hosted on the Northern Ireland Electronic Care Record (NIECR)

As part of the 2018/19 Annual Internal Audit plan, Internal Audit carried out an audit of M & M during October to December 2018. The SHSC Trust was one of four

Trusts audited during this period. The Reviewer has noted that the audit focused specifically on the mortality aspects of this guidance. Internal Audit provided a Limited Assurance in respect of the M&M processes. The Internal Audit Report recognised that there were processes however, timescales for Consultant review and discussion at M&M groups was not routinely followed and some deaths had not been reviewed or discussed. Internal Audit did recognised from their observational audit (attendance at three meetings) that deaths were discussed in detail with a level of robust and challenging professionalism among teams visited. Senior stakeholders within the Board of Directors noted an improving culture in the ethos of utilising M&M for shared learning within the organisation.

As a result of the Internal Audit review of four Trusts, a number of concerns have been raised regionally about the adequacy of the regional M&M process and in particular the need for significant investment in order to ensure M&M regional processes are fit for purpose, especially around Learning Lessons. Trust stakeholders have also identified a lack of resources (see also Sections 4.15 and 4.23.1). If the appropriate staff are to attend specialty meetings, they need time out to learn (as indicated above this is also a recommendation from the IHRD Report), this was identified as a particular challenge for non-medics without job plans. Trust senior stakeholders identified that the lack of multidisciplinary participation was a concern and that that was partially as a result of the culture.

In addition, there is a risk in the context that all deaths must be reviewed, that sufficient time will not be spent on those deaths which provide the most opportunity for learning. This would require a screening/risk assessment process to be built into the regional process. There is no central IT system's overview, so the Trust cannot interrogate the system to generate reports and this lack of reporting functionality was a concern raised by Trust officers.

The Trust established an Outcome Review Group, which met for the first time in June 2018. The remit of this Review Group is to provide an assurance that all hospital deaths are monitored and, reviewed and reported, in line with regional guidance and to ensure that lessons learned and actions are implemented to improve outcomes. It is recommended that the Outcome Review Group (see also Board Governance Structures Section 4.1.9 and Appendix 2).

M&M Chairs have a key function in delivering the RMMR process. Within SHSCT they are responsibility for setting and maintaining the agenda for M&M meetings and for determining, supporting and developing patient safety inputs. They also have a monitoring role which includes; attendance, timely completion of screening templates and medical staff participation in Case Presentation. An M&M Chairs meeting has also been developed with the purpose of informing the ongoing development of M&M meetings and processes. The M&M Chairs should report to the Outcome Review Group.

Within the Trust, stakeholders highlighted the need for IT and administrative support for the process. With the right investment administrative staff could also reconcile deaths with SAIs thus providing another line of assurance that the process is being implemented. The Internal Audit Report indicates that the minutes and presentations

at M&M meetings are held centrally by the Corporate M & M team and Clinical Audit team (see Section 4.23.1).

The M&M Review Process is a core element of the Trust's integrated governance arrangements and patient safety framework. The Clinical Audit/M&M team within the Medical Directorate are a crucial element of the Process. The Outcomes Review Group is an important component of the Trust's assurance framework. I***t is recommended that they are adequately resourced and supported to ensure optimum outputs and clinical engagement. The support will include the development of administrative systems for the central suppository of minutes and attendance logs***.

4.17 Raising Concerns

The Trust's Policy for raising concerns is entitled 'Your Right to Raise a Concern' (Whistleblowing) and is based on Regional guidance. There is no indication of the date the Policy was approved/became operational on the Front Cover. The Lead Director is the Director of Human Resources and Organisational Development.

Board Effectiveness guidance increasingly highlights that the Board of Directors have a role in creating the culture which supports open dialogue. This should include Directors personally listening to complaints, concerns and suggestions from patients and staff, and being seen to act on them fairly (see also Section 4.6 Being Open). The Board should be assured that there is a framework which indicates how staff should raise their concerns and a key element is a clear whistleblowing policy, with support and protection for bona fide whistle blowers. The Reviewer was advised that a Non-Executive Director has been nominated to take a lead in this area.

The aim of the Trust policy is to promote the culture of openness, transparency and dialogue which at the same time; reassures staff that it is safe and acceptable to speak up, upholds patient confidentiality and contributes toward improving services, demonstrates to all staff and the public that the Trust is ensuring its affairs are carried out ethically, honestly and to high standards. The Policy also aims to assist in the prevention of fraud and mismanagement and contains specific guidance and contact details in this respect. The Trust Policy compliments extant Professional Codes and Guidance on responsibilities in raising concerns and clearly states that it is not intended to replace professional codes and mechanisms which also questions about professional competence to be raised.

The Director of HR advised that a gap in awareness training had been identified which would be addressed. She also advised that the use of advocates would be implemented in the medium term. Stakeholders who had participated in investigation cases indicated that this process was another source of learning for the organisation. The Policy contains a template entitled 'Record of Discussion regarding Confidentiality' which is a very useful tool in those situations where confidentiality is an issue for the member of staff raising the concern.

4.18 Information Governance

The Trust has identified that safeguarding the Trust's information is a critical aspect of supporting the delivery of its objectives. Effective management of information risk is a key aspect of this. The Trust has arrangements in place to manage the risk including; an Information Governance Strategy incorporating Framework, Framework, a Personal Data Guardian to approve data sharing (Medical Director and Director of CYP), a Senior Information Risk Owner (Director of Performance and Reform) and Information Asset Owners in place to reduce the risk to personal information within the Trust and training and advice provided to ensure they were aware of their responsibilities. The Senior Information Risk Owner (SIRO) provides an annual report to the Governance Committee which provides a summary of key aspects of the role, the minutes confirm that the Report was last presented in February 2019.

The Information Governance Strategy incorporating Framework is dated 2014/15 – 2016/17 and is underpinned by a suite of policies, procedures and guidance. The Information Governance Policy is dated January 2015 with a two year default for review. ***The Policy should be reviewed to take account of extant legislation and guidance in particular General Data Protection Regulations 2018.***

Information Governance breeches are required to be reported in line with Trust's Incident Reporting Procedure. Stakeholders have identified that learning from information governance incidents should be included in the Lessons Learned Forum (Section 4.20).

As identified in Section 4.1 Freedom of Information and Data Protection summary compliance data is reported to Trust Board on a quarterly basis to ensure completion within statutory timeframes. An information sharing register is in place which records the details of all episodes of sharing of Trust data with other bodies. Information governance training is mandatory within the Trust.

The Trust had taken action to ensure it was prepared for the General Data Protection Regulations (GDPR) in May 2018. Internal Audit provided 'satisfactory' level of assurance in relation to General Data Protection Regulations (GDPR) Readiness within the Trust during the 2017/18 audit cycle.

Cyber Security remains as a 'High' risk rating on the Corporate Risk Register.

4.19 Emergency Planning and Business Continuity

The Trust has a Corporate Emergency Management Plan incorporating Major Incident and Business Continuity. The Plan was approved by Trust Board in January 2013 and was revised during 2018/19 and is dated 15 February 2019. The lead Director is the Executive Medical Director. The Emergency Planning Policy is dated November 2015, approved by SMT on 9 December 2015 and circulated in February 2016 by the Medical Director. The Business Continuity Policy is dated 2012. An Annual Report on Emergency Planning and Business Continuity is submitted to Trust Board.

The Trust's Controls Assurance Emergency Planning Framework self-assessment has identified that the Trust is largely fully compliant with the core standard. Some

actions have been identified including; provision of appropriate resourcing for the Emergency Planning Office; developing an ongoing exercise programme/schedule at directorate and corporate level and a process for implementing actions arising from major incidents/exercises. A training needs analysis is required to identify any gaps in the key competencies and skills required for incident response including chemical, biological, radiological and nuclear defense (CBRN) training. These actions will be monitored by the Trust's Controls Assurance Group (See Section 4.7).

Stakeholders indicated that the development of Business Continuity plans at Directorate level could be improved.

4.20 Shared Learning for Improvement

All of the stakeholders expressed the need for HSC organisations to learn from service user experience and from the analysis of adverse incidents, complaints and claims. The commitment to learn is expressed in the Trust's 'Values' and Corporate Objectives. In the Trust's strategic priority 'Promoting safe, high quality care' the Trust has stated its commitment to 'be a learning and continually developing organisation, where professional standards, best practice and learning from experience share how we improve our services'.

The Trust has a Lessons Learned Forum whose purpose is to provide a corporate cross directorate interface for the identification and sharing of lessons learned from incidents (including near misses), complaints and litigation cases. The Forum is also responsible for identifying areas for improvement in the Trust' management of adverse incident and complaints and if appropriate propose system changes and to provide challenge and scrutiny to the Trust's adverse incident processes. The Forum members are responsible for presenting potential sharing lessons learned from their service areas and for assisting in disseminating the learning within their respective service areas. Stakeholders suggested 'casting the net wider' in respect of sources e.g. systems failures identified in Whistleblowing cases and HR Grievance and Disciplinary investigations (subject to the same rules of working within information governance parameters, maintaining confidentiality and limitations due to ongoing legal processes). Senior stakeholders wanted to see a stronger link between 'Lessons Learned' and Quality Improvement. (See also Section 4.1.9 Board Governance structures.)

Senior stakeholders advised that at times it seemed like the processes for learning were disparate and there was a lack of connectivity for example the learning identified through M&M and learning provided for the Forum. Stakeholders were therefore were keen to ensure that as various Sub Groups are developed within the Trust's integrated governance/assurance framework that duplication of purpose is minimised and the process for shared learning was escalated and disseminated through the proposed Assurance and Accountability framework (Section 4.1.9 and Appendix 4).

During the Review a meeting of the Lessons Learned Forum was held and stakeholders stated that it had been an excellent agenda and provided the organisation with a valuable opportunity to learn. However, the stakeholders were

also disappointed at the lack of attendance by medical staff. It is recognised that time to learn is a challenge for clinical staff. This was recognised in the IHRD Report and Recommendation 66 states *'Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours'*. The Education and Training Workstream have interpreted clinicians in the boarder term to include nursing, Allied Health Professionals and Social Workers. (See also Medical Leadership Section 4.21). Stakeholders were keen to explore alternative forms of sharing learning through e.g. annual safety events, learning lunches, learning letters and safety newsletters shared on Trust's intranet.[32]

Stakeholders also indicated that the challenge and scrutiny function within the Forum's Terms of Reference in respect of the management of adverse incidents had not yet been embedded. However, there may be a more appropriate forum for the Trust to undertake the scrutiny challenge and quality assurance of serious adverse incidents (see Management of SAIs Section 4.10).

In reviewing the Terms of Reference the Trust should consider how the Forum could contribute to the implementation of IHRD Recommendation 40 'Learning and trends identified in SAI investigations should inform programmes of Clinical Audit' (see also Management of SAIs Section 4.10).

4.21 Medical Leadership

Medical leadership was last reviewed in the Trust in 2011 and as the related paper indicates, given the length of time since this review and the changes in the health and social care landscape it was agreed that a further review and potential revision of the medical leadership form and function was required.

The findings were presented to the SMT on 11 June 2019. The 'case for change' highlighted three key areas:

- Performance of Frontline Teams;
- Providing a Link from Ward to Board;
- Supporting and influencing Service Planning.

The review emphasised the importance of implementing a Collective Leadership Model and the need to move on from a concept of command and control leadership. The review report also recognises that due to the power and control which doctors possess they may block potential change efforts and confound improvement initiatives. Engaging doctors within the collective leadership model therefore is crucial.

The review process included an independent survey of medical leaders which was carried out to identify the barriers and enablers. Many of these findings reflect the comments from stakeholders during the Governance Review and included the need to clearly define the roles and accountabilities of medical leaders and provide protected time to deliver in their roles and greater integration with operational management teams.

[32] An example of a Trust serious adverse incident/never event learning letter 'Nevermore' is available to view at www.yorkhospitals.nhs.uk

The Medical Leadership Review indicated that if the proposals were approved, all Medical Leadership management posts would be vacated and reappointed collectively.

To support the Medical Director who carries responsibilities in a wide area including; Medical Professional Governance, Clinical and Social Care Governance, Quality Improvement and Audit and Infection Prevention and Control, it is proposed that two Deputy Medical Directors should be appointed. One of the post holders, Deputy Medical Director Quality Improvement will focus on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, developing a clinical governance strategy and participating in education and training programmes as required. The Deputy Medical Director will work with the [Interim] Assistant Director Clinical and Social Care Governance in a Collective Leadership model and will provide stronger corporate integrated governance oversight and leadership.

As outlined in Sections 4.14 and 4.15 Standards and Guidelines and Clinical Audit and Sections 4.13 Coroners Service and Litigation Management and Section 4.16 M&M the investment in these Medical Leadership management roles is core to delivering clear accountability arrangements that will provide a robust assurance framework for effective integrated governance. In addition, the structure will facilitate the Trust meet the recommendations arising from the IHRD Implementation Programme. To achieve maximum outputs from the Medical Leadership model, the Trust should recognise the need to provide additional administration and clerical support (see also Section 4.23). [33]

4.22 Governance Information Management Systems

The Trust currently uses a commercial risk management/patient safety software programme called Datix. Datix is used in all of the Health and Social Care Trusts and the Health and Social Care Board. The Trust currently uses the Incident reporting, Complaints and Claims modules and has just purchased the Risk Register module.

Stakeholders advised that the Clinical and Social Care Governance Coordinator, Mental Health Service had developed statistical reports/Datix dashboards for his own and other operational Directorates which was a much welcomed tool to support data analysis and provision of governance reports.

All of the stakeholders in the Governance and Patient Safety Department and the Directorates who were interviewed were keen that the collective software system was utilised to the maximum capacity to support the patient safety/integrated governance agenda. They were also keen to explore the advantages that more advanced patient safety software can achieve for example Datix Cloud IQ. This is

[3333] SHSCT 'Medical Leadership Review' June 2019. Section 14.11, page 29.

currently being considered by the IHRD DoH Clinical and Social Care Sub Group in respect of the implementation of Recommendations 67, 68 and 80 (see below).[34]

The Reviewer is aware that the IHRD DoH Clinical and Social Care Sub Group have identified regional issues in respect of Recommendation 80 ~ "*Trusts should ensure that health care data is expertly analysed for patterns of poor performance and issues of patient safety*". Through the initial benchmarking data the DoH workstream identified that HSC Trusts reported various levels of data analysis and various approaches including expert analysis through Data Triangulation Groups. Strong links with existing systems i.e. QI data were identified (dashboards and statistical run charts) and some data from traditional clinical coding e.g. CHKS. Regional variance with commercial systems on trial or in use were also identified e.g. two Trusts use Alamac which consists of 4 models including analytics and governance reporting, service redesign and improvement and operational performance improvement and governance which includes real time data analysis e.g. heat map.

An indication of the direction of potential regional guidance in this matter is not available at present. The DoH workstream have accepted that Encompass will be integral in the future, however it is accepted that they will have to consider a short to medium term solution and are seeking to influence the Regional Data Strategy. During this Review Trust stakeholders also identified issues with the existing ICT infrastructure and the expert and administrative support required to provide the required level of information to provide assurance to Trust Board (see also Section 4.1 and Section 4.23). ***It is recommended that the Trust consider the information management systems and administrative support required to support the implementation of the Governance Review recommendations.***

To ensure that the Trust maximises it's information for integrated governance it is ***vital that a dedicated Datix systems administrator who can ensure the quality of data provided as this has been identified as a gap at present*** (see also Clinical and Social Care Governance Structures below).

4.23 Integrated Governance Structures

4.23.1 Corporate Clinical and Social Care Governance, Medical Directorate

The Executive Medical Director is the Executive Lead for Corporate Clinical and Social Care Governance. The Corporate Clinical and Social Care Governance Team is managed by the [Interim] Assistant Director for Corporate Clinical and Social Care with the support of one very recently appointed Senior Manager (Head of Patient Safety & Improvement). The Team support a large range of integrated governance functional areas including; delivering the Risk Management Strategy, incident reporting including Serious Adverse Incident reporting, complaints, patient

[34] Recommendation 67 ~ ' *Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed'*. Recommendation 68 ~ '*Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining'*. Recommendation 80 ~ '*Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety'*.

safety data and reporting on Clinical and Social Care to the Governance Committee of Trust Board.

Stakeholders advised and as is described in the Sections above that some of the functions are 'light touch' and limited to initial screening or signposting (e.g. complaints). The Reviewer was advised that the Management of Infection Prevention and Control would transfer to the Interim Director. In addition, during the review, the management of Clinical Audit and the M & M system was also transferred from within the Medical Directors Office to the Interim Director and as a result of the Review potentially the management of legal services (with exception of HR legal services),[35] the Board Assurance Framework and Corporate Risk Register would also be considered for transfer.

This centralisation of corporate integrated governance functions under the leadership of the Executive Medical Director represents a best practice 'good' governance structure and will be crucial for effective delivery of the proposed integrated governance assurance and accountability framework (see Section 4.1.9). The revised corporate clinical and corporate governance structure will create a more robust first line of assurance to the Board of Directors on the systems of internal control (including gaps in control and assurance). However, there are concerns for the staffing of this resource in respect of meeting the current demands and more crucially in meeting the increased demands of delivering a more robust assurance framework and in delivering the improvements required in the systems of internal control (Sections 4.4 – 4.22).

The Reviewer has benchmarked the existing corporate clinical and social care governance structure within the Trust with the Northern Health and Social Services Trust (NHSCT) structure who have a similar organisational profile and successfully implemented a robust accountability and assurance framework as recommended above in Section 4.1. [36] The NHSCT corporate governance structure is described below.

The Trust (SHSCT) have recently appointed a Senior Manager (Head of Patient Safety Data and Improvement). This post holder will focus on safety, quality and innovation as key drivers to deliver improved outcomes for patients and clients. This post is responsible for managing the timely and effective provision and communication of a corporate quality and safety analysis service.

The post holder will be responsible for setting the strategic direction for a range of analysis services provided at corporate organisational level within the Trust. This will include Patient Safety, Clinical Audit, Mortality & Morbidity and Trust clinical guidelines, in line with statutory requirements and national, regional benchmarks, peer accreditation frameworks and standardising Trust best practice.

[35] As outlined in Section 4. 13 the management of legal services is subject to review by the IHRD DoH Preparation for Inquest and it is anticipated that there will be a Regional Policy Directive on the management of clinical (professional) negligence and Trust Coronial Services.

[36] Information kindly provided by the NHSCT Assistant Director Governance & Risk Management. The Reviewer recognises that the NHSCT portfolio includes the management of Health and Safety.

The Patient Safety Manager will support the Head of Patient Safety Data and Improvement. The post holder is one of the original Institute for Healthcare Improvement (IHI) HSC Safety Forum members and maintains and updates the Forum Extranet and contributes to regional work. There are examples of best practice improvement initiatives in this area for example the Patient Safety Falls Walking Stick and the Pressure Ulcer Safety Cross. The Patient Safety Manager undertakes a large volume of data analysis activity supporting the Trust's Patient Safety Programme. The role is currently supported only by one Band 3 (24 hours). Therefore, this service is dependent on a single manager which is not sustainable. The post holder has limited time to use his expertise at ward/department level in quality improvement initiatives for example Sepsis6.

Clinical Audit (including M&M) is managed by an Acting Band 7 Manager who during the Review demonstrated commitment to providing a quality service and provided insight into the challenges of delivering both current and future clinical audit and M&M activity. The team to support Clinical Audit has reduced following the Review of Public Administration (RPA) and currently consists of a B5 WTE x 1 and Band 3 WTE x 3 plus 1 part time.

As outlined above, (Sections 4.15) clinical audit is 'back on the radar'. The role of the team is to support the delivery of the Trust's clinical audit programme which includes key national, regional and local drivers for clinical audit (described as 'top-down') balanced against directorate/service priorities and the interests of individual clinicians (bottom-up) initiatives.[37] The team screen audit proposals prior to registration. The post holder advised that there were also challenges in relation to supporting National Confidential Enquiry into Patient Outcome and Death (NCEPOD) activity which is currently person dependent within the Trust and needs to be re-focused.

Also as above (Section 4.15) the Clinical Audit team have a key role to play in delivering the Regional M&M Review system. Within the current resource there is very limited time for support for M&M Chairs which ideally would include pre and post meeting support and support for the Chairs Forum which meet on a quarterly basis. The rolling audit calendar is a particular challenge as support is required for six meetings at the same time.

The third key challenge for the Clinical Audit team with the current resources is supporting the linkages with quality improvement, the management of standards and guidelines (Section 4.14) and Serious Adverse Incidents (Section 4.10) and providing the SMT and Trust Board with assurance that improvement in practice has been implemented and sustained.

Stakeholders have indicated resource challenges in supporting the Trust to respond to the demands arising from the existing work plan of the Regulation and Quality Improvement Authority (RQIA) e.g. thematic reviews. In addition, the Corporate Clinical and Social Care Governance team will have to prepare for the increase in

[37] Healthcare Quality Improvement Partnership (HQIP) propose that clinical audit programmes are categorised into 4 distinct elements with 'external must do' audits being assigned the highest priority as Level 1 projects.

demand as the RQIA fulfil their functions in providing external assurance of compliance with the policies, procedures and guidelines arising from the final stage of the IHRD Implementation Programme, the Assurance Framework. The various workstreams and subgroups are currently working toward this final stage and more explicit information is not available at this time however, the Trust should seek feedback through their Director's Oversight Group from their workstream representatives. In addition, there is also likely to be more Internal Audit activity in respect of integrated governance functions arising from this same phase of the IHRD Programme.

The Governance Coordinator provided insight into core elements of the Clinical and Social Care Governance agenda including; complaints management, adverse incident management (including SAIs) and the use of Datix. She highlighted the lack of the corporate resource required to provide systems-wide quality assurance of these systems.

The range of functional areas for the Corporate Clinical and Social Care Governance team is wide and if proposed corporate governance functions are further integrated these functional areas will increase significantly. In addition to the day-to-day remit of the functional areas, the Clinical and Social Care Governance Team have to respond to a number of external demands for example the DoH IHRD Workstreams and stocktaking exercises, the RQIA (as above) and an ever increasing number of FOI and Media Enquiries. Normally these activities are required in very tight timeframes.

It is the opinion of the Reviewer and senior stakeholders, at director level that the corporate clinical and social care governance function has been under resourced over the past number of years. This underfunding represents a lack of investment in staff and the necessary information technology systems to support a good governance structure.

To deliver a similar portfolio of corporate clinical and social care governance functions the NHSCT have an Assistant Director Governance & Risk Management supported by three Senior Managers for;

- Risk Management;
- Quality, Standards and Learning;
- Assurance, Data and Systems Management.

The Risk Management function is supported by three managers (Band 6 and 7 excluding their Back Care Managers) and 13 support staff (Band 5 x 2, Band 4 x 3, Band 3 x 6 and Band 2 x 1). The Quality, Standards and Learning Function is supported by three managers (excluding their Health and Safety Manager, Resuscitation Officers and Research and Development Manager) and six supporting administrative staff (Band 5 x 1, Band 4 x 4 and Band 3 x 1). The Assurance, Data

and Systems Management function is supported by three managers and 5 administrative staff (Band 4 x 2 and Band 3 x 3).[38]

It is recommended that as a matter of urgency the Corporate Clinical and Social Care Governance team is re-structured and two additional Senior Manager posts are considered to provide leadership to related functional areas. It is proposed that there should be a Senior Manager for Clinical and Social Care which will include; management of Serious Adverse Incidents, Complaints and Claims and a Senior Manager for Corporate Governance which will include Risk Management, Risk Registers, Datix Administration, Controls Assurance and training (see Appendix 3). It will be essential to also consider the administrative support required to support the corporate function areas as has been highlighted throughout the report if the Trust is to meet the ever increasing level of scrutiny and demands to provide assurance to Trust Board and external stakeholders of the efficacy of its internal control systems. ***Therefore, it is further recommended that there is an urgent review of the Corporate Clinical & Social Care Governance structure and business case development for consideration by SMT.***

Given the wider remit of the corporate team it is important that each functional area has an annual action plan/work plan which will underpin the Corporate Clinical and Social Care Governance management plan and which can be linked to Corporate Objectives and staff appraisal.

4.23.2 Directorate Governance Arrangements

It was evident that Directors had invested in their Governance structures, however, they all advised that there was still not the capacity to meet the demands of providing information and assurance to internal and external stakeholders on the wide range of integrated governance elements e.g. standards and guidelines, serious adverse incidents and complaints. Additionally, there is an ever growing demand under RQIA, FOI, Media Inquiries etc.

The extant Integrated Governance Framework requires that each Operational Directorate Governance Forum is responsible for considering all aspects of the Trust's 'Model of Integrated Governance'.[39] Each directorate have developed governance structures which includes an overarching governance forum/group with terms of reference and sub groups which vary from directorate to directorate. The Reviewer was provided with examples of the structures which show clear lines of accountability and communication lines within the Directorate e.g. Mental Health Services. Governance forum sub groups meet at varying intervals within each Directorate. There is also a slight variation in the directorate governance forum/group meeting agendas and again this is not unusual in a Trust that consists of a range of programmes of care.

[38] The Reviewer is aware that the information shared by the NHSCT represents total head count for posts and not detail of whole-time equivalents. The Assistant Director has indicated she will share further detail with the Interim Assistant Director SHSCT as required.

[39] SHSCT 'Draft Integrated Governance Framework 2017/18 – 2020/21'. Section 5 page 21 and Figure 1 page 23.

The high level governance structure, Figure 2 in the extant Integrated Governance Framework, depicts the directorate governance forum reporting 'organisational and directorate intelligence' to the SMT. It is less clear from a review of the SMT Terms of Reference and Agendas how this operates in practice. ***It is recommended that the directorate governance reporting arrangements are included in a review of Trust Board Sub Committee Structure and the review of the SMT Terms of Reference as above (Sections 4.5 and 4.6).*** Also less clear within the Integrated Governance Framework is the role/link between the Executive Lead for Integrated Clinical and Social Care Governance (Medical Director) and the [Interim] Assistant Director for Clinical and Social Care Governance and the Operational Governance Arrangements (see also Section 4.4). This lack of clarity was confirmed by comments from stakeholders during the Review. In addition, some stakeholders indicated concern in dual reporting lines (see also Section 4.4) ***Clarification of lines of accountability, roles and reporting responsibilities should be considered as part of the recommended review of the Integrated Governance Accountability and Assurance Framework following approval of the Governance Review recommendations.***

The operational Directorates have appointed Clinical and Social Care Governance Coordinators. They fulfil a key role in supporting Directorates and in collating the Directorate intelligence. There is some variation in the demanding roles and responsibilities of the post holders which have evolved over time to meet the needs of the Directorates. There is also variation from Directorate to Directorate, in the resources allocated to provide support to the Directorate Clinical and Social Care Governance Coordinators. As above, the Directorate Clinical and Social Care Governance Coordinators and teams carry a wide range of roles and responsibilities at local level across the integrated governance functional areas and demand invariable exceeds capacity. Within Acute Services, the Director of Pharmacy has been supporting the role on a temporary basis. This should be reviewed to enable the post holder fulfil her regional role as Chair of the Regional Pharmaceutical Contracting Executive Group for Northern Ireland.

As previously outlined, there are examples of best practice across the Directorates for example work on complaints management, service user engagement and the model for dissemination of standards and guidelines. The Trust should consider how to share the best practice.

4.23.3 Interface between Corporate C&SGC and Directorates

Weekly Governance Meeting

The Medical Director and Interim Assistant Director Clinical and Social Care Governance have reinstated a weekly Governance Meeting with Directorate Clinical and Social Care Governance Coordinators. The meetings are short, lasting approximately one hour. Currently, the Medical Director where possible, either attends the meeting or joins by teleconference. The Reviewer has been advised that the rationale is to provide an opportunity for both a briefing (e.g. learning and internal safety alerts) and debriefing on newly emerging issues e.g. serious adverse incidents or complaints. These meetings meet the spirit of 'no surprises'. The

meetings are currently held on a Thursday and members can currently 'dial in'. There is a mixed reaction to the weekly Governance meeting with stakeholders identifying that the 'dial in' facility is not conducive to debrief meetings. Stakeholders have also identified that due to the nature of Acute Services the agenda can, at times be described as Acute centric.

The interface meetings are an important development and will underpin the integrated governance arrangements of the Trust's assurance and accountability framework. It is important that this interface meeting continues and develops to meet the needs of all concerned. The Interim Assistant Director advised that the process was at an early stage and the agenda was still being tested and evolving. She further advised that maintaining the efficacy of the interface meetings had resulted in increased workload for both corporate and directorate clinical and social care governance teams. More recently, the membership has increased to include safeguarding, medicines management, litigation management and standards and guidelines and this addition was being positively evaluated.

The Trust has systems in place to brief the Board of Directors of emerging issues in a timely fashion. The output of this meeting will complement existing systems and should be further developed to provide a summary briefing note which when ratified by SMT can be circulated to the Chair and Non-Executive Directors. This will assist the Trust meet IHRD Recommendation 81 ~ *Trust's should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within he Trust are brought to the immediate attention or every Board member*.

It is recommended that the agenda, membership and timeliness of the weekly Governance Meeting is reviewed and terms of reference developed. The meetings should be kept as short briefing meetings and held face to face with members. There should be a short summary template report developed which can then be used as an internal communication to NEDs.

Monthly Clinical and Social Care Governance Meeting

The monthly governance meeting provides an opportunity to consider a wider range of integrated governance issues in more detail. In light of the weekly governance meeting, ***it is recommended that a review of the terms of reference including purpose, membership and frequency is undertaken.***

Appendices

Summary of Recommendations **Appendix 1**

Theme/ Rec No	Recommendation	Timescale[40]
Good Governance Structures – Board Governance		
1	The Trust Board should review the cycle of Trust Board Reports and the Board of Directors' public meeting agenda by April 2020. .	M
2	The Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director.	M
3	The Chair of the Governance Committee should be involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020	S
4	The clinical and social care key performance indicators should be further developed and submitted for approval through the Senior Management Team.	S
5	The SMT Terms of Reference should be reviewed including the provision for tabling urgent papers.	M
6	The remit and responsibilities of the SMT Governance Board should be reviewed and a separate Terms of Reference developed to include the purpose, membership and reporting lines to Trust Board via the Governance Committee of Trust Board. (See also Assurance & Accountability Framework proposals at Section 4 1.9). The role of the SMT Governance Board should also be clearly defined in the Integrated Governance Strategy.	M
7	The Trust Governance Structures should be reviewed and Trust Board Sub Committee/Oversight/Steering Groups constituted to which the various integrated governance steering groups, forum and committees will report and provide the organisation with a first level of assurance (see Appendix 2).	S-M
8	The Terms of Reference and annual work plans/action plans (where applicable) for Board Committees and Sub Committees should be held centrally.	M
9	Any short – medium term Director's Oversight Groups should be added to the Governance Structure (Integrated Assurance Framework) for the duration of their remit as 'Task and Finish Groups' e.g. IHRD Directors Oversight Group.	S

[40] Short Term (S) action within 3 months, Medium Term (M) action within 6 months, Long Term (L) action within 9-12 months.

Theme/ Rec No	Recommendation	Timescale[40]
10	To ensure that all committees provide clarity in their terms of reference, delegated powers and reporting requirements the Trust should consider developing a standard template to define the terms of reference for all Board Sub Committees, Steering Groups and Advisory/Specialist Groups.	M
11	The Trust should consider introducing the role of Board Secretary/Head of Office to support the Trust Board and the Integrated Governance Framework.	M
12	The Integrated Governance Framework should be reviewed as a matter of urgency to ensure it provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Framework provides electronic links to key corporate Trust Strategies and Policies and extant guidance where applicable.	S
13	Arrangements for Adult Safeguarding should be reviewed to identify any potential risks/gaps in control or assurance in this area.	S
'Being Open'		
14	The Trust should consider the implications of implementing the Regional 'Being Open' framework which includes compliance with IHRD Recommendation 69 (i) ~ Trusts should appoint and train Executive Directors with specific responsibility for 'Issues of Candour'.	M
Controls Assurance		
15	The Trust should undertake an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation.	S-M
16	The Trust should develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards.	M-L
Risk Management Strategy		
17	The Draft Risk Management Strategy should be submitted for approval as a matter of urgency.	S
18	The Trust Board should consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register.	M
19	A risk management training programme should be developed and delivered to underpin the publication of the approved Risk Management Strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers	L