Paula Clarke
Director of Performance and Reform
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Madam,

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

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

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

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

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

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

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

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

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

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

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

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

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

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

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

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 42 of 2022]

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

WARNING

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

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

TO:

Paula Clarke
Director of Performance and Reform
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

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

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

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

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

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

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 10th June 2022.**

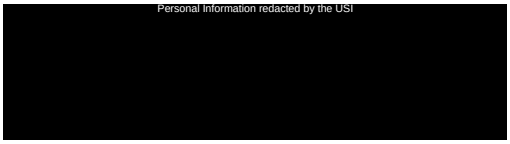
APPLICATION TO VARY OR REVOKE THE NOTICE

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

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 3rd June 2022**.

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

Dated this day 29th April 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE
[No 42 of 2022]

General

1. Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.

2. Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. When answering the questions set out below you will need to equip yourself with a copy of *Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS')* and the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines'),*

Policies and Procedures for Handling Concerns

4. In your role as a Chief Executive what, if any, training or guidance did you receive with regard to:

    I. The MHPS framework;
    II. The Trust Guidelines; and
    III. The handling of performance concerns generally.

5. With regard to Section VI paragraph 1 of MHPS, outline the training, guidance or support provided by the Trust during your time as Chief Executive for the handling of concerns and implementation of the MHPS Framework to those with specific roles under MHPS and the 2010 Guidelines. Your answer should address the training provided to;

    I. Clinical Managers
    II. Case Managers
    III. Case Investigators
    IV. Chief Executives
    V. Designated Board Members
    VI. HR Staff

6. What procedures or processes existed within the SHSCT to ensure that concerns were raised, registered or escalated the Chief Executive as required by Section I paragraph 8 of MHPS and paragraph 2.3 of the Trust Guidelines.

7. With regard to Section I paragraph 29 of the MHPS framework, what processes or procedures existed within the Trust to provide a clear audit route for initiating and tracking the progress of investigations, their costs and resulting actions? Who was responsible for ensuring such processes were in place and what role, if any, did you have as the Chief Executive in relation to these matters?

8. Outline how you understood the role of Chief Executive was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

    I. Clinical Manager;
    II. Case Manager;
    III. Case Investigator;
    IV. Medical Director;
    V. Service Director;
    VI. HR Director;
    VII. Designated Board member,
    VIII. The clinician who is the subject of the investigation; and
    IX. Any other relevant person under the MHPS framework and the Trust Guidelines, including any external person(s) or bodies.

Handling of Concerns relating to Mr O'Brien

9. In respect of concerns relating to the practice of Mr Aidan O'Brien raised with him in March 2016:

    I. Were you as Chief Executive made aware of the concerns?
    II. If so please confirm when and in what manner the concerns were raised, registered or escalated the Chief Executive as required by Section I paragraph 8 of MHPS and paragraph 2.3 of the Trust Guidelines?
    III. On being informed of these concerns, what action did you take?
    IV. If you were not aware of the concerns, outline who in the Trust would have been responsible for bringing this matter to your attention.

10. Confirm when you left your role of Chief Executive in 2016 and who replaced you in that role? Did you provide a handover to that individual regarding any issues of concern relating to Mr O'Brien specifically? If so, what form did that handover take and outline the information you provided as part of this handover. Refer to or disclose copies of any documentation which may have formed part of the handover or confirm that no such documentation exists.

Implementation and Effectiveness of MHPS

11. Having regard to your experience as a Chief Executive, what impression have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr O'Brien?

12. Consider and outline the extent to which you feel you could effectively discharge your role under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

13. Having had the opportunity to reflect, outline whether in your view the MHPS process have been better used in order to address the problems which were found to have existed in connection with the practice of Mr O'Brien.

NOTE:

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

UROLOGY SERVICES INQUIRY

USI Ref: Notice 42 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Paula Clarke

I, Paula Clarke, will say as follows:-

General

1. **Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.**

1.1 I make this statement based on my tenure as Interim Chief Executive of SHSCT from 1 April 2015 to 31 March 2016.

1.2 I make it having regard to sub-paragraph (e) of the Terms of Reference of the Inquiry, which provides that the Inquiry is:

> 'To review the implementation of the Department of Health's "Maintaining High Professional Standards Policy" by the Trust in relation to the

investigation related to Mr O'Brien. The Inquiry is asked to determine whether the application of this Policy by the Trust was effective and to make recommendations, if required, to strengthen the Policy.'

1.3 For a narrative account of my involvement in all relevant matters, including those within the scope of Term of Reference (e), I refer the Inquiry to my witness statement in response to Section 21 Notice No.11 of 2022. I do not believe it is appropriate for me to repeat significant parts of that statement here. Instead, I confirm that I would simply seek to rely upon it.

1.4 As Interim Chief Executive my responsibilities and duties in respect of the 'Maintaining High Professional Standards in the Modern HPSS' ('the MHPS Framework') were set out in the MHPS Framework and the related Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance and, in particular, in section 2.0 and Appendix 6 ("Role Definitions") of the 16 September 2010 iteration of the Trust Guidelines (which were the extant Guidelines during my tenure). These describe the Chief Executive's role and responsibilities under the screening, informal, and formal processes, following concerns being raised about the conduct, clinical performance, and/or health of medical and dental employees.

1.5 At no time during my tenure as Interim Chief Executive were concerns regarding Mr O'Brien's practice escalated to me under the Trust Guidelines or the MHPS Framework. However, I am now aware of these concerns, having been provided with documents from the Trust to support my witness statement to the Inquiry including the MHPS Case Investigator's Report from Dr Neta Chada and the Determination of the Case Manager, Dr Ahmed Khan, dated 28 September 2018. I now understand that concerns were raised formally on 23 March 2016 in a letter to Mr O'Brien from Mr Eamon Mackle (the Associate Medical Director responsible for urology services and Mr O'Brien's Clinical Manager as defined under MHPS) and Mrs Heather Trouton (Assistant Director Surgery Services Mr O'Brien's operational manager). While this happened during my tenure as interim CEO, I was absent during this period as I took annual leave from the Trust, effective from 14 March 2016, and, thereafter, I left my role with the Trust on 31 March 2016. I was unaware

of the letter or indeed of any plans to issue such a letter as this had not been discussed with me under the MHPS framework or in any other context.

2. **Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.**

2.1 Any relevant documents have been provided as referenced in Question 1 and in my responses to Questions 3 to 13 below.

3. **Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. When answering the questions set out below you will need to equip yourself with a copy of *Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS')* and the *'Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines').***

Policies and Procedures for Handling Concerns

4. **In your role as a Chief Executive what, if any, training or guidance did you receive with regard to:**
   - I. **The MHPS framework;**
   - II. **The Trust Guidelines; and**
   - III. **The handling of performance concerns generally.**

4.1 I do not recall receiving specific or dedicated training on the MHPS Framework and related Trust Guidelines and have not had anything provided by the SHSCT Public Inquiry Team in my request for evidence of this. I was aware of the existence of the MHPS Framework and the Trust Guidelines during my tenure and, if confronted with potential or actual issues regarding the conduct or practice of a doctor, I would have reverted to the Framework and Guidelines and sought guidance from the Medical Director and Director of Human Resources as required.

4.2 With respect to handling performance concerns, as they relate generally to individual Trust employees, it was the duty of every individual to equip themselves with knowledge of Trust policies.

5. **With regard to Section VI paragraph 1 of MHPS, outline the training, guidance or support provided by the Trust during your time as Chief Executive for the handling of concerns and implementation of the MHPS Framework to those with specific roles under MHPS and the 2010 Guidelines. Your answer should address the training provided to;**
   - I. **Clinical Managers**
   - II. **Case Managers**
   - III. **Case Investigators**
   - IV. **Chief Executives**
   - V. **Designated Board Members**
   - VI. **HR Staff**

5.1 Regarding I-III and VI in the list of staff above:

a. I was Interim Chief Executive for 12 months (finishing in March 2016) and do not now recall being aware during that time of any training, guidance or support beyond that contained within the Trust Guidelines (which appear to me to be a form of guidance regarding the MHPS Framework and process).

b. I have not had anything provided by the SHSCT Public Inquiry Team in my request for evidence of training, guidance or support specifically for the handling of concerns and implementation of the MHPS Framework and the 2010 Guidelines to clinical managers, case managers, case investigators, designated Board members or HR staff. This information should perhaps be sought from Mr Kieran Donaghy, Director of Human Resources and Organisational Development, and Drs John Simpson and Richard Wright, Medical Directors during my tenure.

5.2 Regarding IV in the list of staff above, I have already responded at question 4.

5.3 Regarding V in the list of staff above, in addition to the Chief Executive, Board members designated within the process include operational Directors, Medical Director, Director of Human Resources and Organizational Development, potentially the Chair and any non-executive Director who may be nominated to oversee a formal case. I do not now recall being aware during that time of any training, guidance or support, beyond that contained within the Trust Guidelines, to such Board members nor have I received any evidence of this from the SHSCT Public Inquiry team in response to my request for same. This information could be sought from Mr Kieran Donaghy, Director of Human Resources and Organizational Development and Drs John Simpson and Richard Wright, Medical Directors during my tenure.

6. What procedures or processes existed within the SHSCT to ensure that concerns were raised, registered or escalated the Chief Executive as required by Section I paragraph 8 of MHPS and paragraph 2.3 of the Trust Guidelines.

6.1 Section I Paragraph 8 of MHPS and paragraph 2.3 of the Trust Guidelines makes clear that the role of the CEO was to establish and follow the required procedures when a concern was raised and required to be screened. Paragraph 2.3 clarifies that "*The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised*". The existence of the Trust Guidelines themselves provides evidence of the procedures and processes that existed within the Trust.

6.2 Although I have stated in my response to questions 4 and 5 above that I have not been provided with evidence of training for Clinical Managers or others, it is my experience that, when Guidelines were developed, there was a process of disseminating them across relevant staff. As stated at 4.3 above, it is also my belief that it was the duty of every individual to equip themselves with knowledge of Trust policies. My own Job Description as Director of Performance and Reform from March 2011 (1. *Director of PR 2010 Paula Clarke located in S21 42 of 2022 Attachments*) and as interim Chief Executive in 2015 *(2. Chief Executive JD 2015 Paula Clarke, located in S21 42 of 2022 Attachments)* contains standard wording that I believe was used in all job descriptions to "*Adhere at all times to all Trust policies/codes of conduct".* It was also my experience that Clinical Managers, such as Clinical Directors or AMDs, were experienced clinicians who would have the opportunity to discuss potential concerns that may need considered under the Trust Guidelines with their line managers including as part of the requirement for all medical staff to participate in an annual appraisal (*Southern Trust Appraisal Scheme for Medical Staff located at Relevant to MDO, reference no 2t).*

6.3 As referenced in my witness statement in response to Section 21 Notice No.11 of 2022, identification of concerns was also supported via the processes in place for risk management, clinical and social care governance, and Whistleblowing and Raising Concerns and Complaints. Reference can be made to the following documents for evidence; *Trust Policy for the Management of Complaints; "Your Right to Raise a Concern (Whistleblowing) HSC Framework located at Relevant to HR/reference no 2i/Ref 2i – YOUR RIGHT TO RAISE A CONCERN (Whistleblowing)*

Regional HSC Framework.pdf; 3. 20151029 email WHISTLEBLOWING POLICY 2 located in S21 42 of 2022 Attachments; Trust Risk Management Strategy located in Ongoing Discovery May 2022/Document Number 2 iii a/201809 Risk Management Strategy.pdf; 4. *20141001 Incident Management Procedure located in S21 42 of 2022 Attachment; Structures for Clinical and Social Care Governance Consultation document Period (December 2010) "A System of Trust" located in S21 42 of 2022 Attachments 5. 20150410 E and Reports Draft Paper Governance - RCSCG CONSULTATION DRAFT 4 A .* The latter document was the output of a review of clinical and social care governance led by the Chief Executive, Mairead McAlinden, in 2010. The Trust Public Inquiry team have been unable to provide the final version of this review, however, the content of the consultation document remained extant at 1st April 2015 when I took up the role of interim Chief Executive.

6.4 Clinical and Social Care Governance structures were embedded within the organisation, covering professional lines of accountability and service Directorates. This is referenced in the Statement of Governance on pages 29-60 in the *Annual Report and Accounts for the Year ended 31 March 2016 located in S21 42 of 2022 Attachments, 9. ANNUAL_REPORT_AND_ACCOUNTS_2015-16* and in *Structures for Clinical and Social Care Governance Consultation document Period (December 2010) "A System of Trust" located at S21 42 of 2022 Attachments 5. 20150410 E and Reports Draft Paper Governance - RCSCG CONSULTATION DRAFT 4 A2.* Each service Directorate had a Governance team who facilitated the senior management of the Directorate (the Director, Assistant Directors and Associate Medical Directors) to identify, assess and manage risk within their area of responsibility. The process of risk identification and management closely followed the HPSS Guidance on the identification and management of risk. This was based on the Australia/New Zealand Models. Directorate Risk Registers were in place within the Trust which informed the Corporate Risk Register. The Senior Management Team and Trust Board via the Governance Committee regularly reviewed the Corporate Risk Register and identified risks to ensure they were properly managed, monitored and escalated externally where appropriate. These embedded processes supported identification of concerns that could be referred into the screening process under the Trust Guidelines.

6.5 As also set out in my other witness statement (No.11 of 2022), as required under The Medical Profession (Responsible Officers) Regulations (NI) 2010, the Medical Director's role as Responsible Officer requires doctors to be revalidated every 5 years. Revalidation confirms evidence to support retention of a doctor's licence to practice and is based on the outcome of a doctor's annual appraisals over a number of years, combined with supporting information drawn from the organisation or organisations in which the doctor has worked. It will include outcomes from patient and colleague feedback (Multi Source Feedback), Continuing Professional Development (CPD) portfolios, and verified clinical performance information, along with the outcomes of any investigations of complaints, concerns, patient safety incidents and other available indicators that can be reliably related to the performance of the individual doctor. This process was governed under the *Trust 20140701 Policy - Southern Trust Appraisal Scheme for Medical Staff located at Relevant to MDO/reference no 2t*.The MD brought an annual report on appraisal compliance to Governance Committee and Trust Board. During my tenure as interim CEO, Dr John Simpson presented this report to public Trust board on 11/6/15 *(6. 20150611 TB Public Minutes located in S21 42 of 2022 Attachments***)** confirming the Trust had achieved 100% completion rates as at 31 December 2014, which equated to 288 of eligible doctors having successfully completed their appraisal documentation and that the Deputy Chief Medical Officer would be commending the Trust to the General Medical Council (GMC) as a model of good practice.

6.6 Trust Board and I received assurance that revalidation and appraisal processes were progressing effectively during the 2015/16 year via the monthly Medical Director Report into Trust Board and Governance Committee. I have reviewed a number of Medical Director reports presented to the Board during my tenure and as an example, refer to the 7. *20160128 MD Report TB located in S21 42 of 2022 Attachments* presented by Dr Richard Wright which advised that the 2013 appraisal round completed with a 100% completion rate with work commenced in April 2015 for the 2014 Appraisal Round as key information became available to issue to medical staff (e.g. complaints/incidents information). Dr Wright also assured that an analysis of the content of appraisal documentation received and an analysis of appraiser and appraisee feedback questionnaires in relation to the quality of the Trust's Medical

Appraisal processes had been completed for the 2014 round. Reference to this audit is also made in the *20151208 Approved Governance Committee Minutes located in S21 42 of 2022 Attachments*.

6.7 Any issues raised through this annual appraisal process could result in triggering the MHPS process which was an additional assurance mechanism for the Trust.

7. With regard to Section I paragraph 29 of the MHPS framework, what processes or procedures existed within the Trust to provide a clear audit route for initiating and tracking the progress of investigations, their costs and resulting actions? Who was responsible for ensuring such processes were in place and what role, if any, did you have as the Chief Executive in relation to these matters?

7.1 Paragraph 29 of Section I of MHPS relates to the formal investigation process only and advises "*All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its' costs and resulting action*".

7.2 The Trust Guidelines cover all aspects of managing concerns about doctors and set out the processes and procedures to initiate and track investigations. Appendix 6 specifically sets out the role of the CEO to appoint an appropriate Oversight Group at the outset of the screening process when concerns are first raised, which would keep the CEO informed of the process throughout and therefore provided a forum to track the progress of investigations and consider and support any resource requirements to complete the investigation. An Extract from Appendix 6 reads:

> *"This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in*

response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns."

7.3 In addition I note that, under Section I, paragraph 8 of the MHPS Framework and paragraph 2.10 of the Trust Guidelines, there was an obligation on the Designated Board Member to oversee any MHPS case to ensure that momentum was maintained.

7.4 Paragraph 3.4 of the Trust Guidelines also required that all formal cases were presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed. At the time of submitting my response I do not recall a specific report tracking MHPS cases nor have I identified evidence of such an update in my review of SMT minutes in 2015/16. I suggest this could be followed up for a more compete response with the Medical Directors during my tenure, Dr John Simpson and Dr Richard Wright.

7.5 The Medical Director and Director of Human Resources were responsible for ensuring that these processes were in place. My role as Chief Executive is as set out in Appendix 6 of the Trust Guidelines.

8. Outline how you understood the role of Chief Executive was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

I. Clinical Manager;
II. Case Manager;
III. Case Investigator;
IV. Medical Director;
V. Service Director;
VI. HR Director;
VII. Designated Board member,
VIII. The clinician who is the subject of the investigation; and

IX. Any other relevant person under the MHPS framework and the Trust Guidelines, including any external person(s) or bodies.

8.1 My understanding of how my role as Interim CEO was to relate to the various designated roles within an MHPS process has been informed by reminding myself of the Trust Guidelines and as set out in the series of flowcharts / text in Appendices 1 to 7 of the Trust Guidelines document. I have summarised the key aspects of how my role as CEO related to each of the designated roles below:

I. **Clinical Manager:** The Clinical Manager was likely to be the practitioner's Clinical Director or AMD and was expected to raise any concerns that might fall under the MHPS Framework with the relevant operational director. As Chief Executive, I would engage with this person through the Oversight Group I was responsible for appointing at the informal stage of the process. I was not expected to be part of the Oversight Group. There would not need to be direct engagement with the Clinical Manager but, as I operated an open-door approach to my leadership, I would have been available to a Clinical Manager and, indeed, any other individuals in this question should they have felt it necessary to discuss anything with me.

II. **Case Manager:** If a formal investigation was recommended following the screening and informal review by the Clinical Manager and the HR Case Manager then, in conjunction with the Oversight Group, I would appoint a Case Manager. The Chair of the Oversight Group, who I would normally expect to be the Medical Director, would keep me updated so I would not expect there to be regular direct engagement with the Case Manager. Should the findings of the formal investigation identify a case of misconduct or a clinical performance issue, or should there be a proposal to formally exclude the practitioner, then this person would be expected to inform me directly as Chief Executive

III. **Case Investigator:** In conjunction with the Oversight Group, I would appoint a Case Investigator at the same time as appointing a Case Manager if a formal investigation was recommended following the screening and informal review by the Clinical Manager and the HR Case Manager. I would not expect to have regular direct engagement with the Case Investigator.

IV. **Medical Director:** The Medical Director would engage with me should any concerns that might require management under the MHPS framework be raised directly with them. He/she would also have been part of the Oversight Group I appointed at the informal screening stage when concerns had been raised and I would expect would have kept me updated through monthly one-to one meetings. I would also expect the Medical Director, along with the Operational Director, to bring any case closed (following conduct or disciplinary procedures being progressed) into an SMT Governance meeting chaired by me to share learning and seek peer review.

V. **Service Director:** The Operational Service Director would engage with me should any concerns that might require management under the MHPS framework be raised with them. He/she would also have been part of the Oversight Group I appointed at the informal screening stage when concerns had been raised and I would expect would have kept me updated through monthly one-to one meetings. I would also expect the Operational Director, along with the Medical Director, to bring any case closed (following conduct or disciplinary procedures being progressed) into an SMT Governance meeting chaired by me to share learning and seek peer review

VI. **HR Director:** The Director of HR and OD would also have been part of the Oversight Group I appointed at the informal screening stage when concerns had been raised and I would expect would have kept me updated through monthly one-to one meetings and advised me on

compliance with all employment legal and policy requirements. I would have expected the HR Director to assure me they had identified a HR Case Manager from the Employee Engagement and Relations Department to provide advice to the Clinical Manager.

VII. **Designated Board Member:** If a formal investigation was required then I would advise the Trust Chair and ask them to identify a non-executive board member to ensure the case was progressed in a timely way and to be a key point of contact for the person being investigated or anyone else to make representations about the investigation. I would expect to have engaged with this person along with the Oversight Group members to brief them on the case background and to be available for them to raise any issues with me about how the case was progressing.

VIII. **The clinician who is the subject of the investigation:** I would not expect to have direct contact with the clinician being investigated and would have relied on advice from my Director of HR about meeting with him or her should they request that. I would be involved in any decision to exclude a practitioner at consultant level but not necessarily engage directly with them in this process as the main point of contact was through the Case Manager.

IX. **Any other relevant person under the MHPS framework and the Trust Guidelines, including any external person(s) or bodies:** Other people or bodies potentially involved in cases under the MHPS Framework could include the National Clinical Assessment Service (NCAS), occupational health staff, the GMC/GDC, the police, and other regulatory bodies. I would generally have expected engagement with these “relevant persons” via the Medical Director, Director of HR and the Operational Director, however, it may have been appropriate in cases of significant seriousness for me as Chief Executive to engage with some of these people.

9. In respect of concerns relating to the practice of Mr Aidan O'Brien raised with him in March 2016:

I. Were you as Chief Executive made aware of the concerns?

9.1 As stated in my answer at Question 1 above, at no time during my tenure as Interim CEO in 2015/16 were concerns regarding Mr O'Brien's practice escalated to me under the Trust Guidelines or MHPS Framework or otherwise. I am, however, now aware (through documents provided to me by the Trust to support my witness statements to the Inquiry) that concerns were raised formally on 23 March 2016 in a letter to Mr O'Brien from Mr Eamon Mackle and Mrs Heather Trouton. As stated above, I was on annual leave at this time and I left my post on 31 March 2016. I was unaware of the letter or indeed of any plan to issue such a letter as, to the fullest of my recollection, this had not been discussed with me under the MHPS framework nor in any other context.

II. If so please confirm when and in what manner the concerns were raised, registered or escalated the Chief Executive as required by Section I paragraph 8 of MHPS and paragraph 2.3 of the Trust Guidelines?

9.2 Not applicable - see my answer at paragraph 9.1.

III. On being informed of these concerns, what action did you take?

9.3 Not applicable - see my answer at paragraph 9.1.

IV. If you were not aware of the concerns, outline who in the Trust would have been responsible for bringing this matter to your attention.

9.4 Paragraph 2.3 of the Trust Guidelines sets out the following:

"*Concerns which may require management under the MHPS framework must be registered with the Chief Executive. The Clinical Manager will be responsible for*

informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised."

9.5 The matter should therefore have been drawn to my attention before 31 March 2016 or to the incoming interim CEO (Mr Francis Rice, who commenced in post on 11 April 2016). As mentioned above, I was on annual leave from 14 March 2016.

9.6 In line with the Trust Guidelines, responsibility to log concerns with me as interim CEO rested with the Director of Acute Services who, at March 2016, was Mrs Esther Gishkori. If the concerns had been raised directly to the Medical Director then responsibility for informing me as interim CEO, and the Director of Acute Services, would have been with Dr Richard Wright as Medical Director at March 2016.

10. Confirm when you left your role of Chief Executive in 2016 and who replaced you in that role?

10.1 I was on annual leave from 14 March 2016 and I formally left the role on 31 March 2016. I handed over to Mr Kieran Donaghy as Deputy CEO. Mr Francis Rice took up the role as Interim CEO on 11 April 2016.

Did you provide a handover to that individual regarding any issues of concern relating to Mr O'Brien specifically?

10.2 I do not recall handing anything over relating to Mr O'Brien specifically, which would be reasonable given that no concerns had been escalated to me about his practice or behaviours prior to my departure.

If so, what form did that handover take and outline the information you provided as part of this handover. Refer to or disclose copies of any documentation which may have formed part of the handover or confirm that no such documentation exists.

10.3 As I did not hand over anything relating to Mr O'Brien this does not apply and no such documentation exists to my knowledge.

11. Having regard to your experience as a Chief Executive, what impression have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr O'Brien?

11.1 From my own recollection, and from the documents that I have reviewed in drafting my statement to the Inquiry as they pertain to my tenure as interim CEO in 2015/16, I believe that the implementation of MHPS and the Trust Guidelines were generally effective.

11.2 However, with respect to the case of Mr O'Brien, I have now seen and considered the formal MHPS Case Investigator's Report from Dr Neta Chada and the Determination of the Case Manager (Dr Ahmed Khan) dated 28 September 2018 (although I have not considered the 36 appendices of Dr Chada's Report). At Section 4.0 paragraph 7, Section 5.0 bullet point 8, and Section 6.0 of Dr Khan's Determination it is stated that there were "*systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate"* and *"missed opportunities by managers to fully assess and address the deficiencies in the 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"*.

11.3 Dr Chada's Report sets out the timeline for the investigation into Mr O'Brien that confirms that a formal MHPS process was initiated from 28/12/16. Section 8 and 9 of this Report equally refer to missed opportunities by managers to understand the extent of the issues, however, Dr Chada also makes it clear that responsibility for triage of referrals was Mr O'Brien's. Her Report identifies managers' attempts to address Mr O'Brien's practice regarding triage, including

implementing a default system to ensure patients were added to the waiting list if not triaged by a consultant within 3 working days. Section 8 of the Report goes on to say that, with regard to the concerns raised formally on March 23rd 2016 in the letter to Mr O'Brien from Mr Eamon Mackle and Mrs Heather Trouton (as referenced in my response to question 9 above), "..*it would appear that when this letter was issued to Mr O'Brien, the extent of the issues of concern had not been assessed. … The 23 March 16* [letter] *was a missed opportunity by managers to fully review and understand the extent of the issues. There was no management follow-up to the letter of 23rd March 2016 with Mr O'Brien*". The impression that I have formed, based on this new information, is that the effectiveness of the Trust Guidelines was entirely dependent on their implementation by clinical and operational managers. In the case of Mr O'Brien, it does not seem as though the Guidelines were implemented as effectively as they could have been (see further my answer to Question 13 in this regard).

12. Consider and outline the extent to which you feel you could effectively discharge your role under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

12.1 When I was in post as Interim CEO (1 April 2015 until 31 March 2016), I believed the extant systems were appropriately robust to allow me to discharge my duties including those duties under MHPS and the Trust Guidelines. This belief is substantiated in the statement made by me as accountable officer in the Governance Statement for the year ended 31 March 2016 included in pages 29 to 60 of the 9. *Trust Annual Report and Accounts 2015/16 located in S21 42 of 2022 Attachments*. Although (as mentioned in my witness statement No.11 of 2022) I didn't personally sign off the Annual Report and Accounts (having left the Trust on 31 March 2016), I was the extant CEO for the period covered by these Accounts and Report and agreed with the statements. I refer specifically to the following parts of these statements :

a. Section 9. Extract from SHSCT Annual Reports and Accounts for the Year

Ended 31 March 2016 (page 50 – 51)

"Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance. My review of the effectiveness of the Trust's system of internal governance is informed by the work of the internal auditors, the executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Senior Management Team, Trust Board, Head of Internal Audit, Audit Committee and Governance Committee. I have referred to the Annual Report from the Head of Internal Audit which details the assurance levels provided from reports in 2015/16 and also the Trust's implementation of accepted 51 internal audit recommendations. A plan to address weaknesses and ensure continuous improvement to the system is in place."

b. Extract from SHSCT Annual Reports and Accounts for the Year Ended 31 March 2016. page 60

"The Trust has a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in Managing Public Money NI. The system operates on a principle of continuous improvement where the performance and effectiveness of governance arrangements are subject to regular review. As outlined, the internal audit review of control systems has resulted in a number of limited assurances and one unacceptable assurance in the Trust. A number of priority one issues have been raised with management and extensively examined by the Audit Committee. The findings of these reports and others such as those issued by RQIA will be incorporated into action plans aimed to address the weaknesses/gaps in control. Further to considering the accountability framework within the Trust and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the Trust has operated a sound system of internal governance during the period 2015/16."

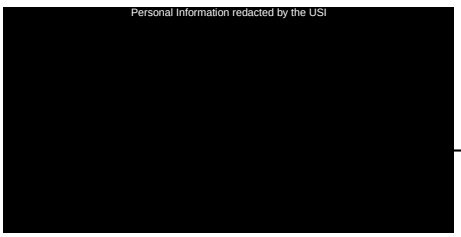
12.2 On reflection, with respect to what could have been done to strengthen or enhance the role of the Chief Executive in effectively discharging responsibility under MHPS Framework and the Trust Guidelines, I would consider establishing a process that requires all of those with roles under the Framework and Guidelines to confirm annually that they had reviewed the requirements of their roles under the Framework and Guidelines, and that they could confirm that they were effectively discharging their role. This could be included in annual appraisals and would provide additional assurance.

13. Having had the opportunity to reflect, outline whether in your view the MHPS process [could] **have been better used in order to address the problems which were found to have existed in connection with the practice of Mr O'Brien.**

13.1 The information provided to me for the purpose of the Inquiry indicates that there were opportunities to have better used the MHPS processes in connection with the practice of Mr O'Brien. It appears that the concerns about Mr O'Brien raised in a letter dated 23 March 2016 were not escalated formally under MHPS until 30 December 2016. In the circumstances, I believe that the MHPS process could have been better used by engaging in screening and an investigation at the earliest possible stage after March 2016. My belief in this regard is based solely on the information I have reviewed (in the context of preparing my Inquiry witness statements) in respect of the MHPS investigations undertaken between December 2016 and 2018.

Statement of Truth

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

Signed: _____ 

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Date: _____8th July 2022_____

S21 42 of 2022

Witness Statement: Paula Clarke

Table of Attachments

Attachment	Document Name
1	Director of PR 2010.Paula Clarke
2	Chief Executive JD 2015.Paula Clarke
3	20151029 email WHISTLEBLOWING POLICY 2
4	20141001 Incident Management Procedure
5	20150410 E and Reports Draft Paper Governance A2
6	20150611 TB Public Minutes
7	20160128 MD Report TB
8	20151208 Approved Governance Committee Minutes
9	ANNUAL_REPORT_AND_ACCOUNTS_2015-16

Southern Health and Social Care Trust

APPLICANT INFORMATION PACK

DIRECTOR OF PERFORMANCE & REFORM

CLOSING DATE FOR RECEIPT OF COMPLETED APPLICATIONS IS TUESDAY 9th NOVEMBER AT 4.30 PM

Southern Health and Social Care Trust

Contents

Southern Health and Social Care Trust

Dear Applicant

Thank you for your interest in the position of Director of Performance & Reform, Southern Health & Social Care Trust. This pack is designed to provide you with information to support you in making your application for this highly challenging position.

I would encourage you to read all sections of this information pack in detail before completing your application form. In particular I would wish to highlight that the Trust will not accept CV's, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms. Full details to support you in completing your application form may be seen at pages 21 – 26 of this pack. Please read this information carefully.

The Southern Health & Social Care Trust aims to deliver safe, high quality health & social care services, respecting the dignity and individuality of all those who use them. Despite the many challenges since merging the legacy Trusts we have achieved the performance targets set for us by Government due to the dedication and commitment of our staff in providing quality care and improving quality of life for people living within the Southern Trust area.

As a member of the Trust Board and the senior management team he/she will share corporate responsibility for the Governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.

For an informal discussion about this post please contact Mr Kieran Donaghy, Director of Human Resources & Organisational Development on Personal Information redacted by the USI Personal Information redacted or email to Personal Information redacted by the USI

Thank you again for your interest and we look forward to receiving your application.

Personal Information redacted by the USI

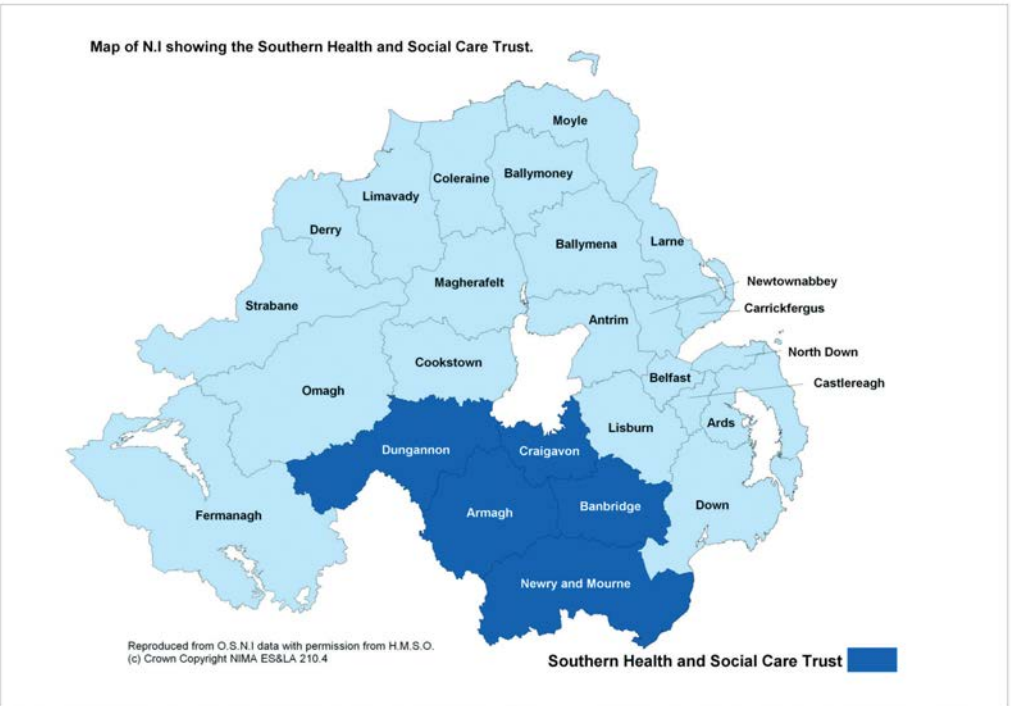
MAIREAD MCALINDEN (Mrs)
Chief Executive

Southern Health and Social Care Trust

AN INTRODUCTION TO THE SOUTHERN HEALTH & SOCIAL CARE TRUST

The Southern Health & Social Care Trust (hereafter referred to as the Trust) was established on 1st April 2007, as part of the Review of Public Administration.

The Trust provides health and social care services to the council areas of Armagh, Banbridge, Craigavon, Dungannon, South Tyrone, Newry and Mourne. The Southern area has a population of 335,000 people.



The Trust provides a wide range of hospital, community and primary care services. Acute in-patient hospital services are located at Craigavon Area Hospital and Daisy Hill Hospital. Working in collaboration with GPs and other agencies, Trust staff provide locally based health and social care services in Trust premises, in people's own homes and in the community. The Trust purchases some services, such as domiciliary, residential and nursing care, from private and voluntary organisations.

The Trust has an income of £487 million and spends £1.3m per day delivering services to local people.

The Trust's vision is to deliver safe, high quality and responsive health and social care services, respecting the dignity and individuality of all who use them. This vision is underpinned by the Trust's values which shape what we do and how we do them. These values are:

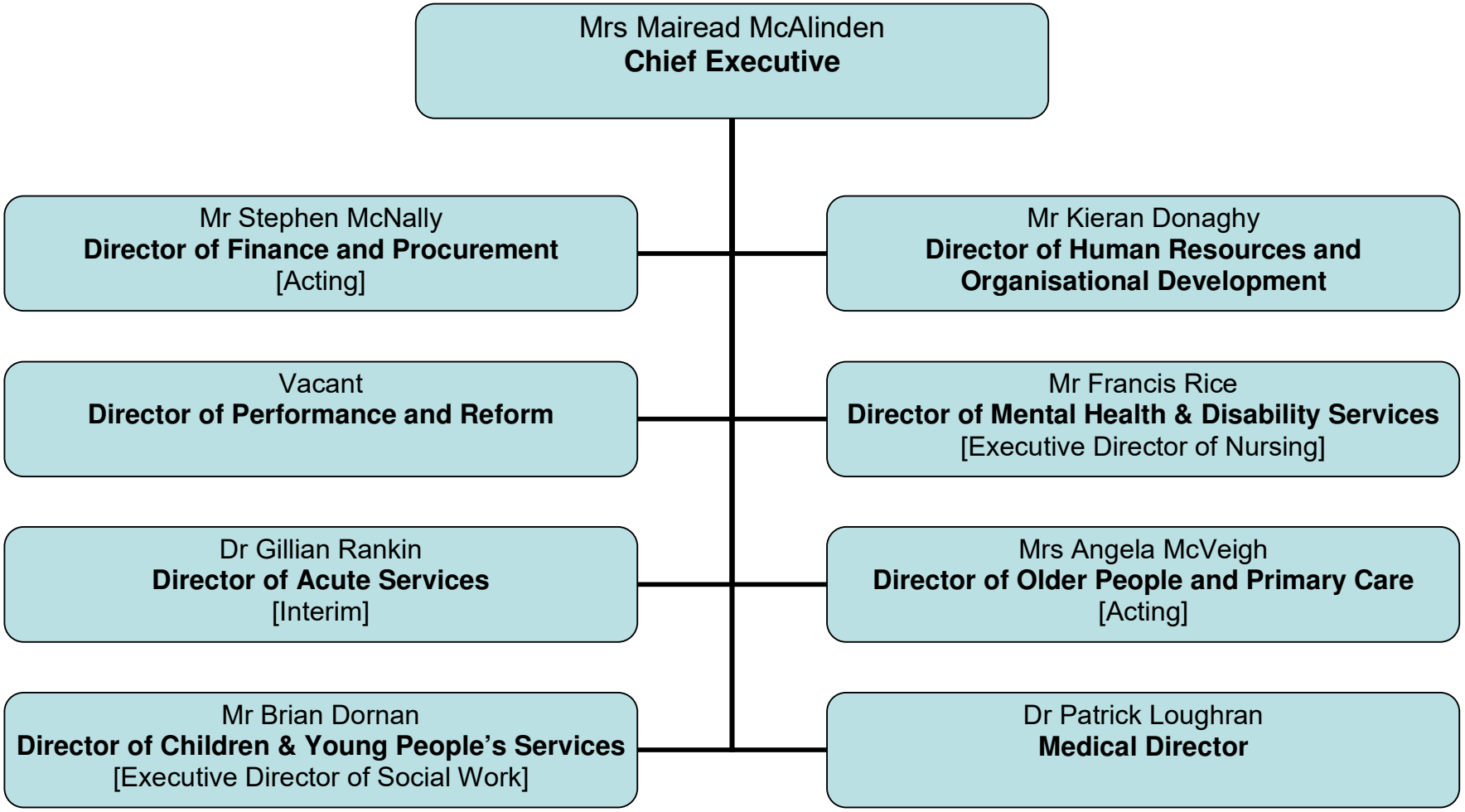
- *We will treat people fairly and with respect*
- *We will be open and honest, and act with integrity*
- *We will put our patients, clients, carers and community at the heart of all we do*
- *We will value and give recognition to staff, and support their development to improve our care*
- *We will embrace change for the better*
- *We will listen and learn.*

We want to be very clear about what is important to us as a Trust, and what we want to achieve. The Trust's priorities are:

- *Providing safe, high quality care*
- *Maximising independence and choice for our patients and clients*
- *Supporting people and communities to live healthy lives and to improve their health and wellbeing*
- *Being a great place to work, valuing our people*
- *Making best use of resources*
- *Being a good social partner within our local communities*

The SHSCT Structure is set out overleaf;

Southern Health and Social Care Trust



Southern Health and Social Care Trust

Southern Health and Social Care Trust

DIRECTOR OF PERFORMANCE & REFORM

Salary Range £71,279 - £95,039 per annum

The Southern Health & Social Care Trust wishes to appoint a high calibre Director of Performance & Reform to provide strong professional leadership in delivering a range of hospital and community services to a population of around 335,000 people in the Southern area.

The successful applicant will be responsible for leadership of the corporate processes in the Trust which will include the performance management framework, strategic and operational planning, capital planning and a strategic approach to reform and modernisation of services and care provided by the Trust.

A full Job Description, Personnel Specification and associated information is available on line at www.HSCRecruit.com or by emailing recruitment.services@southerntrust.hscni.net

Application forms can be returned online through HSCRecruit or in hard copy format to Recruitment & Selection Services, Human Resources Department
The Hill Building, St Lukes Hospital site, Loughgall Road, ARMAGH, BT61 7NQ

The closing date for receipt of completed applications is Tuesday 9th November 2010 at 4.30 pm.

Applicants should note that it is currently anticipated interviews for shortlisted applicants will take place week commencing Monday 29th November 2010 however this may be subject to change.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

JOB DESCRIPTION

JOB TITLE	Director of Performance & Reform
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Chief Executive
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The Director of Performance and Reform will be responsible through the Chief Executive for the leadership of the corporate processes in the Trust which will include the performance management framework, strategic and operational planning, capital planning and the strategic reform and modernisation of services.

He/She will be the key link with the HSC Board on all commissioning and delivery issues. The jobholder will also have a specific responsibility for the Trust's ICT and Estates functions. He/She will provide clear leadership and oversee the management of all staff and the efficient use of resources in the Directorate.

In addition, the jobholder will have a corporate role as a member of the Trust's senior management team that will include leading the ongoing development of the Trust's overall objectives and strategic plans.

KEY RESULT AREAS

Service Delivery

1. Lead the provision of the corporate processes of the Trust, including the performance management framework, strategic and operational planning processes, capital planning and the strategic Implementation of reforms to underpin the delivery of high quality health and social care.

2. Work closely with director colleagues and commissioners to develop and deliver strategic plans to ensure high quality health and social care.

3. Lead on the negotiation and monitoring of service agreements with independent and voluntary sector providers.

4. Lead the strategic management of the Trust's ICT and estate services functions including annual capital programmes and the delivery of large projects on time and within budget.

5. Lead and co-ordinate the utilisation of the Trusts Capital Resource limit / allocation in line with Trust strategic priorities and safety & quality priorities.

6. Lead the development and implementation of the Trusts continuous Improvement Strategy

Performance Management

7. Advise the Chief Executive and Trust Board on all aspects relating to service planning and performance management to include the preparation and presentation of the Trust's corporate plan, service strategies, business cases and performance reports.

8. Act as the key link with the HSC Board on all commissioning, service delivery and performance management issues.

9. Ensure that robust performance management arrangements are developed on an ongoing basis within the Trust to monitor the achievements of targets and objectives, and to highlight potential risks for same.

10. Co-ordinate remedial strategies to address under-performance

11. Ensure information management is developed to provide timely, accurate and effective information flows to underpin the performance framework.

Quality

12. Ensure that the needs of patients, clients and their carers are at the core of the Trust's corporate planning and delivery processes.

13. Ensure high standards of governance including the assessment and management of risk in relation to the services managed.

14. Ensure the Trust's corporate planning, ICT and estates functions comply with all regulatory and requisite standards and the discharge of statutory functions.

15. Lead the processes for innovation and change to underpin the modernisation of services in the Trust.

16. Lead quality initiatives such as Investors in People and Charter Standards in the Directorate.

Strategic Planning and Development

17. Lead on the development and co-ordination of the Trust's strategic planning processes to support high quality health and social care in line with regional strategies, Ministerial and HSC Board priorities.

18. Work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets.

Financial and Resource Management

19. Responsible for the management of the directorate's revenue budget and ensure the meeting of all financial targets.

20. Responsible for the effective delivery of the Trust's capital programme.

21. Lead the development of capital investment strategies ensuring these reflect and contribute to meeting targets set by the HSSA and the Trust's Corporate Plan.

22. Lead the Trusts process for achievement of efficiency savings and productivity improvement targets.

People Management

23. Provide clear and strategic leadership to staff within the directorate and ensure the Trust has a highly skilled, flexible and motivated workforce to provide high quality acute hospital care.

24. Lead the development and implementation of workforce modernisation initiatives within the directorate.

25. Ensure that management structures and practices within the directorate support a culture of effective team working, continuous improvement and innovation.

Corporate Management

26. Contribute to the Trust's corporate planning, policy and decision making processes as a member of the senior management team and ensure the Trust's objectives and decisions are effectively communicated.

27. Develop and maintain working relationships with other director colleagues and non-executive directors to ensure achievement of Trust objectives and the effective functioning of the senior management team and Trust Board.

28. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions and improves the health and well being outcomes of the population it serves.

29. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

30. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

2. Maintain staff relationships and morale amongst staff.

3. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.

4. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

5. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

6. 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.

7. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.

8. Adhere at all times to all Trust policies/codes of conduct, including for example:
   - Smoke Free policy
   - IT Security Policy and Code of Conduct
   - Standards of attendance, appearance and behaviour

9. All employees of the Trust are required to be conversant with the Trusts policy and procedures on records management. Trust Directors are responsible to the Chief Executive for all records held, created or used as part of their business including corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

10. 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 Job Description will 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 postholder works.

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

PERSONNEL SPECIFICATION

JOB TITLE Director of Performance & Reform

Ref No 73210033

Notes to applicants:

1. ***We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms*;**

2. ***You must clearly demonstrate on your application form how you meet the required criteria – failure to do so will result in you not being shortlisted****. Please note that whilst the Essential criteria sets out the minimum requirements it may become necessary to make this more stringent by the introduction of other job related criteria as set out in the Desirable Criteria.* ***Applicants are therefore strongly advised to clearly demonstrate how they meet each element of both the Essential AND the Desirable criteria on their application form.***

3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn*

ESSENTIAL CRITERIA – *these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so will result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

QUALIFICATIONS / EXPERIENCE

1. Hold a university degree or recognised professional qualification or equivalent qualification in a relevant[1] subject AND have a minimum of 5 years experience in a senior management[2] role in a major complex organisation[3].

2. Have at least 3 years experience of managing major change programmes addressing significant[4] organisational, managerial or service change.

3. Have a minimum of 2 years experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant[4] improvements.

4. Have a minimum of 2 years experience working with a diverse range of both internal and external stakeholders in a role which has contributed to the successful implementation of a significant[4] change initiative.

5. Had personal accountability for a budget for a minimum of 3 years, in a major complex organisation[3], securing value for money by effective prioritisation and driving efficiencies.

6. Hold a full current driving license valid for use in the UK and have access to a car on appointment[5]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

The following are essential criteria which will be measured during the interview stage.

KNOWLEDGE, TRAINING & SKILLS

7. Have an ability to provide effective leadership to enable transformation of services.

8. Demonstrate evidence of high level skills in;
   (a) effective planning and organisation
   (b) Governance and Risk Management
   (c) Financial Control
   (d) People Management

9. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

10. Demonstrate effective communication skills to meet the needs of the post in full.

DESIRABLE CRITERIA – *these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted*

1) Experience in the managing of a range of services within a health and / or social care setting.

The following further Clarification on the terms used in the Specification is provided below;

[1] *'relevant subject' will be interpreted to mean any business, administrative, corporate function or health related qualification*

[2]*'senior management' is defined as experience gained at Director, Assistant Director or equivalent in a major complex organisation*

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

[4]'significant' is defined as contributing directly to Key Corporate Objectives of the organisation concerned.

[5]This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

PLEASE NOTE:

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. It is therefore intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to the qualities set out in the NHS Leadership Qualities Framework. Whilst candidates should be prepared to provide examples of their competence against any of the leadership qualities, particular attention will be given to the following elements;

- Effective and strategic influencing
- Seizing the future
- Drive for results
- Leading Change through people
- Holding to Account
- Drive for Improvement
- Self Management

As part of the Recruitment & Selection process it will be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

PERFORMANCE MANAGEMENT ARRANGEMENTS

Performance in the HSCNI is managed under four main areas:

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

Performance management and improvement in the HSCNI includes:

- measurable objectives, standards and targets which define what the HSC has to achieve with clear lines of accountability;

- clear links between resources allocated and outcomes required, with strong commissioning arrangements;

- incentives to ensure targets are achieved;

- robust and appropriate monitoring and information systems;

- assessment, audit and reinforcement measures;

- strong financial control systems with flexibility to innovate and reform at local level

The successful postholder will be required to operate within arrangements to support the Trusts overall agenda through ongoing delivery of services against the challenging agenda set by Government and Regional Health & Social Care Bodies with whom the Trust works.

Southern Health and Social Care Trust

TERMS & CONDITIONS OF SERVICE

Hours

Full Time

Remuneration

Salary Range : £71,279 - £95,039 per annum

HSC Pension Scheme / HPSS Superannuation Scheme

Trust staff may choose to join the Health & Social Care Superannuation Scheme. Further information may be obtained from the HSC Pension Service Website at **www.hscpensions.hscni.net**

Applicants who are already members of the HPSS Superannuation Scheme may continue with their current arrangements.

Annual Leave and General Public holidays

The Trust offers excellent provision for annual leave and General Public Holidays as follows;

On appointment	27 days plus 10 public holidays
After 5 years service	29 days plus 10 public holidays
After 10 years service	33 days plus 10 public holidays

Human Resources Policies

The Trust offers a wide range of Human Resource Policies to underpin the value that is placed on its staff. Further details are available on request.

Committed to Equality of Opportunity

The Trust recognises and values the diversity of its workforce and the population it serves. The Trust is committed to a working environment free from intimidation of any kind. Through a systematic and objective recruitment & selection process the Trust is committed to ensuring that appointment decisions are taken solely on the basis of merit.

CLOSING DATE FOR RECEIPT OF COMPLETED APPLICATIONS

The closing date for receipt of completed applications is Tuesday 9th November 2010 at 4.30pm

Applications can be submitted on line at www.HSCRecuit.com or in hard copy format to;

Recruitment & Selection Services
Human Resources Department
The Hill Building,
St Lukes Hospital site
Loughgall Road,
ARMAGH, BT61 7NQ

Please note the Trust will not accept any late, incomplete or reformatted application forms received after the closing date and time.

Applicants using Royal Mail should note that 1st class mail does not guarantee next day delivery. It is the responsibility of the applicant to ensure that sufficient postage has been paid to return the form to the address above by the stated closing date and time. Existing Health & Social Care staff should not rely on the internal postal system.

SHORTLISTING PROCESS

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified.

The Trust is under no obligation to take account of your planned holiday arrangements.

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

- Effective and strategic influencing
- Seizing the future
- Drive for results
- Leading Change through people
- Holding to Account
- Drive for Improvement
- Self Management

SELECTION PROCESS

In accordance with best practice all appointments within the Trust are made under the 'merit principle' where the best person for any given post is selected in fair and open competition.

Only those applicants who clearly demonstrate on their application form how they meet the essential criteria, and if applied, the desirable criteria, will be shortlisted for interview. It is therefore essential that all applicants clearly demonstrate how they meet each element of the shortlisting criteria on their application form.

At this stage it is anticipated that interviews for shortlisted applicants will be scheduled during week commencing Monday 29th November 2010, however this may be subject to change.

Candidates will be contacted by telephone immediately following completion of the shortlisting to ensure those being invited to interview have as much time available for preparation as possible. Candidates are therefore asked to ensure that mobile telephone numbers are provided where possible and that in any event the contact telephone numbers stated provide for ease of contact. All such communication will be followed up in writing.

PRACTICAL TIPS ON COMPLETING YOUR APPLICATION

The application form is designed to ensure that applicants provide the necessary information to determine how they meet the essential criteria. Some useful tips on completing an on line application on HSCRecruit.com are given overleaf.

To Ensure Equality of Opportunity for all Applicants

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

- Completing the Criminal Convictions / Offences Section - Legislation requires you to tell us about any criminal convictions or offences that you may have. Within the Health and Social Care Service, criminal convictions are never regarded as spent and therefore you must tell us about all previous or pending convictions or offences, even if they happened a long time ago, this even includes motoring offences.

  The Trust is committed to the equality of opportunity for all applicants, including those with criminal convictions. Whilst the disclosure of information does not automatically debar an individual from employment, it is essential that all convictions are disclosed to allow the Trust to adequately consider their relevance to the post in question. The Trust considers that failure by an applicant to declare complete and accurate information about convictions to be a serious breach of trust.

- AccessNI Disclosure – In accordance with the requirements of the Safeguarding Vulnerable Groups (NI) Order 2007 the successful applicant will be required to undergo an Enhanced Disclosure check before any appointment can be confirmed. Further details will be provided to the successful applicant. The Trust operates in line with the ANI Code of Practice. Further details can be obtained on request.

- Completing your current / previous Employment details please;
  - Ensure that full details are provided.
  - Be specific about all the dates that you provide, these should be stated in the following format DD/MM/YYYY.
  - Explain any gaps between periods of employment.
  - Provide a list of key duties that you have been responsible for in current post / previous posts.

Southern Health and Social Care Trust

Some Useful Tips when Completing an Online Application Available on www.HSCrecruit.com

Getting Started

- The online application can be found at: http://www.HSCRecruit.com
- Read the information provided online carefully
- If this is your first visit to HSCRecruit.com you will need to create an Account. Full details are available on the website.

Application Form

- There is no master form however when you select the post you wish to apply for you will be able to apply on line or download the application form.
- If you select the online application it will take you through a series of tabs which must be completed in full. Each of the tabs is a different section of the same form. Each tab/page MUST be completed.
- You should save your work regularly
- You do not need to complete your form at one sitting. You can save it and come back to it later.
- No one has access to your form until you submit it and apply for a job except for you.
- **Please, do not leave it until the last minute as something could happen to the internet at either end.**
- When you submit/apply for a post, sometimes the computer will 'time out' if the internet is running slow. You will need to click on the back button and try submitting again to ensure the application is received.
- Once your form has been submitted you will receive an email confirmation.
- You can print your form before you submit it. It can also be printed after you have applied for a job.

Criteria

- There is a word limit for each criteria – approximately one A4 page of typed text
- You cannot change the font style or size.
- Main formatting tools at your disposal are:
  - New lines and line spaces
  - Capital letters for headings
  - Bullet points - use a hyphen (-) or an asterisk (*).
- When putting in acronyms eg HSC it will automatically change it to Hsc. To avoid this put in spaces between each letter H S C.

- If you have not used your word limit and want to space the text out on the page use returns.

Equal Opportunity Monitoring Form

Please note that this information is regarded as part of your application and failure to complete and return this part of your application may result in disqualification. This information is treated in the strictest of confidence. The selection panel have no access to this information.

Disability requirements

We ask on the application form if you require any reasonable adjustments, due to disability, to enable you to attend the interview. Details of any disability are only used for this purpose and do not form any part of the selection process.

If you wish to discuss your disability requirements further, please contact Karyn Patterson, Head of Recruitment & Selection Services on Personal Information redacted by the USI or Personal Information redacted by the USI or by email to Personal Information redacted by the USI

Southern Health and Social Care Trust

Useful Links

Further details on the HSCNI may be obtained from;

Southern Health and Social Care Trust
www.southerntrust.hscni.net

Department of Health, Social Services and Public Safety www.dhsspsni.gov.uk

Further details on the NHS Leadership Qualities Framework may be obtained from;
www.nhsleadershipqualities.nhs.uk

Further Enquiries / Information

Applicants requiring any further information on the Trust or this post should contact Mr Kieran Donaghy, Director of Human Resources & Organisational Development on Personal Information redacted by the USI or by email to Personal Information redacted by the USI

Applicants requiring any further information on the application process, shortlisting or interview arrangements should contact Karyn Patterson, Head of Recruitment & Selection Services on Personal Information redacted by the USI or Personal Information redacted by the USI or by email to Personal Information redacted by the USI

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

JOB DESCRIPTION

JOB TITLE	Chief Executive
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Trust Board
ACCOUNTABLE TO	Trust Board through to the Minister for Health

JOB SUMMARY

The Chief Executive is the most senior executive member of the Trust Board and leads the development of the vision for the strategic direction of the Trust in line with the overall policies and priorities of the Department of Health, Social Services and Public Safety (DHSSPS), Health and Social Care Board (HSCB).

As the Accountable Officer for the Trust, the Chief Executive is accountable to the Trust Board, DHSSPS and HSCB and ultimately the Minister for the performance and governance of the Trust in the delivery of high quality care, responsive to the needs of the population in line with performance targets established.

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

The Chief Executive will lead reform within the Trust including the achievement of all organisational objectives, ensuring that appropriate, robust systems are in place and necessary changes are achieved.

The Chief Executive is responsible for ensuring the Trust delivers high quality services and achieves the vision, values and priorities of the Trusts business in line with the 5 year Strategic Plan.

KEY RESULT AREAS

DELIVERY

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

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

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

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

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

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

7. Achieve high levels of performance and excellence against Controls Assurance and other standards required.

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

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

STRATEGIC LEADERSHIP

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

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

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

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

CORPORATE MANAGEMENT

14. With the Chairman, be responsible for the organisational structure of the Trust, its probity and effectiveness.

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

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

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

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

GOVERNANCE

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

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

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

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

23. Ensure that arrangements are in place to assure all quality standards.

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

EXTERNAL RELATIONSHIPS

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

26. Develop linkages with other Trusts, the HSCB, Public Health Agency (PHA) and the DHSSPS to promote best practice and innovation in the provision of services.

27. Work with the DHSSPS, the HSCB, the PHA and other Trusts in developing a strategy for dealing with the media which reflects Ministerial views and which secures the confidence of public representatives.

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

FINANCES

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

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

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

STAFF RESOURCES

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

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

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

35. Develop, through the Director of Human Resources & Organisational Development, management information on staff utilisation, development and return on investment, which improve management and a rigorous continuous improvement culture.

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

DEVELOPMENT OF SELF

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

38. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HSC managers.

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

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

40. Review individually, at least annually, the performance of immediately subordinate staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

41. Maintain staff relationships and morale amongst staff.

42. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.

43. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

44. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

45. 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.

46. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.

47. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - Standards of attendance, appearance and behaviour

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

49. 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.

50. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

51. Understand that this post may evolve over time, and that this Job Description *will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.*

52. As Accountable Officer comply with the Code of Business Conduct.

This Job Description will 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 postholder works.

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.

PERSONNEL SPECIFICATION

JOB TITLE Chief Executive

Ref No 73215001

Notes to applicants:

1. ***We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms*;**

2. ***You must clearly demonstrate on your application form how you meet the required criteria – failure to do so will result in you not being shortlisted****. Please note that whilst the Essential criteria sets out the minimum requirements it may become necessary to make this more stringent by the introduction of other job related criteria as set out in the Desirable Criteria.* ***Applicants are therefore strongly advised to clearly demonstrate how they meet each element of both the Essential AND the Desirable criteria on their application form.***

3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn*

ESSENTIAL CRITERIA – *these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so will result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the further assessment process;

QUALIFICATIONS / EXPERIENCE

1) Hold a university degree or recognised professional qualification or equivalent qualification in a relevant[1] subject AND have a minimum of 5 years' experience in a senior management[2] role in a major complex organisation[3]

2) Have at least 3 years' experience of managing major change programmes addressing significant[4] organisational, managerial or service change demonstrated through personal involvement in;
    a. Risk management,
    b. Planning and implementation of the change,
    c. Evaluating the impact of the change in transforming services for the better

3) Have a minimum of 2 years' experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant[4] improvements demonstrated through personal involvement in;
    a. The associated strategy development,

b. Implementation and;
c. Sustainability of the objectives

4) Have a minimum of 2 years' experience working with a diverse range of both internal and external stakeholders;

a. To successfully implement a significant[4] change initiative,
b. Building sustainable commitments in developing and maintaining networks through lasting working relationships,
c. Where the contribution of others is encouraged.

5) Had personal accountability for a budget for a minimum of 3 years, in a major complex organisation[3], demonstrating;

a) how value for money has been secured,
b) how efficiencies have been achieved.

6) Hold a full current driving license valid for use in the UK and have access to a car on appointment[5]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

The following are essential criteria which will be measured during the assessment process;

KNOWLEDGE, TRAINING & SKILLS

7) Have an ability to provide effective leadership at a Strategic level to enable the ongoing development and improvement of services.

8) Demonstrate evidence of high level skills in;
(a) effective planning and organisation
(b) Governance and Risk Management
(c) Financial Control
(d) People Management

9) Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

10) Demonstrate highly effective communication skills to meet the needs of the post in full.

1) Experience in the managing of a range of services within a health and / or social care setting.

The following further Clarification on the terms used in the Specification are provided

[1] 'relevant subject' will be interpreted to mean any business, administrative, corporate function or health related qualification

[2]'senior management' is defined as experience gained at Chief Executive, Director, Assistant Director or equivalent in a major complex organization

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

[4]'significant' is defined as contributing directly to Key Corporate Objectives of the organisation concerned.

[5]This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

PLEASE NOTE:

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. It is therefore intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to the Dimensions set out in the NHS Leadership Model.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

Willis, Lisa

From: Trouton, Heather
Sent: 29 October 2015 09:18
To: Brown, Robin; Gilpin, David; Hurreiz, Hisham; McKay, Damian; Neill, Adrian; Farnan, Turlough; Hall, Sam; Korda, Marian; Leyden, Peter; McNaboe, Ted; Reddy, Ekambar; Epanomeritakis, Manos; Hewitt, Gareth; Lewis, Alastair; Mackle, Eamon; Mallon, Peter; Weir, Colin; Yousaf, Muhammad; Bunn, Jonathon; McKeown, Ronan; McMurray, David; Murnaghan, Mark; Patton, Sean; Wilson, Lynn; Glackin, Anthony; O'Brien, Aidan; Young, Michael; McArdle, Gerarde; Gudyma, Jaroslaw; McCaul, David; Mathers, Helen; Doyle, Timothy; Alam, Ahsan; Watson, Bruce; Rajkumar, Shan; Haynes, Mark; ODonoghue, JohnP; Suresh, Ram
Cc: Mackle, Eamon; Corrigan, Martina; Nelson, Amie; Reid, Trudy
Subject: FW: WHISTLEBLOWING POLICY
Attachments: WhistleblowingPolicyMarch2015-RevisedandFinal.pdf

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Dear All

Following a recent Trust survey of staffs' understanding of Whistle Blowing, please see attached a re issue of the Whistle Blowing policy for your attention.
The Policy is also available on the Intranet in the Human Resources section.

Can you please ensure this is shared with your medical team.

Thanks
Heather

Southern Health and Social Care Trust

WHISTLEBLOWING POLICY

Policy Checklist

Name of Policy:	Whistleblowing Policy and Procedure for Raising Concerns at Work
Purpose of Policy:	The Public Interest Disclosure (Northern Ireland) Order 1998 was introduced to safeguard anyone who raises concerns, and this policy encompasses the requirements of that Order. The policy provides a mechanism for staff to raise concerns about a range of matters at an early stage and in the right way thereby developing a culture of responsible openness and constructive criticism regarding all aspects of the Trust's activities including clinical care.
Directorate responsible for Policy	Directorate of Human Resources & Organisational Development
Name & Title of Author:	Vivienne Toal - Head of Employee Engagement & Relations
Does this meet criteria of a Policy?	Yes
Staff side consultation?	Yes
Equality Screened by:	Vivienne Toal – Head of Employee Engagement & Relations
Date Policy submitted to Policy Scrutiny Committee:	30th March 2015
Policy Approved/Rejected/ Amended	Approved subject to amendments
Communication / Implementation Plan required?	Yes
Any other comments:	
Date presented to SMT	April 2015
Director Responsible	Mr Kieran Donaghy
SMT / Trust Board Approved/Rejected/Amended	Approved
Date returned to Directorate Lead for implementation (DHR& OD)	30th March 2015
Date received by Employee Engagement & Relations for database/Intranet/Internet	30th March 2015
Date for further review	March 2017

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Whistleblowing Policy Version: 2_0 Reference number/document name:
Supersedes	Supersedes: Whistleblowing Policy version 1
Originator	Name of Author: Vivienne Toal Title: Head of Employee Engagement & Relations
Policy Scrutiny Committee & SMT approval	Referred for approval by: Vivienne Toal Date of Referral: Policy Scrutiny Committee Approval SMT approval: As Above
Circulation	Issue Date: September 2017 Circulated By: Vivienne Toal Issued To: Directors, Assistant Directors, Heads of Service for onward distribution to staff.
Review	Review Date: March 2017 Responsibility of (Name): Vivienne Toal Title: Head of Employee Engagement & Relations

Southern Health and Social Care Trust

Quality Care - for you, with you

WHISTLEBLOWING POLICY

AND

PROCEDURE FOR RAISING ISSUES OF CONCERN AT WORK

Author	Vivienne Toal, Head of Employee Engagement & Relations
Directorate responsible	Human Resources & Organisational Development
Date	March 2015
Review date	March 2017

Contents *Page No.*

Appendices

1.0 INTRODUCTION TO POLICY

The Southern Health & Social Care Trust is committed to promoting a culture of openness in which staff are encouraged to raise concerns without fear of reprisal and victimisation; and to ensuring that health and social care services are provided with the highest standards of integrity and honesty. The Trust expects all employees to maintain high standards in all areas of practice. All employees are therefore strongly encouraged to report any perceived wrongdoing by the organisation, its employees or workers that fall short of these principles.

Each of us at one time or another has concerns about what is happening at work. Usually these concerns are easily resolved. However, when they are about dangers to or ill treatment of service users, staff or the public, issues relating to the quality of care provided, patient safety, professional misconduct, unlawful conduct, financial malpractice, fraud, health and safety, or dangers to the environment, it can be difficult to know what to do.

You may be worried about raising such issues. You may want to keep the concerns to yourself, perhaps feeling it's none of your business or that it's only a suspicion. You may feel that raising the matter would be disloyal to colleagues, managers or the organisation. You may decide to say something but find you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next. You may also not be clear how your own professional code of conduct relates to Trust procedures.

2.0 PUBLIC INTEREST DISCLOSURE (NORTHERN IRELAND) ORDER 1998

The Public Interest Disclosure (Northern Ireland) Order 1998 was introduced to protect anyone who raises concerns from detriment and / or dismissal, and this policy encompasses the requirements of that Order. The Order protects employees or workers who make "protected disclosures", i.e. who reports wrongdoing within the workplace. This policy provides a process to enable employees or workers to inform the organisation about any wrongdoing in the workplace which they believe has occurred, or is likely to occur. Protection is against victimisation, disciplinary action or dismissal for employees who raise genuine concerns.

The Order 1998 has a tiered approach to disclosures which most easily gives workers protection for raising a concern internally. It is intended that this policy and associated procedure provide reassurance to staff who wish to raise such matters internally. Guidance from a range of regulatory / professional bodies encourages registrants to raise their concerns internally to ensure maximum level of protection under the Public Interest Disclosure Act.

Further details of the Order can be found using the following web address: http://www.pcaw.co.uk/law/pida.htm.

3.0 PURPOSE AND AIMS

Purpose

The Senior Management Team of the Trust is committed to running the organisation in the best way possible and to do so we need the help of those who work for us. We have this policy is place to reassure those who work for us that it is safe and acceptable to speak up and to enable all workers to raise any concerns that they may have at an early stage and in the right way.

There may be times when, after staff have raised a concern under this policy, it is deemed to be more appropriate to be dealt with differently. However this should not stop staff raising concerns under this Policy.

This policy aims to:

- Provide an avenue for you to raise a concern internally as a matter of course, and receive feedback on any action taken;
- Provide for matters to be dealt with quickly and appropriately and ensure that they are taken seriously;
- Reassure you that you will be protected from reprisals or victimisation for raising the concern in good faith;
- Allow you to take the matter further if you are dissatisfied with the Trust's response.

4.0 POLICY STATEMENT

The Trust would rather that you raised the matter when it is just a concern rather than waiting for proof. It is important to raise any concerns at an early stage, on the basis of any level of concern or relevant information. Indeed, if you have serious suspicions that an offence has been committed, you have a responsibility to report them as soon as possible. We all have a responsibility to protect the Trust, its service users, staff and public. **If in doubt – raise it!**

If something is troubling you that you think the Trust should know about or look into, please use the Procedure for Raising Concerns at Work – see section 10.0. You should never accuse individuals directly, and telling the wrong persons may jeopardise an investigation.

What we do ask is that in order to qualify for protection under this policy, you must:

- Act in good faith (effectively this means honestly) and

- Genuinely believe the information you are going to impart is accurate and
- Not act maliciously.

Our assurances to you

Your safety

The Chair, Chief Executive & Trust Board are committed to this Policy. If you raise a genuine concern under this Policy, you will not be at risk of losing your job or suffering any form of retribution as a result. Provided you are acting in good faith, it does not matter if you are mistaken. Of course, this same assurance is not extended to someone who maliciously raises a matter they know is untrue, and in such cases disciplinary action will be considered.

Your confidence

Confidentiality

The Trust will not tolerate the harassment or victimisation of anyone raising a genuine concern under this Policy. However, we recognise that you may nonetheless want to raise a concern in confidence. If you ask us to protect your identity by keeping your confidence, we will respect your request and it will not be disclosed without your consent. However a situation may arise where we are not able to resolve the concern without revealing your identity (for instance because evidence is needed in court, or the Trust has to act on the information), and this will be discussed with you in advance of any disclosure.

Anonymous allegations

Remember that if you do not tell us who you are, it will be much more difficult for us to look into the matter or to protect your position or to give you feedback. You are encouraged to put your name to any issue of concern you are raising. Allegations expressed anonymously and/or with little detail or information are much less powerful and more difficult to address but may be considered at the discretion of the Trust. Whilst we will give due consideration to anonymous reports, we cannot follow the procedure set out in Section 11.0 for any concerns raised anonymously. The Trust endeavours to promote a supportive environment in which you are able to express your concerns in confidence, thereby hopefully negating the need for raising concerns anonymously.

5.0 SCOPE OF POLICY

This Policy applies to you whether you are a permanent, temporary or bank employee. The Trust is also very dependent on a wide range of contractors, suppliers, and others not directly employed by the Trust such as agency staff, trainees, volunteers, secondees, or a student or anyone on a work experience placement – the policy applies to all individuals in these categories where there are concerns about the activities of the Trust.

6.0 HOW WE WILL HANDLE YOUR CONCERN

Members of staff, including students, can seek support and guidance from their Trade Union or professional organisation when raising a concern. Staff may be represented at any stage of the procedure by a trade union representative or colleague where appropriate.

Once you have told us of your concern, we will look into it to assess initially what action should be taken. This may involve an internal enquiry or a more formal investigation. We will tell you who is handling the matter, how you can contact him/her, the timescale for action and whether your further assistance may be needed.

All staff who raise a concern will be automatically allocated support from the Head of Employee Engagement & Relations or a nominated deputy throughout the investigation process in line with section 8.0.

When you raise the concern you may be asked how you think the matter might best be resolved. If you do have any personal interest in the matter, we do ask that you tell us at the outset. If your concern falls more properly within the Grievance Procedure we will tell you.

While the purpose of this policy is to enable us to investigate possible malpractice and take appropriate steps to deal with it, we will give you as much feedback as we properly can and confirm our response in writing. Please note that we may not be able to tell you the precise action we take where this would infringe a duty of confidence owed by us to someone else.

7.0 RESPONSIBILITIES

7.1 Your responsibilities

The Trust wishes to encourage you to highlight areas where you are aware of inadequacies in the provision of services. In doing so concerns can be addressed at the earliest opportunity thus ensuring an overall improvement in the level of services provided to service users.

In particular you have a responsibility to:

- report any genuine concern of wrongdoing or malpractice preferably to your line manager or alternatively via one of the other options set out in the procedure in section 10.0. Proof of wrongdoing is not required, merely a genuine and reasonable concern. At the same time, you have an equal responsibility not to raise issues maliciously, where no potential evidence or indication or malpractice or danger exists; and

- familiarise yourself with and to understand the procedure for raising concerns outlined in section 11.0.

- be aware that information given unjustifiably to the media may unreasonably undermine public confidence in the Trust and Health and Social Care generally.

7.2 Our Responsibilities

All **managers** contacted by a member of staff, are responsible for:

- ensuring at the earliest opportunity that the appropriate action is taken in line with section 10, considering the nature and seriousness of the concern raised, including informing others, responding to concerns quickly and in confidence, taking all concerns seriously. This action will include deciding how any person, against whom an allegation is made, is informed of the matter, ensuring that the investigation is not jeopardised by the disclosure.

- supporting and reassuring those raising concerns – it is recognised that raising concerns can be difficult and stressful

- responding to all concerns without pre-judging

- recording all concerns, including the date the concern was raised, dates of interviews with employees, who was present at each interview and the action agreed

- keeping all records safely and securely

The **Trust's Senior Management Team,** through the Director of Human Resources & Organisational Development is responsible for:

- ensuring that these procedures are explained to all new staff, as part of Trust Induction

- protecting the interests and confidentiality of staff, for treating any concerns raised seriously, and for investigating them fairly and thoroughly

- ensuring that an investigation report relating to each Whistleblowing concern raised is considered as part of the Trust's Corporate / Clincial & Social Care Governance arrangements.

8.0 SUPPORT FOR EMPLOYEES

It is recognised that raising concerns can be difficult and stressful. Advice and support is available from the Head of Employee Engagement & Relations or a nominated deputy

throughout any investigation process. The Head of Employee Engagement & Relations will not undertake an investigation role in any whistleblowing case but will oversee any investigation undertaken and provide support to the individual raising the concern throughout the process, ensuring that feedback is provided at appropriate stages of the investigation.

The Trust also provides Carecall services to all employees through its Employee Assistance Programme; this service is free to all employees and is available 24/7. Contact details are: 0808 800 0002.

The Trust will take steps to minimise any difficulties which you may experience as a result of raising a concern. For example if you are required to give evidence at disciplinary proceedings, the Head of Employee Engagement & Relations will arrange for you to receive advice about the process.

If you are dissatisfied with the resolution of the concern you have raised or you consider you have suffered a detriment for having raised a concern, this should be raised initially with the Head of Employee Engagement & Relations.

9.0 EQUALITY AND HUMAN RIGHTS CONSIDERATIONS

This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The policy will therefore not be subject to an equality impact assessment.

Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

10.0 ALTERNATIVE FORMATS

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English.

11.0 COPYRIGHT

The supply of information under the Freedom of Information does not give the recipient or organisation that receives it the automatic right to re-use it in any way that would infringe

12.0 PROCEDURE FOR RAISING CONCERNS AT WORK

There are a range of options from which you can choose if you wish to raise a concern.

Concerns are best raised in writing. You should set out the background and history of the concerns, giving where possible:

- names,
- dates,
- places, and
- the reasons why you are particularly concerned about the situation.

If you do not feel able to put the concern in writing, you can of course raise your concern via telephone or in person. A statement can be taken of your concern which can be recorded for you to verify and sign.

12.1 How to raise a concern <u>internally</u>

Staff should raise any concern internally using one of the options listed below:

➢ **Option 1**

Managers have a vital role to play in ensuring that you and your colleagues are able to make constructive contributions and to feel that your ideas are welcomed, appreciated and where appropriate, acted upon in a positive manner.

You are therefore encouraged in the first instance to raise concerns with your line manager. You may wish to involve a Trade Union representative or colleague to advise or assist you. As soon as you have a concern, you should make an immediate note of it. You should write down all the relevant details – what was said or done, date, time, names etc.

➢ **Option 2**

If, for any reason, you feel unable to raise the concern with your line manager, please raise the matter with another senior person you can trust. This might be another manager or a Senior HR representative and again you may wish to involve a Trade Union representative or colleague.

➢ ***Option 3***

If you feel that the concern is so serious that it cannot be discussed with any of the above you can contact:-

- Director of Human Resources & OD direct line [redacted]
- Chief Executive direct line [redacted]
- Non –Executive Director contacted through the Chair's office
  (See Appendix 2 for names) direct line [redacted]

The contact address for any of the above is: -

Southern HSC Trust Headquarters, Craigavon Area Hospital, Lurgan Road, PORTADOWN, BT63 5QQ

12.2 Response required from internal managers / Director to whom concerns are reported

Stage 1

ALL whistleblowing concerns MUST be notified by internal managers to the Director of Human Resources & Organisational Development for logging and investigation. The Director of Human Resources & Organisational Development will ensure that the Head of Employee Engagement & Relations is notified of the concern to ensure support can be provided to the employee.

The manager / Director should be clear on the range of other Trust policies and procedures in the event that the concern raised might be more appropriately dealt with under another policy / procedure e.g. Grievance Procedure, Working Well Together Procedure, Maintaining High Professional Standards (Medical & Dental staff). Advice from Employee Engagement & Relations may help to clarify this at any early stage.

Any internal manager / Director to whom a concern is raised must then arrange to meet with the employee to discuss the concern without delay along with a representative from the Employee Engagement & Relations team.

The manager / Director and HR representative should establish the background and history of the concerns, including names, dates, places, where possible, along with any other relevant information. The manager should also explore the reason why the employee is particularly concerned about the matter.

A record should be made of all discussions at this stage by the manager and Employee Engagement & Relations.

It may be necessary with anonymous allegations to consider whether it is possible, based on limited information provided in the complaint, to take any further action. Where it is

decided that further action cannot be justified, the reasons for this decision should be documented and retained by the Employee Engagement & Relations Department.

Stage 2

Once the preliminary facts / issues of concern have been established, the approach to investigating the concern must be discussed and agreed. A record should be made of the decisions and/or agreed actions which should be signed and dated.

Stage 3

Within 10 working days of the concern being received, the manager receiving the concern must write to the employee:

- Acknowledging that the concern has been received;
- Indicating how the matter will be dealt with;
- Providing an estimate as to how long it will take to provide a final response; and/or
- Telling the employee whether any initial enquiries have been made; and
- Telling the employee whether further investigations will take place and if not why not; and /or
- Letting the employee know when s/he will receive further details if the situation is not yet resolved; and
- Providing the employee with details of whom to contact should s/he be dissatisfied with this response (see 10.4 below)

Advice from Employee Engagement & Relations should be sought when drafting the letter of response.

11.3 How to raise a concern <u>externally</u>

If you are unable to raise the matter internally as outlined above in Options 1 to 3, or if you feel it has not been dealt with properly, we would rather you raise it with an appropriate external agency, detailed in Option 4 below, than not at all.

- **Option 4.**

Provided that you are acting in good faith and have evidence to back up the concern, your concern may also be raised with: -

- Relevant Professional / Regulatory Bodies (e.g. Nursing & Midwifery Council, General Medical Council, Northern Ireland Social Care Council, Health Care Professions Council etc.)

- Statutory Bodies (e.g., Mental Health Commission, Regulation & Quality Improvement Authority (RQIA))

- The Health and Safety Executive for N. Ireland

- Department of Health, Social Services and Public Safety.

Contact addresses and telephone numbers are included in Appendix 1.

11.4 If You Remain Dissatisfied

If you are unhappy with the response you receive when you use this procedure, remember you can go to the other levels and bodies detailed in Section 10.3. While we cannot guarantee that we will always respond to all matters in the manner you might wish, we will do our best to handle the matter fairly and properly. By using this procedure, you will help us to achieve this.

12.0 SOURCES OF INDEPENDENT ADVICE AND FURTHER INFORMATION

You may also wish to access independent advice for example,

- A Trust JNCF Trade Union representative or any other recognised Trade Union official*;*

  or

- The independent charity *Public Concern at Work*
  - telephone 0207 404 6609 where lawyers can give free confidential advice at any stage about how to raise a serious concern.

Appendix 1

Northern Ireland Social Care Council
7th Floor Millennium House
Great Victoria Street
BELFAST
BT2 7AQ
028 90 417600

Nursing & Midwifery Council
23 Portland Place
LONDON
W1B 1PZ
020 76377181

Regulation & Quality Improvement Authority (RQIA)
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT
028 90 517500

General Medical Council
20 Adelaide Street
BELFAST
BT2 8GD
028 90 517022

Health Professions Council
184 Kennington Park Road
LONDON
SE11 4BU
020 78409814

Department of Health, Social Services & Public Safety (DHSSPSNI)
Castle Buildings
Stormont
BELFAST
BT4 3SJ
028 90 520500

Health & Safety Executive for Northern Ireland
83 Ladas Drive
BELFAST
BT6 9FR
028 90243249 (Free phone 0800 0320 121)

Mental Health Commission for Northern Ireland
4th Floor – Lombard House
10-20 Lombard Street
BELFAST
BT1 1RD

DHSSPS Fraud Hotline
Tel 08000 963396

Appendix 2

List of Non-Executive Directors with whom a concern can be raised

Mrs Deirdre Blakely

Mr Edwin Graham

Mrs Siobhan Rooney

Mrs Hester Kelly

Mrs Elizabeth Mahood

Mr Raymond Mullan

Mr Roger Alexander

Contact can be made with any of the above Non-Executive Directors through the Office of the Chair on Personal Information redacted by the USI **.**

Southern Health and Social Care Trust

Quality Care - for you, with you

Southern Health and Social Care Trust

Incident Management Procedure

October 2014

Procedure Checklist

Name of Procedure:	Incident Management Procedure
Purpose of Procedure:	To describe the Trusts systems and processes in relation to Incident Management
Directorate responsible for Procedure:	Corporate Governance, Office of the Chief Executive
Name & Title of Author:	Mrs Margaret Marshall, Interim Asst Director CSCG
Does this meet criteria of a Procedure?	Yes
Trade Union consultation?	No
Equality Screened by:	
Date Procedure submitted to Policy Scrutiny Committee:	
Members of Policy Scrutiny Committee in Attendance:	
Policy Approved/Rejected/ Amended	
Policy Implementation Plan included?	
Any other comments:	
Date presented to SMT	
Director Responsible:	Chief Executive
SMT Approved/Rejected/ Amended	
SMT Comments	
Date received by Employee Engagement & Relations for database/Intranet/Internet:	
Date for further review	

Contents

1.0 Introduction:

The consistent identification, monitoring and review of incidents is central to the Trust"s strategic and operational processes to ensure it can achieve its vision for safe and effective care. As recommended in the document „Safety First: a Framework for Sustainable Improvement in the HPSS" (HPSS 2006) the Trust recognises that incident reporting is a fundamental element of its Risk Management Strategy.

1.1 Purpose:

The purpose of this procedure is to guide all employees of the Trust in the following:

- Identification, reporting, review, monitoring and learning from all incidents which have resulted in or had the potential to result in injury or harm to a person or damage to property or the environment, or a breach of security, confidentiality, policy or procedure.
- Analyse incident trends, root causes, associated costs and to develop appropriate action plans to eliminate or minimise exposure to associated risks.
- Enable staff to participate in, and effect change by ensuring that mechanisms are in place to learn from incidents which occur and that resulting changes in care, policy or procedures are embedded in local practice.
- Notification and recording of incidents from third party organisations from which the Trust commissions services.
- Notification of incidents where appropriate to other relevant agencies, for example the Regional Health and Social Services Board (RHSCB), Regulation Quality and Improvement Authority (RQIA), Department of Health, Social Services and Public Safety (DHSSPS) via appropriate Early Alerts, HM Coroner, Northern Ireland Adverse Incident Centre (NIAIC), Health & Safety Executive Northern Ireland (NIHSE), Police Service of Northern Ireland (PSNI), etc. Please see **Appendix 2.**

1.2 Scope of the Procedure:

The following procedure applies to all employees of the SHSCT. Some aspects, including reporting a serious adverse incident, also applies to independent providers / contractors commissioned or engaged by the Trust. It addresses the Trust's governance responsibilities in relation to incidents and is one element of the Trust's Risk Management Strategy.

2.0 The Roles and Responsibilities:

2.1 Chief Executive:

The Chief Executive is the responsible Officer for the Trust"s statutory duty of quality and is required to drive the delivery of the Trust"s corporate priorities, particularly the priority to provide safe, high quality care. Through the overview of this Trust Policy and Procedure, the Chief Executive will seek to embed the Trust"s corporate values throughout the organisation, to promote the Trust"s values of all staff being open and honest and acting with integrity, to listen and learn and to embrace change for the better.

The Assistant Director for Clinical and Social Care Governance (AD CSCG) reports directly to the Chief Executive and will provide the Chief Executive, Trust Board, Senior Management Team (SMT) and Governance Committee with an on-going overview of this Policy and Procedure through the continuous corporate review and monitoring of Incidents and Serious Adverse Incidents (SAIs).

2.2 Assistant Director of Clinical and Social Care Governance (AD CSCG):

The AD CSCG will provide leadership to ensure a systematic and organisation-wide approach to the reporting of clinical and social care incidents and near misses and will work with SMT to embed a culture of appropriate and timely reporting, analysis and learning across the organisation.

The Assistant Director will participate in monthly meetings with the Clinical and Social Care Governance Coordinators in order that there is a corporate oversight in relation to incidents, risks, trends and learning within the organisation.

It is the responsibility of the AD CSCG to present a trend analysis report quarterly of all incidents reported in the Trust to:

- Senior Management Team (SMT)
- the Governance Committee
- CSCG Working Body

This report will be used by the SMT to inform organisational risk management and governance priorities and will escalate concerns in relation to trends and /or learning.

On behalf of the Chief Executive and SMT, the AD CSCG will provide assurance reports to Governance Committee in relation to the adoption and implementation of procedures relating to incident reporting, monitoring and learning. This includes evidence of cross organisational learning through appropriate forums including the Trust Governance Working Body.

The AD CSCG will act as a conjugate between the Directorates and the Chief Executive, appraising the latter of all major and catastrophic incidents, internal reviews and Serious Adverse Incidents. They will also liaise on behalf of the Trust with the Department, the Public Health Agency (PHA) and the HSCB to ensure the Trust contributes to and is involved in any Regional opportunities for learning.

2.3 Directors:

- Directors are responsible for leading a culture of openness, transparency and learning within their area of responsibility and for ensuring that the actions from any learning are appropriate and the most effective way to minimise risk and provide good care services
- Directors shall ensure that processes are in place to effectively identify, report, review, monitor and learn from all incidents within their Directorate and that the processes are as laid out within this procedure
- They shall ensure that the reviewing, learning from and monitoring of incidents is included on the agenda of all directorate, divisional and team governance meetings
- They shall ensure that action plans and learning to be implemented from incidents are an effective response with an appropriate timescale, prioritised and are reviewed on an on-going basis at directorate governance meetings
- Directors shall consider learning from moderate, major and catastrophic incidents and any trends identified from insignificant / minor incidents to inform directorate governance priorities, education, training and directorate and organisational learning. The latter should be identified through the Directorate Governance forum and be escalated to the AD CSCG for dissemination via the Trust Governance Working Body
- They shall ensure that all current risks recognised from this governance of incidents are considered for the Directorate / Corporate Risk Register
- Training – liaise with the appropriate Executive Directors with responsibility for professional and organisational training

2.4 Assistant Directors & Associate Medical Directors (AMD's for clinical incidents):

All incidents recorded on Datix Web must be reviewed by an ***Incident Review Team*** on a ***weekly*** basis***.*** It is the responsibility of all Assistant Directors / Associate Medical Directors (AMDs) to put in place ***Incident Review Teams*** within their divisions/teams. The membership of an Incident Review Team should include a Head of Service / Senior Manager and an identified Clinician where ***clinical incidents*** are under review.

The Assistant Director / AMDs must also:

- Lead a culture of openness, transparency and learning within their area of responsibility and ensure that the actions from any learning are appropriate and the most effective way to minimise risk and provide high quality care and services

- Include the management, review, monitoring and learning from incidents on the agenda of divisional, service and team governance meetings
- Ensure that action plans and learning to be implemented from incidents are an effective response, appropriately time bound, prioritised and are reviewed on an on-going basis at divisional meetings
- Consider learning from moderate, major and catastrophic incidents and any trends highlighted from insignificant / minor incidents when identifying directorate and divisional governance priorities, education, training and organisational learning in a timely way
- Organisational learning should be identified through to the Directorate Governance forum and be escalated to the AD CSCG for dissemination via the Trust Governance Working Body
- Identify training needs to the appropriate Heads within the Trust
- Ensure through their Heads of Service that any barriers to implementing the learning from moderate, major or catastrophic incidents is risk assessed using the SHSCT risk assessment matrix, highlighted at Directorate Governance Fora and placed on the appropriate risk register if not immediately actioned

2.5 Head of Service/ Team Manager:

It is the Head of Service/Team Manager"s responsibility to:

- Lead a culture of openness, transparency and learning within their area of responsibility and ensure that the actions from any learning are appropriate and the most effective way to minimise risk and provide high quality care and services
- Include the management, review, monitoring and learning from incidents on the agenda of service and team governance meetings
- Ensure that action plans and learning to be implemented from incidents are an effective response, appropriately time bound, prioritised and are reviewed on an on-going basis at team meetings
- Consider learning from moderate, major and catastrophic incidents and any trends highlighted from insignificant / minor incidents when identifying service and team governance priorities, education, training and organisational learning in a timely way
- Escalate any barriers to implementation of action plans relating to incidents to the appropriate Assistant Director and consider if they need to be placed on the appropriate Risk Register
- Ensure through the function of the ***Incident Review Team*** that feedback is provided to the incident reporter on the outcome of incident investigations for all moderate, major and catastrophic incidents

2.6 Incident Review Team:

- The purpose of the ***Incident Review Team*** is to review all incidents, determine any learning from them, make recommendations as to what would constitute an effective response which will minimise risk and communicate this within their teams (and to Heads of Service / Team Manager if they are not part of the Incident Review Team). Learning / effective response to any risks highlighted should then be communicated to the appropriate Head of Service / Team Manager for action within the operational teams. Any barriers to implementation of action plans relating to incidents should be escalated by the appropriate Head of Service to the Assistant Director.

The Review Teams should also consider and review the following:

- The information submitted by the reporter including the incident grade
- Consider the need for additional internal and/or external reporting e.g. Health and Safety, RIDDOR, NIAIC, HSCB, RQIA, Adult Safeguarding (PVA). See **Appendix 2**
- Develop time bound and prioritised action plans as appropriate. All **moderate, major** and **catastrophic** incidents reported will require an action plan which **must** include relevant learning points
- Feedback the outcome of the review of **moderate, major and catastrophic** incidents to the incident reporter
- Inform Assistant Director of any immediate learning which could minimise the risk of further reoccurrence of incident
- Close all incidents following completion of the review process

All Incident Review Teams should adhere to the Datix Web User Guide for Managers/Reviewers which can be accessed from the Trust intranet site. See Hyperlink:

http://vsrintranet.southerntrust.local/SHSCT/documents/DatixWeb_InvestigatorsFinalApproversguidance2012.pdf

2.7 The Directorate CSCG Coordinator:

The CSCG Coordinator will ensure that processes are in place for the recording, reviewing, monitoring and learning from incidents and will provide timely and appropriate information on incidents to the Directorate. Reports will be tailored for Directors, Assistant Directors, Heads of Service and Team Managers.

The CSCG Coordinator will also be responsible for interpreting and analysing incident information to identify risks and/or trends. They will feedback this information to the Directorate through the Directorate Governance structures.

The CSCG Coordinator will provide regular and timely information to the Directorate on the action plans and learning arising from incidents and SAI"s and the progression of these action plans.

On behalf of the Director, the CSCG Coordinator is responsible for monitoring that within each service team, incident information is being acted on appropriately in order to mitigate risk, improve quality of care and patient and client safety and facilitate teams to make any links required from issues identified in incident management to appropriate Risk Registers. They will also ensure that a process is in place to escalate any concerns relating to incidents to the appropriate Director, and that there are appropriate processes in place to identify SAIs in line with the Health & Social Care Board (HSCB) process.

The CSCG Coordinator will participate in monthly meetings with the Assistant Director of Clinical and Social Care Governance in order that there is a corporate oversight in relation to incidents, risks, trends and learning within the organisation.

2.8 All SHSCT Staff:

All SHSCT staff are required to provide safe, high quality care and this includes the reporting of incidents for organisational learning and good risk management as defined below and further in **Appendix 1**, in accordance with this procedure and participate in any subsequent review if required.

3.0 Procedure for the Identifying and Reporting of Incidents – ALL STAFF

3.1 Incident Identification:

A useful definition of an incident is:

"Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation."

The incident may arise during the course of the business of the Trust or any of its commissioned / contracted services.

However this is not an exhaustive definition and using the incident reporting system specifically for clinical outcomes which are unexpected and / or unexplained, but are not believed to be associated with an adverse incident, is also encouraged by the Trust as a means of triggering a thorough review of such cases. These reviews are a beneficial mechanism of providing assurance to staff, patients, clients, carers and relatives that any learning related to any aspect of the case is sought and acted upon.

3.1.1 Other Systems for Reporting:

An incident can sometimes also be reported through other systems such as Adult Safeguarding, Case Management Review, Mortality and Morbidity meetings, etc.

The Trust mechanism for recording all incidents is **Datix Web** and the electronic incident form (IR1) should be completed as soon as possible after the incident occurs or is discovered to have occurred. Staff should then think through what other reporting systems, such as notifying their Line Manager, may need to be considered.

3.1.2 Incidents Occurring Within Services Contracted or Commissioned by the Trust:

Incidents occurring in contracted / commissioned services which are not observed / witnessed by Trust staff and / or not reported to Trust staff are dealt with under the regional contractual arrangement with independent providers. This states that all incidents occurring within the regulated sector which are notifiable to RQIA will also be notified to the appropriate Trust via a central email. From here they will be distributed to the appropriate Directorate for review as per section 4 of this procedure.

If a member of Trust staff observes or witnesses an incident occurring within a service contracted or commissioned by the Trust or has an incident reported to them by a Trust client and / or their family / carers which relates to care provided by a contracted or commissioned service i.e. domiciliary care services, private nursing home, etc. then the member of staff has a duty to report the incident using the Trust Datix web system. The staff member will also instruct the contracted service to report the incident via their reporting mechanisms (which include notifying RQIA and Trust of significant incidents) and this instruction should be documented by Trust staff. If reported to the Trust by the contracted service the Datix incident reports should be merged by the appropriate governance team. **The original incident should be reviewed as per section 4 of this procedure.**

3.1.3 Immediate Action Checklist Following Identification of an Incident:

When an incident is identified and before it is reported please complete the following **immediate action checklist:**

- The extent of injuries/damages to person(s) or property should be ascertained and a determination made regarding the need for emergency or urgent treatment / action. For patient / client care related incidents, contact the relevant medical team to assess where required. The situation must be made safe
- Appropriate obvious treatment / actions should be taken to minimise the likelihood of the incident recurring
- Any equipment involved in the incident should be removed from use and clearly labeled, “Do not use”, until appropriate checks can be carried out. Do not dispose of equipment involved in an incident
- **The patient/client and/or their relatives / carers** should be informed, as soon as possible of the incident and of any treatment that may be necessary taking into consideration any consent issues and referring to the Trust‟s “Being Open” guidance in **Appendix 4**

- Any incident involving a patient or client, and the action taken, should be recorded in their healthcare record
- If the incident is major or catastrophic and requires an immediate action plan to prevent further harm the line manager (if out of hours, the Senior Out of Hours Manager) should be informed
- For incidents requiring further in-depth investigation e.g. SAIs/Internal Root Cause Analysis (RCA"s) / Reviews, patient/client records should be returned as soon as is practical to the Directorate Governance Coordinator to ensure all recorded information is available for review. Retrospective notes are permitted as long as these are clearly marked as being made in retrospect
- Where appropriate and where it would be beneficial to assist in the investigation of the incident, photographs should be taken and retained as evidence – this is particularly useful in Health and Safety type incidents or where damage had occurred to property
- CCTV footage should be sourced and a copy made for all cases which would be subject to PSNI investigation.
- Security staff and/or the PSNI should be informed where appropriate
- Consideration should also be given to the need to activate site based emergency / contingency plans if necessary (in line with current emergency procedures)

3.2 Reporting an Incident:

Where: All incidents must be recorded electronically via the Datix Web based form (IR1 form) which can be accessed as follows from the Trust intranet site. **(Trust intranet/ useful links/ other useful links and scroll down to click on „Datix Web")**

By Whom: This form must be completed by either the member of staff involved in or who has witnessed the incident, or by the person the incident has been reported to.

When: All incidents should be reported via the electronic reporting form (IR1 form), no later than the end of the working shift or day during which it occurred **or** its occurrence became known.

How: Information concerning the incident must be accurate, complete and factual. The description of the incident should not contain opinions, conclusions, subjective or speculative statements. The following instructions should be followed when filling in the electronic incident form. *See Hyperlink below:*

http://vsrintranet/SHSCT/documents/DatixWebIR1FormUserGuidance_000.pdf

Incidents given an initial severity rating of major or catastrophic (as a minimum) will automatically be triggered to the appropriate Head of Service/Team Manager, relevant Assistant Director and the Assistant Director of Governance in an email via Datix Web.

In circumstances where the incident is considered as a potential **Serious Adverse Incident (SAI),** *(see **Appendix 1** for the definition of an SAI)* immediate telephone contact should be

made to the relevant Head of Service/ Line Manager or Out of Hours Manager if appropriate. They will notify the appropriate Director, Assistant Director/Associate Medical Director and Clinical and Social Care Governance Coordinator at the earliest opportunity. The incident will then be reviewed by the latter group against the HSCB SAI criteria and the DHSSPS Early Alert criteria. This group must complete a major/catastrophic incident checklist for all incidents screened as possible SAIs. This checklist, regardless of the outcome of the screening process, will be held by the Directorate CSCG Coordinator and copied to the Assistant Director of Governance via the Corporate Governance Office**. (**See **Appendix 6)** In the event of the incident meeting the Serious Adverse Incident criteria; **section 5.0** of this procedure should be followed and where appropriate, the Director should brief the Chief Executive on SAIs as soon as possible.

4.0 Procedure for Reviewing, Monitoring and Learning from Incidents:

All incidents are to be reviewed on a weekly basis by the service area‟s Incident Review Team. As indicated earlier the purpose of the Incident Review Team is to undertake a local assessment / review of the incident in a timely manner. This review should include:

- Quality assure the information submitted via the Datix system and the initial severity rating given to the incident. Where the review team believes the severity rating should be changed – the incident reporter should be contacted and this should be discussed and agreed
- Calculate the actual and potential risk rating for the incident using the Risk Grading Matrix and impact Table – this is explained on the Datix screen and also in **Appendix 3**
- Consider the need for additional internal and /or external reporting e.g. RIDDOR, NIAIC, HSCB, RQIA, Vulnerable Adults (PVA), Fire **(See Appendix 2 for guidance on advisory contacts re: these additional reporting routes)**
- If the incident is also an adult safeguarding review (this will be recorded on Datix) then the Incident Review team should link with the adult safeguarding Designated Officer (DO) for that incident. If the incident is proceeding to a safeguarding investigation the Incident Review Team should participate in that or at a minimum, review the learning from that investigation and implement as appropriate
- Develop and agree learning and action plans as appropriate. All **moderate, major** and **catastrophic** incidents reported will require a time bound action plan which **must** include relevant learning points. This learning should be communicated and actioned within teams
- Feedback the outcome of the review of **moderate, major and catastrophic** incidents to the incident reporter
- Inform the Assistant Director of any immediate learning which could minimise the risk of further reoccurrence of the incident
- Any barriers to implementation of action plans relating to incidents should be escalated to the appropriate Head of Service and the Assistant Director

- Close all incidents following completion of the review process

4.1 Incident Review:

The following risk assessment process should be applied to all incidents at the time of occurrence in order to decide what level of investigation is required and at what level within the Trust the investigation should be conducted.

***Step One* – What was the impact of the incident at the time of the incident? (Actual Harm)**

4.1.1 The person reporting the incident should undertake this stage of the assessment, entering it on the IR1 form (DIF1). Based on the actual impact of the incident at the time of occurrence (taking into account psychological as well as physical harm) a judgment is made as to the incident‟s severity in the range Insignificant to Catastrophic.

4.1.2 Incidents assessed as causing actual **major** or **catastrophic** harm at the time of the incident must be given immediate consideration for further in depth analysis.

4.1.3 For incidents causing lesser levels of actual harm further questions need to be asked to decide on the level of investigation required.

***Step Two* – What might the impact be if the incident happens again? (Potential harm)**

4.1.4 Where the potential harm of the incident is being considered, staff must ask the following in the context of “if no further action was taken”.

- Was the harm caused by a chance happening?
- Could the actual harm caused realistically have been a lot worse?
- How many people might be hurt if it happened again?
- How seriously might someone be hurt if it happened again?
- What are the control measures already in place, today?

4.1.5 It is important that grading on actual harm and potential harm are completed as separate exercises. This will ensure that the most severe incidents where the level of actual harm is higher are dealt with as a priority. All incidents with a lower level of actual harm but with a potential for a higher level of harm must be managed appropriately.

Step one	Deciding what was the impact / harm of the incident today **(actual)**
Step two	Where there is insignificant to moderate actual impact/harm, deciding what might the realistic impact/harm be if the incident were to happen again under similar circumstances. **(potential impact)**
Step three	Decide what are the chances of the incident happening again under similar circumstances. At this stage consideration should also be given

	to reviewing similar incidents that have happened in the past. **(Likelihood)**
Step four	Decide what the overall risk grading for the event is by plotting: **Impact** multiplied by **likelihood = risk grading**

The level of review applied to an incident is determined by the actual severity (impact) of the incident and/or the potential impact and is as follows:

INSIGNIFICANT AND MINOR – These incidents will usually not require detailed review, however the following questions should be asked to establish any learning:

- What happened?
- Did what happened vary from what should have or was expected to happen?
- If so, why?
- What is the learning from this incident?

However, these incidents could be subject to detailed review if similar incidents are found to occur frequently i.e. where there is a trend. It is the review team"s responsibility to identify such trends and advise the appropriate Head of Service/Team Manager or Assistant Director regarding improvements or action plans required if a trend is identified. Heads of Service and Assistant Directors should also be identifying and analysing trends through their Team / Service / Divisional Governance meetings. Action plans and lessons learnt from this trend analysis should be discussed and actions recorded in the notes of team, service and divisional governance meetings.

MODERATE – These incidents **must** be reviewed as part of the incident review process on a weekly basis. The review team must ensure that an investigation is completed within four weeks and that there is a documented action plan and learning points recorded on Datix Web. These actions and the learning should then be reviewed by the team, division and directorate with respect to progress of implementation.

In undertaking a Moderate Incident review the following questions should be answered **as a minimum:**

- What happened?
- Did what happened vary from what should have or was expected to happen?
- If so, why?
- What is the learning from this incident?

Further guidance on incident review is available in **Appendix 7.**

The Heads of Service and Assistant Directors are responsible for reviewing implementation of any actions and learning following an investigation. Action plans and implementation of learning should also be reviewed at the Directorate Governance forum by the Director.

MAJOR AND CATASTROPHIC - This level of incident will, as previously described, have been automatically notified by the Datix system to the Head of Service, relevant Assistant Director and the Assistant Director of Governance at the time of reporting. It is the responsibility of the relevant Assistant Director to inform the Director and Associate Medical Director (AMD) (in the case of clinical incidents) and the appropriate CSCG Coordinator for that area of the incident.

The incident must be considered against the HSCB (October 2013) criteria for a Serious Adverse Incident (SAI) by the relevant Director, Assistant Director, AMD and CSCG Coordinator. This review of the incident should be documented by the CSCG Coordinator on the major / catastrophic incident checklist which must be completed by the group. Regardless of the outcome of the screening, the completed checklist should be shared with the Assistant Director of Governance via the Corporate Governance Office. In the event of the incident meeting the SAI criteria, **section 5.0** of this procedure should be followed.

If the incident does not meet the SAI criteria the relevant Director may either appoint an independent internal team to review the incident using a Root Cause Analysis methodology (the method used to review an SAI -see section 5) or the incident may be reviewed by the service Incident Review Team. **(**See **Appendix 7)**

Whatever the method of reviewing the incident – either as an SAI, an internal review by an independent team within the Trust or by the clinical review team within the division itself, the service team involved in the incident **must** be informed of the decision regarding how the incident is to be reviewed at the earliest opportunity, by the Assistant Director / Associate Medical Director, and **before** the review commences.

Where an incident is to be reviewed internally by an independent team or if it is the subject of an SAI, the patient /client and/or family/carer must be informed of this review at the earliest opportunity (as per the HSCB SAI guidance April 2014) as should the coroner where the case has previously been referred to them. This action forms part of the major / catastrophic incident checklist and should be documented. In exceptional cases where it is not appropriate to share this decision with the patient /client and/or family/carer, the reasons for this decision **must** be documented on the checklist and on the SAI notification form.

The findings and recommendations of the review - irrespective of how it is carried out, will be discussed and documented at relevant team, service, division, Morbidity and Mortality meetings and directorate governance meetings.

The Heads of Service and Assistant Directors are responsible for reviewing implementation of any actions and learning following an investigation.

Action plans and implementation of learning will also be reviewed at the Directorate Governance forum by the Director.

Cross Directorate learning points should be escalated to the Assistant Director of Governance by the CSCG Coordinators when they meet monthly.

The findings and recommendations of an internal review of an incident or an SAI should be shared with the patient / client and/or family / carer, RQIA and the coroner (if previously referred) at the earliest opportunity.

5.0 Procedure for Reporting and Completing a Review of a Serious Adverse Incident (SAI):

Following the review meeting of the relevant Director, Assistant Director, AMD and CSCG Coordinator where it is agreed to report an incident as a SAI, the SAI notification should be electronically reported to the HSCB, via the Corporate Governance Office, as per the HSCB Procedure for the Reporting of SAIs (HSCB October 2013)

See Hyperlink:
http://www.hscboard.hscni.net/publications/Policies/102%20Procedure_for_the_reporting_and_followup_of_Serious_Adverse_Incidents-Oct2013.pdf

The Directorate CSCG Coordinator will populate the HSCB SAI notification form on behalf of the appropriate Director and forward to the Corporate Governance Office for the attention of the Assistant Director of Governance. All SAI notification forms **must** be fully completed and accurate with an appropriate Datix ID number when submitted to the Corporate Governance Office and should be done so **within 72 hours** of the incident occurring. The Director / their designate should also report the SAI to the Chief Executive.

If the SAI concerns the death of a patient and the death has been reported to the Coroner by the appropriate medical professional this will have been recorded on the major/catastrophic review checklist and the SAI Notification. In this case the Corporate Governance Office will automatically inform Litigation (litigation generic email account) of the SAI review and this will on completion be submitted to the Coroner.

Where the SAI notification form indicates that the RQIA should be informed the Corporate Governance Office will automatically share the notification and report (when finalised) with the RQIA.

If the SAI requires an Adult Safeguarding Investigation, the Adult Safeguarding Investigation will inform the SAI process. The PVA Designated Officer will liaise with the appropriate Governance Coordinator, relevant HoS, and a representative from the Adult Safeguarding Team to compose the Adult Safeguarding Investigation review team membership. That review team must be approved by the Director, Assistant Director, and where appropriate AMD. The PVA Investigation Officer will produce an Adult Safeguarding Investigation report which will be submitted to HSCB/RQIA and to the Coroner if appropriate etc as the SAI report.

5.1 Procedure for Conducting a SAI Review (This procedure should also be applied when conducting an Independent Internal Review):

Timescale	Action	Lead
0 -72hrs	Discuss with Director, Assistant Director, AMD and CSCG Coordinator. Consider the incident against HSCB (Oct 2013) definition of a SAI and using the Major/Catastrophic incident checklist.	Director / CSCG Coordinator
0-72hrs	If above group decides the incident is an SAI they will inform the service team involved in the incident of their decision and the patient/client and/or their relatives. This group should identify nominations for the SAI review team including a Chair. (Advice for Chairpersons - see Appendix 8) Those nominated should have had no involvement in the incident for review, should be from another site / team and should be available to participate during the subsequent 12 weeks. There is the option to nominate external independent persons from other organisations onto the review team – this is done via the Director and Chief executive. This option may be useful when there is a need to engage the appropriate expertise, the incident is particularly distressing for staff involved or is particularly sensitive, where carers and relatives have expressed significant dissatisfaction with a service team or the organisation at an early stage, where a service team is small and based on one site only, where the case may be subject to external or legal scrutiny at a later stage or at any other time where it may be deemed to offer a benefit.	Director / AD/AMD/CSCG Coordinator
0-72hrs	Following confirmation of their involvement all review group nominees will receive an email with the following information: • Notification of their nomination and who nominated them. • Membership and Chair of the group • A brief description of the incident • Timescale for completion of the report • Guide to RCA methodology. The relevant A/D will check and ensure the case note /records have been forwarded to the CSCG Coordinator.	CSCG Coordinator
Week 1	CSCG Coordinator and Chair of review group will agree draft terms of reference for the review. Draft terms of reference and a copy of the case note / records will be circulated with potential dates for meeting 1 of the review. All relevant information will be distributed to the group for consideration prior to meeting 1 of the group.	Chair/CSCG Coordinator
Week 2-3	Meeting 1 will take place. This meeting will normally agree a terms of reference – including the scope of the review. The timeline of events will be discussed - and all relevant points for further analysis identified together with any points needing further clarity from the professional team involved in the incident. It is often useful and appropriate to meet with some / all of the staff involved in the incident so they can give their account to the review team in person, indicate their thought processes at the time and clarify any	Review Team

	outstanding issues. The appropriate members of the review can meet those of similar profession from the team involved in the incident.	
Week 3-6	**Actions from meeting 1 will be completed, including follow up meetings with staff involved in the incident and all information can be forwarded to CSCG Coordinator.**	**Review team**
Week 6	**Meeting 2 can take place. It may be appropriate in less complex cases to have Draft 1 of the report tabled at this meeting for further discussion. However this meeting is more likely to pull together all information received and to analyse the incident and make conclusions, recommendations and propose an action plan.**	**Review team / CSCG Coordinator**
Week 7-9	**A complete draft of the report will be prepared by members of the review team and circulated to all for comment.**	**Review team /CSCG Coordinator**
Week 9-10	**Comments from the review team will be reviewed by the Chair and CSCG Coordinator / review facilitator and a final draft agreed and then circulated to the review team.**	**Chair/ CSCG Coordinator**
Week 10-12	**The final draft will be circulated / shared with all members of the service team involved in the incident for factual accuracy checking and information. The Final Draft will then be forwarded to the appropriate Director, Associate Medical Director and Assistant Director for quality assurance prior to presentation at Directorate governance meetings.**	**Chair/CSCG Coordinator**
Week 12	**Following approval by AD CSCG the report will be submitted to HSCB/ RQIA via the Corporate Governance Office. The report may also be submitted to SMT for information sharing / discussion and if a case involves a death being reviewed by the Coroner it will be shared with their office also.**	**CSCG Coordinator / Corporate Governance**

5.2 Points of Best Practice When Undertaking a SAI Review (Applicable when undertaking an Internal Review of an Incident also):

- The service team involved in the incident are provided with support and assistance following the incident and during and after the review. See **Appendix 5**
- The patient / client and/ or relatives are informed of the review taking place, **BEFORE** it commences, to provide assurance to them that any learning related to the incident is identified and acted upon. See **Appendix 4**
- The service team involved in the incident are informed as soon as possible and **BEFORE** it commences how the incident will be reviewed. They are kept informed with respect to review progress and they can interface with the review team to provide additional information and or clarity when required. The draft review report should be shared with the service team involved in the incident for factual accuracy and information
- The review must be chaired by someone with relevant professional experience and expertise from another geographical area of the Trust who has had no involvement in the case or direct line management responsibility for any of the team involved in the incident

- The review team should be multidisciplinary and have the appropriate expertise to review the incident appropriately. They must be independent from being involved in the care and treatment provided to the patient / client
- There is the option of seeking external independent review team members and this should be considered at the outset by the Director, Assistant Director, and Associate Medical Director and CSCG Coordinator. This option can be used at any time throughout the review
- The facts, findings and recommendations from the review will be shared with the patient /client and /or family / carers. See **Appendix 4**
- Where the case has previously been referred to the Coroner, their office will receive a copy of the review report
- Learning and action plans from SAI"s will be managed in the same way as that from other incidents – **see section 4**

(subject to service users consent)

APPENDIX 1:

KEY DEFINTIONS

Definitions: The following terms describe events, which are defined as incidents and will be recorded and reported within the scope of this procedure and through Datix Web.

Terminology	Definitions
Incident/ Near Miss	Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of an HSC organisation / Special Agency or commissioned service (including a breach of security or confidentiality). However this is not an exhaustive definition and using the incident reporting system specifically for clinical outcomes which are unexpected and / or unexplained, but are not believed to be associated with an adverse incident, is also encouraged by the Trust as a means of triggering a thorough review of such cases. These reviews are a beneficial mechanism of providing assurance to staff, patients, clients, carers and relatives that any learning related to any aspect of the case is sought and acted upon.
Near Miss	**Incidents** that do not lead to harm but could have, are referred to as near misses.
Serious Adverse Incident (SAI)	The following criteria will determine whether or not an adverse incident constitutes a Serious Adverse Incident (SAI) **Serious Adverse Incident Criteria:-** serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self-harm*) of : a service user a service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two years) a staff member in the course of their work a member of the public whilst visiting an HSC facility. unexpected serious risk to a service user and/or staff member and/or member of the public unexpected or significant threat to provide service and/or maintain business continuity serious assault (*including homicide and sexual assaults*) by a service − on other service users, − on staff or − on members of the public occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years). - serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.
Harm	Injury (physical or physiological), disease, suffering, disability or death. In most instance harm can be considered to be unexpected if it is not related to the natural cause of the service user"s illness or underlying harm („Doing Less Harm, National Patient Safety Agency)
Concern	A worry or "gut feeling" about something that could lead to an incident. To highlight a situation which could lead to a full blown incident or suboptimal standards of equipment, practice or performance.

APPENDIX 2:

When and How an Incident Should Also Be Reported To Other Sources

All adverse incidents should initially be reported using the Datix Web incident management system. However some incidents should also be reported to other sources either internally within the Trust and / or externally to other agencies. The following table provides a list of types of incident and where they should be reported to following being recorded as an incident. There is also a list of useful contacts and Web links for additional advice and help.

TYPE OF INCIDENT	WHERE ELSE IT SHOULD BE REPORTED TO	USEFUL CONTACTS AND LINKS ON HOW TO REPORT IT
Potential Adult Safeguarding Incident	Definition available on the link opposite	Info available from Trust Intranet: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/SAFEGUARDINGVULNERABLEADULTSPROCEDUREGUIDANCEVERSION4.pdf Report form available on: http://vsrintranet/SHSCT/HTML/PandP/documents/PVA1BLANK.pdf
Health and Safety Incident	Via the Datix Web form Incidents should be automatically reviewed by Health and Safety	Contact: (Internal) Health & Safety Dept Number: 028 3741 2671 Email: http://vsrintranet.southerntrust.local/SHSCT/HTML/HR/documents/ReportableDiseases.pdf
MHRA	Should be notified (although voluntary) when an Adverse Drug Reaction occurs (ADR)	A paper form can be found in the back of every BNF or alternatively can be completed online at www.mhra.gov.uk/yellowcard
RIDDOR	An Incident is RIDDOR reportable if: **1)**The injury sustained is major, **2)** If a member of the public on Trust premises is killed or taken to hospital **3)** If the injury is sustained is an „Over 3 day injury" **4)** If there has been a Dangerous occurrence	Appropriate information should be completed on the Datix Web IR1 form which alerts the Trust"s Internal Health and Safety Dept. The above department is also contactable on Personal Information redacted by the USI Personal Information redacted by the USI or

	5) If a notification of a reportable work-related disease has been received Further guidance available on Trust Intranet	
SABRE **SHOT**	For adverse blood reactions and events the MHRA (above) has a web based system for reporting known as ***SABRE*** - ****Serious Adverse Blood Reactions and Events**** The hospital blood bank should be informed who will inform a member of the Trust Transfusion Team and the Haemovigilance practitioner will complete online reporting to SABRE. There is an option in the SABRE reporting system also to report to the ***Serious Hazards of Transfusions (SHOT)*** enquiry. All SABRE incidents are discussed at the Hospital Transfusion Committee meetings.	For further information on both SABRE and SHOT please visit www.mhra.gov.uk
CMR	Case Management Review	*New processes have been put in place under Safeguarding Board NI.*
Fire	Relates to all fire Incidents:	An FPN 11 Form should be completed within 24 hours of the Fire Incident. FPN 11 form is available on the Intranet at: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html and should be sent to: Fire Safety Department, Meadowview, Daisy Hill Hospital, when completed.
RQIA	***RQIA are notified about Incidents such as*** -serious injury to, or the unexpected/unexplained death -unexpected serious risk to service user and / or staff member and / or member of the public -unexpected or significant threat to provide service and / or maintain business continuity.	Corporate Governance Office to notify RQIA on receipt of appropriate SAI Notification form.

	-serious assault (*including homicide and sexual assaults*) by a service user -serious incidents of public interest or concern involving theft, fraud, information breaches and data losses	
HM Coroner	There is a general requirement under section 7 of the Coroners Act (Northern Ireland) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.	Guidance on reporting a death to the coroner available at: http://www.courtsni.gov.uk/en-GB/Publications/UsefulInformationLeaflets/Documents/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland%20(PDF).pdf and on the Trust Intranet at: http://vsrintranet.southerntrust.local/SHSCT/HTML/clinical_guidelines.html Corporate Governance Office to also notify Coroner on receipt of SAI Notification form
NIAIC	An incident is NIAIC reportable if it relates to a Medical Device	Contact: Specialist Estates Services Dept (internal) Medical Devices Liaison Officer Email: Personal Information redacted by the USI
DHSSPS Early Alert	Guidance available on Early Alerts at: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html	Notification sent by Corporate Governance Office
HSCB Early Alert	As above -	Notification sent by Corporate Governance Office

Appendix 3

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
	• Minimal disruption to routine activities of staff and organisation.	and organisation, rapidly absorbed.	delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	and organisation - absorbed with some formal intervention with other organisations.	delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Risk Likelihood Scoring Table

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

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

APPENDIX 4:

Guidelines on being open with patients, service users, families and carers when things go wrong or outcomes are unexpected and /or unexplained

- Any incident involving a service user should be discussed with this individual as soon as is appropriate by a senior member of the service team and preferably the lead professional. If the service user is a child or is unable to give consent due to their physical condition or mental capacity the incident should be discussed with their named next of kin contact. If the service user is able to provide consent and wishes the incident to be discussed with another carer or relative, the service team should facilitate this request.

- Specifically those incidents graded moderate, major and catastrophic should be discussed immediately with the service user and/or their relatives / carers, with consent. Those incidents of an insignificant and minor nature which occur out of hours can be discussed with those required at the most appropriate time within the next 24 hours.

- When discussing an incident with a service user and / or designated relatives / carers, the lead professional should outline the facts of the incident as known, the actual and potential consequences for the service user and how the team will review the incident for future learning. If the service user and/or designated carers / relatives wish to have the outcome of the incident review fed back to them the service team should consider this as good practice and should be conducted with consent of the service user if applicable. These interactions should be documented and attached to the incident report on Datix.

- If an incident meets the criteria for notification as an SAI or internal RCA, (**refer to Section 5**) the service user and / or designated relatives / carers must be informed of this decision before the SAI / RCA review begins. Where possible this should be undertaken by the Lead professional involved in the service user"s care. Where this is not possible to due relations being strained or it is judged to be inappropriate the Chair of the SAI /RCA review group supported by the Directorate CSCG Coordinator will undertake this role. This

individual will continue as the point of contact for the service user and / or designated relatives / carers throughout the period of the review and until the findings have been fed back.

- When an SAI / RCA review is completed and has been approved by the Directorate the point of contact for the service user and / or designated relatives / carers should offer to feed back the factual findings and recommendations of the review. This can include a meeting between parties and / or giving the review document to the service user and / or designated relatives / carers. How this process of review feedback is managed should be guided as far as possible by the wishes of the service user and / or designated relatives / carers.

APPENDIX 5:

Guidance on Support for Staff following an Incident

The Trust promotes an open, honest and participatory culture in which adverse incidents can be reported, discussed and reviewed to enable lessons to be identified, active learning to take place and the necessary changes made to improve our services and practices. A key part of that culture involves the need to support staff when an adverse incident occurs and during its review.

Depending upon the nature and circumstances of an adverse incident the levels of support required by staff will vary. Such support can be provided by line managers in a number of ways, for example:

- Providing immediate assistance/aid if required.
- Contacting the relevant staff member(s) as soon as possible following the incident to discuss.
- Facilitating an immediate informal and/or formal debrief of the staff / team involved in the incident. This should include providing staff with the opportunity to discuss their involvement and/or the circumstances leading up to the incident and how they feel about it. It is usually best to do this in a team setting with all those involved in the incident present.
- Informing staff of the Directorate"s processes in relation to incident review; keeping staff informed of likely next steps in that process and informing staff of who they can contact for advice including the Directorate Governance Office who coordinate all serious adverse incident reviews.
- At any time staff can seek advice from outside their team, for example from Directorate and Corporate Governance Offices, the Trust Litigation Department, Trust Legal Advisors or via the appropriate professional bodies.
- Line managers should be visible to all staff members. Physical presence by line managers post-incidents helps decrease anxiety related to an review and provides an accessible resource for clarification of any issues staff may have.
- Providing information on the Trust and external support systems currently available for staff who may be distressed by incidents. This includes counselling services offered by professional bodies; stress management courses; Occupational Health Services, Carecall or Hospital Chaplains.

APPENDIX 6:

Major / Catastrophic Incident Checklist

Directorate:	
Reporting Division:	
Date of Incident:	
Incident (IR1) ID:	
Grade of Incident:	
If Incident involved the death of a service user, was the coroner informed:	
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	
Brief Summary of Incident:	
Summary of discussions re SAI / RCA/ Major / Catastrophic incident review:	
Decision on Level Review Type AND rationale for this:	
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	

Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☐ YES ☐ NO
Contact for service user and / or designated relatives / carers:*(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place:*(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review :	
(Corporate Governance Office / Litigation to complete) Date and by whom Trust Litigation Dept informed:	
Does this incident meet the DHSSPS Early Alert Criteria including rationale:	
POST REVIEW COMPLETION: Date and by whom and how Review is shared with the service user and / or designated relatives / carers: *(In exceptional cases where this is inappropriate rationale should be documented)*	
Date and by whom and how Review is shared with the Coroner:	

This form once completed, regardless of Outcome, should be shared with the AD of Governance via Corporate Governance Office

APPENDIX 7:

Incident Review Guidance

A key principle of the CSC governance framework is that incidents are reviewed and analysed to find out what can be done to prevent their recurrence. Therefore, a key principle of the incident review is that when an incident occurs the important issue is not „who is to blame for the incident?" but „how and why did it occur?

Although there will be some incidents which require review using methodologies as contained within e.g. individual agency reviews, adult safeguarding reviews, health and safety reviews, the majority of incidents can be reviewed using the National Patient Safety Agency (NPSA) Root Cause Analysis Tools. Nonetheless all incident reviews will ask the core questions of:

- What actually happened? *(The facts)*
- How did what happened vary from what should have or was expected to happen?
- Why did it happen in that way? *(The causes)*
- Is there any learning to share with the team or wider Trust services to minimise the likelihood of recurrence?

The above can be expanded to include where appropriate:

- Was there anything about the task/procedure involved?
- Was there anything about the way that the team works together or perceives each other's roles?
- Was there anything about the equipment involved?
- Was there anything related to the working environment or conditions of work?
- Was there anything about the training and education of the staff in relation to their competence to:-

  (a) provide the care/service required, and

(b) manage the incident when it occurred?

- Was there anything relating to communication systems between individual members of the team, departments, or electronic communications, for example, test results via computer?
- Was there anything about the availability, or quality of any guidance notes, polices or procedures?
- Was there anything about the Trust"s strategy, its strategic objectives and priorities?

Further detailed advice in relation to incident review techniques including Root Cause Analysis (RCA) Methodologies can be sought from the Directorate Governance Coordinators or visiting the NPSA RCA toolkit resource here.

APPENDIX 8

Brief Guidance on the Role and Responsibilities of an SAI Review Chairperson

The Chairperson leads an SAI Review Team. The Chairperson's main aim is to ensure that the SAI Review Team explores in an open, fair and critical manner the circumstances surrounding the incident, and establishes what, if any, lessons arising need to be incorporated into practice in order to prevent or minimise the likelihood of reoccurrence of the incident. The review should identify not only areas for improvement but also areas of good practice. The Chairperson will be assisted by the relevant Governance Coordinator or their nominated review facilitator.

The main responsibilities of the review Chairperson are:

1.0 Prior to the Review

1.1 Reviewing all relevant case notes, statements, synopsis of care reports and relevant sections of policies and procedures related to the incident to enable them to lead the initial meeting of the Review Team.

1.2 In conjunction with the Governance Coordinator, prepare a draft Terms of Reference for consideration by the Review Team at the initial meeting.

2.0 During the Review

2.1 Ensuring that all attendees at the review are introduced to each other and are aware of their role.

2.2 Facilitating a process that is conducive to learning and analysis without interference from personal disagreements, criticisms, perceptions or dissatisfaction.

2.3 Ensuring that the review is open, fair and participative. That if required appropriate members of the Review Team are delegated to meet members of the service team involved in the incident to obtain clarity on events.

2.4 Chairing the Review in a manner which ensures that: all salient facts, a clear chronology of events and interventions, areas of strength/weakness of policy or practice are identified and clear action plans are formulated and agreed.

2.5 Ensuring that Review Team members, service teams and patients / clients and /or relatives and carers are kept informed with respect to the review and its progress as required. See **Appendix 4** and **section 5.**

3.0 Following the Review

3.1 Liaising with the Governance Coordinator to ensure that a comprehensive report with recommendations / action points and timescales (where relevant) is produced and agreed ensuring that the service team involved in the incident are given an opportunity to check the information they have contributed to the report for factual accuracy. The Chairperson should sign off/approve the report prior to it being sent to the AMD /Assistant Director / Director.

3.2 If there are queries / comments raised by the AMD / Assistant Director/ Director following their review of the draft report, the Chair should consider these and reconvene the Review Team if necessary to address same.

3.3 Report practices, systems or other issues which the Review Team feel require immediate attention to the relevant Assistant Director, Head of Service and AMD, where appropriate.

3.4 If the Chairperson is the nominated contact with the patient/client and or family/ carers, they will be responsible for sharing the facts/ recommendations and action plan with them as outlined in **Appendix 4.**

Southern Health and Social Care Trust

Quality Care - for you, with you

Revisit of the SHSCT Clinical and Social Care Governance Arrangements

Update to Governance Committee

Purpose of Report

The purpose of this paper is to provide an update Governance committee on the progress of the Revisit of the SHSCT Governance Arrangements which commenced in May 2015

Context of the Revisit

The present Acting Chief Executive requested the revisit to provide assurance that the outcomes of the 2010 SHSCT review of CSCG remain effect and robust in the following areas:

- Provide clarity and transparency of function
- Drive Quality and Safety
- Provide adequate assurances to SMT, TB , Professional Bodies and the Public on areas relating to risk, patient safety and non-compliance
- Take cognisance of recent external reviews

A paper setting out the scope of the revisit (appendix 1) was approved by SMT in early May; the content of the paper was shared with the Trusts Governance Committee in May 2015.

Update on communication with relevant stakeholders

Semi structured interviews have be completed with Directors and Associate Medical Directors. A focus group with Non-Executive Directors has been arranged for the 17th September 2015. Group discussions have taken place with Professional Governance Leads and Governance Coordinators. All discussions focus on the questions set out in appendix 1.

Timeline for completion of Governance Revisit

21st August	Interviews with Directors and Associate Medical Directors completed
17th September 2015	Focus Group arranged with Non-Executive Directors
30th September 2015	Paper outlining findings of the Governance Revisit will be tabled at SMT. SMT will agree: • Recommendations • A phased implementation plan
22nd October 2015	The themes, recommendations and implementation plan of the Governance Revisit will be presented to Trust Board

Appendix 1

SHSCT Clinical and Social Care Governance Arrangements - Continuous Improvement

Introduction:

The present Acting Chief Executive has indicated that it is timely to revisit the outcomes of the SHSCT 2010 Review of Clinical and Social Care Governance in order to provide SMT, Governance Committee and Trust Board with adequate assurance that these arrangements:

- Remain effective and robust
- Provide clarity and transparency of function
- Drive Quality and Safety – SHSCT Quality Improvement Framework
- Provide adequate assurances to SMT, Governance Committee, Trust Board, Professional Bodies and the Public on areas relating to patients safety, risk and non-compliance
- Take cognisance of recent external reviews

The revisit of the clinical and social care governance arrangements will focus on strengths and weakness of the present arrangements and will assist the Trust in identifying areas and solutions for improvement.

Purpose of the paper:

- To inform Governance Committee of SMT's decision to progress this work
- To set out an initial view of the scope of the revisit including a number of areas and questions agreed by SMT for inclusion within the scope
- To indicate how the revisit will progress

Initial Scope:

(1) Consideration of the key roles and responsibilities of the professional, corporate and operational governance leads within the context of:

- Assurance
- Challenge function
- Scrutiny of organisational intelligence
- Clarity of governance arrangements across the organisation which effectively monitor the implementation and effectiveness of changing professional, clinical and operational practice linked to evidence base and lessons learnt.

(2) Consider how effective existing mechanisms, systems and processes are to challenge, scrutinise and provide adequate operational intelligence to assure Trust Board, Operational and Executive Directors and the public on areas relating to organisational risk and patient safety.

Questions for consideration as part of the process with key stakeholders will include the following:

(1) What information do you presently receive to provide you with assurance with regards to risk and patient safety?
(2) If you were asked to give assurances to a professional body or the public would the information presently available to you be adequate?
(3) What processes are presently in place to provide assurance of appropriate challenge and scrutiny?
(4) Consider the effectiveness of SMT Governance as set out in the 2010 review?
(5) Has SMT set out and agreed an organisational governance strategy which provides clarity on roles and functions across all directorates?

Questions will be tailored to specific stakeholders.

The Trusts review of Clinical and Social Care Governance 2010 makes reference to the role of the executive directors in assisting governance committee by providing independent assurance to them and Trust Board; the following questions are in respect to this function

(1) Should there be greater transparency with respect to how operational directors take decisions on when/if to share information with Executive Directors with regards to SAI's and Complaints? Should there be a framework of criteria agreed by SMT to guide this?
(2) What mechanisms are presently in place for the Executive Directors to independently consider trends or review/audit the learning from SAI, Incidents and Complaints?
(3) Should criteria be in place to direct which SAI's should be presented at SMT, Governance Committee and Trust Board? (Please paper for discussion item 8.3 of Governance Committee Agenda

The Way Forward

The scope of this work will include feedback from NED's, AMD's, Directors and Governance Leads considering the above questions and allowing for broader issues to be raised and incorporated.

The ADCSCG will set out for SMT approval a paper detailing the scope, implementation plan and feedback processes for this work. It is envisaged that timescales for completion of the work will be 1st September 2015.

Southern Health and Social Care Trust
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Minutes of a Trust Board meeting held in Public on Thursday, 11th June 2015 at 11.30 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Mrs R Brownlee, Chair
Mrs P Clarke, Interim Chief Executive
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr J Simpson, Medical Director

IN ATTENDANCE:

Mrs D Burns, Interim Director of Acute Services
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs A Magwood, Acting Director of Performance and Reform
Mrs M McClements, Assistant Director of Older People *(Item 6i only)*
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary (Minutes)

APOLOGIES:

None

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting including members of the Public. She reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops are to be used for accessing Trust Board papers only during the meeting.

The Chair sought and received confirmation from members that they had read and fully understood their papers in advance and had come to the meeting with questions prepared.

2. DECLARATION OF INTERESTS

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

3. CHAIR'S BUSINESS

The Chair referred members to her written report and advised that since the previous meeting she had attended the second Health and Social Care Complaints Learning Event on 1 June 2015. She also referred to the recent Volunteers evening held to celebrate and recognize volunteering within Trust facilities and the local communities and commended the outstanding contribution our dedicated 700+ volunteers make to the health and social care needs of people living in this area.

Retirement of Dr Simpson, Medical Director

The Chair advised that Dr Simpson would be retiring from his role as Medical Director, on 31st July 2015. On behalf of Board members, she thanked Dr Simpson for his immense contribution and commitment to both the Trust Board and the Southern Trust and commended his significant achievements in a number of areas including; Clinical Goverance, Morbidity and Mortality and the Trusts highly regarded Appraisal and Revalidation system.

4. CHIEF EXECUTIVE'S BUSINESS

Mrs Clarke referred members to the Chief Executive's written report which included a number of items of business both internal and external to the Trust.

5. MATTERS ARISING FROM PREVIOUS MINUTES

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

6. STRATEGIC ISSUES

i) SH&SCT Consultation – Proposal for the Future of Statutory Residential Care for Older People (ST604/15)

Mrs McVeigh presented, for approval, a proposal to proceed to public consultation on the future of Statutory Residential Care for Older People. Mrs McVeigh advised that the Trust proposes to continue to support the provision of alternative models of care and the consultation paper sets out the changes the Trust proposes to make to achieve its vision for older people's services.

Mrs McVeigh drew members' attention to additional information which she circulated. She explained that the consulation paper and questionnaire had been updated to include DHSSPSNI comments. Mrs McVeigh advised of a revised timescale for responses of 14 weeks commencing on Friday 12th June 2015 until 18th September 2015 to allow for the Summer period and to bring the Trust's consultation period in line with that of other Trusts. Mrs McVeigh informed members of correspondence received to date on the consultation.

In response to a query from Mrs Mahood, Mrs McVeigh agreed to define the difference between Supported and Sheltered Housing in the proposal paper. Mrs Mahood referred to the key rationale for closure of Roxborough House and asked for examples of where the predicted surplus of 179 beds in the Armagh and Dungannon area were. Mrs McVeigh advised that

the Southern Local Commissioning Group had been tasked to carry out a needs assessment and the number of residential beds in the locality has been identified from this needs assessment. Mrs McClements referred members to page 34, Appendix 3 where further detail was included home by home for the locality.

Mrs Blakely made reference to diagram 1 on page 13 and stated that in her opinion the statement relating to the community and voluntary sector was too vague. She also queried the exclusion of respite services from the diagram. Mrs McVeigh stated that the Trust used the regionally agreed criteria in their review of the statutory care homes. She referred to short breaks and stated that the strategic direction of the Trust was to develop alternatives to bed based respite and assured members that those who still require bed based respite services continue to be able to access these through the Trust. Mrs McVeigh agreed to amend the papers to clarify these issues.

The Board approved the SH&SCT Proposal for public consultation (ST604/13)

ii) Draft Trust Delivery Plan 2015/2016 (ST605/15)

Mrs Magwood presented the draft Trust Delivery Plan 2015/16 for approval. She explained that this document sets out the Trust's response to the key themes and priorities identified within the draft regional and local commissioning plans for 2015/16 and also sets out how the Trust will utilise its resources in the year ahead. Mrs Magwood advised members that the document may be subject to change following any substantive change to the draft Commissioning Plan approved by HSCB Board on 11th June 2015.

Mrs Magwood stated that of the 30 targets in the Draft Commissioning Plan 2015/16, 27 are applicable to the Trust. The Trust awaits further confirmation/clarification on 3 identified priorities. Mrs Magwood referred members to the summary of

the Trust's assessment of deliverability of the targets set for 2015/16.

The Chair referred to recent correspondence from Ms Claire Keatinge, Commissioner for Older People in Northern Ireland to the Health and Social Care Board in relation to the impact of financial savings plans across N. Ireland and asked members to be mindful of her findings when considering the document.

The Chair stated that where a target was unlikely to be achieved/affordable, it was important to be explicit in the document as to the reasons why.

The Board approved the Trust Delivery Plan for submission to HSCB/PHA and subsequently the DHSSPS (ST605/13)

iii) SH&SCT Corporate Plan 2014/15

At the request of the Chair, Mrs Magwood set the Corporate Plan in context and explained its linkage with the Regional Commissioning Plan, Trust Delivery Plan etc., for the benefit of those public members gathered.

Mrs Magwood presented the Corporate Plan for 2014/15, stating that the paper focuses on the progress made at year end March 2015 against the key actions set out within the Trust's Corporate Plan 2014/15. These actions are in addition to or elaborate on, the actions proposed in the Trust Delivery Plan. Of the 85 priorities within the Corporate Plan 2014/15, 1 target was no longer applicable; no targets were not achieved; 29 were partially achieved and 55 were fully achieved. Mrs Magwood added that where appropriate, those priorities not yet achieved or only partially achieved will be rolled forward into the Corporate Plan 2015/16.

Mrs Clarke stated that, in the context of a challenging financial situation, the Corporate Plan provides Trust Board with assurance on the progress and improvements made towards achievement of Trust priorities.

Mrs Mahood asked about the development of diagnostics services and the delay of the 2nd CT Scanner at Craigavon Area Hospital and about the Neurology service. Mrs Burns advised that non-recurrent funding has been made available for independent sector CT scans until the 2nd scanner is available and reminded members that neurology services are currently subject to regional review. Mrs Kelly queried development of ultrasound scanning service for babies with suspected development of dysplasia to which no approval for funding has been received. Mrs Burns advised again that this development is subject to regional review. Mrs Mahood pointed out that it was important to state this in the document. Mrs Rooney asked about the reablement service to which Mrs McVeigh advised that in July 2015, Banbridge and Newry/South Armagh reablement teams will be in place. In response to a question from Mrs Blakely about progress on the Stepped Care Model in CAMHS, Mr Morgan advised that the Trust continues to progress on this proposal, however, the outcome of the Regional Reese Review is awaited.

In concluding discussion, the Chair welcomed the positive progress made as reflected in the report.

iv) Update on Newry CTCC

Mrs Magwood spoke to the above named paper which provides an update on work which has been progressed to date for a new Community Treatment and Care Centre in Newry.

In response to a question from Dr Mullan, Mrs Clarke advised that all 3 bidders were successful in gaining outline planning approval. Mrs Mahood asked about the 1 year gap between the announcement of preferred bidder (September 2015) and the award of contract (anticipated July 2016, subject to full planning approval being confirmed). In response Mrs Clarke explained the key activity involved during this period including the development of a full and robust business case and detailed design of rooms. For the benefit of members, Mrs Clarke explained the Gateway Review process. Mrs Rooney stated

that it was encouraging to note the update in terms of GP commitment.

Members noted that this will be an item on the Trust Board agenda on 24th September 2015 for approval of the announcement of the preferred bidder.

Mrs Clarke, Mrs Burns and Mrs Blakely left the meeting at 12.30 p.m.

7. OPERATIONAL PERFORMANCE

i) Human Resources Report (ST606/15)

Mr Donaghy spoke to this report which focused on, enhancement of acute ward based Phletotomy Services, AHP Bank Arrangements, Trusts Resourcing Services and Key Workforce productivity information.

Mr Donaghy advised that following discussion at the Trust Board meeting in April 2015, the AHP Bank process has been reviewed and refined to ensure that all Bank block booked staff have a minimum of 1 month's notice prior to the termination of their block booking. This will be trialled initially in the AHP Bank areas and if successful will be implemented for all Bank block bookings. The Chair welcomed the progress made since the issue was raised.

Mrs Kelly queried Phlebotomy services and asked if nursing staff were still trained to carry out blood sampling as part of their skills set and Mr Rice confirmed that this was the case. A short discussion ensued and members noted that on the Trusts two Acute Hospital sites, ward based phlebotomy services were provided by a range of staff including; i) Band 3 Medical Assistants, trained to NVQ/QCF Level 3 and a small team of Core Phlebotomists. Mr Donaghy spoke of the need for service improvement in order to meet the increased demands required to support effective patient care and updated members on the proposed model of change. Mrs Mahood welcomed the

creativity in rethinking these initiatives and driving forward the safe delivery of health care for our patients.

The Chair raised both long and short term sickness absence and sought assurance that this was being actively managed across all Directorates to which Mr Donaghy assured members that this was the case and that audits are carried out on a regular basis. Mr Rice stated that his Directorate had been working closely with the HR Directorate on sickness absence management and this had proved to be very beneficial.

Mr Donaghy reported that the Trust continues to experience recruitment difficulties for i) Nurse Band 5 posts and ii) Consultants. A short discussion ensued.

Mrs Clarke, Mrs Burns and Mrs Blakely returned at this point.

The Chair raised Medical Locum costs on page 17 of the report and the significant rise from £444,839k at 31 March 2014 compared to £664,870k at 31 March 2015 and stated the importance of monitoring this expenditure.

Dr Mullan asked with regards to the sickness absence for GP Out of Hours medical staff and asked for further clarification on the comment '100% calendar days lost'. Mr Donaghy agreed to provide clarification at the Trust Board meeting on 24th September 2015.

Action – Mr Donaghy

In conclusion the Chair reiterated concern at the significant difficulties facing the Trust at present due to the demands for nursing workforce in all sectors across the province and recruitment drives by other Trusts.

The Board approved the Human Resources Report (ST 606/15)

Mrs Blakely and Mrs Burns left the meeting at this point

8. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Annual Care Management Reviews

Mrs McVeigh presented the above named paper. She reported that compliance at end of March was well improved as compared to the end of February, with a reported increase in performance of 5%, in spite of on-going sickness absence issues. Mrs McVeigh stated her Directorate are actively recruiting additional temporary and permanent admin and clerical staff to work across the Trust area to support the professional staff deliver on the DSF Annual Review Target. Mrs Mahood acknowledged the staffing challenges and welcomed the recruiting process for further permanent staff.

Mrs McVeigh reported that at present there are two homes with failure to comply notices in place from RQIA, however all individuals in these homes have had their annual review completed.

The Chair welcomed the improvement in compliance and paid tribute to Mrs McVeigh and staff for their work in this area.

ii) Medical Director Report

Dr Simpson spoke to his report which provides an update on the Medical Revalidation process advising that as at 5th June 2015, 185 doctors have successfully revalidated. In relation to medical appraisals, Dr Simpson advised that the 2013 appraisal round closed with a 100% completion rate. Work has commenced in March 2015 for the 2014 Appraisal Round.

Mrs Rooney drew members attention to the Junior Doctors Mandatory training competencies and asked a number of questions on movement in status to which Dr Simpson provided responses. Mrs Rooney also asked how often NEWS audits were undertaken. Dr Simpson stated that it was his understanding these are carried out on an annual basis but he agreed to check and update members.

Action – Dr Simpson

Mrs Mahood highlighted the Paying/Private Patients Update included within the report and thanked Dr Simpson for his attendance in the past at Audit Committee to report on this issue. She acknowledged the Trust still has Limited Assurance in this area but commended the progress achieved.

Mrs Rooney made reference to the number of gaps to the Business Continuity Plans (Appendix B). Dr Simpson advised that it was the responsibility of each Directorate to take forward a Business Continuity Plan.

iii) Annual Medical Appraisal & Revalidation Report 2014

Dr Simpson presented the above named report for information. He advised that during the 2013 appraisal round the Trust has achieved 100% completion rates as at 31 December 2014, which equates to 288 of elegible doctors having successfully completed their appraisal documentation. Dr Simpson added that he was pleased to inform Board members that the Deputy Chief Medical Officer would be commending the Trust to the General Medical Council (GMC) as a model of good practice. The Chair welcomed the report and commended the significant progress achieved under the direction of Dr Simpson.

iv) HCAI Update

Dr Simpson reported on HCAI performance year to date (as at 3 June 2015). He advised that the Trust had recorded 6 cases of C.difficile for the period. PfA targets for 2015/16 have yet to be confirmed by the Public Health Agency (PHA).

2015/16 year to date (3 June 2015) the Trust recorded 1 MRSA case that was deemed to be not preventable. PfA targets for 2015/16 remain unconfirmed. There is no MSSA target for 2015/16, surveillance remains mandatory. Year to date (3 June 2015) the Trust recorded 7 cases of MSSA. 6 have been

identified as non-preventalbe with the 7th isolate awaiting a clinical decision on source.

Mrs Mahood asked if the outcome from the multi-disciplinary analysis through Root Cause Analysis (RCA) is fed back into the community. In response Dr Simpson assured members that learning lessons is progressed through i) The GP Forum, managed by Dr Beckett, (ii) Various Trustwide learning events and (iii) Drugs and Theraputic Committee which takes forward antibiotic management system.

v) Executive Director of Nursing

a) Nursing Quality Indicator Framework (NQI) (ST607/15)

Mr Rice presented for approval, the proposals for the implementation of the new NQI framework. He stated that following research findings a steering group had been set up to explore how the framework could be implemented across the Trust. Twelve core NQIs which the Trust is required to report on regionally have been identified and Public Patient Involvement (PPI) also incorporated. Mr Rice stated that one fundamental change proposed would be the introduction of an independent audit on all wards/facilities every 3 months, as opposed to monthly. He explained that this would significantly free up valuable nursing time to care and allow for the collation of richer more meaningful information. The Chair asked about the linkages of the proposed approach and how this could be applied within other work underway including, Nursing Experience Assessment Teamwork, (NEAT). A brief discussion took place and it was agreed that an update would be provided to Trust Board in Autum 2015 when NEAT is being presented.

Action – Mr Rice

The Board approved the Nursing Quality Indicator Framework (NQI) (ST607/15)

b) Briefing on Allied Health Professional Internal Review

Mr Rice presented the above named report for information. He advised that whilst there are ongoing issues related to demand and capacity, improvements to date have seen a significant reduction in access time for Learning Disability and Occupational Therapy services. Mrs Clarke welcomed the improved position. A discussion took place in which the delay in the completion of the regional demand and capacity modelling was highlighted. Mrs Clarke to further consider writing again to the HSCB conveying Trust Board concerns.

vi) Carers Report 2014/15

Mr Graham, the designated Board member for carers' issues, presented the report and reminded members the document had been discussed at Governance Committee on 8 September 2015.

Members noted the significant progress made across a number of areas. Mrs McVeigh advised that Carers Assessments targets continue to be an area of focus. She drew members attention to point 9, Unmet need, RAG rated Red and stated that Regional guidance was still awaited on this issue.

9. **DRAFT ANNUAL REPORT, GOVERNANCE STATEMENT AND ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015 (ST608/15)**

Mr McNally presented the draft Annual Accounts for the year ended 31st March 2015 and highlighted the key elements.

Mr McNally reported a surplus of £41k. He advised that the Trust kept within its Capital Resource Limit (CRL) by £280k, an improved position compared to £810k in the previous year. Management costs amounted to 3.5% in comparison with 3.6% recorded in the previous year.

In relation to prompt payment performance, Mr McNally reminded members that from September 2014 the Trust moved its payment function to BSO Accounts Payable Shared Services. He advised that

a fall in compliance against the 30 day target had been experienced during this year of transition, from 89.4% in 2013/14 to 87.6%. However significant improvement has occurred in the 10 day performance, from 57.3% in 2013/14 to 70.6%. Mr McNally assured members the Trust continues to work closely with BSO and Trust approvers to ensure that all efforts to improve prompt payment compliance continue. During the year the SHSCT paid £149 interest and £216 compensation in respect of late payment of commercial debt.

Mr McNally reminded members that the Trust's Charitable Funds account is once again consolidated with the Public Funds as a result of a change in accounting policy. He reported that charitable donations amounting to £350k were received by the Trust during 2014/15, a decrease from £369k in the prior year. The total fund balances carried forward at 31 March 2015 was £3,039m. In conclusion, Mr McNally stated that the Trust's Charitable Funds account had been reviewed by both the Endowments and Gifts Committee and the Audit Committee.

Mrs Mahood, as Chair of the Audit Committee, advised that the External Auditors (KPMG) had presented their report to those charged with Governance at the Audit Committee on 9th June 2015. She stated that at that meeting, the External Auditors advised that they will be recommending to the C&AG that he certifies the SH&SCT's Public Funds, Patients' and Residents' Monies and Charitable Trust Fund financial statements with an unqualified audit opinion, without modification.

Mrs Mahood brought to members attention 3 Priority One issues raised during the Audit process, i) Payroll overpayments, (ii) Single Tender Actions and (iii) Contracts in the Social Care Sector. Three Priority Two issues were also identified. Mrs Mahood emphasised the importance of taking these recommendations forward into the new financial period. She recorded her thanks to the Trust Finance team and the External Auditors for their sterling work in the preparation and production of the Year End Accounts.

In conclusion, Mrs Mahood stated that the Northern Ireland Audit Office (NIAO) had advised that if agreement remains unreached by

the Northern Ireland Executive on Welfare reform, this could greatly impact the Trust's budget allocation for 2015/16, equating to a reduction in spending of 15% and emphasised the hugh effect on service provision.

Governance Statement

Mr McNally presented the draft Governance Statement. He advised that this had been reviewed separately by both the Audit and Governance Committees. In discussion, members agreed that this was a fair and accurate record of internal control across the Trust.

The Board approved the Annual Report and Accounts for the Year Ended 31 March 2015 and Charitable Trust Fund Accounts for the Year Ended 31 March 2015 (ST608/15)

10. **APPROVAL OF WRITE-OFF OF LOSSES (ST609/15)**

Mr McNally spoke to this report which showed losses amounting to £7,830,569 for the year ended 31 March 2015. He noted that the biggest element of this was due to clinical negligence, employers and public liability claims.

Mrs Mahood stated that the report had been scrutinized fully at Audit Committee. She drew particular attention to the Bookkeeping losses and assured Board members that weaknesses identified in this area have been progressed and lessons learnt.

The Board approved the Write-off of Losses for 2014/15 (ST609/15)

11. **BOARD ASSURANCE FRAMEWORK (ST610/15)**

Mrs Clarke presented the Board Assurance Framework for approval. This sets out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

In reponse to a question from Mrs Blakely on the overspend on domiciliary care, Mrs McVeigh advised that a number of actions were being progressed through the domiciliary care review to reduce expenditure. Following a brief discussion, it was agreed that Mrs Magwood and Mrs McVeigh would circulate a summary paper to Trust Board detailing the KPIs and action being taken to reduce overspend.

Action – Mrs Magwood / Mrs McVeigh

The Chair raised point 1.9, Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status and asked for an update on the timeline. Mrs Clarke advised that the Trust has submitted its application for re-acreditation, to which a timeline for visit is awaited. She undertook to ask Mrs Burns to provide an update for the next meeting.

Action – Mrs Burns

The Board approved the Board Assurance Framework (ST610/15)

12. **APPLICATION OF TRUST SEAL**

i) Loughbrickland Works – Contract Documentation (ST611/15)

Mr Donaghy sought approval for the application of the Trust seal to Contract documentation to relocate Banbridge Transport Department to Loughbrickland PS as part of the programme of works involved in the new Banbridge Health & Care and Day Care Centre.

The Board approved the application of the Trust Seal (ST611/15)

13. **BOARD REPORTS**

i) Functional Support Services Annual Report 2014/15 (ST612/15)

Members noted the content of the above named report which summarises the key achievements relating to each of the following service area in 2014/15 and sets out their key objectives for 2015/16, i) Food Hygience, (ii) Environmental Cleanliness, (iii) Decontamination and (iv) Security Management. The Chair welcomed the report and drew attention to the high level of compliance achieved in all four standards. She referred to the 'Ground Floor' Coffee Bar located in the main foyer at Craigavon Area Hospital and commended the signage erected to inform users of the allergens contained within the food.

The Board approved the Functional Support Services Annual Report 2014/15 (ST612/15)

14. **BOARD COMMITTEES**

i) Governance Committee

- **Minutes of meeting held on 3rd February 2015 (ST613/15)**

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

The Board approved the Minutes of the 3rd February 2015 meeting (ST613/15)

- **Feedback from meeting held on 12th May 2015**

Dr Mullan provided feedback on the subsequent meeting held on 12th May 2015.

ii) Endowments & Gifts Committee

- **Minutes of meeting held on 26th January 2015 (ST614/15)**

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

The Board approved the Minutes of the 26th January 2015 meeting (ST614/15)

- **Feedback from meetings held on 23rd March 2015 and 9th June 2015**

Mrs Kelly provided feedback on the subsequent meeting held on 23rd March 2015.

Mrs Rooney provided feedback on the meeting held on 9th June 2015 following her appointment as Chair of the Committee.

iii) Audit Committee

- **Minutes of meeting held on 12th February 2015 (ST615/15)**

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

The Board approved the Minutes of the 12th February 2015 meeting (ST615/15)

- **Feedback from meetings held on 1st April 2015, 7th May 2015 and 9th June 2015**

Mrs Mahood provided feedback on the subsequent meetings held on 1st April, 7th May and 9th June 2015.

In particular Mrs Mahood drew attention to the Limited Assurance received in relation to financial processes reviewed

with the Acute Directorate and asked that Directors reiterate through their management lines the importance of completing Still in Post (SIP) forms and make proper use of HRPTS and E-procurement. Mrs Clarke agreed to ensure that Mrs Burns was advised of the importance of following this up with staff.

15. **ANY OTHER BUSINESS**

Mr Donaghy informed members that Marie Curie would be the chosen Charity for the Southern Health & Social Care Trust for the year 2015/16 and added it would be beniefical for representatives to attend Trust Board in the Autumn to provide a presentation on their work.

The Chair advised that an additional Trust Board meeting would take place on 27th August 2015.

The meeting concluded at 2.45 p.m.

SIGNED: _____

DATED: _____

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

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 28h January 2016
Title:	Medical Directors Report
Lead Director:	Dr Richard Wright – Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	For assurance

Summary of Key Issues for Trust Board

High level context:

- Update on Medical Revalidation process YTD (22nd January 2016) 261 doctors have successfully revalidated (1.1.1)
- Medical Appraisals 2014 – 98% completed / awaiting final sign-off (1.1.2)
- Progress on Junior Doctor Mandatory Training for August 2015 intake
- Reports on recent NIMDTA Deanery visits

Key issues/risks for discussion:

Work on achievement of Internal Audit paying patients recommendations continues.

Summary of SMT challenge/discussion:

- Efficiency and effectiveness of revalidation process noted and to be used as part of information provided in recruitment processes
- Junior doctors changeover noted as 3 February and plans in place to seek to mitigate impact as part of winter pressure plans
- Excellent Deanery report for ICU commended
- Benefits of E&G funding into R&D to be assessed to inform continuation into 2016/17

TABLE OF CONTENTS

1 Medical Workforce Governance

1.1 Medical Appraisal and Revalidation

The Trust's Revalidation Team continue to oversee quality control of the appraisal process and review all appraisal documentation received into the Medical Director's Office to ensure there is sufficient evidence of appropriate documentation and discussion. Where gaps are identified a feedback template is returned to the Appraiser and Appraisee asking them to address the specified areas and resubmit the documentation for final approval. The current simple checklist has also been augmented to further assist doctors in the completion of the forms.

An annual report for 2014 was produced which included an analysis of the content of appraisal documentation received and an analysis of appraiser and appraisee feedback questionnaires in relation to the quality of the Trust's Medical Appraisal processes. Comparisons were drawn between the 2012 and 2013 analyses and findings indicate that the Trust's comprehensive medical appraisal and revalidation processes are very well received by the medical workforce. A report for the 2014 appraisal round is currently being developed which will also draw comparisons with the previous two years' findings. This will be available shortly.

Revalidation Recommendations:

To date (22nd January 206) 261 doctors have now been revalidated and the remaining Year Three (2015-16) doctors are set to revalidate on schedule.

Appraisal Round 2014

The 2013 appraisal round completed with a 100% completion rate. Work commenced in April 2015 for the 2014 Appraisal Round as key information became available to issue to medical staff (e.g. CLIP reports, complaints/incidents information). The current appraisal status for 2014 is as follows:-

Division/Directorate	No. of Eligible Doctors	% of 2014 Appraisals Completed/In Progress*
Children & Young People's Services Directorate	40 eligible doctors	100% complete
Mental Health & Learning Disability Directorate	27 eligible doctors	100% complete
Anaesthetics, Theatre & ICU Division	36 eligible doctors	100% complete
Surgery & Elective Care	51 eligible doctors	96% complete
Cancer & Clinical Services	33 eligible doctors	100% complete
Medicine & Unscheduled Care	69 eligible doctors	100% complete
Integrated Maternity & Women's Health	24 eligible doctors	96%complete
Emergency Medicine	18 eligible doctors	100% complete
TOTAL	**297**	**99% complete**

Table 1.0 2014 Appraisal Status as at 22 January 2016

*NB: In Progress means the appraisal paperwork has been completed and is currently awaiting final sign-off by the Appraiser of which there are only 10% of the total outstanding. These are due to be submitted by the end of January 2016.

2 Medical Education and Training

2.1 Postgraduate Education

2.1.1 Junior Doctors Induction - Mandatory Training

Following Junior Doctor changeover in August 2015 junior doctors e-declarations continue to be recorded on the Filemaker Postgraduate database. Below is the competency report for the following mandatory training competencies as at 19th January 2016.

- Right Patient Right Blood Assessment and Module
- BMJ Hyponatremia
- Training Tracker
- Infection Control
- National Early Warning System*

*Trainees in IMWH are required to complete OEWS [Obstetric Early Warning System] module in addition to NEWS / Trainees in CYP are required to complete PEWS [Paediatric Early Warning System] only. PEWS module is currently delivered at speciality teaching sessions.

2.2 Competency Report

Competency	STATUS as at 12/11/15		STATUS as at 19/01/16		
	% Completed	% Not Required / Desist	% Completed	% Not Required / Desist	
Right Patient, Right Blood	81%	19%	79%	21%	↓
BMJ Hyponatraemia	85%	N/A	84%	N/A	↓
Training Tracker	83%	N/A	85%	N/A	↑
Infection Control	92%	N/A	91%	N/A	↓
NEWS*	82%	12%	82%	4%	↔
PEWS (CYPS only)	7%	91%	8%	90%	↑
OEWS (IMWH only)	7%	90%	8%	88%	↑

Non-compliance continues to be followed up on a monthly basis in accordance with the Standard Operating Procedure. This includes reminders of modules which have expired or are due to expire in the next 40 days. AMDs are issued with divisional competency reports on a bi-monthly basis.

2.1.2 Junior Doctor Changeover

Preparations are underway for Junior Doctor changeover which will take place on Wednesday 3rd February 2016. Generic induction will be held for all new trainees on the Wednesday morning with Speciality based induction programmes taking place in the afternoon or on the following day.

Generic and speciality induction information is currently being reviewed and updated on Southern Docs web-portal in advance of changeover. Trainees will be directed to the Southern Docs web-portal to undertake their online induction requirements. An updated report of mandatory training competencies based on new starts at February will be available for the next Trust Board report.

2.1.3 NIMDTA Deanery Visits

The Northern Ireland Medical and Dental Training Agency (NIMDTA) carried out a series of cyclical visits and regional speciality reviews throughout the year. Below is summary and update of the most recent visits:-

Obstetrics & Gynaecology Deanery Visit – 15th October 2015

The Deanery carried out a visit to Obstetrics and Gynaecology at both Daisy Hill Hospital and Craigavon Area Hospital on 15th October 2015.

The Daisy Hill Hospital visit outlined that trainees had difficulties printing from their own IT accounts, however this issue has now been resolved and the visit outcome was B1: Satisfactory. The report is now closed.

The Craigavon Area Hospital visit outlined issues raised by trainees regarding practical experience, induction and EWTR compliance. Trust action plan has been submitted and a grading of B2: Satisfactory with conditions has been issued, pending an update on EWTR compliance by 5th February 2016.

Emergency Medicine Deanery Visit – 26th November 2015

The Deanery carried out a Deanery Visit to Emergency Medicine at both Daisy Hill Hospital and Craigavon Area Hospital sites on 26th November 2015.

The Daisy Hill Hospital visit outlined issues including informal handover and patient care due to lack of sustainable senior supervision in the Department. Trust action plan response is due to be returned to NIMDTA by 2nd February 2016.

The Craigavon Area Hospital visit outlined issues including informal handover, clinical supervision, practical experience, lack of simulation facilities and seminar room within the department for dedicated training. Trust action plan response is due to be returned to NIMDTA by 4th February 2016.

2.3 Intensive Care Medicine Speciality Programme Review – 2nd December 2015

The Deanery carried out a regional specialty programme review of Intensive Care Medicine Training which included Craigavon Area Hospital on 2nd December 2015. The review received a grading at A1: Excellent. Patient safety, consultant supervision and handover were all reported to be very good. Dr Raymond McKee was commended for organising an FICM exam preparation course, which was very welcomed by trainees.

2.1.4 GMC Recognising and Approving Trainers

All hospital clinical and educational supervisors will be required to have their Trainer status formally recognised and approved by the GMC by July 2016. In order to achieve this status postgraduate medical trainers will be required to have evidence of training in the following areas:

- Teaching the Teacher (or equivalent)
- Supervisory Skills (or equivalent)
- Trainee Support Workshop (formerly Doctors in Difficulty) (or equivalent)
- Equality, Diversity and Opportunity Training
- Recruitment and Selection

The Medical Education Team continues to highlight these requirements with trainers and has organised in-house training for Teaching the Teacher and Trainee Support Workshop.

2.4 Undergraduate Education

2.2.1 New Undergraduate Teaching Leads

New Undergraduate teaching leads have been appointed as follows:-

- Dr Sylvia Perrott, 4th Year Paediatrics, CAH
- Mr Mick McCann, 4th Year POEM ED, DHH

Mr Robin Brown, 3rd and Final Year lead for Surgery in DHH is due to retire in the near future. Discussions are on-going as to who will look after the students once he retires.

2.2.2Careers Symposium

Annual Career's Symposiums are due to be held at Daisy Hill Hospital on Wednesday 16th March 2016 and Craigavon Area Hospital on Wednesday 23rd March 2016. The symposiums are targeted at local A Level students to give them an insight into the role of the doctor including QUB entry requirements, the student years, the junior doctor, the Hospital Consultant and the General Practitioner. Practical skills stations will be organised to demonstrate CPR, blood pressure, suturing, etc

2.2.3FY0 Assistantship

Preparations are underway for FY0 9 week assistantship in the Trust from 15th March – 13th May 2016 (21 FY0 CAH site and 13 FY0 DHH site). FY0s will be required by QUB have their log-books signed off for topics including RPRB competency training, how to complete a GP discharge, how to order investigations. This year all FY0 will spend one week of their

assistantship placement in General Practice. FY0s will closely shadow FY1 doctors during their placement in preparation for taking up FY1 posts in August 2016.

3 Research & Development

3.1 Charitable Funds for Research & Development

There had been a proposal to use the Charitable Funds of £32,281.49 transferred to Research and Development for a project focusing on quality and patient safety issues. On 19 November 2015, it was confirmed that the funding was not required for that project and therefore could be utilised for other Research and Development initiatives.

Trust researchers were given opportunity to submit proposals and the following were approved – three temporary full time Clinical Research Nurses, Band 6 for Respiratory, Mental Health and Gastroenterology for three months to 31 March 2016. A Critical Care Study was allocated additional funding to meet Pharmacy and statistical costs; an Occupational Therapy Study received funding for additional staff costs; and research equipment for Cardiology and Pharmacy was funded.

This additional funding has proved very beneficial and it is hoped a similar allocation will be made available to Research and Development in 2016/2017.

3.2 Options to enhance research activity in the Trust

Following the Research and Development presentation to Trust Board on 22 October 2015, the Medical Director asked that a paper be prepared on options to enhance research activity. That paper has now been provided to the Medical Director.

3.3 Meetings with Armagh City, Banbridge and Craigavon Borough Council

Dr Sharpe and Miss Knox have been invited by the Borough Council to a North American Linkages event on 27 January 2016 when the United States Consul General Daniel Lawton will be present. The Borough Council has identified the growth of the local economy as a priority and the opportunity to develop partnerships which will expand and increase their business and stakeholder base, improve international relationships and make the area more prosperous.

3.4 Horizon 2020 Application – GEMS – Gestational, Type 1 and Type 2 Diabetes, Empowerment of Mothers through Mobile Technologies

The application is being co-ordinated by the Small Business Research Initiative within Business Services Organisation and two Consultants from the Trust are contributing to the initiative; Dr Mae McConnell, Consultant Physician with interest in Diabetes and Endocrinology and Clinical Lead for Diabetes and Endocrinology and Dr Harmini Sidhu, Consultant Obstetrician and Gynaecologist. Three countries are participating; Northern Ireland, Republic of Ireland and Italy with Catalonia considering participation. The closing date for the application is 12 February 2016.

3.5 Qualcomm Tricorder XPrize

The Qualcomm Tricorder Xprize is a $10 million global competition to stimulate innovation and integration of precision diagnostic technologies helping consumers make their own reliable diagnosis anywhere, anytime.

Dr David McEneaney, Consultant Cardiologist is a member of a team of finalists led by Professor James McLoughlin with Dr Mary Jo Kurth, Randox and Mr Michael Caulfield, Intelesens also involved. The formal announcement of finalist teams was made on 27 August 2014 in Chicago when it was anticipated the Awards Ceremony would be in January 2016. However in December, 2015 it was announced that the Qualcomm Tricorder Xprize had been officially extended to early 2017, providing the finalist teams additional time to make adjustments to their tricorder devices. The period from December 2015 until August 2016 will be a requalifying round and the final round will be from September 2016 until early 2017 when the Awards Ceremony will now take place.

The Team was one of ten finalists out of several hundred applicants and the device is a non-intrusive, wearable, wireless health monitors which has been in development for ten years.

3.6 UK Policy Framework for Health and Social Care Research

The four United Kingdom Health Departments have issued the UK Policy Framework for Health and Social Care Research for public consultation with a closing date for the receipt of comments by 24 March 2016. The Framework will replace the Policy issued in February 2007.

4 Emergency Planning/Business Continuity

4.1 Pandemic Plans

Reporting arrangements have been implemented through this report to allow Directors and Trust Board to monitor the review and testing of plans in line with requirements (Controls Assurance Standard 5.11 : Are the organisation's updated plans validated and tested through regular review and exercises?). The inventory of pandemic plans is provided in Appendix A.

4.2 Business Continuity

The Trust is required to have business continuity measures in place to enable it to anticipate, prepare for, prevent, respond to and recover from disruptions to a pre-defined level, whatever their source and whatever aspect of the business they affect.

Controls Assurance Standards require the Trust to provide evidence that appropriate plans are in place and that business continuity management measures form part of the organisation's core business and are not just an adjunct to it.

A corporate Emergency Management plan, incorporating Business Continuity is in place and is supported by a number of service/department plans. An inventory of these plans has now been compiled to facilitate monitoring of the review and testing of plans. The inventory is attached in Appendix B.

4.3 Special Incidents Plan - Chemical, Biological, Radiological, Nuclear (CBRN)

In line with DHSSPS requirements, the Emergency Planner has drafted and shared internally, a new CBRN plan to address the potential issue of contaminated casualties self -presenting at Emergency Departments. The new plan will replace the current guidance incorporated into the Acute Hospitals Major Incident Plan and will cover new guidance on the use of dry decontamination for non-caustic contaminants which Trusts are required to have implemented. The completed plan will provide clear guidance to staff who would be directly involved in responding to such incidents (security, porters, domestic services, medical and nursing staff).

The working group established to progress this work has been expanded to ensure the full requirements of the plan are now implemented. A meeting took place on 28/10/15 and a further meeting is scheduled for 19/1/16 to progress the actions necessary to complete the plan and to ensure preparedness for such incidents.

When complete, the plan will be shared with other emergency responders through the multi-agency Southern Civil Emergency Preparedness Group.

4.4 Emergency Planning Training Activity

4.4.1 Initial Operational Response

A staff training DVD on the new arrangements for dry decontamination, "Initial Operational Response (IOR)" was made available to both Emergency Departments (EDs) and was uploaded to the Trust's

e-learning platform. The short film clearly demonstrates how casualties or self-presenters contaminated with non- caustic chemical agents should be decontaminated. ED staff who would be involved in this process, (nursing, medical, security and receptionists) have watched the DVD as part of their training for the implementation of the new process.

IOR TRAINING - % STAFF WHO HAVE WATCHED IOR TRAINING DVD			
Date	**Total Number of Staff**	**Staff who have watched DVD**	**% of staff who have watched DVD**
7/12/15	98	53	62

4.4.2 HMIMMS (Hospital Major Incident Medical Management & Support)

Trust Staff continue to be nominated to attend relevant courses as they are arise (e.g. Hospital Major Incident Medical Management & Support, Major Incident Medical Management & Support). Another course will run in February and nominations have been sought from the Acute Directorate.

4.5 Evacuation and Sheltering Guidance

In line with DHSSPS requirements, a working group was established in 2014 to develop an Evacuation and Sheltering plan for the two acute hospitals. The plan is now complete and will be presented to SMT and Trust Board for approval, after which it will be uploaded to the intranet and shared with relevant staff. Wards and Departments are now being asked to develop their own evacuation and sheltering plans.

The Emergency Planner will also share the plan with multi-agency colleagues through the Southern Civil Emergency Preparedness Group.

In 2016, the acute Hospital Evacuation and Sheltering plan will be used as a template for the development of evacuation and sheltering plans for non-acute hospitals and Trust residential facilities. The plan will also be shared with independent sector providers.

4.6 Incidents

The heavy rainfall over the Christmas and New Year period caused flooding in parts of the Southern area, affecting peoples' homes in Portadown, Poyntzpass and Newry and the carpark of Portadown Health Centre. Community services to some clients were affected and staff had to implement business continuity arrangements to ensure client welfare and safety Staff are to be commended for their efforts to maintain services during periods of severe weather conditions.

There was a huge amount of co-operation between agencies to try and mitigate the impact of Storm Frank and the subsequent rainfall and the Southern Civil Emergency Preparedness Group teleconferenced on a regular basis to ensure the provision of timely information and updates to agencies.

4.7 Resourcing

Emergency Planning has been funded for temporary Administrative support up to 31/3/16. The post holder commenced on 26 October and amongst other things has been assisting with the:

- implementation of Emergency Planning performance management arrangements
- Updating Emergency Planning action plans
- Sourcing and ordering of Emergency Planning supplies
- Ensuring Emergency internal and external contact details are updated
- Liaising with directors and Emergency Support Centre Manages to update on-call rotas

5 Appendix A Inventory Of SHSCT Pandemic Plans at 18th January 2016

Directorate	Service	Name of Plan	Plan Owner	Date Created	Date of Last review	Date of Next Review
HROD	All HR services	Pandemic Flu Planning	Vivienne Toal	July 2014	TBA	
	Systems	E-recruitment	SEE BUSINESS CONTINUITY PLANS		TBA	E-recruitment
		Nurse Bank System				
		HSC E-locums				
MHLD	Statutory Day Care	Station Road Resource Centre, Armagh Binnion Resource Centre, Kilkeel Manor Resource Centre, Lurgan Copperfields Resource Centre, Banbridge	Bronagh McKeown	Feb 2012	TBA	
	Transport	Early Pandemic Action Plan	Barry Collins	16/3/12	12/1/16	12/1/17
	Mental Health, Learning Disability and Physical and Sensory Disability Services and SHSCT Transport	Draft Business Continuity during Swine Flu Surge	?	28/10/09	TBA	
OPPC	Statutory Day Care	Pandemic Flu Planning BCP and Guidance Meadows , Crozier Lodge and Edenderry day centres. Lisanally,, Clogher & Keady Day centres Orchard day centre and Donard day centre	Tierna Armstrong	March 2012	April 2015	April 17
	Statutory Residential Homes	Pandemic Flu Planning for Cloughreagh House ,Slieve Roe,Crozier House ,Roxborough House		March 2012	April 2015	April 2017
	Trust Domiciliary Care Service	Domiciliary Care Continuity plan	Claudine mc comiskey	March 2012	December 2015	April 2017
	Care bureau	Care bureau continuity plan	Claudine mc comiskey	April 2014	April 2015	April 2017
CYP	Children's Residential Homes	Children's Residential Homes – Swine Flu Pandemic Plan.	?	Mar 2012	TBA	
	AHP's	Child Health & Disability Division Business Contingency plan - Actions for AHP's - Preparation Stage	Pauline Douglas	Mar 2012	May 2015	May 2017
Acute	Medicine & Unscheduled Care Surgery & Elective Care	Acute Programme of Care - PLANNING FOR PANDEMIC INFLUENZA IN:		Feb 2012	TBA	

	Integrated Maternity & Women's Health Cancer & Clinical Care Pharmacy Functional Support Social Work	Medicine & Unscheduled Care Surgery & Elective Care Integrated Maternity & Women's Health Cancer & Clinical Care Pharmacy Functional Support		Sept 2012		November 2015
	Support Services	AFC Terms and Conditions & Payment Arrangements for 7 day Working - Pandemic Flu Plan				
		Acute Catering Services Contingency Plan (CAH, DHH, Lurgan, STH, Mullinure , Bluestone & Coffee Bars)				
		Laundry Services Contingency Plan	Kate Corley	2008	Annual	Nov 2016
		Sterile Services Contingency Plan				
		Escalation Plan for Domestic Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone)	Anne Forbes	Sep 2011	Annual	Oct 2016
		Escalation Plan for Domestic Services in Non In-patient Community Facilities	Sandra McLoughlin	Jul 2012	Annual	Oct 2016
		Escalation Plan for Security and Portering Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone)	Kate Corley	May 2009	Annual	Nov 2016
		Escalation Plan for Switchboard, CAH	Kate Corley	Sep 2011	Annual	Nov 2016
		Contingency Plan in Event of Total Failure of Referral & Booking Centre				
		Contingency Plan for Health Records in SHSCT	Kate Corley	Sep 2011	Annual	Nov 2016
		Contingency Plan for Admin Services in ED				
			Anne Forbes	Sep 2011	Annual	Oct 2016
			Anita Carroll/Katherine Robinson	August 2012	Bi-annual	Oct 2016
			Helen Forde	August 2010	Annual	Aug 2016
			Helen Forde	Jan 2015	Annual	Jan 2016

6 Appendix B Inventory Of Business Continuity Plans For Trust Services at 18th January 2016

DIRECTORATE	SERVICE	NAME OF PLAN	PLAN OWNER	CREATED	REVIEW SCHEDULE	LAST REVIEWED	NEXT REVIEW	LAST TESTED
ACUTE	Support Services	Acute Catering Services Contingency Plan (CAH, DHH, Lurgan, STH, Mullinure , Bluestone & Coffee Bars)	Kate Corley	2008	Annual	Nov 2015	Nov 2016	June 2015
	Support Services	Laundry Services Contingency Plan	Anne Forbes	Sept 2011	Annual	Oct 2015	Oct 2016	March 2015
	Support Services	Sterile Services Contingency Plan	Sandra McLoughlin	Jul 2012	Annual	Oct 2015	Oct 2016	March 2015
	Support Services	Escalation Plan for Domestic Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone)	Kate Corley	May 2009	Annual	Nov 2015	Nov 2016	March 2015
	Support Services	Escalation Plan for Domestic Services in Non In-patient Community Facilities	Kate Corley	Sept 2011	Annual	Nov 2015	Nov 2016	March 2015
	Support Services	Escalation Plan for Security and Portering Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone)	Kate Corley	Sept 2011	Annual	Nov 2015	Nov 2016	March 2015
	Support Services	Escalation Plan for Switchboard, CAH	Anne Forbes	Sept 2011	Annual	Oct 2015	Oct 2016	March 2015
	Support Services	Contingency Plan in Event of Total Failure of Referral & Booking Centre	Anita Carroll/Katherine Robinson	August 2012	Bi-annual	October 2014	October 2016	March 2015
	Support Services	Contingency Plan for Health Records in SHSCT	Helen Forde	August 2010	A nnual	August 2015	August 2016	
	Support Services	Contingency Plan for Admin Services in ED	Helen Forde	Jan 2015	Annual		Jan 2016	
	Unscheduled Care	Emergency Department	Barry Conway		Bi-annual	October 2014	October 2016	
	Cancer & Clinical Services	Cath Lab	Simon Gibson		Bi-annual	October 2014	October 2016	
	Pharmacy	Asceptic Unit	Tracey Boyce		Bi-annual	August 2014	August 2016	
	Pharmacy	Pharmacy – Medical Gas Testing	Tracey Boyce		Bi-annual	August 2014	August 2016	
	Pharmacy	Pharmacy – Cold Storage	Tracey Boyce		Bi-annual	August 2014	August 2016	
	Pharmacy	Pharmacy Automated Dispensing	Tracey Boyce		Bi-annual	August 2014	August 2016	
	Pathology & Laboratory Services	Laboratory Services: Blood Shortages Bio computer Failure	Brian Magee Tom McFarland Kevin Duffin		Bi-annual 3 yearly Bi-annual	August 2014 June 2013 July 2014	August 2016 June 2016 July 2016	
	Cancer & Clinical Services	Imaging	Jeanette Robinson		Bi-annual	November 2014	November 2016	
	Cancer & Clinical Services	Audiology	Jeanette Robinson		3 yearly	November 2014	November 2016	
	Cancer & Clinical Services	Neurophysiology	Jeanette Robinson		3 yearly	November 2014	November 2016	

		Acute Allied Health Provision – respiratory call outs	Cathie McIlroy		Annual	November 2014	November 2015 (2015)?	November 2015?
	Maternity	Maternity Services – theatres CAH and DHH	Anne McVey Patricia McStay		Annual	November 2014	November 2015	2014 but no plan in place
	Cancer & Clinical Services	Intensive Care - CAH	Mary McGeough		Annual	November 2014	November 2015	
	Cancer & Clinical Services	Emergency Theatres - CAH and Daisy Hill	Mary McGeough		Annual	November 2014	November 2015	
HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT	HCR System Failure	HCR System Failure e– Local Operating Procedures	Karyn Patterson	18/2/11	HCR has now ceased use for general operational activity and remains live only to facilitate remaining use of live waiting lists'	September 2013 Out of Operational Use – Read only Access until April 2016		
	E-recruitment	E-recruitment System Failure Operating Procedures	Karyn Patterson		In Development – system introduced April 2015			
	Nurse Bank System	Nurse Bank System Failure Operating Procedures	Karyn Patterson / Mary Averall		In Development – system upgraded May 2015			
	HSC E-locums	HSC E-locums System Failure Operating Procedures	For SHSCT – Karyn Patterson / Karen McConville		In Development – system upgraded May 2015			
	Estates	Draft Estates Business Continuity Plan	Alan Metcalfe	Jan 2012		Feb 2015		As per Trust test in 2014
PERFORMANCE & REFORM	Informatics	Business Contingency / Continuity Plan (Information Management, Information Systems, ICT, Informatics, Corporate Records, ITS Programme Managements)	Siobhan Hanna	Jan 2011	Annual	January 2015		-
	Informatics	Business Continuity Plan for Managed Print Services	Stephen Hylands	Feb 2012	Annual	December 2014		-
	Informatics	ICT Business Continuity Plan	Andrew Patterson	Nov 2009		January 2015		November 2014
	Performance & Improvement	Business Continuity Plan including flu pandemic contingency arrangements	Lesley Leeman	Mar 2012	Annual	Oct 2014		
OLDER PEOPLE & PRIMARY CARE	Domiciliary Care	CB, AD, N&M Domiciliary Care Continuity Plan V2	CB Mel Byrne AD Geraldine Rushe NM Valerie Magowan	Sept 2011	Annual	December 2015	March 2017	February 2015
	Intermediate Care, stroke and Specialist Primary Care Services.	Continuity plan and support procedures in event of a major disruption to services. . 5998766	Catherine Sheeran	Nov 2011	Annual			

	Promoting Well Being	Business Continuity Plan for Promoting Well being	Gerard Rocks Lynne Smart Carolyn Agnew	March 2013	Annual	February 2015		
	Non-Acute and Day Hospitals	Non-Acute hospitals/Day Hospitals Business Continuity Plan	Pat Nugent/Catherine Sheeran	Nov 2011		Nov 2012		
	GP Out of Hours	GP Out of Hours Business Continuity Plan VI	Cathrine Reid	Mar 2011	Annual	Mar 2012 Reviewed September 2015, and being updated		
	Adastra	GP Out of Hours Contingency Protocol if there is no Access to Adastra in the Call Centre	Cathrine Reid		Annual	June 2013 Reviewed September 2015		June 2013 September 2015
The separate Continuity Plan & Support Procedures in the event of a Major Disruption to Services for OPPC **OT.DN and Social Work are currently under review as a combined OPPC Primary Care Integrated Care Team Continuity Plan. This work is being led by Nuala Gorman Head of Service ICT**	Occupational Therapy	Occupational Therapy Service – Continuity Plan & Support Procedures in the event of a Major Disruption to Services	Nuala Gorman James Todd Miceal McParland Alicia Dickson Patrick Robinson Siobhan Macari	Nov 2011	Jan 2015.	Ongoing. Review to be completed by 30.06.15		
	Memory Service	Memory Service- Continuity Plan & Support Procedures in the event of a major disruption to services V3	C&B Shane Caldwell A&D Siobhan Donaghy N&M	Nov 2011				
	Physiotherapy Service	Physiotherapy Service continuity plan & Support Procedures in the event of a major disruption to services	Teresa Ross	July 2012			May 2015	
	Care Bureau	Care Bureau Service – Continuity Plan & Support	Claudine	March 2014		April 2015	April 2017	

		Procedures in the event of a major disruption	McComiskey					
	Residential Care Homes	BCP for Crozier House, Roxborough House, Slieve Roe, Cloughreagh		Jan 2012 Jan 2011	annual	April 2015		Desk top test 11/12/13
	Access & Information Service	Access & Information Contingency Plan	Mairead Kirk	March 2012	Annual	Nov 2015	May 2016	18/11/2015
	Daycare Centre Service Continuity Plan	BCP Meadows, Crozier Lodge & Edenderry Lisanally, Keady & Clogher, Donard & Orchard	Tierna Armstrong	April 2011	Annual	April 2015		Desk top test 11/12/13
	Nutrition & Dietetic Service	Nutrition & Dietetic Service – Continuity Plan & Support Procedures in the event of a Major Disruption to Services V3	Mandy Gilmore	Nov 2011		Dec 2014		
	District Nursing Service	District Nursing Service – continuity Plan & Support Procedures in the event of a major disruption to services V3	Nuala Gorman James Todd Miceal McParland Alicia Dickson Patrick Robinson Siobhan Macari	Nov 2011	Jan 15	Ongoing. Review to be completed by 30.06.15		
	Social Work/Care	Social Work/Care - continuity Plan & Support Procedures in the event of a major disruption to services V3	Nuala Gorman James Todd Miceal McParland Alicia Dickson Patrick Robinson Siobhan Macari	Nov 2011	Jan 15	Ongoing. Review to be completed by 30.06.15		
	Podiatry	Podiatry Service - continuity Plan & Support Procedures in the event of a major disruption to services	C&B Denise Russell	Nov 2011		Nov 2014	May 2015	TBC
CYP	Children's & Young People's Services	Children's & Young People's Services	**TBA**			Feb 2012		
	Community Dental Services	Community Dental Services	Michelle Oliver	Sept 2008	Bi-annual	May 2015	May 2017	May 2017
	Executive Director of Social Work Responsibilities	Executive Director of Social Work Responsibilities	**Paul Morgan**	**Should be reflected in all PoC Emergency Plans**				
	Social Work Out of Hours Service (Trust Wide)	RESWS (region al emergency social work service)	Regional service 02895049000	May 2013	N/A	N/A	N/A	N/A

	Business Continuity Plan for AHP	Business Continuity Plan for AHP	**Pauline Douglas**		Bi-annually	May 2015	May 2017	May 2017

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

Minutes of a meeting of the Governance Committee held on Tuesday, 8th December 2015, at 10.00 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Dr R Mullan, Non Executive Director (Chairman)
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs S Rooney, Non Executive Director

IN ATTENDANCE:

Mrs P Clarke, Interim Chief Executive
Mr K Donaghy, Director of Human Resources & Organisational Development
Mrs E Gishkori, Director of Acute Services
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Mrs A Magwood, Acting Director of Performance and Reform
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr R Wright, Medical Director
Mrs M Marshall, Assistant Director, Clinical and Social Care Governance
Mrs M McClements, Assistant Director of Older People's Services
Dr T Boyce, Director of Pharmacy
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary (Minutes)

1. **WELCOME AND APOLOGIES**

Dr Mullan welcomed those present to the meeting. An apology was recorded from Mrs A McVeigh, Director or Older People and Primary Care.

2. DECLARATION OF INTERESTS

Dr Mullan asked members to declare any potential conflict of interests in relation to items on the agenda. None were received and the business of the meeting proceeded.

3. CHAIRMAN'S BUSINESS

None.

4. MINUTES OF MEETING HELD ON 8TH SEPTEMBER 2015

The Minutes of the meeting held on 8th September 2015 were agreed as an accurate record and duly signed by the Chairman.

5. MATTERS ARISING FROM PREVIOUS MINUTES

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

6. CORPORATE RISK REGISTER

Members considered the Corporate Risk Register (CRR). There are currently 22 risks, 12 high level and 10 moderate level. Members noted 1 new risk to the Register, 'Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital'.

In light of the aforementioned new risk, Mrs Mahood asked for assurance regarding recruitment in other key areas. Mr Rice updated in terms of nursing recruitment and advised that the regional piece of work he had been tasked to undertake was now complete and would be presented to the regional advisory committee within the next few days. Mr Morgan advised there were no issues to report under Children and Young People's Services.

Dr Mullan drew member's attention to page 12 and asked about, longest waits, some going back as far as 2011/12. Mrs Magwood acknowledged the high volume and explained that long waiters could be on a list for a number of reasons. She confirmed that all Urology

patients for 2011/12 and 2012/13 have been validated and those waiting from 2011/12 have all been offered an appointment date. Mrs Magwood advised that the Trust has been engaging with GPs in an effort to progress this issue. Mrs Clarke acknowledged this to be a long-standing challenge and stated that practice has changed with regards to the discharge and referral process to seek to avoid long review waits going forward. Additional sessions are being delivered to enable consultants to dedicate time to see these long wait patients.

In response to a point raised by Mrs Rooney in relation to the wording of risk 2, page 12, Mrs Magwood agreed to re-visit the wording used.

7. MEDICINES GOVERNANCE REPORT

Members noted the content of the Medicines Governance Report. During the first quarter of 2015/16, 394 medication incidents were reported within the Southern HSC Trust. The average number of reported medication incidents each month was 131 per month, representing an increase from 74 per month in the previous quarter. This spike is due to an educational audit carried out in May 2015, where pharmacists reported every prescribing incident they detected during one week. Dr Boyce welcomed the audit and the learning being taken forward. Following a question from Mrs Mahood, Dr Boyce explained that constraints on pharmacists time do not permit such an audit to be carried out on a weekly basis, but gave assurance that high level auditing processes were in place.

Mrs Rooney asked if medication incidents at ward level where reported and captured. Dr Boyce assured members that medication incidents at ward level are recorded by the clinical member of staff that identifies them and these are recorded onto the datix system using an IR1 form. She went on to explain that on the Acute wards the Governance facilitators or the Heads of Service review each ward's incident reports with the ward manager each month. In addition, the Director of Pharmacy and the Medicines Governance pharmacist review every Trust medication incident each month to look for patterns and trends, which are then fed back through each Directorates Governance system. Dr Wright acknowledged the difficulties around clarifying criteria and stated that direct and immediate feedback is key to moving forward. In conclusion, Mr Rice

emphasized that we need to become more sophisticated in relation to how we extract data from the auditing process.

Dr Boyce left the meeting at 10.45 a.m.

8. CLINICAL AND SOCIAL CARE GOVERNANCE

i) Revisit of Clinical & Social Care Governance – update on progress

Dr Mullan welcomed Mrs Marshall, to deliver a presentation, updating members on the revisit of Clinical & Social Care Governance within the Southern Trust. She began by reminding members that in April 2015, the Interim Chief Executive requested a revisit of the outcomes of the 2010, SHSCT Review of CSCG, to provide Trust Board with an assurance that these arrangements remain effective and robust and to consider how we can best improve. At the outset, of the process, learning from a number of external reviews was considered. Views from a range of senior stakeholders were also sought to inform the process and a number of areas for improvement were identified. Members noted the Action Plan included within the report, taking recommendations forward.

Mrs Marshall referred to the proposed C&SCG reporting arrangements. She guided members through each of the 4 initial indicators agreed by SMT: SAIs, Incidents, Complaints and Standards and Guidelines (S&G) and explained that trends were being classified in relation to complaints and SAI's.

Ms Blakely arrived at this point 11.00 a.m.

Members welcomed the presentation, which they felt was extremely useful alongside the report. In terms of progression, Mr Graham stated that he welcomed the work on trend analysis, something the organisation has not embarked on before. Mrs Clarke reiterated the previous comments and stated that this piece of work would inform the way forward in terms of a corporate approach to how assurance is provided in respect of risk, patient safety and improvement priorities.

Both Mr Rice and Dr Wright referred to the DATIX complaints codes and commended the work undertaken by Mrs Marshall and her team to date, adding that this work would be welcomed by regional colleagues. Concerns were raised regarding the challenges in the area of Standards and Guidelines and in particular, Mrs Rooney noted the quantity of S&Gs brought forward by the DHSSPSNI and the huge amount of work created for staff.

Mrs Kelly asked about the expected timeframe for completion of the review and also queried if a 5 year cycle was too long. In response to the first point, Mrs Marshall reminded members that this is a work in progress and advised that she would envisage being in a position to provide further richness of information within the reports to Governance Committee by the next meeting in February 2016. The new system for the administration of S&Gs should also have commenced by this date. Mrs Clarke responded to Mrs Kelly on the 5 year cycle and stated that she was of the opinion, this should be a rolling process. With good systems and processes in place, this would enable concerns to be raised and taken forward.

Dr Mullan thanked Mrs Marshall for delivering a very informative overview of the review of C&SCG, acknowledging it would take some time to embed into the organisation. In conclusion, Mrs Marshall recorded her thanks to Mr Wallace and the Governance Co-ordinators for their expertise and support throughout the review.

ii) **Clinical and Social Care Governance Dashboard**

a) Incidents and Complaints
b) Ombudsman Cases
c) Serious Adverse Incidents
d) Standards and Guidelines

Members considered the content of the proposed report format and were reminded that this format will require further development to incorporate information on how Directorates are

implementing learning from incidents, SAI and complaints through existing work streams/quality improvement activities. Appendix 1, Proposal for classifying Trust Serious Adverse Incidents and Appendix 2, Proposal for classifying Trust Complaints was included for member's information.

iii) **Annual Complaints Report 2014-15**

Mrs Marshall presented an overview of complaints within the Southern Trust for the 2014/15 financial year. The Trust received 1166 formal complaints (by subject) within the period, an increase on the previous year's figures. A further 298 subjects were noted on an enquiry or informal basis. Members welcomed the detail included for information.

9. **PROFESSIONAL GOVERNANCE REPORTS**

i) **Medical Director**

(a) Audit of Documentation for 2013 Appraisal Round

Dr Wright presented a detailed analysis of SHSCT Medical appraisal documentation and feedback questionnaires, received for the 2013 appraisal round and a comparison of 2012 results, along with recommendations for improvement. Members welcomed the detail within the document and the overall improvement recorded between 2012 and 2013 comparisons.

Dr Wright referred to the National Review of Revalidation being taken forward by the General Medical Council (GMC) and stated that new recommendations will evolve from this process. In conclusion Mrs Clarke commended the Trust's appraisal system and advised of a request to present it regionally.

(b) SHSCT Mortality Reports

Dr Wright presented the SHSCT Annual Mortality Review for i) period April 2013 to March 2014 and ii) period July 2013 to

June 2014. He began by pointing out that addendums have been produced by CHKS, relating to the data quality sections of these reports but given the low impact of the new data the Trust and CHKS have agreed there would be no gain by rerunning the reports.

Dr Wright referred to an ongoing regional piece of work and possible changes in future reporting. He advised that the Trust would continue to engage with the DHSSPSNI on this. In terms of performance, Dr Wright commended the Trust's position within the 'CHKS Top UK Hospitals' group. Members welcomed the reports and the progress recorded.

10. RQIA STATUS UPDATE REPORT

Members considered the detail within the report for the period 1 July 2015 – 30 September 2015. Mr Morgan referred to the RQIA visit to Neonatal Unit in CAH for the second year's audit. He advised that the Trust were awaiting the final written report, however initial verbal feedback from RQIA Inspectorate team was positive.

11. CARERS ACTION PLAN UPDATE

Mr Graham, as the designated Board member for carers introduced the report.

Mrs McClements presented the update, based on the current Southern Trust Carers Action plan for the period April 2015 – March 2016. She began by highlighting Carers Matter and spoke of the pressures being experienced, due to the sickness absence of key staff. Mrs McClements drew member's attention to page 11 of the report, and updated on progress achieved. She spoke of the submission of an IPT for Self-directed support (SDS) and welcomed the £75k funding, agreed recurrently from 2016/17 for carers. Mrs Rooney referred to the cash grant scheme 2014/15 on page 10 of the report and welcomed the £69,343, from which 488 Carers benefitted from Carers grants.

In conclusion Mr Graham thanked Mrs McClements for an informative update and reminded members of the ongoing challenges in providing support to both services users and those who are in the caring role.

12. **SIRO INFORMATION GOVERNANCE REPORT**

Mrs Magwood presented the above named annual report, advising that it provided a summary of the key aspects of the role undertaken by the Senior Information Risk Owner (SIRO).

Mrs Magwood referred to the Northern Ireland Electronic Care Record (NIECR) and the need for clarity around the sharing of information with 3rd parties etc. Mrs Clarke advised that she had corresponded on a number of occasions with Dr Harper, Public Health Authority (PHA), concerning information governance issues. Members noted that a short-life working group, chaired by Dr Harper has been set up to take issues forward. The Trust is also seeking additional legal advice that will inform the working group.

13. **FREEDOM OF INFORMATION, ENVIRONMENTAL INFORMATION AND SUBJECT ACCESS REQUESTS – SUMMARY REPORT FOR THE PERIOD 1.7.2015 – 30.9.2015**

Mrs Magwood presented the summary report for the period 1 July – 30 September 2015. A total of 64 requests were received and responded to in this period and of these 44 were processed within the 20 day deadline and 14 processed outside of the 20 day deadline. Members noted that the majority of requests were received from the public, businesses and the media. Details of the individual requests for information are included within the report.

Mrs Magwood drew members' attention to additional information on Subject Access Requests included within the report for the first time, for the period 1 July – 30 September 2015. A total of 80 requests were received and responded to in this period and of these 68 responses were processed within the 40 day deadline and 12 processed outside of the 40 day deadline. The majority of Data Protection Act information requests were received from the public, insurance companies and family members.

Members acknowledged the continued challenges in dealing with the volume and complexity of these requests.

14. **LEADERSHIP WALKS REPORT**

Members considered the Leadership Walks Report for the period 1 January 2015 – 30 September 2015. A total of 12 leadership walk arounds were undertaken by Board members within the period.

15. **NON-EXECUTIVE DIRECTOR'S VISITS TO CHILDREN'S HOMES REPORT**

Mr Morgan presented the above named report. During the period April 2015 – September 2015, a total of 15 Children's Home visits were undertaken by Board members. Four key themes were identified, details of which are included within Appendix 1 of the paper.

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

Mr Graham, Chair of the Patient and Client Experience Committee provided a verbal update on the meeting held on 3rd December 2015. He referred to the raising PPI panel membership within the Committee and welcomed the good engagement and valuable input they provide. Mr R Dixon, attended the meeting and updated members on the work of the Patient Client Council.

17. **ANY OTHER BUSINESS**

Mr Morgan advised that the Minister for Health, Social Services and Public Safety, will make a statement on 10 December 2015 advising of the outcome of the Child Sexual Exploitation (CSE) SBNI Thematic Review. Mr Morgan assured members that young people under the care of the Trust have been versed and support from staff has been put in place.

Dr Mullan paid tribute to fellow Non-Executive Director colleagues, Mrs Kelly and Mrs Blakely. He recorded thanks to both, for their

commitment and constructive contribution over the past number of years and wished them well for the future. On behalf of the Governance Committee, Dr Mullan expressed deepest sympathy to Mr McNally, Director of Finance and Procurement on the tragic death of his brother.

The meeting concluded at 12.45 p.m.

SIGNED: _____

DATED: _____

SOUTHERN HEALTH AND SOCIAL CARE TRUST

ANNUAL REPORT & ACCOUNTS

FOR YEAR ENDED 31 MARCH 2016

SOUTHERN HEALTH AND SOCIAL CARE TRUST

ANNUAL REPORT & ACCOUNTS

FOR YEAR ENDED 31 MARCH 2016

Laid before the Northern Ireland Assembly under Article 90(5) of the Health and Personal Social Services (NI) Order 1972 (as amended by the Audit and Accountability Order 2003) by the Department of Health, (formerly known as the Department of Health, Social Services and Public Safety)

on

26th August 2016

SOUTHERN HEALTH AND SOCIAL CARE TRUST

ANNUAL REPORT & ACCOUNTS FOR YEAR ENDED 31 MARCH 2016

Contents Pages

SOUTHERN HSC TRUST

ANNUAL REPORT AND ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

FOREWORD

These accounts for the year ended 31 March 2016 have been prepared in accordance with Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, in a form directed by the Department of Health, Social Services and Public Safety.

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COMMENTS

If you have any comments about this report or would like extra copies please telephone Irrelevant information redacted by the USI

DIFFERENT FORMATS

This report can be made available on request in large print, on disk, via email, in Braille, on audiocassette or in minority languages for anyone not fluent in English. Telephone: Irrelevant information redacted by the USI.

SOUTHERN HSC TRUST

PERFORMANCE REPORT

OVERVIEW

Message from Chair and Interim Chief Executive

All of us who work in health and social care are very much aware that the pace of change, and increasing demand for our services, continues to present significant challenges to those responsible for delivering care.

As we reflect on yet another busy year, it is only right that we acknowledge the efforts of the over 14,000 staff who are engaged in health and social care in this area.

There are over 369,000 people living in the Southern Trust area – and virtually everyone who lives here will come into contact with our staff at some point during the year.

It might be in hospital, through care at home, in day care, being supported by mental health services – it might be for a few minutes, it might be for weeks or months - but no matter where, or for how long, what every member of staff brings to the service is vital to our success.

There is no doubt that once again our staff have risen to the challenges we face – and have not only met those challenges, but have demonstrated on a regional and national level, that the work we do here is amongst the best in the UK.

We are proud to once again have this opportunity to report on the many achievements across the Trust this year, to acknowledge the challenges we face and to look forward to a changing health and social care environment that will, no doubt, present many opportunities for development in the year ahead.

Any visitor to our acute hospital sites at Daisy Hill in Newry and Craigavon Area Hospital will notice how much development work is going on at both sites.
Our plans to modernise hospital services for children and young people are now well underway, with major construction work on both sites. The Department of Health has supported our plans with an investment of £14.5m on a new, dedicated children's surgical centre at Daisy Hill and a new children's centre on the Craigavon site.

We have also celebrated the official opening of the Banbridge Health and Care Centre and Day Care Facility, by Health Minister, Simon Hamilton. It's a fabulous new building, providing a wonderful environment for adults with a learning and physical disability and a range of health and social care services for the local community.

Staff, patients and visitors to Craigavon Hospital have been very tolerant while we carried out some essential maintenance work in the wards. It was a huge effort from everyone to complete the work in such a short time, so great credit must go to all those involved in improving the ward environments for the benefit of our patients.

Our Learning Disability Crisis Response team, the first of its kind in Northern Ireland, has been recognised nationally as an example of positive practice, and is now a model for the development of services elsewhere in Northern Ireland.

The Trust's 'Acute Care at Home' service is now offering hospital care to older people either in their own house or nursing/residential home and has been getting well deserved national recognition for this excellent initiative. Our Quality Improvement Day in October showcased this service and so much more that the Trust does well and was a credit to all who took part.

Many of our staff have been recognised both regionally and nationally for their work and we are very proud of their achievements, all of which contribute to ensuring we deliver excellent care. Two highlights have been the award for UK Radiography Team of the Year and the multi -award winning project to raise awareness of the signs and symptoms of lung cancer – there are too many winners to personally acknowledge here but you will see examples of ground-breaking work elsewhere in the report.

We continue to work closely with our partners outside the Trust. The Councils in the Southern Trust area have reduced from five to three – Armagh, Banbridge and Craigavon; Mid-Ulster and Newry, Mourne and Down. While there are some new faces, our working relationships remain strong and we continue to liaise closely with our colleagues on improving the health and well-being of our population.

Our staff have chosen to support Marie Curie as Charity of the Year. The enthusiastic response of our staff is a reflection of their generosity and their commitment to others – we look forward to the Southern Trust 'Strictly Come Dancing' event later this year.

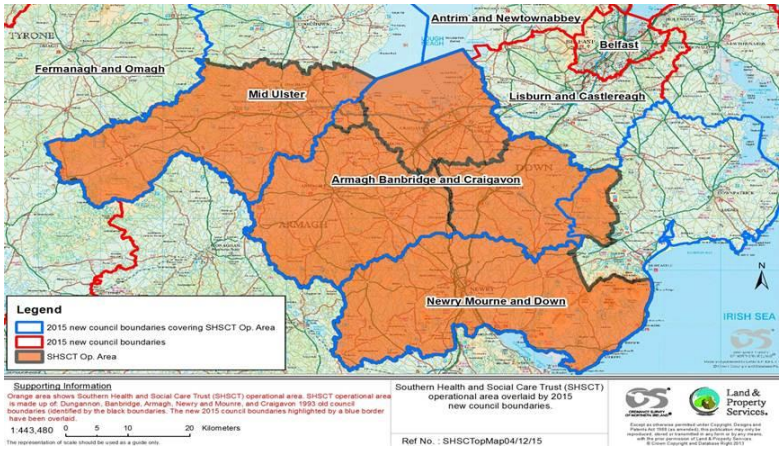
Next year will bring many challenges - a changing political environment, increasing patient and client numbers, financial pressures and a growing population in the Southern Trust.

It is critical to our future success that we have the skills, expertise and a quality infrastructure to support the high level of care we want to deliver – we remain committed to driving forward improvement, investing in our staff, continually enhancing the experience of the population we serve and being recognised as a high performing Trust.

About the Trust

The Southern Health and Social Care Trust was formed on 1 April 2007 following the Review of Public Administration.

Location and type of facilities provided



The Trust provides integrated health and social care services to the council areas of Armagh, Banbridge and Craigavon; Mid-Ulster and Newry, Mourne and Down.

The Trust provides a wide range of hospital, community and primary care services. Main in-patient hospital services are located at Craigavon Area Hospital and Daisy Hill Hospital. Working in collaboration with GPs and other agencies, staff deliver locally based services in Trust premises, in people's own homes and in the community. The Trust purchases some services including domiciliary, residential and nursing care from independent and community/voluntary agencies.

Population

Age	Population
0-14	79,208
15-64	221,033
65+	69,150
Total Population	**369,391**

Key Financial Facts

In 2015/16 the Trust incurred gross expenditure of £615m**.** The Trust employs around 9,893 (whole time equivalent) staff and manages an estate worth £304m.

Our Vision

To deliver safe high quality health and social care services, respecting the dignity and individuality of all who use them.

Our Values

We will:

- Treat people fairly and with respect;
- Be open and honest and act with dignity;
- Put patients, clients, carers and community at the heart of all we do;
- Value staff and support their development to improve our care;
- Embrace change for the better; and
- Listen and learn.

A year across the Southern Health and Social Care Trust

April

- The final phase of a major £15.5 million redevelopment of the main theatres at Craigavon Area Hospital was completed. Work began on the ambitious projects in May 2011 and completion of this final phase means that the hospital's main theatre department meets the highest modern quality standards.
- Two new theatres were constructed as part of the scheme which also included the refurbishment of existing theatres.

May

- Trainee anaesthetists from the Southern Health and Social Care Trust scooped the top three places in the prestigious Dundee Medal competition organised by the Northern Ireland Society of Anaesthetists.
- Two Anaesthetic Registrars based at Craigavon Area Hospital, Dr Stephen Cullen and Dr Alison Blair, came joint first place whilst Staff Grade, Dr Jill Cochrane, who works at Daisy Hill Hospital, took second prize at the annual awards in memory of Professor John W. Dundee OBE.

June

- The Craigavon Area Hospital team of physiotherapists was the first in the UK to introduce ground breaking aquatic therapy to treat critically ill patients.
- One patient who took part in the pioneering treatment was 27 year old Gareth Galway who, due to Guillain-Barré Syndrome, had complete paralysis and respiratory failure. Following seven weeks in Intensive Care, Gareth benefitted from aquatic therapy, improving his mobility and assisting greatly in his recovery.

- Following a successful fundraising partnership with the Southern Area Hospice, this year staff nominated Marie Curie as the Trust's Charity of the Year. The enthusiasm and generosity of staff is already evident, with thousands of pounds already raised.

August

- The Southern Trust's Learning Disability Crisis Response Team received national recognition as an example of Positive Practice in the 'Strengthening the Commitment: Living the Commitment' National Report. This Crisis Response Service is the first of its kind in Northern Ireland and helps adults with learning disabilities avoid a hospital admission in a time of difficulty. It has also been identified by the Health and Social Care Board as a model upon which similar services are to be established regionally.

September

- We introduced a new web based system to help improve the way information from the Endoscopy Service is recorded. Prior to this around 80 staff and 300 patients across Daisy Hill, Craigavon and South Tyrone Hospitals had to complete paper surveys each year which had to be manually collated and summarised. The new electronic solution is much easier and more convenient to complete and the anonymous feedback is immediately submitted and automatically summarised.

October

- Our consultant-led 'Acute Care at Home' service began offering hospital care to older people either in their own house or nursing/residential home. In its first year, the pilot service has prevented around 400 hospital admissions and has supported a much earlier discharge for about 100 people.

November

- Radiology staff at Daisy Hill Hospital welcomed a major upgrade to their department. The £485,000 investment in digital technology follows an initial upgrade in 2014 so the entire department is now operating from a digital platform, as part of on-going modernisation of our hospital services.

December

- Daisy Hill was the first hospital in Northern Ireland to trial a new baby heart screening test. The paediatric team worked closely with their maternity colleagues to introduce a routine oxygen saturation test for all new babies before they are discharged home.

January

- On Monday 25 January 2016, the new £16 million Health and Care Centre and Day Care facility in Banbridge officially opened for business.

- The new centre, which includes the Linenbridge Day Care Centre for clients with physical and learning disabilities, is conveniently based beside local GP practices on the Health Village site. It brings three previous facilities together into a modern, purpose-designed centre, providing a superb environment for a wide range of patients and clients.

February

- Construction got underway on the £14.5 million plan approved by the Department of Health, to modernise hospital services for children and young people across the Trust. The development will see all planned paediatric surgery for the Trust centralised to a new £7.9m paediatric centre at Daisy Hill and a further £6.6m used to build a new paediatric centre on the Craigavon Area Hospital site.

March

- We are now smoke free. Since 9 March, 2016, smoking and the use of e-cigarettes is no longer permitted on any of the Trust sites (i.e. entrances, doorways, walkways, buildings, internal roads, bus shelters, car parks, cars, bicycle shelters etc.)
  The new policy applies to all staff and volunteers, patients, visitors, contractors and anyone who enters the Trust's hospitals, buildings and grounds.

- Also in March, the Trust hosted the launch of a new regional service to improve the treatment of people with cancer .
  Consultant in Respiratory Medicine, Dr Rory Convery, explained how the Acute Oncology Service improves patient safety and the overall care for people with cancer.

- One of our patients, Mr Samuel Keers from Dromore shared his experience of the service, and was profiled on BBC Newsline.

- The finale to our year saw Health Minister Simon Hamilton MLA move the Helicopter Emergency Medical Service (HEMS) and the major trauma network a step closer to implementation.
- The Minister, during a visit to Craigavon Area Hospital, announced the key findings of the HEMS consultation including the management and funding models, home base location, target patient groups and collaboration with other services.

Staff Highlights 2015/16

One of our most important resources here at the Southern Trust is our staff and in 2015/16 it was great to see the following receive national recognition:

Angela Gemmell, Lead Physiotherapist currently working in Care of the Elderly Wards at Lurgan Hospital, picked up a Chartered Society of Physiotherapy (CSP) Excellence Award at the CSP's Annual Awards, for demonstrating patient involvement. Every year the CSP Awards recognise excellence and best practice throughout the physiotherapy profession and across the whole membership.

Donna McLoughlin, a midwife based at Daisy Hill Newry, has been honoured as the Emma's Diary Mums' Midwife of the Year 2016 for Northern Ireland. Donna was nominated by Aine Cunningham, a local mum and a midwife herself. The award is one of The Royal College of Midwives (RCM) Annual Midwifery Awards, recognising the work done by midwives across the country.

Two Biomedical Scientists from the Southern Health and Social Care Trust have recently gained their Higher Specialist Examination, a professional qualification from the Institute of Biomedical Science.

Mairead Caraher who specialises in Haematology and Graham Scott, in Transfusion Science, are the only two to hold this award in their respective fields in Northern Ireland.

A number of our staff were recognised at the prestigious Institute of Health Care Management Awards.

Consultant Geriatrician Dr Patricia McCaffrey won the Medical Leader of the Year and Kay Carroll, Head of Service for Cardiology, was awarded with Manager of the Year.

Head of Physiotherapy Teresa Ross, was shortlisted in the Allied Health Professional Manager of the Year category; the Rapid Access Respiratory Clinic was shortlisted for the Regional Excellence and Quality Award; Speech and Language Therapy Manager, Vivienne Williamson and Information Communications Technology Training Manager, Anna-Marie McCreanor, were both shortlisted in the Manager of the Year category.

Allied Health Professionals from the Southern Health and Social Care Trust have been recognised amongst the best in Northern Ireland at the 2016 Advancing Healthcare Awards.

The Macmillan Award for Rethinking the Patient Pathway and over all Award Winner at the prestigious event went to Craigavon Area Hospital Radiographers Janet Eagle and Helena Kincaid for their redesign of the diagnosis and treatment of fertility problems in women.

Dietitians were finalists in two categories: Head of Nutrition and Dietetics, Mandy Gilmore, and Community Dietitian, Elizabeth O'Connor, for developing the 'Health Call Under Nutrition Service' which is a remote monitoring service for adults at risk of malnutrition in care homes, and Specialist Dietitians, Vanessa McMinn and Wendy Murray, for the X-PERT group patient education programme for people with Type 2 Diabetes.

Physiotherapist Cathy McKeown was recognised as a finalist for developing a Falls Pathway alongside Northern Ireland Ambulance Service colleagues. Dietitian, Elizabeth O'Connor, and Physiotherapist, Annette Kearney, alongside midwifery colleagues contributed to a Regional project 'Weigh to a Healthy Pregnancy' which was shortlisted.

Tara Davison, Peripetetic Assessor and Julie Mullen, Physiotherapy Support Worker, were finalists for their work in developing the Allied Health Professional (AHP) workforce.

Special Recognition as a 'Rising Star' was also given to Senior Occupational Therapist, Melanie Sheenan, who works at the Memory Centre helping people living with dementia.

Congratulations also go to Learning Disability Epilepsy Nurse Specialist Sandra Wylie, Epilepsy Nurse Clare McCooe and Daytime Opportunities Worker Linda Daly who scooped the Epilepsy Award at this year's Northern Ireland Healthcare Awards.

PERFORMANCE ANALYSIS 2015/16

Achievement of Ministerial priorities

In 2015/2016 the Minister directed a number of targets for all Trusts to work towards. The targets cover all aspects of planning and delivering health and social care. The Trust has in place senior clinical and management oversight to regularly monitor progress against these and other standards that are set by our commissioner.

This year has been a challenging year for the Trust in terms of securing the level of resources needed to meet demand in the southern area. The Trust has worked closely with our local commissioner and to secure recurrent resources in a number of key areas however, significant challenges remain.

At the same time the Trust's main priority is to strive to deliver care that is safe, personal and effective and seeks to continually improve and modernise the services offered to make the best use of its resources and improve the quality and experience of our service users.

Ministerial targets look at a range of areas including for example the following:

- Time patients wait to be seen in the Emergency Department;
- How long patients wait to receive their first assessments, diagnostics tests and treatments across our hospital and community services including services for the elderly, children and those with mental health or disability needs;
- How we support our carers;
- How stable our placements are for those children the Trust cares for;
- How well we manage patients admitted with stroke or waiting for surgery for hip fractures; and
- Infection rates in our hospitals.

Our performance reports go to the public Trust Board meetings with the information published on our website at www.southerntrust.hscni.net.

This level of performance management helps us to ensure that what we do is safe, that we are making best use of our resources and meeting targets which are there to benefit patients and clients.

Emergency Department

There are two Emergency Department (ED) standards, which the Trust aims to achieve. These include seeking to ensure 95% of patients attending should be treated, admitted or discharged within 4-hours and that no patient should wait longer than 12-hours.

The Trust works hard to ensure that patients do not wait unnecessarily long times in ED, but this does happen on occasions when patients are waiting to be admitted to a

hospital bed and/or where it is deemed that there might be a clinical risk in moving the patient from ED.

Our performance in relation to the 4-hour target was 80.1% with 93 patients waiting in excess of 12 hours during 2015/16. This was in a year when the Trust's total attendances at ED increased by 4% with over 6000 more people attending than the previous year. Whilst these 93 occurrences represent only 0.1% of our total ED attendances the Trust feels strongly that this is not an acceptable time to wait and the Trust is continually working to improve our processes and performance in this area to avoid any excess waiting.

In order to support staff in the delivery of patient care within the Emergency Department, the Trust maintains both a management and a clinical presence, in and out of hours, 7 days per week. The Trust also works closely with the Health & Social Board to identify demand and capacity issues that result in increased pressures in our Emergency Departments particularly during times of peak pressures.

Access Times – Out-Patients

In 2015/2016 the Trust aimed to have 60% of its general out-patients treated within 9 weeks, with no patient waiting longer than 18 weeks. Throughout Northern Ireland the demand for outpatient services has increased and within the Southern Trust there are shortfalls in our capacity to see all patients within the timescales set, however the Trust ensures that those patients that are urgent or have suspected cancer are always given priority and seen first. The Trust continues to review opportunities to address the shortages in capacity with the Health and Social Care Board, in line with available resources. In 2015/16 39% of patients were treated within 9 weeks and 12,521 patients waited longer than 18 weeks.

Within Mental Health services, the Trust aimed to have no patients waiting longer than 9 weeks for adult services, children and adolescent services and for dementia services and no patients waiting longer than 13 weeks for access to psychological therapy services. Our performance during 2015/16 demonstrated 81 adults and 69 dementia patients waiting longer than 9 weeks and 10 patients waiting longer than 13 weeks for psychological therapies. Whilst this is an improving position for mental health services the Trust continues to work to improve this.

Access Times – In-Patients

In 2015/2016 the Trust aimed to have 65% of in-patients or patients staying as a day case treated within 13 weeks, with no patient waiting longer than 26 weeks. Our performance demonstrated that 56.3% of patients were treated within 13 weeks and that 1,552 patients were waiting in excess of 26 weeks.

The Trust has a recognised shortfall in capacity across a number of specialist areas, which has impacted on our ability to see all patients within the timescales set, however the Trust ensures that those patients that are urgent or have suspected cancer are always given priority and treated first. The Trust continues to review opportunities to address the shortfalls in capacity with the Health and Social Care Board, in line with available resources.

Support to Carers

In 2015/16 the Trust aimed to continue to increase the number of carers, offered carer assessments; the targets set for 2015/16 represent an increase of 10% from the previous year, which equates to a total of 838 assessments. The Trust acknowledged this to be an extremely challenging target in 2015/16 following on from very high performance in 2014/15 as a baseline. At the end of December 2015 the Trust had offered 693 carers assessments. Whilst additional assessments will be offered up to the end of March 2016, it is not anticipated that the full target will be met.

This offering of assessment is one part of how we support carers. The Trust has a Carers Reference Group and Forum and ensures carers are involved with its various PPI (Patient and Public Involvement) plans to include their voice in our future planning.

Children in our Care

The Trust is subject to a number of standards in relation to looking after the children in our care including the target timescale for adoption processes to complete within 3 years. The Trust's performance against these standards remains an on-going priority and is influenced by a number of external factors such as the availability of carers, timing of court processes and changes from fostering to adoptive placements.

In 2014/15, which is the most recent information available, 25% of children were adopted within 3 years, with 65% adopted between 3 and 5 years. Whilst our timescale for adoption was beyond our target overall, the Trust secured successful adoption placements for 20 children which is the highest number of children adopted through an individual Trust and represents 28% of all children adopted in Northern Ireland in 2014/15.

Management of patients in our hospitals

The Trust has a number of standards which they aim to deliver in relation to the clinical management of our patients in hospital.

Within the area of stroke, the Trust achieved its target in 2015/16 of administering thrombolysis therapy to 13% of patients who had suffered an ischemic stroke and were considered suitable for this treatment.

For people that present with a broken hip the Trust's target is to have 95% of these patients surgically treated, as clinically appropriate, within 48 hours. In 2015/16 the Trust saw a significant increase in the number of people being admitted with trauma to our Trauma & Orthopaedic service. This means that our clinicians have to decide who will benefit from treatment first dependent on their clinical condition. In 2015/16 91% of patients had surgery within 48 hours.

Infection rates

In 2015/16 the Trust aimed to continue to improve its hospital infection rates and have no more than 5 cases of the Methicillin Resistant Staph Aureus (MRSA) infection and no more than 32 cases of Clostridium Difficile (C Diff) infection in the year. During 2015/16, the Trust had 2 cases of MRSA and achieved the target however, the C Diff target was not achieved with 54 cases reported.

Infection prevention and control is one of the Trust's key quality priorities and the Trust continues to put in place a range of actions to ensure effective prevention measures are undertaken, including training for staff and raising awareness with staff, patients, visitors and the public.

Southern Trust facts and figures 2015/16

The Trust spent £1.685m gross per day delivering services to local people. This was spent as follows.

During the past year:

- There were a total of 5,976 births in the Southern HSC Trust. There were 4,145 births in Craigavon Area Hospital and 1,831 in Daisy Hill Hospital;

- 84,125 people attended Craigavon Area Hospital Emergency Department and 51,267 attended Daisy Hill Hospital Emergency Department;

- A total of 28,765 people received treatment at the Minor Injuries Units at South Tyrone Hospital;

- Total Number of Outpatient Attendances – 392,790;
    - new outpatient attendances – 115,715
    - review outpatient attendances – 277,075

- Total number of inpatient admissions – 57,883;
    - Elective – 6,582
    - Non-elective – 51,301
- The Trust received 12,707 child care referrals;
- The GP Out of Hours (OOH) service received 93,769 initial patient telephone calls into the GP OOHs service;
    - 52,354 patients were assessed by a GP, Nurse or Pharmacist via telephone and provided with healthcare advice;
    - 36,265 patient appointments were provided in the Out of Hours centres at Daisy Hill, South Tyrone, Armagh, Craigavon and Kilkeel;
    - 502 patients did not attend for a booked appointment;
    - 5,150 home visits to patients were undertaken by GPs across the Trust area;
    - 203 patients chose to attend the Out of Hours centre in Castleblayney (via the Co-operation and Working Together (CAWT) cross border project);
- The Trust provides care and support through the following care packages:

Programme of Care	Residential Care	Nursing Home Care	Domiciliary Care	TOTAL
Elderly	232	763	2,903	3,898
Memory Service	135	598	644	1,377
Mental Health	52	100	431	583
Learning Disability	104	168	755	1,027
Physical and Sensory Disability	4	45	732	781
TOTAL	**527**	**1,674**	**5,465**	**7,666**

Financial Performance 2015/16

Financial Environment

In common with previous financial years, 2015/16 also proved to be a difficult period with significant financial and operational challenges facing the Trust. Staff at all levels of the organisation continued to work hard to reduce reliance on the vacancy control and other contingency measures necessary to bridge the time between funding reductions and the implementation of the reforms necessary to return the

service to a sustainable financial balance. The Trust is pleased to report that it has again delivered a breakeven position.

Financial Targets

The Trust's main funding source is its Revenue Resource Limit (RRL) from the DHSSPS. Expenditure remained within the RRL of £576m by £137k. The Trust also receives a limited amount to spend on capital, the Capital Resource Limit (CRL). It kept within the CRL of £21.4m by £310k.

The above achievements have been delivered through the concerted efforts of our staff, the continued implementation of service reform initiatives and sound financial management.

Profile of Income and Expenditure in 2015/16

As stated above, the majority of funding (94%) for the Trust comes from the DHSSPS, through the Health and Social Care Board and Public Health Authority. The remaining funding received is mainly for medical education as well as income from paying patients and clients in residential and nursing homes.

In 2015/16, this funding was spent on staff salaries (63%) and significant non-pay expenditure included 9% on clinical and general supplies such as drugs and medical supplies and a further 18% on residential, nursing and domiciliary care delivered by other organisations on the Trust's behalf.

Compliance with Prompt Payment Policy

The DHSSPS requires that Trusts pay their Non HSC suppliers in accordance with applicable terms and appropriate Government Accounting guidance i.e. it requires Trusts to pay 95% of Non HSC suppliers within 30 days of receipt of goods or a valid invoice (whichever is later). The Trust's payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is as follows (for both the number and value of payments made).

Public Sector Payment Policy (continued)

	2016 Number	2016 Value £000s	2015 Number	2015 Value £000s
Total bills paid in year	**206,478**	**273,264**	**172,426**	**224,108**
Total bills paid within 30 days or under agreed payment terms	**193,206**	**250,692**	**151,068**	**200,413**
Percentage of bills paid within 30 days or under agreed payment terms	**93.6%**	**91.7%**	**87.6%**	**89.4%**
Total bills paid within 10 days	**173,700**	**226,085**	**121,745**	**170,785**
Percentage of bills paid within 10 days	**84.1%**	**82.7%**	**70.6%**	**76.2%**

From 1 April 2015 the scope of the prompt payment compliance measurement increased to take account of all categories of supplier payments made by Trusts, with the only exception being payments made to other organisations within the broader HSCNI.

Achievement of the 30 day target of 95% is dependent both on procedures within BSO Accounts Payable Shared Service and appropriate action by Trust nominated approvers. During 2015/16 the Trust worked closely with BSO and Trust approvers to ensure an improvement in prompt payment compliance and continues this work in an effort to achieve the target of 95%.

During the year the SHSCT paid £343 interest and £210 compensation in respect of late payment of commercial debt.

Charitable Trust Funds

The Trust's Charitable Trust Fund account is, again, consolidated with the public funds account but this has no impact on the reported financial position. During 2015/16, charitable donations of £297k were received by the Trust, an increase of £57k from prior year. These funds were used to support expenditure in the following areas:

- Patient / Client / Relative / Visitor Comfort and Amenity;
- Staff education and training / skills enhancement; and
- Academic Research and Development.

Individual donors are too numerous to mention, but examples of improvements the Trust has been able to make during 2015/16 as a result of donations and legacies received include:

- The purchase of two portable machines for cardiac investigations;
- The purchase of a Stress System treadmill;
- ECG carts and cardiac monitors;
- CCTVs for visually impaired clients;
- Reflexology for patients;
- Christmas gifts for patients; and
- Flights, accommodation and course fees for staff education over and above that which would normally be provided.

Protecting the Environment

Sustainability

The Trust Sustainability Strategy 2020 incorporates the key environmental priorities for the Trust and DHSSPS Northern Ireland including the three key components of sustainability:

- Taking a holistic view of all activities and considering their environmental, social and economic implications;
- Thinking about whole life issues when planning, designing, building and maintaining the Estate; and
- Making sure that everyone thinks about the way resources are used each and every day within the Trust and at home.

Sustainability Policy

The policy articulates how the Trust will strategically meet its obligations in respect of sustainability issues both now and in the future.

Environmental Benchmarking

This year, the Trust took part in the 2015 Arena Network Environmental Survey – Northern Ireland's leading environmental benchmarking exercise. We were awarded Silver status scoring 78% (5% increase on last year) representing a high level of assurance in environmental performance.

Energy

Carbon Reduction Commitment (CRC)

The Trust continues to meet compliance under CRC legislation whereby there is a requirement to report on emissions for electricity and natural gas consumed. Since 2010/11 there has been an overall reduction of 6%.

There are a number of schemes now coming online that will help to improve carbon emissions over the next year including the use of the combined heat and power (CHP) system at Craigavon Area Hospital.

Display Energy Certificates

The Trust also achieves legal compliance in the display of Energy Certificates at relevant properties detailing the energy efficiency of each building above 250m2.

Waste Management

The Southern Trust generates approximately 1,500 tonnes per annum of domestic waste and 800 tonnes of clinical waste. Domestic waste increased by 3% (1,297 tonnes (2014/15) to 1,336 tonnes in 2015/16). However, the recycling rate has also increased from 13% in 2014/15 to 13.65% in 2015/16 which includes both cardboard and MDR (Mixed Dry Recyclables). At Craigavon Area Hospital the Trust is recycling approximately 90 tonnes per annum or 1.73 tonnes per week. MDR across the Trust has increased significantly from 84 tonnes to 120 tonnes (increase of 42% on last year). This includes 13 tonnes generated at Craigavon Area Hospital where a number of wards/departments have commenced recycling. Other waste types generated within the Trust include all skip waste, Waste Electronic and Electrical Equipment (WEEE) and other specialist waste types which are managed at the main hospital sites.

Future Developments

2016/17 is likely to be another challenging year for the Trust. Some of the issues and risks already facing the Trust, both financial and non–financial are outlined in the Governance Statement on pages 29 to 60.

Long term Expenditure Trends and Plans

Revenue

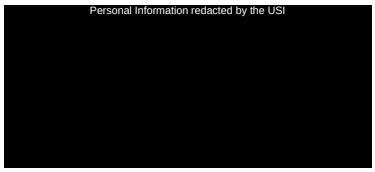
The amount of expenditure that the Trust can incur is constrained by the amount of income made available by the NI Assembly. In response to prevailing economic

conditions, real growth in the amount of funding available for health and social services, as is the case for all aspects of public service provision throughout the United Kingdom, will be heavily curtailed for the foreseeable future.

The population of the southern area and the associated demand for services, however, continues to grow at a faster rate than that experienced in other areas. As in the recent past, this increase in demand has to be funded, at least in part, by continual improvements in efficiency and effectiveness and service transformation.

Capital

The Trust's estate is rapidly approaching the point at which significant renewal and redevelopment is required. The need to improve efficiency and the demands of a growing population also places significant pressure on capital resources. As with revenue funding, the amount of capital investment funding is equally influenced by the state of the economy. It is unlikely that the 'ideal' level of investment will be available in the near future and the Trust will continue to prioritise demands and direct funding to the maintenance and stability of core service provision.

Signed: 

Mr Francis Rice

Accounting Officer **Date:** 9/6/16

SOUTHERN HSC TRUST

ACCOUNTABILITY REPORT

GOVERNANCE REPORT

Directors' Report

Board of Directors

The Board of Directors during the year was as follows:

Mrs Roberta Brownlee
Chair
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Executive Directors

Mrs Paula Clarke
Interim Chief Executive (to 31 March 2016)
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Mr Francis Rice
Interim Chief Executive (from April 2016)
Director of Mental Health and Disability Services/ Executive Director of Nursing and AHPs (Until April 2016)
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Mr Stephen McNally
Director of Finance and Procurement
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Dr Richard Wright
Medical Director (from July 2015)
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Dr John Simpson
Medical Director (to August 2015)
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Trust Directors

Mrs Aldrina Magwood
Acting Director of Performance and Reform
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Mr Kieran Donaghy
Director of Human Resources and Organisational Development
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Mr Miceal Crilly
Acting Director of Mental Health and Disability Services (to April 2015)
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Mrs Angela McVeigh
Director of Older People and Primary Care
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Mrs Esther Gishkori
Director of Acute Services (from August 2015)
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Mrs Debbie Burns
Acting Director of Acute Services (to August 2015)

Non-Executive Directors

Mrs Deirdre Blakely
(to 31 December 2015)

Mr Edwin Graham
(Chair of the Patient & Client Experience Committee)

Mrs Hester Kelly
(to 31 December 2015)
(Chair of Endowments and Gifts Committee to 31 December 2015)

Mrs Elizabeth Mahood
(Chair of Audit Committee)

Dr Raymond Mullan
(Chair of Governance Committee)

Mrs Siobhan Rooney
(Chair of Endowments and Gifts Committee from June 2015)

Mrs Hilary McCartan
(from 15 February 2016)

Ms Eileen Mullan
(from 15 February 2016)

Mr John Wilkinson
(from 15 February 2016)

A declaration of Board members' interests has been completed and is available on request from the Chief Executive's Office, Trust Headquarters, College of Nursing, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ. Telephone 028 3861 3960.

Related Party Transactions

The Trust is an Arm's length body of the DHSSPS and, as such, the Department is a related party with which the Trust has had various material transactions during the year:

Funding – Revenue Resource Limit £576m of which Non-Cash Revenue Resource Limit was £32.06m.

In addition to the above, during the year the Trust entered into transactions with the following related parties (as defined by IAS 24), which are organisations in which one or more Directors disclosed interests:

	Total Value of Transactions	Balance Outstanding at Year End
	£	£
Enable NI	Payments: 189,284 Receipts: 50 (32 transactions)	10,961 (Creditor)
Ann's Homecare Domiciliary Care Agency	Payments: 4,323,501 (150 transactions)	248,821 (Creditor)

Audit

The accounts and supporting notes relating to the Trust's activities for the year ended 31 March 2016 have been prepared in a form determined by the Department of Health, Social Services and Public Safety based on guidance from the Department of Finance and Personnel's Financial Reporting Manual (FReM). They have been audited by the Northern Ireland Audit Office. The report of the Comptroller and Auditor General is included on pages 83-84.

The Interim Chief Executive and each Director has taken all the steps that he/she ought to have taken as Chief Executive/Director to make himself / herself aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

So far as the Interim Chief Executive and each Director is aware, there is no relevant audit information of which the Trust's auditor is unaware.

The notional cost of the audit of the accounts for the year ended 31 March 2016 which pertained solely to the audit of the Public Funds Accounts was £59,000. The notional cost of the audit of the Charitable Funds Accounts was £5,000. No other audit or non-audit services were provided to the Trust in 2015/16.

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003), the Department of Health, Social Services and Public Safety has directed the Southern Health and Social Care Trust ('the Southern HSC Trust') to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of affairs of the Southern HSC Trust, of its income and expenditure, changes in taxpayers equity and cash flows for the financial year.

In preparing the financial statements the Accounting Officer is required to comply with the requirements of Government Financial Reporting Manual (FREM) and in particular to :

- observe the Accounts Direction issued by the Department of Health, Social Services and Public Safety including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- make judgements and estimates on a reasonable basis.
- state whether applicable accounting standards as set out in FREM have been followed, and disclose and explain any material departures in the financial statements.
- prepare the financial statements on the going concern basis, unless it is inappropriate to presume that the Southern HSC Trust will continue in operation.
- keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Southern HSC Trust.
- pursue and demonstrate value for money in the services the Southern HSC Trust provides and in its use of public assets and the resources it controls.

The Permanent Secretary of the Department of Health, Social Services and Public Safety as Accounting Officer for health and personal social services resources in Northern Ireland has designated Mr Francis Rice of Southern HSC Trust as the Accounting Officer for the Southern HSC Trust. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Southern HSC Trust's assets, are set out in the Accountable Officer Memorandum, issued by the Department of Health, Social Services and Public Safety.

Governance Statement for the year ended 31 March 2016

1. Scope of Responsibility

The Board of Directors of the Southern HSC Trust (the Trust) is accountable for internal control. As Accounting Officer and Interim Chief Executive of the Trust, I have responsibility for maintaining a sound system of internal governance that supports the achievement of the organisations policies, aims and objectives, whilst safeguarding the public funds and assets for which I am responsible in accordance with the responsibilities assigned to me by the Department of Health, Social Services and Public Safety (DHSSPS).

In delivering these responsibilities, I am accountable for the Trust's performance to the Health and Social Care Board (HSCB) and DHSSPS and report through agreed performance management arrangements and Service and Budget Agreements.

This has entailed regular performance management meetings at a senior level with the HSCB and both scheduled and ad hoc meetings between Trust officers and the Performance Management Service Improvement Directorate within the HSCB.

In order to improve the quality, safety, effectiveness and efficiency of services, the Trust works in partnership with the HSCB, Public Health Authority (PHA), other public sector partners and the independent sector. A range of processes are in place to facilitate and enable this partnership working with examples including:

- meetings with Trust, HSCB, Local Commissioning Group (LCG) and PHA senior teams collectively and on issue specific basis;
- monthly meetings between Trust and HSCB Chief Executives;
- regional and local Transformation Programme Boards to work together to implement Transforming Your Care (TYC);
- engagement with local GPs through locality forums and senior Trust attendance at Local Medical Committee (LMC) services development committee;
- regular meetings with Independent Health and Care Providers (IHCP) and other independent sector providers about key interface issues;
- forums such as the regional children's service planning project board that include HSC partners, community/voluntary sector and other statutory agencies such as Education; and
- promoting health and wellbeing processes involving a range of partners focussed on ensuring effective collaboration to address the specific and individual needs of local communities.

With respect to the Trust's inter-relationship with the DHSSPS, the framework within which the Trust is required to operate is defined and agreed in the Management Statement (MS) and Financial Memorandum (FM). This model MS/FM for executive

Non-Departmental Public Bodies (NDPBs) is intended to provide departments with a document that sets out a clear framework of strategic control for each of their executive NDPBs. The framework covers the operations, financing, accountability and control of the NDPB and the conditions under which any government funds are provided to the body. The specific requirements for the Trust as an Arm's Length Body ('ALB') are further defined and agreed annually in the Annual Business Plan.

2. Compliance with Corporate Governance Best Practice

The Trust applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The Trust does this by undertaking continuous assessment of its compliance with Corporate Governance best practice and the effectiveness of the Trust's governance arrangements are regularly considered by the Governance Committee on behalf of the Trust Board.

This incorporates, in line with best practice, the Board annual review of its effectiveness, which the Trust Board conducted during 2015/16, in addition to the completion of the DHSSPS Board Governance Self-Assessment Tool. During 2015/16, Internal Audit undertook a review of Board Effectiveness and this included independent assessment of the Trust's 2014/15 self-assessment. A satisfactory level of assurance was provided.

3. Governance Framework

In my role as Accounting Officer, I am supported by the Trust Board.

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

- Management Statement and Financial Memorandum;
- A schedule of matters reserved for Board decisions;
- A scheme of delegation, which delegates decision making authority within set parameters to the Chief Executive and other officers;
- Standing orders and standing financial instructions;
- An Audit Committee;
- A Governance Committee;
- An Endowments and Gifts Committee;
- A Remuneration Committee; and
- A Patient and Client Experience Committee.

The Trust adopts an integrated approach to governance and risk management and an Integrated Governance Strategy is in place which covers all domains of governance associated with the delivery of health and social care services. A review

of this strategy is currently underway. Committee structures are in place to reflect this integrated approach and to support the Trust Board. The following describes in more detail the role of the Trust Board, its Committee structure and attendance during the reporting period.

The Trust Board

The composition and membership of the Trust Board is defined by the Membership, Procedure and Administration Arrangements Regulations and comprises a Chair, seven Non-Executive Directors, the Chief Executive and four Executive members. Four members of the Senior Management Team also attend Trust Board meetings. Non-Executive Directors are independent members and provide support, guidance and challenge to the Trust Board.

In the 2015/16 year, the Trust Board held eight formal Board meetings in public and, in accordance with Standing Orders, were quorate for each meeting.

Name of Board member	No. of Meetings attended	No. of Possible Meetings	Comments
Mrs R Brownlee Chair	8	8	
Mrs D Blakely Non Executive Director	5	6	Term expired 31/12/2015
Mr E Graham Non Executive Director	8	8	
Mrs H Kelly Non Executive Director	6	6	Term expired 31/12/2015
Mrs E Mahood Non Executive Director	8	8	
Mrs H McCartan Non Executive Director	1	1	Commenced 15/02/2016
Ms E Mullan Non Executive Director	1	1	Commenced 15/02/2016
Dr R Mullan Non Executive Director	8	8	
Mrs S Rooney Non Executive Director	8	8	
Mr J Wilkinson Non Executive Director	1	1	Commenced 15/02/2016
Mrs P Clarke Interim Chief Executive	7	8	Resigned 31/03/2016
Mrs D Burns Interim Director of Acute Services	2	2	Resigned 31/08/2015
Mr K Donaghy Director of Human Resources and Organisational Development	7	8	
Mrs E Gishkori Director of Acute Services	6	6	Commenced 17/08/2016
Mrs A Magwood Director of Performance and Reform (Acting)	8	8	
Mr S McNally Director of Finance and Procurement	8	8	

Mrs A McVeigh Director of Older People and Primary Care Services	6	8	
Mr P Morgan Director of Children and Young People's Services/Executive Director of Social Work	6	8	
Mr F Rice Director of Mental Health and Disability Services/Executive Director of Nursing	6	8	
Dr J Simpson Medical Director	2	2	Retired 31/07/2015
Dr R Wright Medical Director	6	6	Commenced 1/07/2015

During the reporting period, the following changes occurred with regard to Board membership:-

- Two Non-Executive Directors completed their tenure on 31 December 2015; three new Non-Executive Directors were appointed with effect from 15 February 2016; three have had their terms of office extended for a further one year period to 31 March 2017 and one commenced their second term of office with effect from 29 August 2015. The Chair is currently in her second term of office.
- The resignation of the Interim Chief Executive on 31 March 2016.
- With effect from 1 February 2016, a Deputy Chief Executive was appointed on a temporary basis to 31 March 2016.
- The appointment of a Medical Director on 1 July 2015 and Director of Acute Services on 17 August 2015.

Trust Board meetings were widely publicised through the press and the Trust website. Agendas, minutes and papers of all Trust Board meetings are publicly accessible on the Trust website.

The Trust Board has corporate responsibility for ensuring that the organisation fulfils the aims and objectives set by the Department/Minister and for promoting the efficient, economic and effective use of staff and other resources. It has a key role in overseeing sound financial management and corporate governance of the Trust.

Each Trust Board agenda comprises strategic, operational, quality and performance items. The Trust Board received management reports at each meeting on the financial position, workforce information and performance against targets to assist it in discharging its role.

Two Board workshops were held during the year, at which members explored strategic issues and planned service developments. The Trust Board held a Development Day on 12 November 2015 which provided members with the opportunity to take 'time out' to consider lessons and best practice from elsewhere

on leadership, teamwork and communication and explore the application of these to the role of the Board. Board Effectiveness was a key focus of the agenda and an action plan developed with areas identified for development and/or improvement.

All Trust Board Committees are chaired by a Non-Executive Director and have clear terms of reference and lines of reporting and accountability agreed by the Trust Board. Minutes of the Sub Committees are presented at Trust Board public meetings in a timely manner with the Chair of each Committee highlighting any specific issues for the attention of the Board via completion of a Board Report Summary Sheet. In addition, the Committee Chairs meet with the Trust Chair and Chief Executive after each meeting to provide feedback on the work of their respective Committees and raise any issues of concern.

In accordance with good practice, the Trust Chair meets with the Committee Chairs on an annual basis to reflect on the work of the Committees and to share any learning.

Audit Committee

The Audit Committee supports the Trust Board and my role as Accounting Officer with regard to our responsibilities for issues of risk, control and governance and provides associated assurance through a process of constructive challenge.

The committee comprises five Non-Executive Directors who are independent of Trust management. The Director of Finance, Head of Internal Audit (Business Services Organisation (BSO)), external auditors (Northern Ireland Audit Office (NIAO)) and their sub-contracted auditors are in attendance. The Committee is also attended by other Finance and Internal Audit staff as required.

During 2015/16, the Committee held 6 meetings to provide the Trust Board with independent assurance on the adequacy and effectiveness of internal control systems and that all regulatory and statutory obligations are met. There was full attendance at three out of these six meetings.

Name of Audit Committee member	No. of Meetings attended	No. of Possible Meetings	Comments
Mrs E Mahood (Chair) Non Executive Director	6	6	
Mrs D Blakely Non Executive Director	4	4	Term expired 31/12/2015
Mr E Graham Non Executive Director	4	4	Joined the Committee 01/06/2015. Stood down on 31/03/2016 to take up membership of the Remuneration Committee
Mrs H McCartan Non Executive Director	0	1	Commenced 15/02/2016
Ms E Mullan Non Executive Director	0	1	Commenced 15/02/2016

Dr R Mullan Non Executive Director	3	6	
Mrs S Rooney Non Executive Director	1	1	Stood down from the Audit Committee on 02/04/2015 to take up membership of the Remuneration Committee
Mr J Wilkinson Non Executive Director	1	1	Commenced 15/02/2016

To ensure linkages across the Audit and Governance Committees, the Chair of the Audit Committee is a member of the Governance Committee and likewise, the Chair of the Governance Committee is a member of the Audit Committee.

In carrying out its work, the Committee used the findings of Internal Audit, External Audit, assurance functions, financial reporting and Value for Money activities. It approved the Internal Audit programme of work and reviewed progress on implementing internal and external audit recommendations. It considered reports from Internal Audit at each meeting and overall accepted the findings and recommendations of Internal Audit in its reports for 2015/16. The Audit Committee particularly focused on bringing closure to the long standing internal audit recommendations from 2013/14 and prior. Fraud is a standing item on the Committee's agenda and there is on-going reporting to the Committee in respect of compliance with Departmental directions/circulars.

On an annual basis, the Committee reviews the findings of the External Auditor concerning the Trust's Annual Accounts, including the Governance Statement.

The Committee assessed its effectiveness against the National Audit Office (NAO) Audit Committee self-assessment checklist. One action emerged with regard to ensuring the effective induction and training of new Audit Committee members. This will be taken forward in 2016/17.

Governance Committee

The Governance Committee is the overarching strategic Committee responsible for providing assurance to the Board on all aspects of governance (except internal financial control) and during the year the Committee regularly considered the effectiveness of the Trust's governance arrangements.

The Committee comprises all Non-Executive Directors who are independent of Trust management. The Chief Executive, members of the Senior Management Team, the Director of Pharmacy and the Assistant Director of Clinical and Social Care Governance are in attendance at all meetings.

During 2015/16, the Governance Committee met on four occasions.

Name of Governance Committee member	No. of Meetings attended	No. of Possible Meetings	Comments
Dr R Mullan (Chair) Non Executive Director	4	4	
Mrs D Blakely Non Executive Director	2	3	Term expired 31/12/2015
Mr E Graham Non Executive Director	4	4	
Mrs H Kelly Non Executive Director	3	3	Term expired 31/12/2015
Mrs E Mahood Non Executive Director	4	4	
Mrs H McCartan Non Executive Director	0	0	Commenced 15/02/2016
Ms E Mullan Non Executive Director	0	0	Commenced 15/02/2016
Mrs S Rooney Non Executive Director	4	4	
Mr J Wilkinson Non Executive Director	0	0	Commenced 15/02/2016

In order to discharge its responsibilities, the Committee has a Schedule of Reporting in place and the key areas reported at meetings are in line with this. Assurance reports were received from lead Directors in relation to their areas of responsibility being Medical, Social Work and Social Care and Nursing and Allied Health Professions, as well as Medicines Governance.

In April 2015, a revisit of the outcomes of the 2010 Review of Clinical and Social Care Governance was undertaken and progress updates were provided to the Committee. As an outcome of the revisit, the Trust has commenced a project to review and further improve on how Serious Adverse Incidents, Adverse Incidents and Complaints are used to learn, improve patient safety and reduce risk. The Trust is currently developing and testing the reporting format to Governance Committee.

Reports and findings from external bodies/agencies were also presented to the Committee and discussed, particularly those that indicated practice below acceptable levels and areas of high risk. The Committee sought assurance that action plans were in place to address recommendations and were being effectively implemented through measurable outcomes. Where the organisation has challenges in meeting recommendations, the Governance Committee ensures these are appropriately escalated to the Trust Board.

The Governance Committee reviewed the Corporate Risk Register at each meeting and ensured that risks that are outside the Trust's ability to solely manage were escalated to the Trust Board and beyond.

The Chair of the Governance Committee undertook an evaluation of the performance of the Committee during the year and presented the Committee's Annual Report to the Trust Board.

Endowments and Gifts Committee

The Endowments and Gifts Committee is the committee responsible for providing assurance to the Board on all aspects of the stewardship and management of funds donated or bequeathed to the Trust.

The membership of the Endowments and Gifts Committee comprises three Non-Executive Directors, the Director of Acute Services and the Director with responsibility for Estates Services. The Director of Finance is in attendance. Two members had full attendance at all meetings during the year, with the remaining members missing one or more meetings.

During 2015/16, the Committee held four meetings to oversee the administration of the Endowments and Gifts funds, their investment and disbursement. The Committee also revised the Procedures for the Management of Charitable Trust Funds.

The Chair of the Endowments and Gifts Committee undertook an evaluation of the performance of the Committee during the year. One issue arose relating to the importance of Director attendance, however, where a Director was unable to attend a meeting, a nominated deputy attended.

Remuneration Committee

The Remuneration Committee makes recommendations to the Trust Board on all aspects of remuneration and terms and conditions of employment of the Chief Executive and other senior executives.

The committee comprises the Trust Chair and two Non-Executive Directors, who are independent of Trust management. The Director of Human Resources and Organisational Development is in attendance.

The Committee held three meetings during 2015/16. There was full attendance by all members during the year. The Chair brings recommendations of the Remuneration Committee following each meeting to the Trust Board.

Patient and Client Experience Committee

The Patient and Client Committee provides assurance to the Trust Board that the Trust's services, systems and processes provide effective measures of patient/client and community experience and involvement.

The membership of the Patient and Client Experience Committee comprises the Trust Chair, four Non-Executive Directors and four representatives from the Trust's

PPI Panel. Trust Directors, the Assistant Director of Promoting Wellbeing, the Assistant Director of Clinical and Social Care Governance and a representative from the Patient and Client Council are in attendance.

During 2015/16, the Committee held four meetings. Attendance across the four meetings in 2015/16 ranged from 89% to 67%.

This Committee leads the co-ordination, development, implementation and monitoring of the Trust's PPI Action Plan, monitors the Patient Client Experience Standards Audit programme and complaints across the organisation.

The Chair of the Patient and Client Experience Committee undertook an evaluation of the performance of the Committee during the year and presented the Committee's Annual Report to the Trust Board.

4. Business Planning and Risk Management

Business planning and risk management is at the heart of governance arrangements to ensure that statutory obligations and ministerial priorities are properly reflected in the management of business at all levels within the organisation.

The state of the economy continues to place severe restrictions on the funding available to the Trust at a time when the local population and the associated demand for service is growing at a faster rate than the rest of Northern Ireland. A requirement to review priorities and ways of working in order to generate internal savings is now a constant feature of service delivery and brings a new dimension to corporate governance and risk management.

This following section provides an overview of the Trust's Business planning process and considers how objectives are identified, managed and reviewed.

The Trust's three year Strategic Plan **" Improving through Change"** aims to ensure clarity about the strategic direction for services delivered by the Trust during 2015-2018 and specifically to identify what implementing *"Transforming Your Care"* will mean locally for individual services. This plan builds on the Trusts 2013-2015 strategic plan *"Changing for a Better Future".*

It sets out the actions the Trust will take in support of each of the corporate objectives. This will ensure that our local communities know what to expect from us, that all of our staff are aware of their role in delivering on these priorities and that we can demonstrate improvements and progress by the end of the plan.

This Strategy sets out the Trust's vision 'to deliver safe, high quality health and social care services, respecting the dignity and individuality of all who use them'. This vision is underpinned by the Trust's values which shape what it does and how it does it.

The current strategic plan which runs until 2018 is underpinned on an annual basis by the Trust's Delivery Plan.

The **Trust Delivery Plan (TDP)** represents the annual response of the Trust to Regional and Local Commissioning Plans and to the specific targets signalled in the Minister's Commissioning Plan Direction. Within this document the Trust identifies how it will seek to deliver on each of the key commissioning and ministerial priorities for the incoming year. The Plan also sets out how the Trust will utilise its resources in the year ahead, including its financial strategy, workforce strategy, capital investment plans, governance strategy and plans to promote wellbeing, personal and public involvement (PPI) and the patient experience.

The targets set out within the Commissioning Plan are allocated to Directorates. It is the responsibility of Heads of Service to make their team aware of the targets relevant to their area of work and to ensure that issues which may impact on achievement are flagged up through Divisional Team meetings or staff supervision throughout the year.

The TDP is brought to SMT and Trust Board for approval prior to submission to HSCB.

Monitoring of performance subsequently occurs on a monthly basis. Operational Directors receive a monthly report which provides a tool for focus with escalation of areas which are in excess of the required commissioning plan targets and standards and Trust Board also receive a monthly report. This includes a summary of performance, key actions and issues. It is the responsibility of Directors to ensure that Directorates under their control have appropriate plans and monitoring arrangements in place.

Directorate Work Plans are developed annually on the basis of the Strategic Plan and TDP. These plans summarise the key deliverables falling under each objective in the Strategic Plan and TDP but will also detail the actions, action owner and timescales for achievements.

Progress updates are generally carried out on a quarterly basis and some Directorates have found it useful to apply a traffic light system to assist in the monitoring of their actions at a high level for this purpose with more detailed discussion and monitoring taking place through staff.

It is essential that linkages between plans at Corporate and Directorate level are clearly stated and there must be a clear understanding and connection at all levels between objectives and associated risks. This is evidenced through the business planning and risk management processes in the Trust.

Risk Management

Risk management is an organisation-wide responsibility.

The key components of the Trust's risk management strategy (2014) are underpinned by the HPSS Controls Assurance Standard for Risk Management. The purpose of this Strategy is to ensure that the Trust manages risks in all areas using a systematic and consistent approach. It provides the framework for a robust risk management process. All supporting procedures for the identification and management of risk also reflect this standard.

The Trust's Risk Assessment Tool ensures that a consistent approach is taken to the evaluation and monitoring of risk in terms of the assessment of likelihood and impact. Risks are monitored through a formal reporting process where the assessed level of risk and its strategic significance determines where it will be reviewed and monitored.

In the Trust, there are two key levels at which the risk management process is formally documented:

- The Trust's Corporate Risk Register, which focuses on the principal risks to the Trust's delivery of its statutory responsibilities and corporate objectives; and
- Directorate risk registers which focus primarily on the risks to the achievement of Directorate objectives.

The Corporate Risk Register is reviewed by the Governance Committee at each of its meetings. The Corporate Risk Register is complementary to and works in conjunction with the Board Assurance Framework which is presented to the Trust Board on a six-monthly basis. Examples of indicators which may identify risks within the organisation include reports from external bodies e.g. RQIA, Accreditation bodies, independent reviews; various occurrences such as complaints, incidents, litigation, staff turnover; and internal assessments/reporting such as self-assessments, monitoring reports etc.

Directors are responsible for ensuring that Directorates under their control have fully functioning Directorate Risk Registers.

Each operational Directorate is supported by a Governance Team who facilitates the Director, Assistant Directors and Associate Medical Directors to identify, assess and manage and report on risk within their area of responsibility. Risks identified and control measures in place are discussed monthly by the operational teams through the Directorate Governance Forums where they are reviewed, monitored and escalated as appropriate. The Senior Management Team reviews the Corporate Risk Register monthly.

All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust. There are structured processes in place for incident reporting, analysis and the investigation of serious incidents. The Trust has reviewed the arrangements in place for communicating and involving patients and their families in incident investigations also.

The content of the Trust's risk management training and awareness is presently under review; it was identified through an internal audit of risk management in 2015 that the Trust should improve on the numbers of staff trained in this area across all Directorates. This work stream remains on-going.

The system of internal governance is designed to help manage risk rather than to eliminate it and controls must at all times be commensurate with the nature of the risk. Internal Audit reviewed the Trust's Risk Management system in 2015/16 and provided a satisfactory level of assurance.

5. Information Risk

Safeguarding the Trust's information is a critical aspect of supporting the Trust in the delivery of its objectives and effective management of information risk is a key aspect of this. Arrangements in place to manage this risk include:

- A Trust Information Governance Framework which includes strategy, policy and a suite of procedures and guidance.
- An Information Governance Forum which is led by the Personal Data Guardian (Medical Director) and Senior Information Risk Owner (SIRO) (Acting Director of Performance and Reform). It reports to the Trust's Governance Committee.
- Information Asset Owners (IAOs) are in place to reduce the risk to personal information within the Trust and are aware of their responsibilities;
- An information sharing register is in place which records the details of all episodes of sharing of Trust data with other bodies;
- Monitoring of Freedom of Information and Data Protection requests

Information Governance incidents are reported in accordance with the HSC Risk Management strategy. Three incidents have been reported to the Information Commissioners Office (ICO) during 2015/16. None of these resulted in data loss. These have been fully investigated and action plans have been implemented. Internally, information governance incidents are monitored and reviewed at the Information Governance Forum; ensuring lessons learned are disseminated throughout the Trust.

Data protection and records management training is mandatory for all Trust staff, providing them with up to date awareness of information governance issues and risks.

6. Public Stakeholder Involvement

In line with the Regional Strategy (DHSSPS, 2004), Departmental Guidelines for Personal and Public Involvement (PPI) (DHSSPS, 2007 and 2012), sections 19 and 20 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Quality Standards for Health and Social Care (DHSSPS, 2006) the Trust continues to prioritise PPI within all aspects of its business agenda and operates a range of governance, management and reporting mechanisms that reflect this.

Arrangements in place include:

- PPI is a standing agenda item on the Trust Patient and Client Experience Committee, a sub-committee of the Trust Board;
- Each Trust Board agenda includes a patient/client centred service which incorporates feedback and learning from PPI activity;
- PPI arrangements have been subject to verification by PHA in 2015/16 and the Trust has completed a self-assessment PPI Performance Management Report for PHA;
- Corporate PPI Annual Action plan to ensure continuous improvement;
- Implementation of PPI Checklist - a tool to enable senior managers to determine compliance with the PPI Indicators across all programmes of care; and
- Influence in the design and development of the PHA-funded PPI training programme, Engage and Involve.

Further information on the Trust's involvement mechanisms, processes and resources to support staff and service users and carers is available at

http://www.southerntrust.hscni.net/about/1600.htm

7. Assurance

A systematic approach is taken to ensure that the systems upon which the Trust relies are challenged and tested. The Board Assurance Framework is a statutory requirement for the Trust and is an integral part of the Trust's governance arrangements. The Framework has been compiled in conjunction with all Directorates and provides the systematic assurances required by the Board on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary to ensure the achievement of corporate

objectives and the delivery of high quality health and social care. In its Board Assurance Framework, the Trust Board has determined the level of assurance it requires to manage the principal risks facing the organisation and the Trust Board reviews this on a six-monthly basis. A standard template attached to the Board Assurance Framework ensures that Board members consider, based on sufficient evidence, whether the current controls and assurance systems are sufficient and are working effectively. Trust Board minutes attest to the challenge and scrutiny applied to the Board Assurance Framework.

The Framework illustrates the wide range of assurance from internal and external sources. The sources of external assurance and system validation as identified in the Board Assurance Framework include, for example, the Regulation and Quality Improvement Authority, Internal and External Auditors, Royal Colleges and Professional Councils. These are supplemented from non-independent sources such as performance management, self-assessments and proposed work streams on national audits.

The Board Assurance Framework sits alongside the Corporate Risk Register, the Controls Assurance Standards process and performance reporting to provide structured assurance about how risks are effectively managed to deliver agreed objectives. Where risks are outside the Trust's ability to solely manage, these are escalated to the Trust Board and beyond.

Compliance with the controls assurance standards and the annual self-assessments against the standards provide an important assurance to the Trust Board. Separately, the Audit and Governance Committees review compliance with Controls Assurance Standards to provide assurance to the Trust Board that action plans are in place for all 22 standards to maintain/further improve compliance against each standard going forward.

The Trust Board agenda is structured to ensure assurance is provided on key areas such as patient safety and quality and performance in terms of finance, human resources and operational performance.

The quality of information presented to the Trust Board is regularly reviewed by members. A standard template is attached to the front of all Board papers ensuring that the report is aligned to specific corporate objectives and key issues/risks and decisions required are drawn to Board members immediate attention. Board members regularly discuss and challenge the quality of the information presented to them and collectively reflect on information received. A Non-Executive Director is a member of the Trust Information Governance forum which addresses assurance processes for data quality. In addition, Trust Board receives reports from external organisations which provide assurance in relation to some areas of data quality. No significant issues have been raised.

Members continue to consider further how to develop the searching questions and processes to ensure effective challenge by the Board. The Executive professional roles (Medical, Nursing and Social Work) ensure executive challenge as these posts are designed to give independent professional assurance to the Trust Board.

Controls Assurance Standards

Controls assurance standards are a central feature of the Trust's corporate governance system. The Trust assessed its compliance with the applicable Controls Assurance Standards which were defined by the Department and against which a degree of progress is expected in 2015/16. Each standard has an action plan in place to address any areas of non-compliance.

Substantive compliance is required across all 22 standards.

The table below provides a summary of the expected and achieved levels of compliance for 2015/16.

Standard	**DHSS&PS Expected Level of Compliance**	**Trust Level of Compliance**
Buildings, land, plant and non-medical equipment	75% - 99% (Substantive)	Substantive
Decontamination of medical devices	75% - 99% (Substantive)	Substantive
Emergency Planning	75% - 99% (Substantive)	Substantive
Environmental Cleanliness	75% - 99% (Substantive)	Substantive
Environment Management	75% - 99% (Substantive)	Substantive
Financial Management (Core Standard)	75% - 99% (Substantive)	**Substantive***
Fire safety	75% - 99% (Substantive)	Substantive
Fleet and Transport Management	75% - 99% (Substantive)	Substantive
Food Hygiene	75% - 99% (Substantive)	Substantive
Governance (Core Standard)	75% - 99% (Substantive)	**Substantive***
Health & Safety	75% - 99% (Substantive)	Substantive
Human Resources	75% - 99% (Substantive)	Substantive
Infection Control	75% - 99% (Substantive)	Substantive
Information Communication Technology	75% - 99% (Substantive)	Substantive

Standard	DHSS&PS Expected Level of Compliance	Trust Level of Compliance
Information Management	75% - 99% (Substantive)	Substantive*
Management of Purchasing	75% - 99% (Substantive)	Substantive
Medical Devices and Equipment Management	75% - 99% (Substantive)	Substantive
Medicines Management	75% - 99% (Substantive)	Substantive*
Research Governance	75% - 99% (Substantive)	Substantive
Risk Management (Core Standard)	75% - 99% (Substantive)	Substantive*
Security Management	75% - 99% (Substantive)	Substantive
Waste Management	75% - 99% (Substantive)	Substantive

**De-notes subject to verification by HSC Internal Audit in 2015/16*

The above table demonstrates that the required levels of compliance have been achieved in 2015/16.

8. Sources of Independent Assurance

The Trust obtains Independent Assurance from the following sources:

- ***Internal Audit;***
- ***RQIA;***
- ***External Review/Benchmarking;***
- ***Licensing and other Regulatory bodies***

Internal Audit

The Trust has an internal audit function which operates to defined standards and whose work is informed by an analysis of risk to which the body is exposed and annual audit plans are based on this analysis.

In 2015/16 Internal Audit reviewed the following systems:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
Finance Audits:	
Management of Client Monies in the Independent Sector (including St Francis Private Nursing Home)	Satisfactory - Most Facilities Limited - Glenview
Payments to staff	Limited
Non Pay Expenditure	Satisfactory
Bank and Cash	Satisfactory
Budgetary control	Satisfactory
FPL Systems Administration	Satisfactory
Asset Management	Satisfactory
Adult Supported Living – Mental Health and Disability Directorate	Satisfactory
Client Monies and cash and Valuables Handling in Social Care Facilities	Satisfactory
Income and debt management (including identification and charging of non-UK residents)	Satisfactory – Income/debt management Limited – Identification and charging of Non UK residents
Client Monies - Valley Nursing Home	Satisfactory
Management and use of Agency and Locum staff	Satisfactory
Laboratory procurement and contract management	Limited
Fostering and adoption payments	Limited
Management of Estates Contracts	Limited
Domiciliary care - Enable Care	Unacceptable
Corporate Risk Based Audits:	
Performance Management	Satisfactory

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
Directorate Risk Based Audit – Children and Young People's Directorate	Satisfactory
Corporate Mandatory Training and Appraisals	Satisfactory: Human Resources and Organisational Development (HROD) Limited - Directorates
Compliance with Standards and Guidelines	Satisfactory
Case Management	Limited
Management of Licences and Accreditations	Satisfactory
Governance Audits:	
Risk Management	Satisfactory
Clinical and Social Care Governance	Satisfactory
Board Effectiveness	Satisfactory
Whistleblowing and Fraud processes	Satisfactory
Complaints Management	Satisfactory

Consultancy and Other Assignments

A number of other assignments were undertaken by Internal Audit during the year which included:

- Review of GP Out of Hours financial procedures
- Verification of sample of re-imbursement of client monies by the Haven Nursing Home

Follow up work

342 of 460 previous priority one and two Internal Audit recommendations which were due to have been implemented, were fully implemented at year end (74%), a further 18% were partially implemented and 8% have not yet been implemented. There were 8 priority one findings which have not been implemented. Four of these relate to the HRPTS system, three of which require BSO input to address. One relates to implementation of KSF gateways under Agenda for Change which requires a regional approach and the other three are Trust clinical and social care governance

issues. Where it is within the control of the Trust to do so, these recommendations will be progressed in 2016/17.

Shared Services Audits

As the Trust is a customer of BSO Shared Services, the following audit reports have been shared with the Trust for information.

Shared Service Audit	Assurance
Payments Shared Service (as at September 2015)	Satisfactory
Payments Shared Service (as at March 2016)	Satisfactory
Payroll Shared Service (as at September 2015)	Limited
Payroll Shared Service (as at March 2016)	Limited
Income Shared Service	Satisfactory
Recruitment Shared Service	Unacceptable
Business Services Team	Satisfactory
Benefits Realisation	Satisfactory

Limited assurance has been provided again in 2015/16 in respect of the Payroll Shared Service Centre and a significant number of priority one findings and recommendations have been reported. Improvement is required particularly in the following areas: variance monitoring; management and reporting of overpayments; authorisation and processing of manual payments; accuracy of maternity payments; payroll information relating to pension calculations; and HRPTS access controls.

Unacceptable assurance has been provided in respect of the Recruitment Shared Service Centre. There are significant E-Recruitment system functionality issues and performance of the Recruitment Shared Service is not being effectively managed and monitored. Improvement is noted as required in the following areas: E-Recruitment system functionality; standing operating procedures; performance management; management of customer queries; information governance; and control of user access rights.

Internal Audit also followed up on the implementation of priority one and priority two BSO shared service recommendations at the end of 2015/16. In total, 294 BSO shared service recommendations were followed up. 78% of these recommendations have been fully implemented, a further 20% partially implemented and 2% were not yet implemented at the time of review.

Overall Opinion for 2015/16

In her annual report, the Head of Internal Audit reported that the Trust has a satisfactory system of internal control designed to meet the organisation's objectives. However, it was also noted that Limited assurance has been provided in a number of areas and Unacceptable assurance has been provided in relation to controls within an Independent Domiciliary Care contracting organisation.

Details of the significant issues identified within the limited and unacceptable assurance reports provided to the Trust are noted below:

Payments to staff: priority one issues were raised in relation to insufficient controls in place to check self-payment by staff; BSO reporting and management of overpayments; and evidence of insufficient validation of travel claims by Trust managers prior to authorisation.

Fostering and Adoption payments: priority one issues were identified in relation to a high level of errors in the rate of adoption payments sampled; and weaknesses in the completeness of foster care contract documentation.

Laboratory procurement and contract management: priority one issues related to the lack of contract documentation and contract performance processes with the Belfast HSC Trust for significant services provided to the Trust; and incomplete contract management and documentation for a number of smaller laboratory suppliers.

Management of Estates Contracts: two priority one issues were identified and relate to controls around the approval of measured term contract (MTC) invoices for payment and monitoring of the performance of quantity surveyors who conduct the financial review of MTC invoices.

Case Management: the priority one findings in this reported highlighted that the new case management procedures are not embedded and fully understood across all Trust teams tested. In addition, three service users in the community were highlighted where Trust staff are involved in managing their finances without adequate segregation of duties.

Management of Client Monies in Glenview Nursing Home: Particular issues were found in relation to Glenview Nursing Home which included lack of appropriate signed residents' agreements; no procedures in place for the Clients' Comfort Fund, including no dedicated receipt book, no double signing of withdrawals and no evidence of review of account reconciliations.

Corporate Mandatory Training and Appraisals: compliance with mandatory training requirements by a number of Directorates in the Trust was noted, where compliance was less than 60% in 9 out of 14 mandatory training areas.

Income and debt management (including identification and charging of non-UK residents): Internal Audit noted several weaknesses within the current arrangements in the Trust for capturing potential income associated with treatment of patients who are not ordinarily resident.

Domiciliary Care - Enable Care: this report identified eight priority one issues, six concerning controls within the supplier and two regarding controls in the Trust. The systems in place within the supplier were very basic and weak. Internal Audit was unable to validate hours actually worked by care workers due to the failure to retain rotas and timesheets for the periods tested. The management of Enable Care have accepted the audit findings and are working with the Trust on their implementation.

The recommendations of the Internal Auditor to address control weaknesses have been considered by the Audit Committee. They have been or are being taken forward by the management of the Trust and their implementation will continue to be monitored by the Audit Committee regularly during 2016/17.

Northern Ireland Audit Office (External auditor)

The external auditor undertakes an examination of the annual financial statements in accordance with auditing standards issued by the Auditing Practices Board. Based on the findings of this audit, the Comptroller and Auditor General (C&AG) will report his opinion to the NI Assembly as to the truth and fairness of the annual financial statements, that expenditure and income have been applied to the purposes intended by the Assembly and that the transactions conform to the authorities which govern them (regularity).

In addition, the external auditor will provide a Report to those charged with Governance which brings to the attention of the Accounting Officer findings during the course of the external audit. The external auditor reports all of these findings to the Audit Committee. In the course of the external audit for 2015/16, the external auditor has brought to the attention of management one priority one issue.

The Northern Ireland Audit Office also conducts a number of Value for Money studies across the health sector on an annual basis and these are presented to the Audit Committee.

A representative of the NIAO attends Audit Committee four times per year.

RQIA

The RQIA provides independent assurance by conducting a rolling programme of planned clinical and social care governance and thematic reviews across a range of subject areas in HSC organisations.

As part of the revisit of its Clinical and Social Care Governance arrangements, the Trust is presently establishing a better system to track and monitor RQIA thematic

reviews and inspections and the Trust responses. This will further improve governance arrangements and enhance assurance to be gained from this area.

External Review/Benchmarking

The Trust participates in a service which facilitates external benchmarking of hospital based data against a UK peer group of like hospitals. The service provider provides annual reporting on a range of key performance indicators including efficiency and safety measures, and quarterly reporting on mortality issues which is a key area of review. It provides independent assessment of performance against peer and against the top percentile, supporting this function with analysis and support at Directorate level.

Licensing and other Regulatory bodies

Trust services are subject to a range of standards and regulations from external licensing and regulatory authorities to ensure appropriate standards of care are delivered. The four main licensing authorities are the Human Tissue Authority (HTA), the Medicines and Healthcare Products Regulatory Agency (MHRA), the Human Fertilisation and Embryology Authority (HFEA) and the Administration of Radioactive Substances Advisory Committee (ARSAC). The Trust is developing an IT system for the corporate logging, monitoring and reporting on these licenses.

The management of licences and accreditations in the Trust was subject to Internal Audit in 2015/16 and a satisfactory level of assurance provided.

In 2014/15, the Trust highlighted that its Biochemistry laboratory had not maintained its CPA accreditation. The inspection for re-accreditation took place on 12, 13 and 14 of April 2016.

9. Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance. My review of the effectiveness of the Trust's system of internal governance is informed by the work of the internal auditors, the executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Senior Management Team, Trust Board, Head of Internal Audit, Audit Committee and Governance Committee. I have referred to the Annual Report from the Head of Internal Audit which details the assurance levels provided from reports in 2015/16 and also the Trust's implementation of accepted

internal audit recommendations. A plan to address weaknesses and ensure continuous improvement to the system is in place.

10. Internal Governance Divergences

Prior Year Issues

A number of governance matters arising in previous years have now been addressed and no longer represent reportable governance issues for the Trust.

Compliance by Independent Sector Homes with circular HSS (F) 57/2009

The DHSSPS issued HSC (F) 15/2016 “Safeguarding of Service User’s Finances within Residential and Nursing Homes and Supported Living Settings” in February 2016. Compliance with this circular by homes and facilities improved during 2015/16. Learning has been incorporated for the annual process now underway and any remaining issues are being taken forward under normal business arrangements.

Safeguarding of Residents’ Interests

In 2012/13 the Trust commenced two adult safeguarding investigations into two independent sector residential homes. The Trust continues to liaise with the Home Owners, their legal representatives and external agencies in relation to the issues identified.

However, new case management procedures were introduced in the Trust as part of the learning outcomes from these investigations. These procedures were introduced in February 2015 and have been embedding. An audit of compliance was conducted in 15/16 by Internal Audit and limited assurance provided to the Trust. The areas identified for improvement will be taken forward under normal business arrangements.

Progress on Prior Year Issues which continue to be considered as control issues

A number of governance matters arising in prior years are still considered to represent internal governance divergences for 2015/16. These are as follows:

Contract & Procurement Management

Estates

The appropriate procurement of Service and Maintenance contracts, which are within the scope of the Centre of Procurement Excellence (CoPE), has been an area of concern for a number of years.

A new HSC regional model, involving both BSO Procurement and Logistics Service (PaLS) and Trust Estates teams has been agreed during 2015/16 to address this procurement need and to ensure compliance with procurement legislation and guidelines. The establishment of this model is being overseen by a Regional Estates Procurement Group.

It is envisaged that it will take approximately five years to establish this model in full across both BSO PaLS and Trusts.

In the interim, the Trust continues to manage the associated risks by ensuring the provision of appropriate training to Estates staff, the use of robust procedures and direct award contracts as appropriate and regular monitoring and review.

Estates Contracts were the subject of Internal Audit in 2015/16 and a limited assurance was provided. This report verified that previous audit recommendations in this area had been largely implemented, however new issues were identified in relation to the management and control of Measured Term Contracts. Management will take forward the recommendations as appropriate.

Social Care Procurement

Progress has been made regionally, with agreement on an approach for the procurement of social care and other specific contracts further to the new 2015 Public Contract Regulations and guidance on the 'Light Touch Regime'. Further guidance is awaited on the scope of the regulation and approach to practical management of social care contracts, particularly those under the agreed threshold.

In 2015/16 the Trust agreed a temporary approach to increase procurement capacity for social care, in the absence of an agreed regional approach, to address priority procurements. A temporary procurement resource established, operating under the influence of the Social Care Procurement Unit, has undertaken a number of procurements related in the main to operational need and strategic change.

The Trust also continues to operate a discipline around the roll forward of contracts which provides assurance that:

• That objectives of the provider are/continue to be in line with objectives of the Trust.

• That a service specification has been prepared or reviewed defining the service delivery outcomes with clear measures of performance.

• That value for money has been examined and efficiencies sought or obtained accordingly.

The Trust will continue to work with the Social Care Procurement Group of the Regional Procurement Board, HSCB to develop an agreed regional approach for social care procurement.

General Contract Management

Due to lack of resource, the implementation of a central contracts database or improvement in general contract management arrangements/training in the Trust during 2015/16 has not progressed. The Trust continues to highlight this risk of lack of central monitoring and assurance regarding general contract management in the Trust.

Following a prioritisation exercise to manage this risk, the Trust decided that the estates procurement issues were more pressing and therefore worked actively with PaLS and the other Trusts to address these issues. The new arrangements are now active. The Trust continues to periodically remind all contract managers and their Directors of their roles and responsibilities. The establishment of a central contract management team with supporting systems continues to be a priority and as with the estate issue, will be reviewed on a regular basis as further opportunities for managerial / administrative changes arise and open the potential for reinvestment.

Estate Risks

Water Borne Risks (Legionella, Pseudomonas etc.)

The Trust continues to manage Water Borne Risks through implementation of the arrangements set out in its Water Safety Plan. Performance against this plan will be reviewed in early 2016/17 by an independent specialist.

Installation of a Copper Silver ionisation system for the treatment of water and control of pathogens such as Legionella and Pseudomonas in Craigavon Area Hospital has exhibited success in reducing the instances of positive legionella detections. Based on this, similar systems are being implemented across other hospital sites and facilities and should be operational in early 2016/17.

A Water Safety testing contract was awarded effective from 1 June 2015; however it has been terminated due to under-performance and will be re-procured in 2016/17.

Trust Estate Risks

The age, condition and nature of the estate continue to pose potential risks and are exacerbated by limited capital investment in major renewal and replacement projects. All key risks are included on the Trust Corporate Risk Register ensuring regular scrutiny and follow up on action plans. The Trust prioritises available funding to the mitigation of these estates risks and continues to pursue additional funding through all appropriate streams. Specific risks which continued during 2015/16 were:

Electrical infrastructure, **Craigavon Area Hospital:** The action plan for this area focussed around a three phased approach for low/high voltage works. Only one aspect of this plan remains outstanding: Installation of new NIE High Voltage supply and upgrade of LV/HV infrastructure. The programmed completion date for these works is September 2016.

Fire Safety: The internal audit recommendations concerning this area in 2013/14 have been substantially addressed. However a number of fire incidents in 2015/16 have raised concerns and procedures are currently under review to ensure their effectiveness.

Business Continuity: Progress continues to be made in Estates to support business continuity. The new electricity supply arrangements for Craigavon Area Hospital are almost complete and a Trust wide telecoms infrastructure upgrade is underway. These initiatives include increased resilience in support of patient services.

Estates Staffing

Trust financial contingency measures in 2014/15 meant that a number of vacancies remained unfilled within the Estates Structure during 2014/15 and 2015/16. The risk associated with these vacancies and the impact upon the service delivered was reflected on the Trust's Corporate Risk Register during the year. Whilst a number of key vacancies were filled in 2015/16, the impact of internal appointments has maintained vacancies at high levels. It is anticipated these vacancies will be filled in early 2016/17, mitigating the risks in this area.

Sewage

The sewage system serving the wards at Craigavon Area Hospital had reached a critical point with frequent blockages leading to bursts and subsequent contamination of patient and support areas. This presented a serious infection control risk; caused disruption to services; and has been reported in the press potentially damaging service user confidence. An extensive sewage pipe replacement programme commenced in August 2015 and involved a carefully coordinated and phased programme of ward decants which was required due to limited decanting provision and Winter Pressures. Works were carried out to the most critical areas. Although a significant amount of works have been completed, thus reducing the risk level, further work and funding is required to complete this programme of work in 2016/17.

Fire Safety

Internal Audit recommendations (2013/14) have now been addressed including the completion of baseline fire risk assessments and the establishment of a review programme. Staff training has increased to approximately 70% and there is an on-going programme of training for evacuation aids and Fire Extinguishers. A number of fire incidents occurred in 2015/16 relating to hot works on 'built-up felt roofs'. All similar work was suspended until investigations were completed and further robust control measures were introduced (including extended fire watch procedures and the use of Thermal Imaging post works, controlled under Permit). A number of unwanted fire alarm signals caused by contractors (dust etc.) prompted the Trust to develop new procedures aimed at reducing such occurrences.

Clinical and Social Care Risks

Inquiry into Hyponatraemia-related Deaths

The Inquiry into Hyponatraemia- related deaths in five children concluded its public hearings in 2013/14. The Trust contributed to the governance section of the above Inquiry. The Trust will consider the learning points and recommendations from that Inquiry when available and take forward as appropriate.

Child Sexual Exploitation/Marshall Inquiry/Safeguarding Board for Northern Ireland (SBNI) Thematic Review

The Trust fully participated in the Marshall Inquiry and SBNI Thematic Review. The SBNI Thematic Review report was published in December 2015 and action from the review will be taken forward as part of the Safeguarding Board NI Business Plan 2016/17 and Southern Safeguarding Panel Business Plan 2016/17. Following the publication of the Thematic Review, the Trust has completed 4 case management review notifications to the SBNI regarding young people who were subject to the thematic review and suffered significant harm as a result of abuse. These cases will be considered by the SBNI CMR Panel in May 2016. CSE is a standing item on a number of Trust and Regional Fora to ensure appropriate training; improved assessments; interagency working and good governance arrangements.

Elective Care

The Trust continued to have a number of specialty areas with capacity gaps in 2015/16 resulting in the target that the majority of patients should waiting no longer than 9 weeks for an outpatient/diagnostic appointment and 13 weeks for allied health professions and inpatient/day case treatment not being met.

In the absence of recurrent investment in 2015/16, a level of non-recurrent funding was allocated by the HSCB in quarters 3 and 4 to provide additional capacity. As a result a number of time limited areas of performance improvement were demonstrated within elective access times and within the unscheduled care pathway as follows:

- The number of patients waiting less that 9 weeks, for out-patient assessment, increased by 4.4% (1,444 patients), from 35.8% at 31 December 2015 (12,294 patients) to 40.2% at 31 March 2016 (13,738 patients). The number of patients waiting in excess of 18 weeks decreased by 1,373 from 14,736 at 31 December 2015 to 13,363 at 31 March 2016.
- The number of patients waiting in excess of 9 weeks, for diagnostic imaging, decreased by 1,945, from 3,892 at 31 December 2015 to 2,180 at 31 March 2016.
- The number of patients waiting less than 13 weeks, for in-patient/day case treatment, increased by 2.2% (105 patients), from 56.5% at 31 December 2015 (3,892 patients) to 58.7% at 31 March 2016 (3,997 patients). The number of patients waiting in excess of 26 weeks demonstrated a more significant decrease - 344 patients, from 1,709 patients at 31 December 2015 to 1,365 patients at 31 March 2016.
- The Trust demonstrated an improvement in discharge performance for non-complex discharges within 6 hours. Performance at 31 March 2016 demonstrated 95.5% in comparison to 90.9% at 31 December 2015. The Trust further demonstrated improvement in complex discharges within 48 hours. Performance at 31 March 2016 demonstrated 100% in comparison to 90.1% at 31 December 2015.

Despite this time limited improvement, the non-recurrent allocation was insufficient to address the demand in excess of capacity and waits continued to increase. Further, the ability to increase capacity, where funding was available, has been challenged in a number of areas by workforce issues and an inability to continue to flex up short term temporary staffing arrangements in key professional areas. The Trust expects that the position will deteriorate further if no funding is made available for areas with agreed capacity gaps in 2016/17; however it is continuing to work with the HSCB and continues to ensure that available capacity is directed to areas of clinical priority in the first instance.

Unscheduled Care

The Trust continues to be challenged in respect of significant service demand for unscheduled care services on both acute sites and specifically peaks in demand for ED attendances and emergency admissions. Specifically targets were not achieved in 2015/16 in respect of unscheduled care relating to the 4 and 12 hour Emergency Department targets and non-complex discharges from Acute hospitals where unscheduled care has been subject to sustained demand and heightened pressures.

The Trust received funding from the regional task group for unscheduled care to implement a range of measures to improve patient flow in the unscheduled care pathway, including 7 day working models including AHP and social work support to ED, and access to radiology, as well as funding for a dedicated minor injuries stream in ED. These measures have contributed to maintaining performance. However, full effectiveness has been limited mainly by workforce/ recruitment pressures. The Trust will continue to work with the HSCB through the newly formed unscheduled care governance structures to challenge and review current service profile and service design and to test new models of care to support improved performance.

A range of regional and local indicators of quality are in place which provide assurance on safety and quality of services.

Financial Risks

Performance of Finance Functions within BSO Shared Services Centres

The Head of Internal Audit has reviewed the shared services functions provided by BSO as noted on page 47 during 2015/16. Payroll Shared Service has continued to receive a limited assurance throughout 2015/16, showing no improvement in assurance levels from 2014/15. The other finance functions have received a satisfactory assurance.

There have continued to be a number of difficulties experienced with the HRPTS system and Internal Audit have highlighted that improvement is required by BSO Payroll in the areas noted on page 47.

In correspondence from the Interim Chief Executive of BSO, BSO acknowledge that a continued combination of systems in operation between HSC organisations, in relation to the submission of payroll and travel information for payment, and the increased workload associated with this, has reduced the controls within the BSO Payroll process, particularly around the authorisation of transactions.

The Trust Board are disappointed that there remains no improvement in assurance levels in respect of the payroll shared service and that satisfactory assurance has still not been achieved. Whilst BSO management have accepted the recommendations and provided assurance that action plans are in place, this situation continues to present reputational and other difficulties for the Trust.

The Trust will continue to monitor progress at Audit Committee.

New Control Issues in 2015/16

Clinical and Social Care Risks

The Donaldson Report

In April 2014 a review was undertaken by Sir Liam Donaldson which examined the HSC in its entirety in respect of its openness and transparency; appetite for inquiry and learning; and approach to re-dress and to making amends. The publication of the Donaldson Report 'The Right Time, The Right Place' in January 2015 made a range of recommendations across HSC. In response to the report's recommendations the Minister announced a number of actions in 2015/16 which focus on elements of Clinical & Social Care Governance as follows:

- The use of Serious Adverse Incidents and Adverse Incidents to improve patient safety and reduce risk;
- The deaths of children from natural causes should not be classified as an SAI; and
- The introduction of a regional morbidity and mortality review system.

The Trust is participating in a number of work streams with the DHSSPS, HSCB, RQIA and GAIN in respect to strengthening and modifying our existing incident reporting and investigation processes to maximise learning, highlight risk and improve patient safety both internally within the Trust and across the region. The Child death notification process has been embedded into the Trust's Morbidity and Mortality processes. The Trust is preparing to begin implementation of the regional mortality and morbidity systems in August 2016. Progress will be monitored by the Trust's Governance Committee during 2016/17.

Food safety testing

In June 2015, the results of routine sampling by an external laboratory detected possible E. Coli 0157 in the kitchen at Craigavon Area Hospital. As a result, the Trust immediately introduced precautionary measures in the interests of public safety at a cost of some £79k. Subsequently, the external laboratory partner recalled the original test results following further investigatory analysis. The Trust is currently working with PaLS and the Directorate of Legal Services regarding the contractual position with this supplier and seeking appropriate compensation. The Trust reviewed its own processes following this incident to ensure their effectiveness.

Recruitment

Throughout 2015/16, the Trust has experienced difficulties in meeting its demand for recruitment of medical, nursing and GP staff for the provision of high quality and safe services. Whilst the Trust has worked with the HSCB and DHSSPS on a number of

measures to address this, the situation has not been assisted by the existence of internal competition within the HSC for limited staff resources. The Trust will seek to generate discussion with other Trusts, the HSCB and the DHSSPS on how these competitive tensions can be minimised and managed going forward.

Emergency Department at Daisy Hill Hospital

Throughout 2015/16, a Strategic Oversight Group that included representatives from Senior Management Team and senior HSCB Commissioning representatives agreed additional measures to sustain the ED service 24 hours and 7 days a week in Daisy Hill Hospital. This included actions to recruit and stabilise the medical workforce in ED and additional support to junior staff in the ED in the out of hours period, on-going recruitment for Medical staff at all levels offering enhanced terms and conditions, augmented locum cover at middle grade in medicine and surgery out of hours, two additional short stay observation beds opened overnight for patients requiring senior review, appointment of additional Emergency Nurse Practitioners and additional Band 6 Clinical Sisters.

These actions have secured the service to date however there remain significant concerns regarding the sustainability of the current service model.

Finance Risks

Fraud cases

In 2015/16 there have been 22 reported cases of fraud. Two of these cases have been referred to the PSNI following investigation by the Counter Fraud and Probity Services. One case involves inappropriate claims by an employee and the second, inappropriate claims by a contractor. The Trust is pursuing recovery of losses incurred.

The Trust has a zero tolerance approach to fraud.

All identified actual, suspected and potential frauds are reported to the Audit Committee as a standing agenda item.

BSO Recruitment Shared Services

Following the roll out of the E-Recruitment system and Recruitment Shared services to a number of other large HSC organisations during 2015/16, issues have emerged regarding the length of time taken to complete the overall recruitment process. The Southern Trust has experienced significant delays in filling vacancies during 2015/16.

Recruitment Shared Services had only developed a limited ability to generate management and performance information from the E-Recruitment system, which has meant that information, has not been available to provide robust evidence of, and reasons for, the delays reported.

The further roll out of recruitment shared services has been put on hold until the current service is stabilised and a formal recovery plan instigated. BSO Senior Management will be monitoring and reviewing progress against this plan weekly, until the service is stabilised.

Internal Audit has provided an unacceptable assurance in 2015/16 as noted on page 47.

BSO management have accepted the recommendations and provided assurance that action plans are in place to assist with the implementation of the recommendations in 2016/17. The Trust will continue to monitor progress at the Audit Committee.

Conclusion

The Trust has a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in Managing Public Money NI. The system operates on a principle of continuous improvement where the performance and effectiveness of governance arrangements are subject to regular review.

As outlined above, the internal audit review of control systems has resulted in a number of limited assurances and one unacceptable assurance in the Trust. A number of priority one issues have been raised with management and extensively examined by the Audit Committee. The findings of these reports and others such as those issued by RQIA will be incorporated into action plans aimed to address the weaknesses/gaps in control.

Further to considering the accountability framework within the Trust and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the Trust has operated a sound system of internal governance during the period 2015/16.

REMUNERATION REPORT FOR THE YEAR ENDED 31 MARCH 2016

Fees and allowances paid to the Chairman and other Non-Executive Directors are as prescribed by the Department of Health and Social Services and Public Safety.

The remuneration and other terms and conditions of Executive Directors are by the Remuneration and Terms of Service Committee. Its membership includes the Chair and all Non-Executive Directors. The terms of reference of the Committee are based on Circular HSS (PDD) 8/94 Section B.

For the purposes of this report the pay policy refers to Senior Executives, defined as Chief Executive, Executive Director and Functional Director and is based on the guidance issued by the Department of Health and Social Services and Public Safety on job evaluation, grades, rate for the job, pay progression, pay ranges and contracts.

Pay progression is determined by an annual assessment of performance. It is the responsibility of the Remuneration and Terms of Service Committee to monitor and evaluate the performance of the Chief Executive ensuring that any discretionary awards in terms of performance related pay are justifiable in light of the Trust's overall performance against the annual Trust Delivery Plan. During 2015/16, emphasis continued to be on patient safety and quality improvement, ministerial targets and financial balance. The Chief Executive in turn is responsible for the assessment of performance of the Senior Executives based on the attainment of individual objectives established at the outset of the year, and for the submission of recommendations to the Remuneration and Terms of Service Committee for its annual review of salaries which are conducted in accordance with the relevant circulars issued by the Department of Health, Social Services and Public Safety.

The levels of performance pay permitted applied by the Remuneration and Terms of Service Committee are prescribed by Department of Health and Social Services and Public Safety. Pay progression as at 1 April 2015 based on performance for Senior Executives in the period 1 April 2014 to 31 March 2015 has been set at 2% for fully acceptable performance for those employed on contracts before 23 December 2008 and 1% (non-consolidated) for those employed on contracts after 23 December 2008. There is no ‘Superior Performance Award’. No award is made for unsatisfactory performance. Senior Executive pay ranges have not been increased with effect from 1 April 2015.

During 2015/16, all contracts were permanent and provided for three months’ notice for both parties, with the exception of:

- Mrs Paula Clarke, who undertook the role of Interim Chief Executive from 1 April 2015 to 31 March 2016.
- Mrs Aldrina Magwood, who continued to undertake the Director of Performance and Reform on an acting basis during 2015/16.
- Mr Kieran Donaghy, who undertook the role of Temporary Deputy Chief Executive from 1 February 2016 to 31 March 2016.

As far as all Senior Executives are concerned, the provisions for compensation for early termination of contract are in accordance with the appropriate Departmental guidance.

Senior Employees' Remuneration (Audited)

The salary and the value of any taxable benefits in kind of the most senior members of the Southern HSC Trust were as follows:

	2015/2016				2014/2015			
Name	**Salary £000s**	**Bonus/ Performance pay £000s**	**Benefits in Kind (rounded to nearest £100)**	**Total £000s**	**Salary £000s**	**Bonus/ Performance pay £000s**	**Benefits in Kind (rounded to nearest £100)**	**Total £000s**
Non-Executive Members								
Mrs R Brownlee (Chair)	25-30	0	0	25-30	25-30	0	0	25-30
Mrs E Mahood	5-10	0	0	5-10	5-10	0	0	5-10
Mrs D Blakely (to 31 December 2015)	5-10	0	0	5-10	5-10	0	0	5-10
Mr E Graham	5-10	0	0	5-10	5-10	0	0	5-10
Mrs H Kelly (to 31 December 2015)	5-10	0	0	5-10	5-10	0	0	5-10
Dr R Mullan	5-10	0	0	5-10	5-10	0	0	5-10
Mrs S Rooney	5-10	0	0	5-10	5-10	0	0	5-10

	2015/2016					2014/2015				
Name	**Salary £000s**	**Bonus / Performance pay £000s**	**Benefits in Kind (rounded to nearest £100)**	**Pension Benefits £000s**	**Total £000s**	**Salary £000s**	**Bonus/ Performance pay £000s**	**Benefits in Kind (rounded to nearest £100)**	**Pension Benefits £000s**	**Total £000s**
Mrs H McCartan (from 15 February 2016)	0-5 (5-10 full year equivalent)	0	0	0	0-5 (5-10 full year equivalent)	0	0	0	0	0
Ms E Mullan (from 15 February 2016)	0-5 (5-10 full year equivalent)	0	0	0	0-5 (5-10 full year equivalent)	0	0	0	0	0
Mr J Wilkinson (from 15 February 2016)	0-5 (5-10 full year equivalent)	0	0	0	0-5 (5-10 full year equivalent)	0	0	0	0	0
Executive Members										
Mrs P Clarke – Interim Chief Executive (from 1 April 2015 to 31 March 2016)	95-100	0	0	110	205-210	75-80	0	0	66	140-145
Mrs M McAlinden - Chief Executive (Resigned 31 March 2015)	0	0	0	0	0	100-105	0	0	20	120-125
Mr S McNally - Director of Finance & Procurement	90-95	0	0	N/A	90-95	90-95	0	0	18	105-110

	2015/16					2014/15				
Name	**Salary £000s**	**Bonus / Performance pay £000s**	**Benefits in Kind (rounded to nearest £100)**	**Pension Benefits £000s**	**Total £000s**	**Salary £000s**	**Bonus/ Performance pay £000s**	**Benefits in Kind (rounded to nearest £100)**	**Pension Benefits £000s**	**Total £000s**
Dr J Simpson - Medical Director (to 31 July 2015)	30-35 (100-105 full year equivalent)	0	0	N/A	30-35 (100-105 full year equivalent)	165-170	0	0	(7)	155-160
Dr R Wright – Medical Director (from 1 July 2015)	75-80 (100-105 full year equivalent)	0	0	125 (166 full year equivalent)	200-205 (265-270 full year equivalent)	0	0	0	0	0
Mr P Morgan - Director of Children & Young People's Services	75-80	0	0	8	80-85	75-80	0	0	15	85-90
Mr F Rice – Director of Mental Health & Disability Services & Executive Director of Nursing & AHPs	100-105	0	0	38	135-140	95-100	0	0	27	120-125
Other Members										
Mr K Donaghy - Director of Human Resources & Organisational Development (Also temporary Deputy Chief Executive effective from 1 February to 31 March 2016)	85-90	0	0	99	185-190	80-85	0	0	17	95-100

	2015/16					2014/15				
Name	**Salary £000s**	**Bonus / Performance pay £000s**	**Benefits in Kind (rounded to nearest £100)**	**Pension Benefits £000s**	**Total £000s**	**Salary £000s**	**Bonus/ Performance pay £000s**	**Benefits in Kind (rounded to nearest £100)**	**Pension Benefits £000s**	**Total £000s**
Mr M Crilly – Acting Director of Mental Health & Disability Services (to 30 April 2015)	5-10 (70-75 full year equivalent)	0	0	1 (9 full year equivalent)	5-10 (80-85 full year equivalent)	70-75	0	0	8	80-85
Mrs A McVeigh - Director of Older People & Primary Care	80-85	0	0	9	90-95	80-85	0	0	16	95-100
Mrs D Burns - Interim Director of Acute Services (Resigned 31 August 2015)	30-35 (65-70 full year equivalent)	0	0	(2) ((5) full year equivalent)	25-30 (60-65 full year equivalent)	70-75	0	0	13	85-90
Mrs E Gishkori – Director of Acute Services (from 19 August 2015)	46-50 (65-70 full year equivalent)	0	0	32 (47 full year equivalent)	75-80 (120-125 full year equivalent)	0	0	0	0	0
Mrs A Magwood – Acting Director of Performance & Reform (from 1 March 2015)	75-80	0	0	16	90-95	5-10 (65-70 full year equivalent)	0	0	4 (45 full year equivalent)	10-15 (110-115 full year equivalent)

The value of pension benefits accrued during the year is calculated as: (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increase or decreases due to a transfer of pension rights.

Two Non-Executive Directors came to the end of their term of office in December 2015 and three new Non-Executive Directors were appointed from February 2016.

Senior Executive remuneration stated above includes a pay award for two years – 2013/14 and 2014/15. The comparative figures did not include a pay award for 2013/14 due to the late issue and finalisation of the DHSSPS circular for that year.

Pensions of Senior Management (Audited)

The pension entitlements of the most senior members of the Southern HSC Trust were as follows:

	2015/2016				
Name	**Real Increase in pension and related lump sum at age 60 £000s**	**Total Accrued pension at age 60 and related lump sum £000s**	**CETV at 31/03/15 £000s**	**CETV at 31/03/16 £000s**	**Real Increase in CETV £000s**
Executive Members					
Mrs P Clarke – Interim Chief Executive (from 1 April 2015 to 31 March 2016)	5-7.5 plus 12.5-15 lump sum	25-30 plus 85-90 lump sum	415	519	89
Mrs M McAlinden - Chief Executive(Resigned 31 March 2015)	0	0	0	0	0
Mr S McNally - Director of Finance & Procurement **Note 1**	0	0	0	0	0
Dr J Simpson - Medical Director (to 31 July 2015) **Note 2**	0	0	0	0	0
Dr R Wright – Medical Director (from 1 July 2015)	7.5-10 plus 22.5-25 lump sum	50-55 plus 160-165 lump sum	182	1,069	155
Mr P Morgan – Director of Children & Young People's Services	0-2.5 plus 0-2.5 lump sum	30-35 plus 90-95 lump sum	661	703	18

	2015/16				
Name	**Real Increase in pension and related lump sum at age 60 £000s**	**Total Accrued pension at age 60 and related lump sum £000s**	**CETV at 31/03/15 £000s**	**CETV at 31/03/16 £000s**	**Real Increase In CETV £000s**
Mr F Rice – Director of Mental Health & Disability Services & Executive Director of Nursing & AHPs	0-2.5 plus 7.5 lump sum	40-45 plus 125-130 lump sum	716	781	40
Other Members					
Mr K Donaghy - Director of Human Resources & Organisational Development (Also temporary Deputy Chief Executive effective from 1 February to 31 March 2016)	2.5-5 plus 12.5-15 lump sum	40-45 plus 125-130 lump sum	846	986	109
Mr M Crilly – Acting Director of Mental Health & Disability Services (to 30 April 2015)	0-2.5 plus 0-2.5 lump sum	30-35 plus 90-95 lump sum	597	634	16
Mrs A McVeigh – Director of Older People & Primary Care	0-2.5 plus 2.5-5 lump sum	35-40 plus 105-110 lump sum	709	752	18
Mrs D Burns - Interim Director of Acute Services (Resigned 31 August 2015)	0-2.5 plus (0-2.5) lump sum	15-20 plus 50-55 lump sum	252	264	4
Mrs E Gishkori – Director of Acute Services (from 19 August 2015)	0-2.5 plus 5-7.5 lump sum	10-15 plus 40-45 lump sum	212	261	43
Mrs A Magwood – Acting Director of Performance & Reform	0.2-5 plus (0-2.5) lump sum	15-20 plus 50-55 lump sum	276	297	12

Note 1: Mr S McNally is beyond the threshold for calculation of CETV, so this is not applicable in 2015/16.

Note 2: Dr J Simpson retired during the year. No CETV is disclosed for Pensioners.

Mrs P Clarke resigned her post as Interim Chief Executive with effect from 31 March 2016.

Mr K Donaghy was temporary Deputy Chief Executive from 1 February to 31 March 2016.

Dr J Simpson, Medical Director, retired in July 2015. Dr R Wright commenced as Medical Director from July 2015.

Mrs D Burns Interim Director of Acute Services resigned with effect from 31 August 2015.

Mrs E Gishkori was appointed to the post of Director of Acute Services from 19 August 2015.

Mr M Crilly was Acting Director of Mental Health & Disability Services to the 30 April 2015.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of Pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSC pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or

arrangement) and uses common market valuation factors for the start and end of the period.

Staff Report (Audited)

The Trust employs 14,702 staff with 78.5% of staff providing direct hands on care to patients and clients. This figure includes staff with more than one job position.

14% of employees are male (1,680 headcount) and 86% are female (10,253 headcount). These figures include bank, staff on employment breaks and staff seconded out of the Trust. Of the nine Directors (including the Chief Executive) within the Trust at 31 March 2016, 5 are male and 4 are female.

Staff sickness and absenteeism

The cumulative sickness and absenteeism rate for the Trust as at 31 January 2016 was 5.27%.

Employee Policies

The Trust's Joint Consultative & Negotiating Forum is committed to the involvement of staff at all levels in shaping service delivery and being part of the decision making which affects their working lives and the delivery of health and social care. Significant efforts have been made by the Trust and the Trade Unions to develop a partnership working approach to how business is conducted. The Trust's Partnership Agreement sets out the approach to partnership working and a clear set of values to promote a culture of involvement. This partnership approach has continued to develop across all directorates and clearly has resulted in staff and management working together to deliver a number of very significant change initiatives and service reforms over the past number of years. A Staff Involvement Framework is in place to govern how the Trust involves staff in decisions that affect them through a range of processes, procedures and initiatives to develop a consistent approach to involving staff.

Significant work is on-going across the Trust to continually improve services for patients and clients, and a key focus with many of these improvement initiatives is the involvement of staff who work day by day within the services. Many of these improvement initiatives are reported and showcased in the Trust's Continuous Improvement Newsletters prepared by the Directorate of Performance & Reform, which are distributed via global email.

The Trust has in place an Equal Opportunity Policy which emphasises its continuing commitment to the provision of equality of opportunity. The scope of the current policy covers age, marital or civil partnership status, sex, sexual orientation, gender reassignment, religious belief, political opinion, race (including colour, nationality, ethnic

or national origins, or being an Irish Traveller), disability, pregnancy or maternity leave and with/without dependants. Key achievements during the year included mainstreaming equality, disability and human rights considerations within policy development and decision making processes; participation in a regional workshop on 'HSC Procurement, Commissioning and Planning' - ensuring a human rights, equality and disability perspective is embedded in good procurement practice and contracts management; supporting deployment of an IT portal to ensure the timely and cost effective use of qualified interpreters for all service users and revision of an information booklet on access to health and social care services.

The Trust also recognises that attention needs to be given to the position of people with disabilities in the service and it is for this reason that the Trust also has a Policy on the Employment of People with Disabilities in place. This Policy takes account of the Disability Discrimination Act 1995 (the DDA), as amended. In developing this policy, the Trust has taken account of its duty under Section 49A of the DDA (as amended), which requires the Trust, when carrying out its functions, to have due regard to the need to promote positive attitudes towards people with disabilities and the need to encourage their participation in public life.

Staff Costs and Numbers

Staff costs comprise:

	2016			2015
Staff costs comprise:	**Permanently employed staff**	**Others**	**Total**	**Total**
	£000s	**£000s**	**£000s**	**£000s**
Wages and salaries	288,012	15,576	303,588	296,485
Social security costs	19,034	1,200	20,234	18,965
Other pension costs	37,713	166	37,879	29,936
Sub-Total	**344,759**	**16,942**	**361,701**	**345,386**
Capitalised staff costs	(339)	0	(339)	(319)
Total staff costs reported in Statement of Comprehensive Expenditure	**344,420**	**16,942**	**361,362**	**345,067**
Less recoveries in respect of outward secondments			(252)	(498)
Total net costs			**361,110**	**344,569**

	£000s	**£000s**
Southern HSC Trust	361,110	344,569
Total	**361,110**	**344,569**

Staff Costs exclude £339k charged to capital projects during the year (2015: £319k).

Pension Liabilities

The Trust participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. A full valuation for Resource Accounts purposes as at 31 March 2012 was certified in February 2015 and is used in the 2015/16 accounts.

The accounting treatment of pension liabilities is explained in Note 1.19 of the annual accounts on page 102.

Retirements due to ill-health

During 2015/16 there were 19 early retirements from the Trust (2014/15: 13), agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £10k (2014/15: £12k). These costs are borne by the HSC Pension Scheme.

Median Remuneration

	2015/16	**2014/15**
Band of Highest Paid Director's Total Remuneration **(£000s)**	155-160	165-170
Median Total Remuneration (based on paid salary)	£29,300	£29,079
Ratio	5.4	5.8

The median reflects the aggregation of earnings where staff have multiple contracts.

Reporting entities are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce, excluding the highest paid director.

In 2015/16, 27 (2014/15: 18) employees received remuneration in excess of the highest paid director. Remuneration ranged from £155k to £285k (2014/15: £165k to £250k). All of these employees were clinicians.

Total remuneration includes salary, non-consolidated performance-related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

In 2015/16 and 2014/15 the most highly paid Director was the Medical Director.

Average Number of Persons Employed

The average number of paid whole time equivalent persons employed during the year was as follows:

	2016			2015 Restated
	Permanently employed staff	Others	Total	Total
	No.	No.	No.	No.
Medical and dental	638	71	709	670
Nursing and midwifery	3,386	32	3,418	3,232
Professions allied to medicine	1,070	9	1,079	1,045
Ancillaries	713	141	854	787
Administrative & clerical	1,612	50	1,662	1,626
Estates & Maintenance	104	0	104	101
Social services	1,198	5	1,203	1,158
Domiciliary/Homecare Workers	875	0	875	920
Total average number of persons employed	9,596	308	9,904	9,539
Less average staff number relating to capitalised staff costs	(7)	0	(7)	(8)
Less average staff number in respect of outward secondments	(4)	0	(4)	(11)
Total net average number of persons employed	**9,585**	**308**	**9,893**	**9,520**

Of which:

Southern HSC Trust	9,893
Charitable Trust Fund	0
	9,893

A number of minor changes have been made to the numbers of staff disclosed within categories in 2015 to correct classifications.

Number of Senior Staff by Band (Assistant Director and above but excluding Senior Management)

Gender Breakdown by Earnings Range 2015/16 – Senior Staff (Assistant Director and above)			
Earnings Range £'000	Female	Male	Total
95-100	1	0	1
65-70	14	8	22
60-65	2	1	3
55-60	4	0	4
45-50	0	1	1
40-45	0	1	1
30-35	1	0	1
15-20	2	6	8
Total	**24**	**17**	**41**

Gender Breakdown by Earnings Range 2014/15 – Senior Staff (Assistant Director and above)			
Earnings Range £'000	Female	Male	Total
95-100	1	0	1
65-70	13	9	22
60-65	3	0	3
55-60	5	0	5
40-45	0	2	2
30-35	1	0	1
15-20	2	6	8
Total	**25**	**17**	**42**

The earnings rates disclosed above are *pro rata***:** not all individuals work full-time.

Associate Medical Directors (AMD) receive an allowance in addition to earnings from clinical duties; AMD additional allowance only is included in above.

Reporting of Early Retirement and Other Compensation Scheme – exit packages (Audited)

Exit Package Cost Band	Number of Compulsory Redundancies		Number of other Departures Agreed		Total Number of Exit Packages by Cost Band	
	2015/16	2014/15	2015/16	2014/15	2015/16	2014/15
<£10,000	0	0	6	0	6	0
£10,001-£25,000	0	0	4	0	4	0
£25,001-£50,000	0	0	1	0	1	0
£50,001-£100,000	0	0	3	2	3	2
Total number of exit packages	**0**	**0**	**14**	**2**	**14**	**2**

	£000s	£000s	£000s	£000s	£000s	£000s
Total Resource Cost	**0**	**0**	**289**	**182**	**289**	**182**

Total Number of Exit Packages by Types		
	2015/16	**2014/15**
Change of Management	0	2
Voluntary Exit Scheme	14	0
Total	**14**	**2**

The above exit costs of £289k (2014/15: £182k) are reflected in Note 3.2 of the Annual Accounts within operating expenses.

The exit packages in 2015/16 which impact net expenditure represent voluntary leavers as a consequence of the HSC Voluntary Exit Scheme.

Where early retirements have been agreed, the additional costs are met by the employing authority and not by the HSC Pension Scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

Staff Benefits

There were no staff benefits in 2015/16 or 2014/15.

Trust Management Costs

	2016	**2015**
	£000s	**£000s**
Trust management costs	21,066	20,905
Income:		
RRL	576,154	565,143
Income	39,224	38,656
Non cash RRL for movement in clinical negligence provision	(16,120)	(6,089)
Less interest receivable	(1)	(2)
Total Income	599,257	597,708
% of total income	**3.5%**	**3.5%**

The above information is based on the Audit Commission's definition "M2" Trust Management costs as detailed in HSS (THR) 2/99.

Expenditure on Consultancy

The Trust did not incur expenditure on external consultancy during 2015/16.

Off Payroll Engagements

The Trust is required to disclose the details of off-payroll engagements at a total cost of over £58,200 per annum that were in place during the year.

The Trust's use of Off Payroll Staff Resources in 2015/16 and 2014/15 is shown below:

	2015/16		**2014/15**
	Number of staff		**Number of staff**
Off Payroll Staff as 1st April 2015	10	Off Payroll Staff as 1st April 2014	11
New engagements during the year	9	New engagements during the period	1
Number of engagements transferred to payroll	0	Number of engagements transferred to payroll	0
Number of engagements that have come to an end during the year	(7)	Number of engagements that have come to an end during the year	(2)
Off payroll staff as at 31 March 2016	**12**	**Off payroll staff as at 31 March 2015**	**10**

The current contract for medical agency is in place following a procurement exercise carried out before 1 October 2014.

ACCOUNTABILITY AND AUDIT REPORT

Compliance with regularity of expenditure guidance

The Trust Management Statement (MS) and the Financial Memorandum (FM) which exists between the DHSSPS and the Trust, outlines the framework in which the Trust will operate and details certain aspects of financial provisions which the Trust will observe.

The discharge of the responsibilities within the MS/FM is supported by the Standing Financial Instructions (SFIs) of the Trust. These were updated during the year and approved by Trust Board in October 2015.

The Standing Financial Instructions are the "business rules" that Directors and employees must follow when acting on behalf of the Trust. They outline the key financial responsibilities which apply to everyone working for the Trust and are mandatory. SFIs are then further supported by finance policies and detailed financial procedures which must be kept up to date with DHSSPS circulars as appropriate. This overall framework is designed to ensure that the Trust has assurance that the income and expenditure recorded in its financial statements have been applied to the purposes as intended by the NI Assembly and the financial transactions recorded in the financial statements of the Trust conform to the authorities which govern them.

Both Internal Audit and External Audit provide an independent assessment of the Trust's adherence to this framework of financial governance and control, with the External Auditor providing an annual opinion on regularity within the certified financial statements of the Trust. The External Auditor's opinion on regularity for 2015/16 is unqualified.

Formal Complaints Management

To help the Trust identify areas in which it needs to improve we welcome all comments and complaints regarding our services. Information about how you can make a complaint is explained in our "We Value Your Views" leaflet on the Southern Trust website. We recognise that at times, patients, families and carers may have concerns about their care or treatment. We are committed to engage with patients and their families to ensure that we learn from their experiences.

The total number of complaints received for the period 1 April 2015 – 31 March 2016 was 1,045.

The Trust uses issues raised through the complaints process as an important source of information for safety and quality improvement. This information informs learning and development and is fed back to staff involved. Within the Trust it is the responsibility of all Trust Directors, Assistant Directors, Heads of Service and Senior Managers to utilise

the information and trends from their complaints to ensure learning and development and to monitor learning. Complaint reports are shared at Senior Management Governance meetings, Governance Committee meetings and Directorate meetings to highlight complaint themes across the Trust to ensure improvement and learning takes place.

Statement of Losses and Special Payments recognised in the year

Losses and special payments are items of expenditure that the NI Assembly would not have contemplated when it agreed funding to the Trust. They are subject to special controls and procedures and require specific approval in accordance with limits set by the DHSSPS. The limit delegated to the Trust, for approval of losses, differs depending on the type of loss but all losses and special payments, irrespective of value, require approval by the Trust Board. Losses over a particular threshold require approval by the DHSSPS.

Losses and special payments are reported to the Audit Committee for review and to Trust Board for approval annually. They are audited as part of the audit of the Annual Accounts.

Statement of Losses and Special Payments recognised in the year (continued)

Type of Loss and Special Payment	2015/16		2014/15 Restated	
	CASES	£	CASES	£
Cash Losses				
Cash Losses – Other causes	6	5,168	95	7,208
Claims abandoned				
Waived or abandoned claims	0	0	3	54,679
Administrative write-offs				
Bad debts	821	346,354	394	223,305
Fruitless payments				
Late Payment of Commercial Debt	5	553	9	365
Other Fruitless payments and constructive losses	2	65,183	2	1,719
	7	**65,736**	**11**	**2,084**
Stores Losses				
Losses of accountable stores through any deliberate act	0	0	1	1,800
Other stores losses (Note 1)	919	31,830	4,892	65,598
	919	**31,830**	**4,893**	**67,398**
Special Payments				
Compensation payments				
- Clinical Negligence	85	2,015,585	89	6,911,848
- Public Liability	11	106,984	17	101,395
- Employers Liability	28	198,048	32	459,081
- Other	1	1,300	0	0
	125	**2,321,917**	**138**	**7,472,324**
Ex-gratia payments	**4**	**3,999**	**5**	**3,571**
TOTAL (Note 2)	**1,882**	**2,775,004**	**5,539**	**7,830,569**

Note 1: The number of cases of other stores losses was omitted in 2014/15.

Note 2: Eight of the above losses, which range from £12,539 to £64,383, require DHSSPS approval. Seven of these are in respect of debts relating to deceased clients and / or statute barred cases. One loss (£64k) is in respect of costs incurred in activating the Trust's catering contingency plan on receipt of independent microbiological food testing information which was inaccurate. The total loss, inclusive of £15k lost income, was £79k as referenced on page 58 however only the costs involved are reflected in the statement above.

Losses and Special Payments over £250,000

	2015/16		2014/15	
Losses and Special Payments over £250,000	**Number of Cases**	**£**	**Number of Cases**	**£**
Special Payments Clinical Negligence Cases	2	614,835	3	2,989,600
TOTAL	**2**	**614,835**	**3**	**2,989,600**

There were 2 clinical negligence cases on which payments recognised in the year exceeded £250,000 – one of £425k, the second £289k.

Gifts made over limits in Managing Public Money Northern Ireland

The Trust made no gifts in 2015/16.

Remote Contingent Liabilities

In addition to Contingent Liabilities reported within the meaning of IAS37, (included in the Annual Accounts Note 21), the Southern HSC Trust also reports liabilities for which the likelihood of a transfer of economic benefit in settlement is too remote to meet the definition of Contingent Liability. There are no remote contingent liabilities of which the Trust is aware.

Signed: Personal Information redacted by the USI

Mr Francis Rice

Accounting Officer **Date:** 9/6/16

SOUTHERN HEALTH AND SOCIAL CARE TRUST

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

I certify that I have audited the financial statements of the Southern Health and Social Care Trust and its group for the year ended 31 March 2016 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. The financial statements comprise the Consolidated Statements of Comprehensive Net Expenditure, Financial Position, Changes in Taxpayers' Equity, Cash Flows, and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration and Staff Report and Accountability and Audit Report within the Accountability Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the group's and Southern Health and Social Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Southern Health and Social Care Trust; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the group's and of Southern Health and Social Care Trust's affairs as at 31 March 2016 and of the net expenditure, cash flows and changes in taxpayers' equity for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health (formerly Department of Health, Social Services and Public Safety) directions issued thereunder.

Opinion on other matters

In my opinion:

- the parts of the Remuneration and Staff Report and the Accountability and Audit Report to be audited have been properly prepared in accordance with Department of Health directions made under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended; and
- the information given in the Performance Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the parts of the Remuneration and Staff Report and Accountability and Audit Report to be audited are not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with Department of Finance's (formerly Department of Finance and Personnel) guidance.

Report

I have no observations to make on these financial statements.

Personal Information redacted by the USI

KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast
BT7 1EU

24th June 2016

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Annual Accounts for the Year Ended 31 March 2016

FOREWORD

These accounts for the year ended 31 March 2016 have been prepared in accordance with Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, in a form directed by the Department of Health, Social Services and Public Safety.

Southern HSC Trust

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

CERTIFICATES OF DIRECTOR OF FINANCE, CHAIR AND CHIEF EXECUTIVE

I certify that the annual accounts set out in the financial statements and notes to the accounts pages 87 to 142 which I am required to prepare on behalf of the Southern Health and Social Care Trust (Southern HSC Trust) have been compiled from and are in accordance with the accounts and financial records maintained by the Southern HSC Trust and with the accounting standards and policies for HSC bodies approved by the DHSSPS.

Director of Finance (Southern HSC Trust) [redacted]

Date 09/06/2016

I certify that the annual accounts set out in the financial statements and notes to the accounts pages 87 to 142 as prepared in accordance with the above requirements have been submitted to and duly approved by the Board.

[redacted]

Date 09/06/2016.

[redacted]

Interim Chief Executive (Southern HSC Trust)

Date 9/6/16

SOUTHERN HSC TRUST

CONSOLIDATED STATEMENT OF COMPREHENSIVE NET EXPENDITURE for the year ended 31 March 2016

	NOTE	2016 Trust £000s	2016 CTF £000s	2016 Consolidated £000s	2015 Trust £000s	2015 CTF £000s	2015 Consolidated £000s
Income							
Income from activities	4.1	29,483	0	29,483	27,972	0	27,972
Other Operating Income	4.2	9,741	298	10,039	10,682	241	10,923
		39,224	298	39,522	38,654	241	38,895
Expenditure							
Staff costs	3.1	(361,362)	0	(361,362)	(345,067)	0	(345,067)
Purchase of Goods and Services	3.2	(160,864)	(29)	(160,893)	(157,218)	(23)	(157,241)
Depreciation, amortisation and impairment charges	3.2	(15,213)	0	(15,213)	(38,188)	0	(38,188)
Provision Expense	3.2	(16,789)	0	(16,789)	(6,610)	0	(6,610)
Other Expenditures	3.2	(61,013)	(404)	(61,417)	(56,675)	(238)	(56,913)
Total Operating Expenditure		**(615,241)**	**(433)**	**(615,674)**	**(603,758)**	**(261)**	**(604,019)**
Net Operating Expenditure		**(576,017)**	**(135)**	**(576,152)**	**(565,104)**	**(20)**	**(565,124)**
Finance Income	4.2	1	125	126	2	109	111
Finance Expense	3.2	(1)	0	(1)	0	0	0
Net Expenditure for the year		**(576,017)**	**(10)**	**(576,027)**	**(565,102)**	**89**	**(565,013)**
Revenue Resource Limit (RRL)	24.1	576,154	0	576,154	565,143	0	565,143
Add back charitable trust fund net expenditure		0	10	10	0	(89)	(89)
Surplus against RRL		**137**	**0**	**137**	**41**	**0**	**41**
OTHER COMPREHENSIVE EXPENDITURE							
Items that will not be reclassified to net operating costs:							
Net gain/(loss) on revaluation of property, plant and equipment	5.1/ 8/ 5.2/ 8	11,830	0	11,830	(5,115)	0	(5,115)
Net gain/(loss) on revaluation of intangibles	6.1/ 8/ 6.2/ 8	0	0	0	0	0	0
Net (loss)/gain on revaluation of charitable assets	7	0	(174)	(174)	0	167	167
Items that may be reclassified to net operating costs:							
Net gain/(loss) on revaluation of available for sale financial assets		0	0	0	0	0	0
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March 2016		**(564,187)**	**(184)**	**(564,371)**	**(570,217)**	**256**	**(569,961)**

The notes on pages 91 to 142 form part of these accounts.

SOUTHERN HSC TRUST

CONSOLIDATED STATEMENT OF FINANCIAL POSITION as at 31 March 2016

		2016		2015	
	NOTE	Trust	Consolidated	Trust	Consolidated
Non Current Assets		£000s	£000s	£000s	£000s
Property, plant and equipment	5.1/5.2	304,076	304,076	284,328	284,328
Intangible assets	6.1/6.2	0	0	69	69
Financial assets	7.0	0	2,671	0	2,845
Trade and other receivables	12.0	694	694	906	906
Total Non Current Assets		**304,770**	**307,441**	**285,303**	**288,148**
Current Assets					
Assets classified as held for sale	9.0	1,381	1,381	1,108	1,108
Inventories	10.0	2,987	2,987	2,880	2,880
Trade and other receivables	12.0	13,532	13,600	15,771	15,834
Other current assets	12.0	3,035	3,035	4,526	4,526
Financial assets	7.0	0	0	0	0
Cash and cash equivalents	11.0	1,184	1,416	1,575	1,750
Total Current Assets		22,119	22,419	25,860	26,098
Total Assets		**326,889**	**329,860**	**311,163**	**314,246**
Current Liabilities					
Trade and other payables	13.0	(68,267)	(68,383)	(65,756)	(65,800)
Provisions	15.0	(7,439)	(7,439)	(5,231)	(5,231)
Total Current Liabilities		(75,706)	(75,822)	(70,987)	(71,031)
Total Assets Less Current Liabilities		**251,183**	**254,038**	**240,176**	**243,215**
Non Current Liabilities					
Provisions	15.0	(35,673)	(35,673)	(23,888)	(23,888)
Total Non Current Liabilities		(35,673)	(35,673)	(23,888)	(23,888)
Total Assets less Total Liabilities		**215,510**	**218,365**	**216,288**	**219,327**
Taxpayers' Equity					
Revaluation reserve		47,080	47,080	34,585	34,585
SoCNE reserve		168,430	168,430	181,703	181,703
Other reserves - charitable fund		0	2,855	0	3,039
Total Equity		**215,510**	**218,365**	**216,288**	**219,327**

The note[redacted] part of these accounts.

Signed [redacted] (Chairman) Date: 9/6/16

Signed [redacted] (Interim Chief Executive) Date: 9/6/16

SOUTHERN HSC TRUST

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2016

	NOTE	SoCNE Reserve	Revaluation Reserve	Charitable Fund	Total
		£000s	£000s	£000s	£000s
Balance at 1 April 2014		**183,158**	**40,540**	**2,783**	**226,481**
Changes in Taxpayers Equity 2014-15					
Grant from DHSSPS		562,750	0	0	562,750
Transfers between reserves		840	(840)	0	0
(Comprehensive expenditure for the year)		(565,102)	(5,115)	256	(569,961)
Transfer of asset ownership		0	0	0	0
Non cash charges - auditors remuneration	3.2	57	0	0	57
Balance at 31 March 2015		**181,703**	**34,585**	**3,039**	**219,327**
Changes in Taxpayers Equity 2015-16					
Grant from DHSSPS		563,350	0	0	563,350
Transfers between reserves		(665)	665	0	0
(Comprehensive expenditure for the year)		(576,017)	11,830	(184)	(564,371)
Non cash charges - auditors remuneration	3.2	59	0	0	59
Balance at 31 March 2016		**168,430**	**47,080**	**2,855**	**218,365**

The notes on pages 91 to 142 form part of these accounts.

SOUTHERN HSC TRUST

CONSOLIDATED STATEMENT OF CASHFLOW FOR THE YEAR ENDED 31 MARCH 2016

	NOTE	2016 £000s	2015 £000s
Cash flows from operating activities			
Net expenditure after interest		(576,027)	(565,013)
Adjustments for non cash costs		32,057	44,688
Decrease/(Increase) in trade and other receivables		3,937	(1,458)
(Increase)/Decrease in inventories		(107)	180
Increase/(Decrease) in trade payables		2,583	(16,210)
Less movements in payables relating to items not passing through the NEA			
Movements in payables relating to the purchase of property, plant and equipment		(1,314)	11,860
Use of provisions	15	(2,796)	(7,756)
Net cash outflow from operating activities		(541,667)	(533,709)
Cash flows from investing activities			
Purchase of property, plant & equipment	5	(22,126)	(29,956)
Proceeds of disposal of property, plant & equipment		109	169
Proceeds on disposal of assets held for resale		0	130
Drawdown from investment fund		0	100
Share of income reinvested		174	(167)
Net cash outflow from investing activities		(21,843)	(29,724)
Cash flows from financing activities			
Grant in aid		563,350	562,750
Movement in Charitable Trust Funds		(174)	167
Net financing		563,176	562,917
Net (decrease) in cash & cash equivalents in the period		(334)	(516)
Cash & cash equivalents at the beginning of the period	11	1,750	2,266
Cash & cash equivalents at the end of the period	11	**1,416**	**1,750**

The notes on pages 91 to 142 form part of these accounts.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

STATEMENT OF ACCOUNTING POLICIES

1. Authority

These accounts have been prepared in a form determined by the Department of Health, Social Services and Public Safety based on guidance from the Department of Finance and Personnel's Financial Reporting Manual (FReM) and in accordance with the requirements of Article 90(2) (a) of the Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14) as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003.

The accounting policies follow IFRS to the extent that it is meaningful and appropriate to HSC Trusts. Where a choice of accounting policy is permitted, the accounting policy which has been judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The Trust's accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Currency and Rounding

These accounts are presented in UK Pounds Sterling. The figures in the accounts are shown to the nearest £1,000.

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Land, Buildings, Dwellings, Transport Equipment, Plant and Machinery, Information Technology, Furniture and Fittings, and Assets under Construction.

Recognition

Property, plant and equipment must be capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and
- The item has cost of at least £5,000; or

- collectively, a number of items have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

On initial recognition property, plant and equipment are measured at cost including any expenditure such as installation, directly attributable to bringing them into working condition. Items classified as “under construction” are recognised in the Statement of Financial Position to the extent that money has been paid or a liability has been incurred.

Valuation of Land and Buildings

Land and buildings are carried at the last professional valuation, in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation - Professional Standards in so far as these are consistent with the specific needs of the HSC.

The last valuation was carried out on 31 January 2015 by Land and Property Services (LPS) which is part of the Department of Finance and Personnel. The valuers are qualified to meet the ‘Member of Royal Institution of Chartered Surveyors’ (MRICS) standard.

Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

Land and buildings used for the Arm’s Length Body (ALB) services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

Land and buildings used for the Trust’s services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Fair values are determined as follows:

- Land and non-specialised buildings – open market value for existing use;
- Specialised buildings – depreciated replacement cost; and
- Properties surplus to requirements – the lower of open market value less any material directly attributable selling costs, or book value at date of moving to non-current assets.

Modern Equivalent Asset

DFP has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. Land and Property Services (LPS) have included this requirement within the latest valuation.

Assets under Construction (AuC)

Properties in the course of construction for service or administration purposes are carried at cost less any impairment loss. Cost includes professional fees as allowed by IAS 16 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Short Life Assets

Short life is defined as a useful life up to and including 5 years. From 1 April 2008 HSC entities had the option to elect to cease indexing all short life assets (other than IT which is not indexed). The Trust did not elect to cease indexing all short life assets, (other than IT), as these assets are not held separately on its fixed asset register. Therefore, fixtures and equipment, whether they are short life or have an estimated life in excess of 5 years, are indexed each year and depreciation will be based on the indexed amount. All other short life assets are not indexed but carried at depreciated historic cost as this is not considered to be materially different from fair value and are depreciated over their useful life.

Revaluation Reserve

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an

impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

1.4 Depreciation

No depreciation is provided on freehold land since land has unlimited or a very long established useful life. Items under construction are not depreciated until they are commissioned. Properties that are surplus to requirements and which meet the definition of “non-current assets held for sale “are also not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and similarly, amortisation is applied to intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over the lower of their estimated useful lives and the terms of the lease. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. The following asset lives have been used:

Asset Type	Asset Life
Freehold Buildings	Up to 88 years
Leasehold property	Remaining period of lease
IT Assets	3 – 10 years
Intangible assets	3 – 10 years
Other Equipment	3 – 15 years

1.5 Impairment Loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure within the Statement of Comprehensive Net Expenditure. If the impairment is due to the consumption of economic benefits the full amount of the impairment is charged to the Statement of Comprehensive Net Expenditure and an amount up to the value of the impairment in the

revaluation reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.6 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure which meets the definition of capital restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.7 Intangible Assets

Intangible assets comprise software and licences. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise

from contractual or other legal rights. Intangible assets are considered to have a finite life. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised while intangible assets which fall within the grouped asset definition must be capitalised if their individual value is at least £1,000 each and the group is at least £5,000 in value.

The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

Intangible assets acquired separately are initially recognised at fair value. Following initial recognition, intangible assets are carried at fair value by reference to an active market, and as no active market currently exists depreciated replacement cost has been used as fair value.

1.8 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. In order to meet this definition IFRS 5 requires that the asset must be immediately available for sale in its current condition and that the sale is highly probable. A sale is regarded as highly probable where an active plan is in place to find a buyer for the asset and the sale is considered likely to be concluded within one year. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value, less any material directly attributable selling costs. Fair value is open market value, where one is available, including alternative uses. Assets classified as held for sale are not depreciated.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount. The profit from sale of land, which is a non-depreciating asset, is recognised within income. The profit from sale of a depreciating asset is shown as a reduced expense. The loss from sale of land or from any depreciating assets is shown within operating expenses. On disposal, the balance for the asset on the Revaluation Reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve.

Property, plant or equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Income

Operating income relates directly to the operating activities of the Trust and is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Grant in Aid

Funding received from other entities, including the Department of Health, Social Services and Public Safety and the Health and Social Care Board is accounted for as grant in aid and is reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.11 Investments

The Trust does not have any investments.

1.12 Other Expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.13 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

<u>The Trust as lessee</u>

Property, plant and equipment held under finance leases is initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the

minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land may be either an operating lease or a finance lease depending on the conditions in the lease agreement and following the general guidance set out in IAS 17. Leased buildings are assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.15 Private Finance Initiative (PFI) Transactions

The Trust has had no PFI transactions during the current or prior year.

1.16 Financial Instruments

- **Financial assets**

Financial assets are recognised on the balance sheet when the Trust becomes party to the financial instrument contract or, in the case of trade receivables,

when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

- **Financial liabilities**

Financial liabilities are recognised on the balance sheet when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

- **Financial risk management**

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within Trusts in creating risk than would apply to a non public sector body of a similar size, therefore Trusts are not exposed to the degree of financial risk faced by business entities. Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Trusts in undertaking activities. Therefore the HSC is exposed to little credit, liquidity or market risk.

- **Currency risk**

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

- **Interest rate risk**

The Trust has limited powers to borrow or invest and therefore has low exposure to interest rate fluctuations.

- **Credit risk**

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

- **Liquidity risk**

Since the Trust receives the majority of its funding through its principal Commissioner which is voted through the Assembly, it is not exposed to significant liquidity risks.

1.17 Provisions

In accordance with IAS 37, provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, it is assumed the settlement is made at the beginning of the year rather than its cessation and its carrying amount is the present value of those cash flows using DFP's discount rate of -1.55% (negative real rate) for 1 year up to and including 5 years, -1.00% (negative real rate) after year 5 up to 10 years and -0.80% in real terms for 10 years or more (+1.37% for employee early departure obligations for all periods).

The Trust has also disclosed the carrying amount at the beginning and end of the period, additional provisions made, amounts used during the period, unused amounts reversed during the period and increases in the discounted amount arising from the passage of time and the effect of any change in the discount rate.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an

asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the

obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.18 Contingencies

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to the Assembly separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to the Assembly. Under IAS 37, the Trust discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

In addition to contingent liabilities disclosed in accordance with IAS 37, HSC Trusts should disclose for Assembly reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to the Assembly in accordance with the requirements of Managing Public Money Northern Ireland.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

1.19 Employee Benefits

Short-term Employee Benefits

Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been estimated using staff numbers and costs applied to the average untaken leave balance determined from the results of a survey to ascertain leave balances as at 31 March 2015. It is not anticipated that the level of untaken leave will vary significantly from year to year. Untaken flexi leave is estimated to be immaterial to the Trust and has not been included.

Retirement Benefit Costs

Past and present employees are covered by the provisions of the HSC Pension Scheme.

The Trust participates in the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Pension Scheme can be found in the HSC Pension Scheme Statement in the Departmental Resource Account for the Department of Health, Social Services and Public Safety.

The costs of early retirements are met by the Trust and charged to the Statement of Comprehensive Net Expenditure at the time the Trust commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. The 2012 valuation for the HSC Pension Scheme will be used in the 2015/16 accounts.

1.20 Reserves

Statement of Comprehensive Net Expenditure Reserve

Accumulated surpluses are accounted for in the Statement of Comprehensive Net Expenditure Reserve.

Revaluation Reserve

The Revaluation Reserve reflects the unrealised balance of cumulative indexation and revaluation adjustments to assets.

1.21 Value Added Tax

Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets.

1.22 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 24 to the accounts.

1.23 Government Grants

Government assistance for capital projects whether from UK, or Europe, are treated as a Government grant even where there are no conditions specifically relating to the operating activities of the entity other than the requirement to operate in certain regions or industry sectors. Such grants (does not include grant-in-aid) were previously credited to a government grant reserve and were released to income over the useful life of the asset.

DFP issued new guidance effective from 1 April 2011. Government grant reserves are no longer permitted. Income is generally recognised when it is received. In exceptional cases where there are conditions attached to the use of the grant, which, if not met, would mean the grant is repayable, the income should be deferred and released when obligations are met. The note to the financial statements distinguishes between grants from UK government entities and grants from European Union.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

1.24 Losses and Special Payments

Losses and special payments are items that the Assembly would not have contemplated when it agreed funds for the HSC or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had HSC Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.25 Charitable Trust Account Consolidation

In accordance with IAS 27, the Trust consolidates the accounts of the SHSCT Charitable Trust Funds with the Trust's financial statements. It is important to note, however, the distinction between public funding and the other monies donated by private individuals still exists.

As far as possible, donated funds have been used by the Trust as intended by the benefactor. It is for the Endowments and Gifts Committee within the Trust to manage the internal disbursements. The committee ensures that the charitable donations received by the Trust are appropriately managed, invested, expended and controlled in a manner that is, as far as possible, consistent with the purposes for which they were given and with the Trust's Standing Financial Instructions, Departmental guidance and legislation.

1.26 Accounting Standards that have been issued but have not yet been adopted

The IASB have issued new and amended standards (IFRS 10, IFRS 11 & IFRS 12) that affect the consolidation and reporting of subsidiaries, associates and joint ventures. These standards are effective with EU adoption from 1 January 2014.

Accounting boundary IFRS' are currently adapted in the FReM so that the Westminster departmental accounting boundary is based on ONS control criteria, as designated by Treasury. A review of the NI financial process, which

will bring NI departments under the same adaptation, has been presented to the Executive, but a decision has yet to be made. Should the Executive agree to the recommendations, the accounting boundary for departments will change and there will also be an impact on departments around the disclosure requirements under IFRS 12. ALBs apply IFRS in full and their consolidation boundary may change as a result of the new Standards.

Management considers that any other new accounting standards issued but not yet adopted are unlikely to have a significant impact on the accounts in the period of the initial application.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 2 ANALYSIS OF NET EXPENDITURE BY SEGMENT

	2016			2015		
Directorate	**Staff Costs £000s**	**Other Expenditure £000s**	**Total Expenditure £000s**	**Staff Costs £000s**	**Other Expenditure £000s**	**Total Expenditure £000s**
Children's Services	53,609	20,129	73,738	49,138	20,239	69,377
Acute Hospital Services	164,619	64,225	228,844	154,028	63,528	217,556
Older People's Services	69,736	83,210	152,946	64,674	80,370	145,044
Mental Health and Disability Services	55,270	42,175	97,445	52,129	40,443	92,572
Planning, Performance Management and Support Services	18,128	12,083	30,211	25,098	9,423	34,521
Expenditure for Reportable Segments net of Non Cash Expenditure	**361,362**	**221,822**	**583,184**	**345,067**	**214,003**	**559,070**
Non Cash Expenditure			32,057			44,688
Total Expenditure per Net Expenditure Account			615,241			603,758
Income Per Net Expenditure Account			39,224			38,656
Net Expenditure			576,017			565,102
Revenue Resource Limit			576,154			565,143
Surplus against RRL			**137**			**41**

The Trust is managed by way of a directorate structure, each led by a Director, providing an integrated healthcare service for the resident population. The Directors along with Non-Executive Directors, Chair and Chief Executive form the Trust Board which coordinates the activities of the Trust and is considered to be the Chief Operating Decision Maker. The information disclosed in this statement does not reflect budgetary performance and is based solely on expenditure information provided from the accounting system used to prepare the accounts.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 2 (continued) ANALYSIS OF NET EXPENDITURE BY SEGMENT

Acute Directorate

- Cancer and clinical services (includes Laboratory & Radiology Services)
- Surgery and Elective Care
- Medicines and Unscheduled Care
- Integrated maternity and Women's Health
- Functional Support Services (includes all hotel services, health records, laundry and CSSD)
- Pharmacy

These services are delivered at the Acute Hospital Sites at Craigavon Area Hospital and Daisy Hill Hospital. Services including outreach clinics, day procedure services and diagnostic services are also delivered on South Tyrone Hospital Site, Lurgan Hospital Site and at Banbridge Health and Care Centre, Kilkeel and Crossmaglen Health Centres and Armagh Community Hospital.

Directorate of Mental Health and Disability Services

- Provides a range of hospital and community services, including social services, community nursing, home treatment, crisis response, Allied Health Professionals and specialist teams.
- Acute Mental Health Services are provided at the Bluestone Unit, Craigavon and at St Lukes Hospital, Armagh.
- On the St Lukes site there is a long-stay hospital
- Longstone Hospital for Learning Disability patients
- Nursing & residential home, domiciliary, respite and day care services as well as support to tenants who reside in supporting people accommodation
- Trust Transport services

Older People and Primary Care Services

- Domiciliary care, residential and nursing care and dementia support
- District nursing and allied health professionals supporting the elderly population
- Specialist services such as family planning, continence and GP out of hours and minor injuries units and all aspects of supporting people in the community
- Partnership working with Voluntary and community organisations incorporating grant aid payments and community support.

Children and Young People Services

- Includes all health services provided for children and adolescents
- Paediatric wards and special care baby units located in Acute facilities
- Disability services including respite, CAMHS, Children Community nursing of complex needs, Dental services and Allied Health Services
- Corporate Parenting
- Family support, Early Years, Health visiting and school nursing are included together with all Sure Start Projects.
- Social Services Training Unit

Planning, Performance Management and Support Services

- Office of the Chief Executive, including Trustwide Communication Team
- Finance and Procurement Directorate
- Human Resource Directorate, (including Health & Safety, Occupational Health and Estates)
- Performance & Reform (IT, Corporate Planning and Performance Improvement)
- Medical Directorate (Governance Patient/Client Safety, Medical Management, Clinical Audit and Emergency Planning.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 3 STAFF COSTS AND OPERATING EXPENSES

3.1 Staff Costs

Staff costs comprise:	2016 Permanently employed staff £000s	2016 Others £000s	2016 Total £000s	2015 Total £000s
Wages and salaries	288,012	15,576	303,588	296,485
Social security costs	19,034	1,200	20,234	18,965
Other pension costs	37,713	166	37,879	29,936
Sub-Total	**344,759**	**16,942**	**361,701**	**345,386**
Capitalised staff costs	(339)	0	(339)	(319)
Total staff costs reported in Statement of Comprehensive Expenditure	**344,420**	**16,942**	**361,362**	**345,067**
Less recoveries in respect of outward secondments			(252)	(498)
Total net costs			**361,110**	**344,569**

	2016 £000s	2015 £000s
Southern HSC Trust	361,110	344,569
Total	**361,110**	**344,569**

Staff Costs exclude £339k charged to capital projects during the year (2015: £319k)

The Trust participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. A full valuation for Resource Accounts purposes as at 31 March 2012 was certified in February 2015 and is used in the 2015/16 accounts.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 3.2 Operating Expenses

	2016			2015		
	Trust £000s	CTF £000s	Consolidated £000s	Trust £000s	CTF £000s	Consolidated £000s
Operating Expenses are as follows:-						
Purchase of care from non-HPSS bodies	105,546	0	105,546	102,507	0	102,507
Revenue grants to voluntary organisations	5,498	0	5,498	5,375	0	5,375
Personal social services	6,445	0	6,445	6,371	0	6,371
Recharges from other HSC organisations	1,645	0	1,645	1,730	0	1,730
Supplies and services - Clinical	43,760	0	43,760	43,029	0	43,029
Supplies and services - General	6,078	0	6,078	6,530	0	6,530
Establishment	11,691	0	11,691	11,032	0	11,032
Transport	2,600	0	2,600	2,619	0	2,619
Premises	28,417	0	28,417	24,347	0	24,347
Bad debts	48	0	48	803	0	803
Rentals under operating leases	960	0	960	835	0	835
Interest charges	1	0	1	0	0	0
BSO services	3,606	0	3,606	3,075	0	3,075
Training	1,187	0	1,187	871	0	871
Professional fees	229	29	258	347	23	370
Patients travelling expenses	378	0	378	445	0	445
Costs of exit packages not provided for	289	0	289	182	0	182
Other charitable expenditure	0	404	404	0	238	238
Miscellaneous expenditure	3,445	0	3,445	3,905	0	3,905

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 3.2 Operating Expenses (continued)

	2016			2015		
	Trust £000s	CTF £000s	Consolidated £000s	Trust £000s	CTF £000s	Consolidated £000s
Non cash items						
Depreciation	17,753	0	17,753	16,171	0	16,171
Amortisation	69	0	69	145	0	145
Impairments	(2,609)	0	(2,609)	21,872	0	21,872
(Profit) on disposal of property, plant & equipment (excluding profit on land)	(106)	0	(106)	(179)	0	(179)
Loss on disposal of property, plant & equipment (including land)	102	0	102	12	0	12
Provisions provided for in year	16,832	0	16,832	6,709	0	6,709
Cost of borrowing of provisions (unwinding of discount on provisions)	(43)	0	(43)	(99)	0	(99)
Auditors remuneration	59	5	64	57	6	63
Add back of notional charitable expenditure	0	(5)	(5)	0	(6)	(6)
Total	**253,880**	**433**	**254,313**	**258,691**	**261**	**258,952**

The Southern HSC Charitable Trust Funds Auditors remuneration of £5,000 (2015: £5,750) related solely to the audit, with no other additional work undertaken.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 4 INCOME

	2016			2015		
4.1 Income from Activities	**Trust £000s**	**CTF £000s**	**Consolidated £000s**	**Trust £000s**	**CTF £000s**	**Consolidated £000s**
GB/Republic of Ireland Health Authorities	367	0	367	309	0	309
HSC Trusts	265	0	265	214	0	214
Non-HSC:- Private patients	436	0	436	376	0	376
Non-HSC:- Other	1,504	0	1,504	1,199	0	1,199
Clients contributions	26,911	0	26,911	25,874	0	25,874
Total	**29,483**	**0**	**29,483**	**27,972**	**0**	**27,972**
4.2 Other Operating Income						
Other income from non-patient services	8,175	0	8,175	9,022	0	9,022
Seconded staff	252	0	252	498	0	498
Charitable and other contributions to expenditure by core trust	725	0	725	830	0	830
Donations / Government grant / Lottery funding for non current assets	395	0	395	130	0	130
Charitable Income received by charitable trust fund	0	298	298	0	241	241
Investment Income	0	125	125	0	109	109
Other Income	194	0	194	202	0	202
Interest Receivable	1	0	1	2	0	2
Total	**9,742**	**423**	**10,165**	**10,684**	**350**	**11,034**
4.3 Deferred Income						
Income released from conditional grants	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL INCOME	**39,225**	**423**	**39,648**	**38,656**	**350**	**39,006**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.1 Consolidated Property, Plant & Equipment Year Ended 31 March 2016

	Land	Buildings (excluding dwellings)	Dwellings	Assets under Construction	Plant and Machinery (Equipment)	Transport Equipment	Information Technology (IT)	Furniture and Fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or Valuation									
At 1 April 2015	26,839	190,498	11,828	12,217	53,320	6,438	26,433	950	328,523
Indexation	200	12,264	802	0	638	37	0	5	13,946
Additions	15	11,646	0	6,158	1,889	24	3,302	11	23,045
Donations / Government grant / Lottery funding	0	152	0	0	228	0	15	0	395
Reclassifications	0	16,807	0	(16,849)	42	0	(4)	4	0
Transfers	0	(287)	0	0	0	0	0	0	(287)
Revaluations	114	0	0	0	0	0	0	0	114
Impairment charged to the SoCNE	0	(4,988)	0	0	(655)	0	(1)	(3)	(5,647)
Impairment charged to the revaluation reserve	0	(1,097)	0	0	(98)	0	0	0	(1,195)
Reversal of impairments (indexn)	1,431	6,023	242	0	5	0	0	0	7,701
(Disposals)	0	(5)	0	0	(1,374)	(756)	(1,665)	0	(3,800)
At 31 March 2016	**28,599**	**231,013**	**12,872**	**1,526**	**53,995**	**5,743**	**28,080**	**967**	**362,795**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.1 (continued) Consolidated Property, Plant & Equipment Year Ended 31 March 2016

	Land	Buildings (excluding dwellings)	Dwellings	Assets under Construction	Plant and Machinery (Equipment)	Transport Equipment	Information Technology (IT)	Furniture and Fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Depreciation									
At 1 April 2015	0	1,277	61	0	30,707	3,318	8,040	792	44,195
Indexation	0	631	30	0	383	21	0	4	1,069
Reclassifications	0	0	0	0	1	0	(1)	0	0
Transfers	0	(14)	0	0	0	0	0	0	(14)
Revaluation	0	0	0	0	0	0	0	0	0
Impairment charged to the SoCNE	0	(4)	0	0	(551)	0	0	0	(555)
Impairment charged to the revaluation reserve	0	(1)	0	0	(33)	0	0	0	(34)
Reversal of Impairments (indexn)	0	0	0	0	0	0	0	0	0
(Disposals)	0	0	0	0	(1,278)	(753)	(1,664)	0	(3,695)
Provided during the year	0	8,100	374	0	3,281	688	5,262	48	17,753
At 31 March 2016	**0**	**9,989**	**465**	**0**	**32,510**	**3,274**	**11,637**	**844**	**58,719**
Carrying Amount									
At 31 March 2016	**28,599**	**221,024**	**12,407**	**1,526**	**21,485**	**2,469**	**16,443**	**123**	**304,076**
At 31 March 2015	**26,839**	**189,221**	**11,767**	**12,217**	**22,613**	**3,120**	**18,393**	**158**	**284,328**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.1 (continued) Consolidated Property, Plant & Equipment Year Ended 31 March 2016

	Land £000s	Buildings (excluding dwellings) £000s	Dwellings £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Asset Financing									
Owned	28,599	221,024	12,407	1,526	21,485	2,469	16,443	123	304,076
Carrying Amount									
At 31 March 2016	**28,599**	**221,024**	**12,407**	**1,526**	**21,485**	**2,469**	**16,443**	**123**	**304,076**
Of which:									
Southern HSC Trust at 31 March 2016	28,599	221,024	12,407	1,526	21,485	2,469	16,443	123	304,076
Charitable Trust Fund at 31 March 2016	0	0	0	0	0	0	0	0	0
	28,599	**221,024**	**12,407**	**1,526**	**21,485**	**2,469**	**16,443**	**123**	**304,076**
Southern HSC Trust at 31 March 2015	26,839	189,221	11,767	12,217	22,613	3,120	18,393	158	284,328
Charitable Trust Fund at 31 March 2015	0	0	0	0	0	0	0	0	0
	26,839	**189,221**	**11,767**	**12,217**	**22,613**	**3,120**	**18,393**	**158**	**284,328**

Of which:	
Trust	304,076
Charitable Trust Funds	0

Any fall in value through negative indexation or revaluation is shown as an impairment.

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure Account in respect of assets held under finance leases and hire purchase contracts is £Nil (2014/15: £Nil).

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.1 (continued) Consolidated Property, Plant & Equipment Year Ended 31 March 2016

The fair value of assets funded from the following sources during the year was:

	2016 £000s	2015 £000s
Donations	395	130
Government grant	0	0
Lottery funding	0	0

Professional revaluations of land and buildings are undertaken by Land and Property Services (LPS) at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS. The last valuation was carried out on 31 January 2015. See Accounting policy note 1.3 for more details of valuation of Property, Plant & Equipment.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.2 Property, Plant & Equipment Year Ended 31 March 2015

	Land	Buildings (excluding dwellings)	Dwellings	Assets under Construction	Plant and Machinery (Equipment)	Transport Equipment	Information Technology (IT)	Furniture and Fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or Valuation									
At 1 April 2014	37,246	245,005	14,492	9,356	51,016	6,696	23,746	935	388,492
Indexation	0	0	0	0	858	0	0	0	858
Additions	0	8,937	0	9,508	3,435	673	7,820	15	30,388
Donations / Government grant / Lottery funding	0	0	0	0	130	0	0	0	130
Reclassifications	0	6,305	0	(6,305)	0	0	0	0	0
Revaluations	(4,873)	(47,428)	(2,183)	0	37	(312)	(9)	0	(54,768)
Impairment charged to the SoCNE	(5,414)	(16,227)	123	(342)	0	0	0	0	(21,860)
Impairment charged to the Revaluation Reserve	(120)	(5,827)	(604)	0	0	0	0	0	(6,551)
Reversal of Impairments (indexn)	0	0	0	0	0	0	0	0	0
(Disposals)	0	(267)	0	0	(2,156)	(619)	(5,124)	0	(8,166)
At 31 March 2015	**26,839**	**190,498**	**11,828**	**12,217**	**53,320**	**6,438**	**26,433**	**950**	**328,523**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.2 (continued) Property, Plant & Equipment Year Ended 31 March 2015

	Land £000s	Buildings (excluding dwellings) £000s	Dwellings £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Depreciation									
At 1 April 2014	4,950	41,480	2,185	0	28,883	3,546	9,243	720	91,007
Indexation	0	0	0	0	503	0	0	0	503
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	(4,950)	(48,124)	(2,500)	0	(45)	(312)	59	0	(55,872)
Impairment charged to the SoCNE	0	0	0	0	0	0	0	0	0
(Disposals)	0	(14)	0	0	(1,888)	(592)	(5,120)	0	(7,614)
Provided during the year	0	7,935	376	0	3,254	676	3,858	72	16,171
At 31 March 2015	**0**	**1,277**	**61**	**0**	**30,707**	**3,318**	**8,040**	**792**	**44,195**
Carrying Amount At 31 March 2015	**26,839**	**189,221**	**11,767**	**12,217**	**22,613**	**3,120**	**18,393**	**158**	**284,328**
At 1 April 2014	**32,296**	**203,525**	**12,307**	**9,356**	**22,133**	**3,150**	**14,503**	**215**	**297,485**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.2 (continued) Property, Plant & Equipment Year Ended 31 March 2015

	Land £000s	Buildings (excluding dwellings) £000s	Dwellings £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Asset Financing									
Owned	26,839	189,221	11,767	12,217	22,613	3,120	18,393	158	284,328
Carrying Amount									
At 31 March 2015	**26,839**	**189,221**	**11,767**	**12,217**	**22,613**	**3,120**	**18,393**	**158**	**284,328**
Asset financing									
Owned	32,296	203,525	12,307	9,356	22,133	3,150	14,503	215	297,485
Carrying Amount									
At 1 April 2014	**32,296**	**203,525**	**12,307**	**9,356**	**22,133**	**3,150**	**14,503**	**215**	**297,485**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.2 (continued) Property, Plant & Equipment Year Ended 31 March 2015

	Land £000s	Buildings (excluding dwellings) £000s	Dwellings £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Southern HSC Trust at 31 March 2015	26,839	189,221	11,767	12,217	22,613	3,120	18,393	158	284,328
Southern HSC Trust charitable trust fund at 31 March 2015	0	0	0	0	0	0	0	0	0
Southern HSC Trust at 31 March 2015	**26,839**	**189,221**	**11,767**	**12,217**	**22,613**	**3,120**	**18,393**	**158**	**284,328**
Southern HSC Trust at 31 March 2014	32,296	203,525	12,307	9,356	22,133	3,150	14,503	215	297,485
Southern HSC Trust charitable trust fund at 31 March 2014	0	0	0	0	0	0	0	0	0
Southern HSC Trust at 31 March 2014	**32,296**	**203,525**	**12,307**	**9,356**	**22,133**	**3,150**	**14,503**	**215**	**297,485**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 6.1 Consolidated Intangible Assets Year Ended 31 March 2016

	Software Licenses	Software	Total
	£000s	£000s	£000s
Cost or Valuation			
At 1 April 2015	1,399	0	1,399
Indexation	0	0	0
Additions	0	0	0
Donations / Government grant / Lottery funding	0	0	0
Disposals	0	0	0
At 31 March 2016	**1,399**	**0**	**1,399**
Amortisation			
At 1 April 2015	1,330	0	1,330
Reclassifications	0	0	0
Disposals	0	0	0
Provided during the year	69	0	69
At 31 March 2016	**1,399**	**0**	**1,399**
Carrying Amount			
At 31 March 2016	**0**	**0**	**0**
At 31 March 2015	**69**	**0**	**69**
Asset financing			
Owned	0	0	0
Carrying Amount			
At 31 March 2016	**0**	**0**	**0**

There were no assets funded by Donations/Government Grant or Lottery Funding during the year. (2014/15: £Nil)

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 6.2 Consolidated Intangible Assets Year Ended 31 March 2015

	Software Licenses	Software	Total
	£000s	£000s	£000s
Cost or Valuation			
At 1 April 2014	1,399	0	1,399
Indexation	0	0	0
Additions	0	0	0
Donations / Government grant / Lottery funding	0	0	0
Disposals	0	0	0
At 31 March 2015	**1,399**	**0**	**1,399**
Amortisation			
At 1 April 2014	1,185	0	1,185
Reclassifications	0	0	0
Disposals	0	0	0
Provided during the year	145	0	145
At 31 March 2015	**1,330**	**0**	**1,330**
Carrying Amount			
At 31 March 2015	**69**	**0**	**69**
At 31 March 2014	**214**	**0**	**214**
Asset financing			
Owned	69	0	69
Carrying Amount			
At 31 March 2015	**69**	**0**	**69**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 6.2 Consolidated Intangible Assets Year Ended 31 March 2015

Carrying amount comprises:

	Software Licenses £000s	Software £000s	Total £000s
Southern HSC Trust at 31 March 2015	69	0	69
Southern HSC Trust charitable trust fund at 31 March 2015	0	0	0
	69	0	69
Southern HSC Trust at 31 March 2014	214	0	214
Southern HSC Trust charitable trust fund at 31 March 2014	0	0	0
	214	0	214

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 7 FINANCIAL INSTRUMENTS

NOTE 7 Financial Instruments

	2016			2015		
	Investments	Assets	Liabilities	Investments	Assets	Liabilities
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April	2,845	0	0	2,678	100	0
Additions	0	0	0	0	0	0
Disposals	0	0	0	0	(100)	0
Revaluations	(174)	0	0	167	0	0
Balance at 31 March	**2,671**	**0**	**0**	**2,845**	**0**	**0**
Trust						
Charitable trust fund	2,671	0	0	2,845	0	0
	2,671	**0**	**0**	**2,845**	**0**	**0**

NOTE 7.1 Market value of investments as at 31 March 2016

	Held in UK	Held outside UK	2016 Total	2015 Total
	£000s	£000s	£000s	£000s
Investments in a Common Deposit Fund or Investment Fund	2,671	0	2,671	2,845
Total market value of fixed asset investments	**2,671**	**0**	**2,671**	**2,845**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 8 IMPAIRMENTS

	2016		
	Property, Plant & Equipment	Intangibles	Total
	£000s	£000s	£000s
Total value of impairments for the period	(1,448)	0	(1,448)
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	(1,161)	0	(1,161)
Impairments credited to Statement of Comprehensive Net Expenditure	**(2,609)**	**0**	**(2,609)**

	2015		
	Property, Plant & Equipment	Intangibles	Total
Total value of impairments for the period	28,432	0	28,432
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	(6,560)	0	(6,560)
Impairments charged to Statement of Comprehensive Net Expenditure	**21,872**	**0**	**21,872**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 9 ASSETS CLASSIFIED AS HELD FOR SALE

	Land		Buildings		Total	
	2016	2015	2016	2015	2016	2015
	£000s	£000s	£000s	£000s	£000s	£000s
Cost						
At 1 April	0	0	1,193	1,482	1,193	1,482
Transfers in	0	0	287	0	287	0
(Disposals)	0	0	(85)	(168)	(85)	(168)
Impairment	0	0	0	(121)	0	(121)
At 31 March	**0**	**0**	**1,395**	**1,193**	**1,395**	**1,193**
Depreciation						
At 1 April	0	0	85	197	85	197
Transfers in	0	0	14	0	14	0
(Disposals)	0	0	(85)	(26)	(85)	(26)
Impairment	0	0	0	(86)	0	(86)
At 31 March	**0**	**0**	**14**	**85**	**14**	**85**
Carrying amount at 31 March	**0**	**0**	**1,381**	**1,108**	**1,381**	**1,108**

Non current assets held for sale comprise non current assets that are held for resale rather than for continuing use within the business.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 10 INVENTORIES

	2016			2015		
Classification	**Trust £000s**	**CTF £000s**	**Consolidated £000s**	**Trust £000s**	**CTF £000s**	**Consolidated £000s**
Pharmacy supplies	2,034	0	2,034	1,835	0	1,835
Building & engineering supplies	75	0	75	70	0	70
Fuel	155	0	155	239	0	239
Community care appliances	324	0	324	225	0	225
Laboratory materials	158	0	158	184	0	184
Stationery	0	0	0	0	0	0
Laundry	57	0	57	55	0	55
Other	184	0	184	272	0	272
Total	**2,987**	**0**	**2,987**	**2,880**	**0**	**2,880**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 11 CASH AND CASH EQUIVALENTS

	2016			2015		
	Core Trust	CTF	Consolidated	Core Trust	CTF	Consolidated
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1st April	1,575	175	1,750	2,168	98	2,266
Net change in cash and cash equivalents	(391)	57	(334)	(593)	77	(516)
Balance at 31st March	**1,184**	**232**	**1,416**	**1,575**	**175**	**1,750**

The following balances at 31 March were held at

	2016			2015		
	Core Trust	CTF	Consolidated	Core Trust	CTF	Consolidated
	£000s	£000s	£000s	£000s	£000s	£000s
Commercial banks and cash in hand	1,184	232	1,416	1,575	175	1,750
Balance at 31st March	**1,184**	**232**	**1,416**	**1,575**	**175**	**1,750**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 12 TRADE RECEIVABLES AND OTHER CURRENT ASSETS

	2016				2015			
	Trust	CTF	Consolidation Adjustments	Consolidated	Trust	CTF	Consolidation Adjustments	Consolidated
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Amounts falling due within one year								
Trade receivables	8,534	0	0	8,534	10,013	0	0	10,013
VAT receivable	4,600	0	0	4,600	5,421	0	0	5,421
Other receivables - not relating to fixed assets	398	68	0	466	337	91	(28)	400
Trade and other receivables	**13,532**	**68**	0	**13,600**	**15,771**	**91**	**(28)**	**15,834**
Prepayments and accrued income	3,035	0	0	3,035	4,526	0	0	4,526
Other current assets	**3,035**	**0**	0	**3,035**	**4,526**	**0**	**0**	**4,526**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 12 (continued) TRADE RECEIVABLES AND OTHER CURRENT ASSETS

	Trust	CTF	2016 Consolidation Adjustments	Consolidated	Trust	CTF	2015 Consolidation Adjustments	Consolidated
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Amounts falling due after more than one year								
Trade receivables	694	0	0	694	906	0	0	906
Trade and other receivables	**694**	**0**	**0**	**694**	**906**	**0**	**0**	**906**
TOTAL TRADE AND OTHER RECEIVABLES	**14,226**	**68**	**0**	**14,294**	**16,677**	**91**	**(28)**	**16,740**
TOTAL OTHER CURRENT ASSETS	3,035	0	0	3,035	4,526	0	0	4,526
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**17,261**	**68**	**0**	**17,329**	**21,203**	**91**	**(28)**	**21,266**

The balances are net of a provision for bad debts of £5,796k (2015: £6,095k).

The Southern HSC Trust did not have any intangible current assets at 31 March 2016 or at 31 March 2015.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 13 TRADE PAYABLES AND OTHER CURRENT LIABILITIES

13.1 Trade Payables and Other Current Liabilities

	2016				2015			
	Trust	CTF	Consolidation Adjustments	Consolidated	Trust	CTF	Consolidation Adjustments	Consolidated
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Amounts falling due within one year								
Other taxation and social security	11,963	0	0	11,963	11,342	0	0	11,342
Trade capital payables - property, plant and equipment	8,529	0	0	8,529	7,215	0	0	7,215
Trade revenue payables	17,579	0	0	17,579	16,377	0	0	16,377
Payroll payables	21,556	0	0	21,556	21,310	0	0	21,310
Clinical negligence payables	554	0	0	554	1,027	0	0	1,027
VER payables	146	0	0	146	538	0	0	538
BSO payables	3,342	0	0	3,342	1,449	0	0	1,449
Other payables	279	116	0	395	990	72	(28)	1,034
Accruals and deferred income	4,319	0	0	4,319	5,508	0	0	5,508
Trade and other payables	**68,267**	**116**	0	**68,383**	**65,756**	**72**	**(28)**	**65,800**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 13.2 Loans

The Southern HSC Trust did not have any loans payable at 31 March 2016 or at 31 March 2015.

NOTE 14 PROMPT PAYMENT POLICY

NOTE 14.1 Public Sector Payment Policy – Measure of Compliance

The Department requires that Trusts pay their non HSC trade suppliers in accordance with applicable terms and appropriate Government Accounting guidance. The Trust's payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is:

	2016 Number	2016 Value £000s	2015 Number	2015 Value £000s
Total bills paid	206,478	273,264	172,426	224,108
Total bills paid within 30 day or under agreed payment terms	193,206	250,692	151,068	200,413
% of bills paid within 30 day target or under agreed payment terms	**93.6%**	**91.7%**	**87.6%**	**89.4%**
Total bills paid within 10 day target	173,700	226,085	121,745	170,785
% of bills paid within 10 day target	**84.1%**	**82.7%**	**70.6%**	**76.2%**

14.2 The Late Payment of Commercial Debts Regulations 2002

	£
Amount of compensation paid for payment(s) being late	210
Amount of interest paid for payment(s) being late	343
Total	**553**

This is also reflected as a fruitless payment in the Statement of Losses and Special Payments in the Accountability Report.

New late payment legislation (Late Payment of Commercial Debts Regulations 2013) came into force on 16 March 2013. The effect of the new legislation is that a payment is normally regarded as late unless it is made within 30 days after receipt of an undisputed invoice.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 15 PROVISIONS FOR LIABILITIES AND CHARGES – 2016

	Pensions relating to former directors	Pensions relating to other staff	Clinical negligence	CSR restructuring	Other	2016
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	277	3,964	20,681	0	4,197	29,119
Provided in year	0	0	18,627	0	1,002	19,629
(Provisions not required written back)	(5)	(201)	(2,399)	0	(192)	(2,797)
(Provisions utilised in the year)	(15)	(191)	(2,016)	0	(574)	(2,796)
Cost of borrowing (unwinding of discount)	4	52	(108)	0	9	(43)
At 31 March 2016	**261**	**3,624**	**34,785**	**0**	**4,442**	**43,112**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 15 (continued) PROVISIONS FOR LIABILITIES AND CHARGES – 2016

Comprehensive Net Expenditure Account charges	2016 £000s	2015 £'000
Arising during the year	19,629	10,540
Reversed unused	(2,797)	(3,831)
Cost of borrowing (unwinding of discount)	(43)	(99)
Total charge within Operating expenses	**16,789**	**6,610**

Analysis of expected timing of discounted flows

	Pensions relating to former directors	Pensions relating to other staff	Clinical negligence	CSR restructuring	Other	2016
	£000s	£000s	£000s	£000s	£000s	£000s
Not later than one year	15	194	6,035	0	1,195	7,439
Later than one year and not later than five years	62	803	10,023	0	1,999	12,887
Later than five years	184	2,627	18,727	0	1,248	22,786
At 31 March 2016	**261**	**3,624**	**34,785**	**0**	**4,442**	**43,112**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 15 (continued) PROVISIONS FOR LIABILITIES AND CHARGES – 2015

	Pensions relating to former directors	Pensions relating to other staff	Clinical negligence	CSR restructuring	Other	2015
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	262	3,949	21,504	0	4,550	30,265
Provided in year	27	165	9,662	0	686	10,540
(Provisions not required written back)	0	0	(3,422)	0	(409)	(3,831)
(Provisions utilised in the year)	(15)	(199)	(6,912)	0	(630)	(7,756)
Cost of borrowing (unwinding of discount)	3	49	(151)	0	0	(99)
At 31 March 2015	**277**	**3,964**	**20,681**	**0**	**4,197**	**29,119**

Provisions have been made for 7 types of potential liability: Clinical Negligence, Employer's and Occupier's Liability, Early Retirement, Injury Benefit, Employment Law, Agenda for Change and Restructuring in connection with Transforming Your Care (TYC). The provision for Early Retirement and Injury Benefit relates to the future liabilities for the Trust based on information provided by the HSC Pension Branch. For Clinical Negligence, Employer's and Occupier's claims and Employment Law the Trust has estimated an appropriate level of provision based on professional legal advice. The costs of exit packages associated with TYC are included on the basis of the policy outlined in TYC and HR advice.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 15 (continued) PROVISIONS FOR LIABILITIES AND CHARGES – 2015

Analysis of expected timing of discounted flows

	Pensions relating to former directors	Pensions relating to other staff	Clinical negligence	CSR restructuring	Other	2015
	£000s	£000s	£000s	£000s	£000s	£000s
Not later than one year	14	202	3,911	0	1,104	5,231
Later than one year and not later than five years	61	833	7,670	0	1,953	10,517
Later than five years	202	2,929	9,100	0	1,140	13,371
At 31 March 2015	**277**	**3,964**	**20,681**	**0**	**4,197**	**29,119**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 16 CAPITAL COMMITMENTS

	2016	2015
	£000s	£000s
Contracted capital commitments at 31 March not otherwise included in these financial statements		
Property, Plant & Equipment	16,757	11,139
	16,757	**11,139**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 17 COMMITMENTS UNDER LEASES

Note 17.1 Operating Leases

Total future minimum lease payments under non-cancellable operating leases are given in the table below for each of the following periods.

Obligations under operating leases comprise	2016 £000s	2015 £000s
Land & Buildings		
Not later than 1 year	316	311
Later than 1 year and not later than 5 years	203	659
	519	**970**
Other		
Not later than 1 year	746	477
Later than 1 year and not later than 5 years	940	797
	1,686	**1,274**

Note 17.2 Finance Leases

The Southern HSC Trust did not have any finance leases at 31 March 2016 or at 31 March 2015.

Note 17.3 Operating Leases

Total future minimum lease income under operating leases are given in the table below for each of the following periods.

Obligations under operating leases issued by the Trust comprise:

	2016 £000s	2015 £000s
Land and Buildings		
Not later than 1 year	117	79
Later than 1 year and not later than 5 years	84	68
Later than 5 years	125	119
	326	**266**

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 18 COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENT CONTRACTS

18.1 Off balance sheet PFI and other service concession arrangements schemes

The Trust has no off balance sheet (SoFP) PFI and other service concession arrangement schemes.

18.2 On balance sheet (SoFP) PFI Schemes

The Trust has no on balance sheet (SoFP) PFI and other service concession arrangements schemes.

18.3 Charge to the Statement of Comprehensive Net Expenditure account and future commitments

As the Trust has no commitments there is no charge to the Statement of Comprehensive Net Expenditure account .

NOTE 19 OTHER FINANCIAL COMMITMENTS

The Southern HSC Trust did not have any other financial commitments at either 31 March 2016 or 31 March 2015.

NOTE 20 FINANCIAL GUARANTEES, INDEMNITIES AND LETTERS OF COMFORT

Because of the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within Trusts in creating risk than would apply to a non public sector body of a similar size, therefore Trusts are not exposed to the degree of financial risk faced by business entities. Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Trusts in undertaking activities. Therefore the HSC is exposed to little credit, liquidity or market risk.

The Southern HSC Trust has not entered into any quantifiable guarantees, indemnities or provided letters of comfort, at either 31 March 2016 or 31 March 2015.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 21 CONTINGENT LIABILITIES

Material contingent liabilities are noted in the table below, where there is a 50% or less probability that a payment will be required to settle any possible obligations. The amounts or timing of any outflow will depend on the merits of each case.

Contingent Liabilities

	2016 £000s	2015 £000s
Clinical negligence	2,308	2,045
Public Liability	58	5
Total	**2,366**	**2,050**

There are a number of active employment claims against the Trust. The expenditure which may arise from such claims cannot be determined as yet.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 22 RELATED PARTY TRANSACTIONS

The Southern HSC Trust is an Arm's length body of the Department of Health, Social Services and Public Safety and as such the Department is a related party with which the Southern HSC Trust has had various material transactions during the year

- Funding – Revenue Resource Limit of £576,154k (2015: £565,143k) of which the Non Cash Revenue Resource Limit is £32,057k (2015: £44,590k)

During the year, none of the board members, members of key management or other related parties has undertaken any material transactions with the Southern HSC Trust, apart from the transactions with the Department noted.

Interests in the following organisations were declared by non-executive, executive and other Directors and recorded on the Trust's Register of Interests. Where an interest is disclosed, the related party is not involved directly in the award of a contract with the related organisation.

The interests declared and the value of the related party transactions was as follows:

Mr Edwin Graham, Committee Member of Enable NI. The value of transactions between related parties was £189,334 (32 transactions) in respect of grant payments for respite services and day care and provision of training to voluntary organisations. Balance outstanding at year end was £10,961.

Mrs Angela McVeigh, has a personal friend who is the owner of Ann's Homecare Domiciliary Care Agency. The value of transactions between related parties was £4,323,501 (150 transactions) in respect of Domiciliary Care Provision. The balance outstanding at year end: £248,821.

NOTE 23 THIRD PARTY ASSETS

The Southern HSC Trust held £7,816k cash at bank and in hand at 31 March 2016 (31 March 2015: £7,184k) which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts. A separate audited account of these monies is maintained by the Trust.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 24 FINANCIAL PERFORMANCE TARGETS

NOTE 24.1 Revenue Resource Limit

The Southern HSC Trust is given a Revenue Resource Limit which it is not permitted to overspend

The Revenue Resource Limit (RRL) for Southern HSC Trust is calculated as follows:

	2016 Total £000s	2015 Total £000s
HSCB	531,668	508,453
PHA	5,848	5,458
SUMDE & NIMDTA	6,976	6,772
Non cash RRL (from DHSSPS)	32,057	44,590
Total agreed RRL	576,549	565,273
Adjustment for income received re Donations / Government grant / Lottery funding for non current assets	(395)	(130)
Total Revenue Resource Limit to Statement Comprehensive Net Expenditure	**576,154**	**565,143**

24.2 Capital Resource Limit

The Trust is given a Capital Resource Limit (CRL) which it is not permitted to overspend.

	2016 Total £000s	2015 Total £000s
Gross capital expenditure	23,045	30,388
Prepayment for Capital Scheme	0	1,227
Release of Prior Year Prepayment for Capital Scheme	(1,848)	0
(Receipts from sales of fixed assets)	(109)	(299)
Net capital expenditure	21,088	31,316
Capital Resource Limit	21,398	31,596
Underspend against CRL	(310)	(280)

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 24 FINANCIAL PERFORMANCE TARGETS

24.3 Financial Performance Targets

The Southern HSC Trust is required to ensure that it breaks even on an annual basis by containing its net expenditure to within 0.25 % of the Revenue Resource Limit.

	2015/16 £000s	2014/15 £000s
Net Expenditure	(576,017)	(565,102)
RRL	576,154	565,143
Surplus against RRL	137	41
Break Even cumulative position(opening)	(2,097)	(2,138)
Break Even cumulative position (closing)	**(1,960)**	**(2,097)**

Materiality Test:

	2015/16 %	2014/15 %
Break Even in year position as % of RRL	0.02%	0.01%
Break Even cumulative position as % of RRL	(0.34)%	(0.37)%

The Southern HSC Trust reduced its cumulative overspend by achieving a small surplus in 2015/16. However, as the Trust continues to face a challenging financial position, it is unclear when the cumulative reported overspend will be recovered.

NOTE 25 POST BALANCE SHEET EVENTS

There are no post balance sheet events having a material effect on the accounts.

NOTE 26 DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 24 June 2016.

ACCOUNT OF MONIES HELD ON BEHALF OF PATIENTS/RESIDENTS

YEAR ENDED 31 MARCH 2016

SOUTHERN HSC TRUST

ACCOUNT OF MONIES HELD ON BEHALF OF PATIENTS/RESIDENTS

YEAR ENDED 31 MARCH 2016

STATEMENT OF TRUST'S RESPONSIBILITIES IN RELATION TO PATIENTS/RESIDENTS MONIES

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, the Trust is required to prepare and submit accounts in such form as the Department may direct.

The Trust is also required to maintain proper and distinct accounting records and is responsible for safeguarding the monies held on behalf of patients/residents and for taking reasonable steps to prevent and detect fraud and other irregularities.

SOUTHERN HEALTH AND SOCIAL CARE TRUST – PATIENTS' AND RESIDENTS' MONIES

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

I certify that I have audited Southern Health and Social Care Trust's account of Patients' and Residents' Monies for the year ended 31 March 2016 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended.

Respective responsibilities of the Trust and auditor

As explained more fully in the Statement of Trust Responsibilities in relation to Patients' and Residents' Monies, the Trust is responsible for the preparation of the account in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health (formerly Department of Health, Social Services and Public Safety) directions made thereunder. My responsibility is to audit, certify and report on the account in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the account

An audit involves obtaining evidence about the amounts and disclosures in the account sufficient to give reasonable assurance that the account is free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Southern Health and Social Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Southern Health and Social Care Trust's; and the overall presentation of the account. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited Patient's and Resident's Monies account and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the financial transactions recorded in the account conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects the financial transactions recorded in the account conform to the authorities which govern them.

Opinion on account

In my opinion:

- the account properly presents the receipts and payments of the monies held on behalf of the patients and residents of Southern Health and Social Care Trust for the year ended 31 March 2016 and balances held at that date; and

- the account has been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health directions issued thereunder.

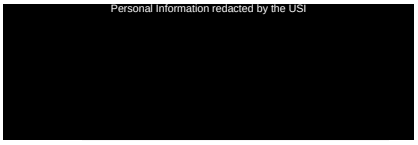
Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the account is not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with Department of Finance's (Department of Finance and Personnel) guidance.

Report

I have no observations to make on this account.



KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast
BT7 1EU

24th June 2016

SOUTHERN HSC TRUST

ACCOUNT OF MONIES HELD ON BEHALF OF PATIENTS/RESIDENTS

YEAR ENDED 31 MARCH 2016

Previous Year				
	RECEIPTS			
£	Balance at 1 April 2015		£	£
5,794,912	1.	Investments (at cost)	6,249,213	
860,443	2.	Cash at Bank	930,592	
3,936	3.	Cash in Hand	4,171	7,183,976
6,659,291				
2,222,976	Amounts Received in the Year		2,639,882	
54,301	Interest Received		41,879	2,681,761
8,936,568	**TOTAL**			**9,865,737**
	PAYMENTS			
1,752,592	Amounts paid to or on Behalf of Patients/Residents			2,049,325
	Balance at 31 March 2016			
6,249,213	1.	Investments (at Cost)	6,291,092	
930,592	2.	Cash in Bank	1,520,173	
4,171	3.	Cash in Hand	5,147	
7,183,976				7,816,412
8,936,568	**TOTAL**			**9,865,737**

Cost Price £	Schedule of investments held at 31 March 2016	Nominal Value £	Cost Price £
6,249,213	Bank of Ireland	6,291,092	6,291,092

I certify that the above account has been compiled from and is in accordance with the accounts and financial records mai

Personal Information redacted by the USI

Director of Finance

Date: 09/06/2016

I certify that the above account has been submitted to and duly approved by the Board.

Interim Chief Executive

Personal Information redacted by the USI

Date: