

Paula Clarke
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

28 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.

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

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

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

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

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

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

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

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

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

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

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI

Mobile: Personal Information redacted by the USI

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

Chair's Notice

[No 11 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
C/O
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

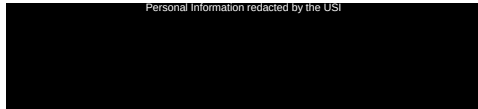
AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

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 28th April 2022

Signed:

Personal information redacted by the USI


Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE
[No 11 of 2022]

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the Inquiry if you would provide this narrative in numbered paragraphs and in chronological order.
2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* (“USI”), except where those documents have been previously provided to the USI by the SHSCT. Please also 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 discuss this with 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, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.

The Inquiry understands that you are no longer employed by the SHSCT. All questions asked in this Notice refer to the period of your tenure as Interim Chief Executive. The Inquiry has named personnel in this Notice, which it understands as holding certain posts during your tenure. Please either confirm those are the correct post holders when answering those questions or, if not, please identify who held the posts referred to and name any additional personnel which you are aware of as being relevant to the Inquiry's Terms of Reference.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.
5. Please set out all posts you held during your period of employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.
6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly reported and those departments, services, systems, roles and individuals whom you managed or had responsibility for.
7. With specific reference to the operation and governance of urology services, please set out your roles and responsibility and lines of management.
8. It would be helpful for the Inquiry for you to explain how those aspects of your roles and responsibilities which were relevant to the operation and governance of urology services, differed from and/or overlapped with, for example, the roles of the Directors and Assistant and Associate Directors, the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service and with any other role which had governance responsibility.

Engagement with Staff and the Trust Board, Governance and Risk Issues

9. Describe how, if relevant, you usually engaged with your Senior Management Team on a day-to-day basis, including the Medical Director and Head of Service.
10. Describe how you usually engaged with your clinical staff on a day-to-day basis.
11. Please also set out the details of any weekly and monthly scheduled meetings with those staff members (referred to by you at 6, 7 and 8), and how long those meetings typically lasted. If a minute was taken of such meetings, please provide all minutes of any meeting which referenced urology services during your tenure from January 2015 until March 2016.
12. Please explain how you, as Chief Executive, assured both yourself and the Board that the clinical governance systems in place during your tenure were adequate. How did you ensure that the Board was appraised of both serious concerns and current performance given the applicable standards of clinical care and safety? What is your view of the efficacy of these systems in place, if any?
13. During your tenure, was the Board appraised of those departments within the Trust which were performing exceptionally well or unsatisfactorily and, if so, how was this done? Was there a committee which was responsible for overseeing performance? If so, where did it sit in the managerial structure and hierarchy and how did the Trust Board gain sight of these matters?
14. Please provide details of any specific training you received in respect of any aspects of clinical governance, patient care and safety or any other risk factors relevant to the Trust's operational functioning.
15. How, as the accountable officer, did you ensure that all Board members were kept up to date on clinical governance best practice?

16. How did you ensure that learning from clinical governance failures which may have been identified as a result of investigations were raised during Board discussions? Please illustrate your answer with examples, if applicable. Were any such issues concerning urology services raised with the Board?
17. Was it a requirement of your role that you undertook annual continuing professional development? If not, did you undertake such training anyway? In any event, please provide details of any training undertaken by you in your role as the CEO when you took up post?
18. Were you aware of any avenues for sharing best/worst practice between Chief Executives of health care Trusts in NI, health care providers in the Republic of Ireland and NHS Trusts throughout the UK? If not, do you consider that the sharing of information in this way would assist in maintaining and enhancing clinical governance and overall patient care? Whether you agree or not, please explain your answer.
19. What is your view of the adequacy of the risk management arrangements in the Trust during your time in post?
20. Did you consider that the training and development for staff at all levels, including at senior management and Board level, encouraged a culture of reporting and learning from incidents? Please explain your answer. During your time, was the Board made aware of any problems in this area and, if so, what was done about it?
21. How was the Board assured, if at all, that there was a continued focus on reflective learning from the things that go wrong and celebration of the things that go well?
22. As former CEO, what is your view of the efficacy of the quality and safety monitoring systems that were in place in the Trust and executed through your operational teams during your tenure? Are there specific aspects of these systems that you found particularly helpful and are there parts of these systems

that required improvement? If yes, please explain. What changes did you put in place or attempt to put in place to augment the assurance that was in place, and what direct observations and conversations did you have with clinical staff on the ground to see for yourself what the issues and problems were and what services are providing excellence?

23. How much time did you spend talking to your Senior Management Team and the Trust Board about clinical governance issues generally? This might helpfully be expressed as a percentage of daily/weekly hours.
24. How did staff generally inform you about or engage you in conversations regarding clinical governance issues? Was it your usual experience that they generally do so informally, or in writing, or both?
25. How would you describe the methods which you deployed to ensure that you got to know that what is expected of people in terms of compliance with clinical governance standards and arrangements was actually being carried out? Did you consider these methods successful? It would assist if you could illustrate your answer with examples.
26. Please provide examples of a number of issues that were escalated through to the Trust Board or Trust Board Committees where there were patient quality and safety concerns. The examples can come from any department, but we would be particularly interested to hear about any issues from urology.. You should describe the route by which those concerns passed through the clinical governance structures and the route by which the Board then agreed a plan to improve matters and then sought assurance that the issues had been resolved. Did you as CEO have any concerns about these processes? If so, what changes, if any, did you make to improve assurance and ownership at all levels in the Trust?
27. In respect of your role, please detail your lines of engagement with the Trust Board, to include all formal and informal avenues.

28. Who on the Trust Board had responsibility for clinical governance and patient safety during your time in post? Please explain the Board oversight of clinical governance and patient safety generally, including the name(s) of and duties of any *Board Assurance Manager* during your tenure.
29. How did you let the Board know if problems regarding clinical governance arose? Did you utilise both formal and informal methods of contact and, if so, who was your point of contact and why? Did you think the mechanisms for doing this were good enough and, if not, what would have improved them?
30. Describe the most significant clinical governance/clinical risk challenges which you faced during your tenure as Chief Executive, and explain how you addressed them.
31. Did you engage in any program with a view to improving any aspect of clinical governance or clinical risk management during your tenure as Chief Executive? If so, fully explain the steps which you took as part of this program and outline any changes which resulted.
32. What percentage of the time at Trust Board was taken up with care quality and patient safety concerns and what emphasis was placed on receiving assurance that any such issues were resolved?
33. Was it your experience while in post that the Board had taken appropriate actions in relation to quality and safety concerns and sought to prioritise resources appropriately for these actions to be effective?
34. Do you have any knowledge of, or personal experience of, matters regarding clinical governance and patient safety not having been dealt with properly by the Trust and/ or the Trust Board during your tenure? If so, please provide full details, including setting out whether any failure to properly act has been admitted to and addressed, and any subsequent lessons identified and implemented – and if not, why do you think that did not happen?

35. Please set out what you considered to be the challenges in terms of learning the lessons from clinical governance and safety issues, and how staff were appraised of these and encouraged to reflect and learn? Are there any examples of this where minutes and presentations, if any, can be provided and where improvements have been put into place and embedded as demonstrated by audit?
36. Did you and the Trust Board identify and share lessons learned from adverse incidents, complaints, litigation and public inquiries, etc., concerning clinical governance and patient care and safety, both regionally and nationally? Whether your answer is yes or no, please explain. Do you consider it practicable that such lessons learned are shared and, if not, what needs to change to allow that to happen in a meaningful way?
37. How would you describe the “*risk appetite*” of the Trust and the Trust Board while you were Interim Chief Executive? Was there, as part of the risk management strategy and process within the Trust, an annual Board appraisal of risk appetite in relation to quality and safety, operational performance and finance?
38. Were you, as Interim CEO, able to assure the Board that high standards of professional practice were maintained? How did you seek to gain this assurance? Did this involve nurses, allied health professionals, doctors, technicians, and managers?
39. How were you assured as to how clinical appraisal was managed in the Trust? What assurance does the Board receive in this regard? Did you have any concerns about this during your tenure?
40. Did the Trust Board ever raise the issue of budget allocation and the prioritisation of risk, or seek to establish whether you, and they, were content that an acceptable risk prioritisation/budget allocation balance had been struck?

41. Please provide all notes and minutes of any meetings with the Trust Board, Trust Committees, any Trust or Departmental Staff or any third party or health body in which the problems with Urology Services were discussed during your time in post.
42. Do you consider that the Board operated efficiently and effectively during your tenure? If not, please describe your experiences.
43. Was it your view that the Board was, individually and collectively, motivated to address concerns regarding governance and clinical and patient safety as they arose within Urology Services or more generally? Did they always follow up on concerns raised? Were meetings conducted in an open and transparent manner? What was your experience of the Boards appetite for identifying concerns and implementing lessons learned?
44. Explain how your performance was appraised, to include how often and by whom, and how this was recorded. How were your performance targets evaluated?
45. Please explain how, if at all, the consideration of clinical risk within an area/specialty influenced how you allocated annual budgets for Departments? If you did prioritise clinical risk, what methodology did you use and what criteria did you apply? In other words, how, if at all, did you reflect clinical risk in budget allocation?
46. During your tenure, was it your experience that Departments or specialities sought an increased budget allocation to reflect their specific risk and, if so, what was your response? Please provide specific examples to explain your answer.
47. Did you have any personal knowledge whether such a system, which permitted budgetary requests specific to risk management, existed before your time in post?

48. Are you aware of other Trusts or health care providers who take or apply this risk/budget allocation approach or model?

49. How, if at all, did you satisfy yourself that the approach taken to risk in allocating budgets was acceptable?

Urology services/Urology unit: Staffing

50. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

51. What, if any, performance indicators were used within the urology unit at its inception?

52. Was the '*Integrated Elective Access Protocol*' published by DOH in April 2008, or any previous or subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants and staff in the SHSCT? If yes, how and by whom was this done? If not, why not?

53. How, if at all, did the '*Integrated Elective Access Protocol*' (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of that protocol or any previous or subsequent protocol? What action, if any, was taken (and by whom) if time limits were not met?

54. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

- I. What is your knowledge of and what was your involvement, if any, with this plan?
- II. How was it implemented, reviewed and its effectiveness assessed?
- III. What was your role, if any, in that process?
- IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

55. As far as you are aware, were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

56. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

57. Do you think the urology unit was adequately staffed and properly resourced during your tenure? If that is not your view, can you please expand noting the deficiencies as you saw them?

58. Were you aware of any staffing problems within the unit during your tenure? If so, please set out the times when you were made aware of such problems, how and by whom.

59. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

60. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?
61. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?
62. Did your role change in terms of governance during your tenure? If so, explain how and why it changed with particular reference to urology services, as relevant?
63. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff.
64. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?
65. Were any concerns raised with you about the adequacy and/or availability of administrative staff for urology clinicians? Are you aware of such concerns having been raised with any other staff? If so, please explain and provide any documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.
66. Did administrative staff within urology services ever raise any concerns directly with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.
67. Who was in overall charge of the day to day running of the urology unit during your tenure? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person/ those persons answered.
68. What, if any role did you have in staff performance reviews?

69. Was your own role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

Engagement with unit staff

70. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.
71. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.
72. Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?
73. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

Complaints

74. Please describe your role, and the role of members of the management team, should a complaint about clinical governance and/or patient safety be made by (i) member of staff, (ii) a patient, or (iii) anyone else, and provide an overview of how any such complaint was handled and your role in the process. It would be helpful if your answer referred to a specific example/s, preferably from urology, if any.

75. Please explain your understanding of how the management of clinical governance operated between clinical, nursing and other Directors and Departments, and detail your involvement in any of those processes.
76. During your tenure, did you think the relative responsibility for different aspects of clinical governance was clearly allocated between the relevant professional members of your senior team? Did you have cause to question or improve this? Was there a clear demarcation of particular responsibilities and, if so, how was this communicated within the senior team? Was it clearly set out or did it cause issues?
77. What is your view of how the complaints and whistle-blowing procedures, etc. operated and did you make any improvements in those areas? Have there been incidences where a member of staff or members of staff or a patient or anyone else raised concerns about how effective those procedures were and what was your response to that?

Governance – generally

78. What was your role in relation to the Directors Human Resources and Organisational Development, the Assistant and Associate Directors, the Head of Service for Urology, the Medical and Clinical Directors, consultants and other clinicians in the urology unit, including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.
79. Who oversaw the clinical governance arrangements of the urology department and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately? Please explain and provide documents relating to any procedures, processes or systems in place on which you rely on in your answer.

80. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?
81. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing performance metrics?
82. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?
83. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?
84. Did those systems or processes change over time? If so, how, by whom and why?
85. How did you ensure that you were appraised of any concerns generally within the unit?
86. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary? If yes, please explain.
87. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.
88. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?
89. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

90. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.
91. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?
92. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your time in post, including the name(s) and role(s) of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.
93. Did you feel supported in your role by the Trust Board and general management and medical line management? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

Concerns regarding the urology unit

94. The Inquiry is keen to understand how, if at all, during your tenure you liaised with and had both formal and informal meetings with:
- (i) The Trust Board
 - (ii) The Chair of Trust Board – the Inquiry understands this to have been Roberta Brownlee
 - (iii) The Medical Directors - the Inquiry understand these to have been John Simpson and Richard Wright;
 - (iv) The Directors of Acute Service – the inquiry understands these to have been Debbie Burns and Esther Gishkori;

- (v) The Director of Human Resources and relevant Human Resources personnel – (please name)
- (vi) The Assistant Directors - the inquiry understands these to have been Heather Trouton and Ronan Carroll;
- (vii) The Associate Medical Directors - the inquiry understands this to have been Eamon Mackle and Mark Haynes (Surgery) and Charlie McAlister and Damian Scullion (Anaesthetics)
- (viii) The Clinical Directors, the inquiry understands this to have been Robin Brown and Sam Hall;
- (ix) The Head of Service, namely Martina Corrigan,
- (x) The consultant urologists in post.
- (xi) The Nurse Managers – the inquiry understands this to have been Shirley Tedford and Gillian Henry.

The Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to urology services concerns. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc. Your answer should also include any individuals not named in (i) – (xi) above but with whom you interacted on matters falling with the Inquiry's Terms of Reference.

95. Can you explain from your perspective how you understood Urology Services was supposed to operate from a clinical governance and patient care and safety perspective during your time in post compared to how it did in fact operate?

96. Can you identify in what aspects you considered Urology Services to be operating adequately and in what respects it was failing to do so? If your understanding changed over time, please explain this within your answer.

97. During your tenure, please describe the main problems you encountered or that were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:

- (a) What were the concerns raised with you, when were they raised and who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.
- (b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?
- (c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not?
- (d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements and how was this done? Please provide all relevant documents.
- (e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?
- (f) If you were given assurances by others, please name those individuals and set out the assurances they provided to you. How did you test those assurances?
- (g) Were the systems and agreements put in place to rectify the problems within urology services successful?
- (h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

98. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

- (a) properly identified,
- (b) their extent and impact assessed,
- (c) the potential risk to patients properly considered?

99. What, if any, support was provided to urology staff (other than Mr. O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q114 will ask about any support provided to Mr. O'Brien).

100. Was the urology department offered any support for quality improvement initiatives during your tenure?

Mr. O'Brien

101. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

102. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

103. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?

104. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.
105. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.
106. Did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? If so:
- (i) what risk assessment did you undertake, and
 - (ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person and, if known, any steps taken
107. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr. O'Brien and others, given the concerns identified.
108. Did you ever speak to or contact Mr. O'Brien, either formally or informally, regarding the concerns raised, or any proposed actions or plans, or about any matter falling within the Inquiry's Terms of Reference? If so, please provide full details.

109. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?
110. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?
111. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?
112. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?
113. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:
- (a) outline the nature of concerns you raised, and why it was raised
 - (b) who did you raise it with and when?
 - (c) what action was taken by you and others, if any, after the issue was raised
 - (d) what was the outcome of raising the issue?
- If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?
114. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

115. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.
116. Did you communicate in any way, either formally or informally, with your predecessor Chief Executive, Mairead McAlinden, or your successor, Francis Rice, in relation to any issues of concern regarding urology services, such as patient safety, clinical risk or governance issues? If so, please provide all details and any relevant documentation.

Learning

117. What was the position regarding the concerns raised regarding urology by the end of your tenure? Had concerns of which you were made aware been addressed to your satisfaction? If so, please explain. If not, why not?
118. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why, and why you consider it did not come to your attention.
119. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?
120. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and the concerns involving Mr. O'Brien in particular?
121. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your

answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

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

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

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

NOTE:

By virtue of section 43(1) of the 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 11 of 2022

Date of Notice: Received by witness via DLS on Friday 29th March 2022

Witness Statement of: Paula Clarke

I, Paula Clarke will say as follows:-

Schedule No 11 states at the outset (para 2 Q3) that “*All questions asked in this Notice refer to the period of your tenure as Interim Chief Executive*”. The responses below are therefore set within this statement. Where I believe there is relevant information to the Inquiry that includes my tenure within the SHSCT in other roles, or where I have been asked explicitly to respond for other roles beyond my tenure as interim CEO, I have included this.

This statement reflects the responses I have been able to make in the time allotted by the Inquiry to complete it and the timeliness with which the SHSCT have responded to my requests to access relevant documents.

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

- 1.1** In the context of the broad scope of the Terms of Reference of the Inquiry, I want to provide the Inquiry team with some opening comments and contextual information that I will refer to throughout my response.

- a) I am ex-employee of SHSCT who left the Trust over 6 years ago on 31/3/16 and have been working in the NHS in England since that date as an Executive Director in a large, acute NHS Foundation Trust. I have not maintained an interest in NI media reporting generally or specifically for health and social care and therefore feel quite removed from the operating environment. I had no awareness of nor involvement in the concerns regarding SHSCT urology services that have resulted in the Public Inquiry apart from being contacted in November 2021 to authorize the Trust to access my emails as interim CEO in 2015/16.
- b) This 6-year period of separation has impacted on my recollection of the details of how SHSCT operated internally and within the NI Health and Social Care structures, however, I have endeavored to respond as fully as I can to all of the questions raised by the Inquiry supported by access to a very large number of documents through the SHSCT Public Inquiry Team that I have not been able to assess comprehensively.
- c) I have also spoken to the following people to help me recall some specific areas of Trust business and processes in support of as full a response as I can provide. I will also refer to the discussion with these individuals at the relevant question response:
- i. Mrs Lesley Leeman, Assistant Director of Performance; during my tenure as interim Chief Executive
 - ii. Mrs Martina Corrigan, Head of Urology Services during my tenure as interim Chief Executive;
 - iii. Mrs Mairead McAlinden, Chief Executive prior to my tenure (up to 31/3/15).
- d) I must state at the outset that I have only been able to respond to most of the questions in this section 21 notice by reviewing, to the best of my ability, the documents provided as I have little recollection of the detail of my tenure with SHSCT.

1.2 I worked in the Trust from March 2008 to March 2016. For the year 2015/16 I was privileged to lead the Trust as interim Chief Executive and Accountable Officer. This role carried the following key responsibilities that I believe to be relevant to the TOR of the Inquiry and summarised from the Chief Executive Job description, which *can be located at S21 No 11 of 2022 Attachments, 1. Chief Executive JD 2015*. Paula Clarke:

- a) Accountable 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.
- b) 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.
- c) 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.
- d) Achieve high levels of performance and excellence against Controls Assurance and other standards required.
- e) Achieve and sustain a high level of public confidence in the appropriateness, priority, safety and effectiveness of services provided by the Trust
- f) 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

- g) With the Chair and Trust Board 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 and deliver effective governance in accordance with public sector values and the codes of operation and Accountability.
- h) Ensure that robust arrangements are in place to meet the statutory clinical and integrated governance requirements, assure quality standards and 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.

Operating Context for SHSCT in 2015/16.

1.2 While the inquiry focus is on urology services and the associated clinical and corporate governance arrangements and procedures within the Trust, the operating context for the Trust in 2015/16 when I was interim Chief Executive provides important information for the inquiry to consider in understanding the responses I have given in this section 21 notice.

1.3 Key aspects of the operating context are summarised in paragraphs 1.5 to 1.7 with specific reference to the following document:

- a) SHSCT Draft Financial Plan 2015/16 (dated 26/3/15) which can be located at S21 11 of 2022 Attachments, 2. Item 09 - 05 - SHSCT Draft Financial Plan 2015-16 PDF

1.4 The operating context for SHSCT in 2015/16, along with all health and social care organisations, was challenging in a number of aspects. The Trust operated within a framework of accountability which required delivery in accordance with the requirements as set by the Minister for Health, Social Services and Public Safety and within the regional Commissioning Plan (developed by the Health and Social Care Board and Public Health Agency) and associated Service and Budget Agreements.

The Trust had a statutory duty to ensure the safety and quality of care provided to patients and clients and to break-even regardless of the financial environment in which it operated. Of note, in 2015/16 the Southern Trust had been advised it needed to deliver £13m in cash savings during 2015/16 as part of the wider health and social care financial settlement approved within the NI Assembly budget. This is detailed in SHSCT Draft Financial Plan 2015/16 (dated 26/3/15) with key points/extracts summarised below.

1.5 In response to the Assembly budget settlement, the Department of Health, Social Services and Public Safety, (DHSSPS) developed a draft plan to deliver financial balance in 2015/16. This final budget settlement included an expectation that all Arms' Length Bodies (ALBs) needed to achieve significant savings in order to finance such cost pressures and commitments. The Trust developed a draft plan within the constraints of the statutory duty to break even financially, stating clearly that:

“the Trust remains mindful of its statutory duty to provide safe, high quality care which is effective, efficient, accessible and responsive to the needs of our patients and clients. However, balancing the requirements of both these statutory duties means difficult decisions are required. Where some degree of service change is required, the Trust will ensure that:

- *best practice is applied and followed:*
- *necessary alternative capacity is available to support any proposed shifts in activity.*

The ability to expand and develop new services in 2015/16 will be restricted and there will be a need to consolidate some of our existing services to ensure safe, effective care and value for money is achieved. Proposals will be subject to public consultation and equality screening, as appropriate and in line with Departmental and organisational legislation and guidance.

The Trust's financial plan for 2015/16 is set in the context of the Southern Trust's overall position with respect to performance, relative efficiency and significant demographic pressures compared with the rest of the region:

- *Performance: We continue to deliver against the majority of our Service and Budget volumes, uplifted for additional activity to deliver non-cash releasing efficiency savings.*

- *Efficiency: We can demonstrate through external benchmarking that we retain our position as one of the most efficient Trusts in NI and within the UK Top 40 hospitals.*

- *Demography: We have seen local population growth of 18% between 2000 and 2011 compared with the NI average of 7% and we have further projected growth of 15% by 2023 compared to the NI average of 7%.*

Furthermore, the Trust's savings requirements for 2015/16 are set in the context of what has already been achieved as part of the current comprehensive spending review (CSR) period as well as emerging pressures within our hospital and community services.

Within the context outlined above, delivering £13m savings presents a significant task for the Trust. Our primary focus in 2015/16 will be to continue to aim to deliver on plans that achieve safe, quality and efficient care in a sustainable and financially recurrent way to achieve a degree of stability however the Trust will also be required to continue with a number of shorter-term contingency measures (non-recurrent actions) to secure the level of savings required during this financial year. To this end, we will continue to protect the Trusts' most critical services as a priority. This includes ensuring we deploy skilled staff to best effect in service areas where demand is high, and they can be most effective and ensuring the most efficient approach to service delivery that maintains the quality and level of services available to service users."

1.6 The Draft SHSCT Trust Delivery Plan 2015/16 (June 2015) also provides important contextual information for the Inquiry team. The Trust Delivery Plan (TDP) represented the response of the Southern Health & Social Care Trust to the Health & Social Care Board (HSCB) & Public Health Agency (PHA) Commissioning Plan for 2015/16 which was developed in response to the Commissioning Plan Direction published by the Minister for Health, Social Services and Public Safety on 6th March

2015. The Trust's decision-making and activities during my tenure as Interim CEO (1/4/15 to 31/3/16) were taken within this framework of accountability. The Trust had a statutory duty to ensure the safety and quality of care provided to patients and clients and to break-even regardless of the financial environment in which it operated. Below are extracts from the Draft TDP as presented to SHSCT Board meeting 11th June 2015. I will refer to these paragraphs in my response to relevant questions in this section 21 notice.

a. *"The TDP provides a response to the regional commissioning priorities and decisions for 2015/16 set by the Minister and the HSCB & PHA as well as priorities and decisions being taken forward at a local level by the Southern Local Commissioning Group. Service and Performance 'targets' where there is a material risk to delivery have been highlighted along with responses to each of the Regional & Local Commissioning Group Objectives that are identified within the Commissioning Plan."*

b. Pages 20, 22, 41 of the Draft TDP reference urology services and risk to delivery of Ministerial standards and performance targets, as follows:

i. Page 20 - *"Elective Care: From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment, and no patient waits longer than 18 weeks. Assessed as Unlikely to be Achieved/Affordable."*

Patients demand in excess of the Trust's agreed Service & Budget Agreement makes achievability of the target subject to availability of additional resources. Should available resource become available the lead in time to secure the additional capacity will define the ability or otherwise to achieve this target. The Trust is also required to balance risk associated with emergent urgent demand and review patients waiting beyond their clinically indicated timescales and has discussed the management of this shared risk with HSCB. Urology capacity continues to be an issue regionally. All consultant posts have now been filled but the ability to meet the access target for routine referrals will continue to come under pressure due to the high volume of suspected cancer and urgent referrals and the need to prioritise these".

ii. Page 22 - "Elective Care: From April 2015, at least 65% of inpatients and day cases are treated within 13 weeks and no patient waits longer than 26 weeks. Assessed as Partially Achievable/ Achievable with Additional Resources

Urology waiting times will continue to be an issue. All consultant posts have now been filled but this specialty continues to come under pressure due to the high volume of cancer work and other urgent surgery which must be prioritised."

iii. Page 41 "The development, by December 2015, of a networked urology service on a safe, sustainable basis. A Regional Planning and Implementation Group is currently being established to progress this development. The Trust will be represented on this Group."

Overview of Governance in SHSCT in 2015/16

1.8 I refer to the following document in giving the Inquiry an overview of the scope of my responsibility as the Interim CEO in 2015/16 and the governance arrangements and assurance framework in place for the Trust and its Board. This is largely reflected in the Annual Statement of Governance from which I have drawn the most relevant extracts that provide the context for my response throughout this statement and to which I will refer in my response to pertinent questions.

- *Annual Report & Accounts for Year Ended 31/3/16, can be located at S21 11 of 2022Attachments,
3.20160425MonthlyPerfReportApril(MarchPerf)_TB_V1_0_LLappin*

1.9 The wording below is directly extracted from the Statement of Governance for the year ended 31 March 2016 in pages 29 to 60 of the Annual Report. This is a statutory document verified by independent audit.

"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.

Compliance with Corporate Governance Best Practice

1.10 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.

Governance Framework

1.11 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:

- a. Management Statement and Financial Memorandum.*
- b. A schedule of matters reserved for Board decision*
- c. A scheme of delegation, which delegates decision making authority within set parameters to the Chief Executive and other officers.*
- d. Standing orders and standing financial instructions.*
- e. An Audit Committee; A Governance Committee; An Endowments and Gifts Committee; A Remuneration Committee; and A Patient and Client Experience Committee.*

1.12 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 was initiated in 2015/16. 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. (Note for the Inquiry team - I have included more information for the most relevant committees in this statement with full details accessible via the Annual Report and Accounts for the year ended March 2016 document.)

The Trust Board:

1.13 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.

1.14 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.

1.15 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:

1.16 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. 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.

1.17 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. On an annual basis, the Committee reviews the findings of the External Auditor concerning the Trust's Annual Accounts, including the Governance Statement.

Governance Committee:

1.18 *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.*

1.19 *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.*

1.20 *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.*

1.21 *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.*

1.22 *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.*

Business Planning and Risk Management.

1.23 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.

The following section provides an overview of the Trust's Business planning process and considers how objectives are identified, managed and reviewed.

a. 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.

b. 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 the TDP 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.

c. 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.

d. 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.

e. 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

1.24 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.

1.25 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:

- a. 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*
- b. Directorate risk registers which focus primarily on the risks to the achievement of Directorate objectives.*

1.26 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 and monitoring reports etc.

1.27 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.

1.28 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.

1.29 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.

Assurance.

1.30 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.

1.31 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.

1.32 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.

1.33 *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.*

1.34 *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.*

1.35 *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.*

1.36 *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.*

1.37 *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. (Inquiry team to note that the table on page 43/44 of the Annual Report and Accounts for the year ended March 2016 provides a summary of the expected and achieved levels of compliance for 2015/16 in all 22 standards (all substantive). Two core standards relate to Governance and Risk Management both of which were independently verified as substantive by Internal Audit in 2015/16).

Sources of Independent Assurance.

1.38 The Trust obtains Independent Assurance from the following sources:

- a. Internal Audit.*
- b. RQIA.*
- c. External Review/Benchmarking.*
- d. Licensing and other Regulatory bodies Internal Audit*

1.39 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 systems in Finance, Corporate Risk and Governance areas.” (Note to the Inquiry – audits completed in 2015/16 are detailed in the table on page 45/46 of the Annual Report and Accounts for the year ended March 2016 with the assessed level of assurance reported.) The Governance audits completed in 2015/16 included:

- a. Risk Management (Satisfactory Assurance)*
- b. Clinical and Social Care Governance (Satisfactory Assurance)*
- c. Board effectiveness (Satisfactory Assurance)*
- d. Whistleblowing and Fraud processes (Satisfactory Assurance)*
- e. Complaints Management (Satisfactory Assurance)*

“Overall Opinion for 2015/16

1.40 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 included in pages 48/49 of the Annual Report and Accounts for the year ended March 2016. None are directly related to urology services.

RQIA

1.41 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 progressed work in 2015/16 to establish 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

1.42 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 (note for inquiry this was Comparative Health Knowledge Systems CHKS), 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.

Review of Effectiveness of the System of Internal Governance

1.43 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."

Internal Governance Divergences

1.44 The Annual Report and Accounts for the year ended March 2016, located at S21 11 of 2022, Attachments

3.20160425_MonthlyPerfReportApril(MarchPerf)_TB_V1_0_LLappin areas that represented internal control governance divergences and hence were brought to the attention of the Board and the public. The areas that I believe are contextually relevant to my statement and the Inquiry include those below relating to Clinical and Social Care Risks:

1.45 "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 committed to consider the learning points and recommendations from that Inquiry when available and take forward as appropriate.

1.46 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.

1.47 Elective Care.

The Trust continued to have a number of specialty areas with capacity gaps in 2015/16 resulting in targets, that the majority of patients should be waiting no longer than 9 weeks for an outpatient/diagnostic appointment and no longer than 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:

- a. The number of patients waiting less than 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.
- b. 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.
- c. 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.

1.48 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.

1.49 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:

- a. The use of Serious Adverse Incidents and Adverse Incidents to improve patient safety and reduce risk.
- b. The deaths of children from natural causes should not be classified as an SAI; and
- c. The introduction of a regional morbidity and mortality review system.

1.50 The Trust is participating in a number of work streams with the DHSSPS, HSCB, RQIA and GAIN in respect to strengthening and modifying 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.

1.51 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.

1.52 Conclusion to Annual Report and Accounts for the Year Ended 31 March 2016

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 as Chief Executive 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."

- 2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also 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 discuss this with the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

2.1 I have provided any documents within my custody or control relating to the Terms of Reference of the Inquiry and to the responses I have made in this section 21 notice.

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

The Inquiry understands that you are no longer employed by the SHSCT. All questions asked in this Notice refer to the period of your tenure as Interim Chief Executive. The Inquiry has named personnel in this Notice, which it understands as holding certain posts during your tenure. Please either confirm those are the correct post holders when answering those questions or, if not, please identify who held the posts referred to and name any additional personnel which you are aware of as being relevant to the Inquiry's Terms of Reference.

My position(s) within the SHSCT

- 4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.**

4.1 Academic/Professional Qualifications:

- MA Honours History (2:1), Edinburgh University (1987)
- MBA (with Distinction), University of Ulster (2005)
- Member of Institute of Healthcare Management.

4.2 Occupational History prior to March 2008

ROLE/DURATION	OVERVIEW
Acting Director of Planning and Performance Management – Southern Health & Social Services Board August 2006 – February 2008	Board member responsible for leading the commissioning function including the management of a multi-disciplinary planning process to translate regional policy/strategy and local needs into commissioning plans and performance management processes. Responsible for developing effective commissioning strategies that optimised the £500m commissioning budget.
Head of Modernisation and Redesign for Southern area SHSSB April 2005 – July 2006	Led transformation and innovation strategy for the Southern area, working in partnership with four local Trusts and 75 GP practices. Led development of unscheduled care and radiology Managed Clinical Networks, a regional critical care network, implemented an integrated care pathway for COPD.
Local Health and Social Care Group Chief Officer - SHSSB Jan 2003 - March 2005	Responsible for strategic planning, OD and operational management of this new Group aimed at involving GPs, local service users and professionals in the commissioning and planning of services.
Senior Service Programme Planner – SHSSB Sept 1995 - Dec 2002	Support to the Director for planning, commissioning and performance management processes. Chair of multidisciplinary planning teams for older people, mental health & disability.
Career break	N/A

Dec 2000 - April 2002	
Contracts Manager Craigavon & Banbridge Community Health and Social Care Trust Feb 1993 - August 1995	Management of Trust contracting processes including development of contracting framework for new community care responsibilities. Provision of specialist business management analysis and advice/development of business cases.
NHS/General Management trainee Sept 1991 - January 1993	One of 5 trainees in N. Ireland selected for fast-track NHS management development programme.
Internal audit Manager SHSSB Sept 1990 - August 1991	Various duties supporting completion of audits to provide assurances on VFM/governance arrangements.
Trainee Accountant Coopers & Lybrand London /Belfast offices Oct 1987 - August 1990	Trainee accountant/part of audit teams for multinational and medium-sized businesses.

5. Please set out all posts you held during your period of employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

Role and tenure	Brief summary of role responsibilities	Is the JD an accurate reflection of my duties and responsibilities
Interim CEO 1/4/15 - 31/3/16	A copy of my Chief Executive Job description, <i>can be located at S21 No 11 of 2022 Attachments, 1.Chief Executive JD 2015.Paula Clarke as interim</i>	Yes

	CEO is provided with this response and a summary of my role and responsibilities given in paragraph 1.2. In brief, this included: • Leading the development of the strategic vision of the Trust in line with the priorities and policies of DHSSPS and HSCB. • Overall responsibility for the management and performance of the Trusts including meeting Ministerial priorities as defined by DHSSPS and HSCB, statutory requirements, achieving performance targets, securing continuous improvement and for providing high quality and effective services within a clear financial framework. Accounting Officer responsibilities were also set out for me by the Permanent Secretary DHSSPS, <i>which can be located at S21 No 11 of 2022 Attachments, 4. 20150325 Ltr RP292 letter to P Clarke re Acting Accounting Officer – Appointment Letter and 5. 20150325 Ltr RP292 letter to P Clarke re Acting Acc Officer - Accounting Officer Memorandum A1</i> with specific reference to compliance with Chapter 3 of Managing Public Money Northern Ireland (MPMNI) which sets out the responsibilities of accounting officers.	
Director of Performance and Reform – (Acting Director	A copy of my Job description as Director is provided with this response <i>and can be located at 21 11 of 2022 Attachments, 1. Chief Executive JD 2015.Paula Clarke.</i> In summary, my roles and	Yes

September 2009. Appointed substantive Director from March 2011 to 31/3/15)	responsibilities were to lead the corporate processes in the Trust which included the performance management framework, strategic and operational planning, capital planning and the strategic reform and modernisation of services. I was the key link with the HSC Board on all commissioning and delivery issues and held responsibility for the Trust's ICT and Estates functions	
Assistant Director of Performance Improvement March 2008 to September 2009	A copy of my Job description as AD of Performance Improvement is provided with this response <i>and can be located at S21 No 11 of 2022 Attachments, 6. Assistant Director JD Performance and Reform.</i> In summary, I was responsible for the performance management, service modernisation and reform and contracting functions within the Trust and was Programme lead for the Trusts' Comprehensive Spending Review cash-releasing Reform, Productivity and Efficiency processes and plans.	Yes

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly reported and those departments, services, systems, roles and individuals whom you managed or had responsibility for.

6.1 As interim Chief Executive from 1/4/15 until 31/3/16 I was accountable to Trust Board with a line management relationship through the Chair of the Board, Mrs Robert Brownlee.

6.2 As accounting officer for SHSCT I was also accountable to the Minister for Health and Social Care through the Permanent Secretary DHSSPS, Mr Richard Pengelly, and to the Health and Social Care Board through its Chief Executive, Mrs Valerie Watts. In this role, I was responsible for the management and performance of the whole Trust services (as per the Job description referenced in 5.1) with line management for the Directors of the Trust who were as below: *JDs for all Directors have been provided for:*

- a. Mr Kieran Donaghy, Director of Human Resources and Organisational Development (HROD) (located in Relevant to HR, reference no 2b, SMT JDs, Director HROD JD).
- b. Mr Stephen McNally, Director of Finance and Procurement (*S21 11 of 2022 Attachments 6c. Director of FP 2010. Stephen McNally*)
- c. Mr Paul Morgan, Director of Children and Young Peoples Services and Executive Director for Social Care (*located in Relevant to HR, reference no 2b, SMT JDs, Director CYPS JD - January 2011 (P Morgan)*)
- d. Mrs Angela McVeigh, Director of Older Persons and Primary Care Services (*S21 11 of 2022 Attachments 6e. Director of OPPC JD 2011*)
- e. Mr Francis Rice, Director of Mental Health and Disability Services and Executive Director of Nursing and AHPs (*S21 11 of 2022 Attachments 6f. Francis R - JD PS*)
- f. Mr Miceal Crilly Acting Director of Mental Health and Disability Services to April 2015 – Mr Crilly had been covering a period of sick leave for [REDACTED] [REDACTED] (*S21 11 of 2022 Attachments 6d. Director of MHDS JD 2013*)
- g. Mrs Deborah Burns, Director of Acute Services to August 2015 (*S21 11 of 2022 Attachments 6b. Director of Acute Services JD 2013 D Burns*)
- h. Mrs Esther Gishkori, Director of Acute Services from August 2015 (*S21 11 of 2022 Attachments 6a. DIRECTOR OF ACUTE SERVICES Esther Gishkori*)
- i. Dr John Simpson, Medical Director to August 2015 (*S21 11 of 2022 Attachments 6g. Medical Director JD 2011 J Simpson*)
- j. Dr Richard Wright, Medical Director from July 2015 (*Relevant to HR, reference no 2b, 20150800-REF15-Dr R Wright - Medical Director Job*)

Description)

- k. Mrs Aldrina Magwood, Acting Director of Performance and Reform from 1/4/15 (Relevant to HR, reference no 2b, SMT JDs, Director CYPs JD - January 2011 (P Morgan), Director P_R JD (A Magwood))

6.3 I also had line management responsibility for the following people in 2015/16:

- a. Mrs Elaine Wright, Office Manager;
- b. Mrs Jane McKimm and Mrs Ruth Rogers, Head of Communications (job share);
- c. Mrs Sandra Judt, Board Assurance Manager (who reported to the Trust Chair);
- d. Mrs Margaret Marshall, Acting Assistant Director of Clinical and Social Care Governance.

6.4 As Director of Performance and Reform from March 2011 and acting Director of Performance and Reform from September 2009, I reported to Mrs Mairead McAlinden (Acting Chief Executive from September 2009) and substantive Chief Executive from November 2010 until 31/3/15. I was responsible for performance management; strategic and operational planning; capital planning; service transformation and improvement; Informatics/e-health; Estates and Contracting functions. I line-managed the following in this role:

- a. Alan Metcalfe, Assistant Director for Estates Services;
- b. Mrs Lesley Leeman, Assistant Director Performance and Improvement;
- c. Martin Kelly commenced as Assistant Director of Corporate Planning from 1 July 2000. He was seconded out of the Trust (and from this role) from 24 October 2011 until he left the Trust on 30 June 2014. Mrs Charlene Stoops was seconded as Assistant Director of Corporate Planning from 14/11/2011 - 31/01/2013. She was then permanently appointed to this role from 01/02/2013 – 06/05/2019 when she left the Trust.
- d. Mrs Aldrina Magwood, Assistant Director of Best Care Best Value;
- e. Mrs Siobhan Hanna, Assistant Director of Informatics;
- f. Mrs Sharon Radcliffe, Personal Assistant.

6.5 As Assistant Director of Performance Improvement (March 2008-September 2009) I was responsible for the performance management, service modernisation and reform and contracting functions. I reported to Mrs Mairead McAlinden as Director of Performance and Reform (until August 2009) and believe I line-managed the following people but have not had evidence provided to me to confirm this or the correct titles for the roles:

- a. Mrs Lesley Leeman, Head of Performance;
- b. Mrs Aldrina Magwood, Best Care, Best Value.

6.6 The Trust Public Inquiry team have provided a number of organisational charts to support understanding of the structures in place which can be located in S21 No 11 of 2022 Attachments and are as follows:

7. PandR Organisational Chart 16.01.14, 8. Org Chart - Dec 2016, 9. Office of the Chair Jan 2016, 10. ACUTE Organisational Chart December 2015

7. With specific reference to the operation and governance of urology services, please set out your roles and responsibility and lines of management.

7.1 I am responding as the interim CEO of the Trust from 1/4/15 until 31/3/16, however, I have provided some additional information to clarify any responsibilities for the operation and governance of urology services in prior roles in the Trust.

7.2 As Accounting Officer and Interim Chief Executive of the Trust (1/4/15 to 31/3/16), I was accountable to the Trust Board, DHSSPS and HSCB and Minister for the performance and governance of the Trust with responsibility for maintaining a sound system of internal governance that supported the achievement of the organisations policies, aims and objectives including Trust performance against Ministerial standards and targets for all services including urology.

7.3 I had no direct role in the operational management and delivery of urology services as this responsibility was discharged through delegated accountability to the Director of Acute Services (Mrs Debbie Burns, Acting Director of Acute Services to

August 2015, and Mrs Esther Gishkori, Director of Acute Services from August 2015). The Director of Acute Services role carried the responsibility and accountability for the safety and quality of acute services including urology and of the workforce delivering the care, supported by the Executive Directors when appropriate in relation to professional workforce matters. The role was also responsible for the overall delivery and performance of acute services within the priorities of the Trust and the DHSSPS and HSCB. The Director of Acute Services was supported in this role by their senior team of Assistant Directors and Associate Medical Directors. The acute directorate organisational chart sets this out *and can be located at S21 No 11 of 2022 Attachments, 10. Acute Organisational Chart December 2015*

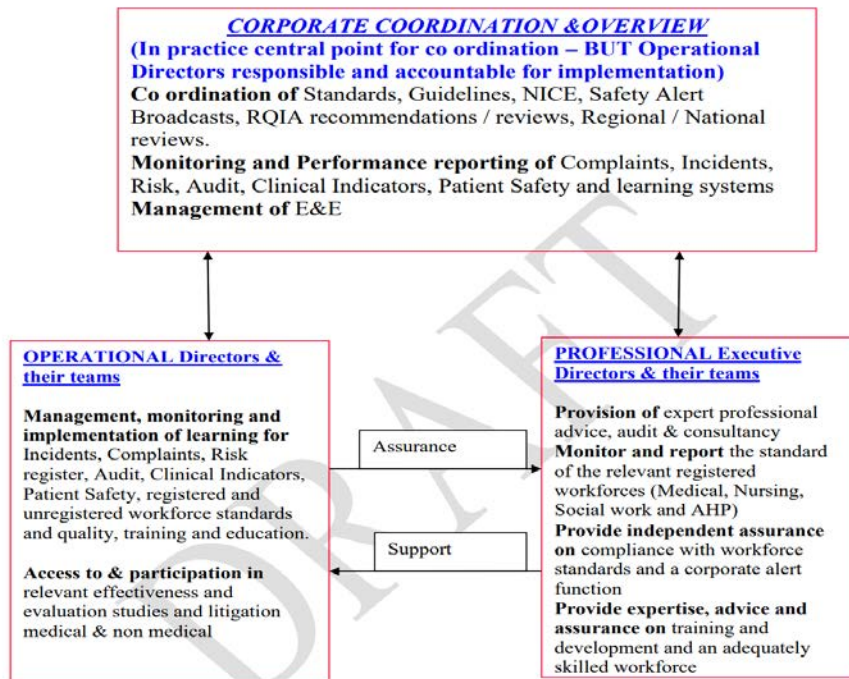
7.4 With respect to governance of urology services, I discharged my responsibilities for all clinical services through the Trust Integrated Governance Framework and assurance processes. These are set out in paragraphs 1.11–1.22, 1.24-1.43 and in the Structures for Clinical and Social Care Governance Consultation document Period (December 2010) “A System of Trust” *which can be located at S21 11 of 2022 Attachments, 11. 20150410 E and Reports Draft Paper Governance - RCSCG CONSULTATION DRAFT 4 A2*. The latter document was the output of a review of clinical and social care governance led by the then Chief Executive, Mairead McAlinden. SHSCT Public Inquiry team have so far been unable to provide the final version of this review, however, the content of the consultation document remained extant as at 1st April 2015 when I took up the role of interim Chief Executive.

7.5 “A System of Trust” sets out understanding and agreement of the ‘professional’ Executive Director role and responsibilities to provide the organisation with resolved professional guidance, advice and expertise in relation to standards for quality and safety of care and of the professional workforce (medical, nursing, social work and AHP). They also independently assess and provide assurance on the levels of compliance to SMT Governance and Governance Committee, while providing a corporate alert when compliance with standards is at an unacceptable level. The Executive professional Directors in my tenure are set out at 6.1.

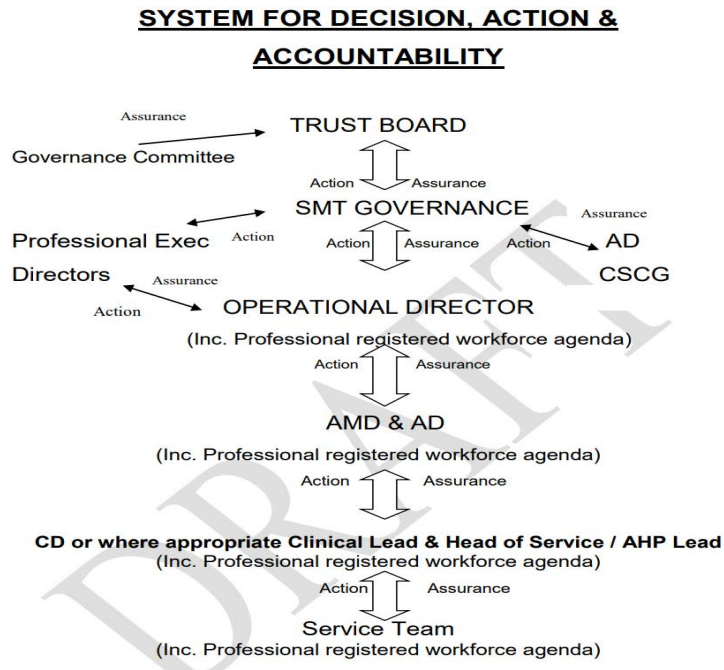
7.6 A summary of the distinct roles of the Executive professional and operational

Directors and their teams and of the corporate Clinical and Social Care Governance Co-ordination team who reported under myself as interim Chief Executive through the Assistant Director of Clinical and Social Care Governance (Mrs Margaret Marshall in my tenure), is set out on page 8 of “A System of Trust” as below:

Three Core Components of CSCG



7.7 Page 12 of “A System of Trust” defined the accountability through the organisation in the diagram below. Pages 13-30 of the document set out the detail of the processes in place and being developed to support the Clinical and Social Care Governance (CSCG) agenda as well as investment in new roles to support Clinical and Social Care Governance effectiveness. This made clear that Operational Directors were responsible and accountable for patient safety and quality and for implementing agreed workforce standards and providing assurance to the executive functions that action was taken to ensure a workforce of an acceptable standard to deliver safe, high-quality care. Operational Directors were responsible and accountable for all aspects of CSCG to SMT Governance and its chair the Chief Executive, and via this body through to Trust Board. The AMDs and Assistant Directors were responsible and accountable for all aspects of CSCG within their area to the Operational Director.



7.8 Given the terms of reference of the inquiry and the specific issues relating to the practice of a medical consultant, I want to specifically refer to the role and responsibility of the Medical Director as the designated Responsible Officer introduced under “The Medical Profession (Responsible Officers) Regulations (NI) 2010”. The DHSSPS “Confidence in Care Guidance on the Role of Responsible Officers for Doctors and Employers February 2011” (*relevant document located at S21 11 of 2022 Attachments 12. ro-guidance-doctors-employers*). My duties as accountable officer for the standards of care delivered by medical staff in the Trust were discharged through the Medical Director who, during my tenure, was Dr John Simpson (until August 2015) and Dr Richard Wright (from July 2015). Paragraph 66 of “Confidence in Care Guidance” refers to the specific requirement that the Responsible Officer must ensure that:

- they maintain a list of doctors they are responsible for;
- there is an integrated system for monitoring doctors’ performance, recognising good practice, encouraging and supporting development and learning;
- effective systems and processes of appraisal are in place;
- appropriate action is taken to remedy identified areas of weakness;
- progress against doctors’ personal development plans is monitored.

All of these applied to urology services.

7.9 Director of Performance and Reform (Acting from September 2009, substantive from March 2011 to 31/3/15). As a Director of the Trust Board I carried corporate responsibility along with all Directors for delivery of quality care the needs of the population served, within the allocated resources. I had no line management relationship for the operation and governance of urology services.

7.10 As the Assistant Director of Performance Improvement, from March 2008 until September 2009, I had no responsibility for the operational delivery or governance of the urology service. My role provided support into all operational teams as required (which included urology) for performance improvement and agreeing contract levels of activity.

8. It would be helpful for the Inquiry for you to explain how those aspects of your roles and responsibilities which were relevant to the operation and governance of urology services, differed from and/or overlapped with, for example, the roles of the Directors and Assistant and Associate Directors, the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service and with any other role which had governance responsibility.

8.1 I have set out at my response to question 7, the distinct roles and responsibilities for governance and operation of clinical services attributed to myself as interim Chief Executive and to Executive professional Directors, Operational Directors and the corporate co-ordination function for clinical and social care governance. This makes clear the Director of Acute Services was responsible for the operation and governance of all acute clinical services under their remit supported by their senior team of Assistant Directors and AMDs. This included Operational Director responsibility for patient safety and quality and for implementing agreed workforce standards with AMDs and ADs being responsible and accountable for all aspects of CSCG within their area to the Operational

Director.

8.2 For clarity, the role of Assistant Director of Clinical and Social Care Governance was established in April 2011 following the “A System of Trust” review described in my response to question 7. This role reported to myself in 2015/16 as interim Chief Executive with specific responsibilities to assist the Chief Executive, Trust Board and Senior Management Team in driving forward effective Clinical and Social Care Governance (C&SCG) arrangements in the Trust; taking a lead role in providing assurance to the Trust Board and Senior Management Team that the Trust’s C&SCG and risk management systems, processes and governance arrangements are appropriate and working effectively; providing intelligence for assurance purposes by Operational and Executive Directors that clinical and social care services are safe and of good quality and that standards are being met.

Engagement with Staff and the Trust Board, Governance and Risk Issues

I am responding to all questions under this heading as the interim CEO of the Trust from 1/4/15 to 31/3/16.

9. Describe how, if relevant, you usually engaged with your Senior Management Team on a day-to-day basis, including the Medical Director and Head of Service.

9.1 The Trust Directors, including the Medical Director, were located in Trust HQ in the College of Nursing building on the CAH site (with the exception of the Director of Mental Health and Disability who was located in Bannvale House, Gilford, and the Director of Acute Services, whose office was located in the main building of Craigavon Hospital). Engagement on a daily basis involved both informal and formal meetings and interactions in person as well as by email and, if required, by telephone. I operated an open-door leadership approach and encouraged my team to drop in and discuss any issues or share information that was emergent and kept us all connected. Fixed meetings provided a drumbeat of more formal engagement with the Senior Management Team (SMT) and daily interactions could also involve email communication and phone calls. The fixed meeting schedule included the following:

- a) Weekly meeting of the SMT of which one in four meetings was focussed on governance;
- b) Monthly CEO and Director 1:1 meetings;
- c) Attendance by Directors and myself at Board and Committee meetings and development days;
- d) SMT away days – scheduled in across the year to provide time out together and create space to team-build and focus on issues of challenge and complexity requiring a leadership direction;
- e) From October 2015, I established a monthly informal SMT breakfast meeting to support team building and time out together.

9.2 Assuming the Head of Service referred to in this question is the Head of Urology Service, during my tenure this role was undertaken by Martina Corrigan. For factual accuracy purposes, Martina was not a member of the Senior Management Team as this was made up of Executive Directors only. I did not, as interim CEO, have any regular schedule of engagements or meetings in place with Martina Corrigan or any Heads of Service as their line management arrangements were under the relevant Director. In Martina's case this was the Director of Acute Services (Debbie Burns up to August 2015, Esther Gishkori from August 2015). I did try and establish a working culture of an open-door policy and encouraged staff to feel able to come directly to me with any issues, ideas or concerns but do not recall any such approach by the Urology Head of Service in my tenure as Interim CEO. To remind myself of some information in support of a more complete response to the inquiry, I met Mrs Corrigan on 8th June 2022, and she confirmed her recollection was that she had not met me for any specific reason nor on a regular basis in 2015/16.

10. Describe how you usually engaged with your clinical staff on a day-to-day basis.

10.1 My engagement with Clinical staff who were members of the Board, Committees and SMT is as per my answer to question 9. With regards to the wider body of clinical staff, and as context for the Inquiry, in 2015/16 the Trust employed 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. This included the following Whole Time Equivalent paid clinical staff; 670 medical and dental staff; 3232 nursing and midwifery staff; 1045 Allied Health Professional staff.

10.2 My engagement with clinical staff was both formal and informal. I would, for example, meet staff on walkabouts or visits to departments, annual staff recognition events and making contact to recognise significant actions or progress. The Annual Report for 2015/16, (*located at S21 11 of 2022 Attachments, 13. ANNUAL_REPORT_AND_ACCOUNTS_2015-16*) pages 4-22 sets out examples of the variety of achievements made by staff across the Trust with photographs of myself and other members of the Board engaging with clinical and other staff to celebrate and say thank you. I also made a point of having coffee or lunch in the canteens at Craigavon and Daisy Hill Hospitals on a regular basis to encourage informal conversations. At the monthly public Trust Board meetings a standing item was also included re Chief Executive's Business and Visits that set out a list of business and visits undertaken since the previous Board meeting and reflected opportunities for engagement with clinical staff.

10.3 More formal engagement with clinical staff was through attendance at meetings such as the Medical Staff Committee at both Daisy Hill and Craigavon Hospitals, which I recall attending as Chief Executive on a number of occasions e.g. 4/3/16, the Medical Forum covering medical leaders (consultants) from across the Trust clinical services and the Joint Negotiation and Consultation Group which involved staff side representatives including UNISON and Royal College of Nursing. As an example of what was discussed, notes from the Medical forum on 17/9/15 are provided (*located at S21 11 of 2022 Attachments, 14. 20160122 Diary Medical Forum Meeting A2*) reflecting discussion on the review of governance and extant risks associated with Daisy Hill Hospital. Clinical staff also attended Governance Committee and Board meetings to present reports including best practice, risks and learning. Governance Committee was also attended by the Director of Pharmacy. Examples of clinical staff presenting to Governance Committee evidenced in the minutes of relevant Meeting of the Governance Committee

(dates below) include:

- a. 3/2/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 15. 20150203 Approved Governance Committee Minutes*) Mrs Anne McVey, Assistant Director of Acute Services, and Mr James Heaney, Biomedical Scientist, gave feedback following the NI Quality Assurance Reference Centre visit to the Trust's cervical screening service which identified a number of points of good practice, for which the staff were commended as well as highlighting a number of areas for improvement or consideration.
- b. Dr Martina Hogan, Associate Medical Director of Integrated Maternity and Women's Health Services, updated on NIAO report "Safer Births: Using information to improve quality" ", with a focus on Perinatal statistics. Challenge was given to the rate of C-Sections within the Trust with follow up at the 8/9/15 Committee meeting (*relevant document can be located at S21 No 11 of 2022 Attachments, 31b(iii). Governance Committee Minutes*) attended by Dr Hogan, Dr Sim (Consultant Obstetrician/Gynaecologist) and Dr McCracken (Consultant Obstetrician). The minutes also indicate this discussion reflected learning from the Morecambe Bay Report which highlighted failings within a maternity unit.
- c. Examples of clinical staff presenting to Trust Board are available in minutes of the public Trust Board meetings on **27/8/15** (*relevant document can be located at S21 No 11 of 2022 Attachments, 32b(viii). 20150827 TB Public Minutes*), **22/10/15** (*relevant document can be located at S21 11 of 2022 Attachments, 32b(xii). 20151022 TB Public Minutes*), **28/1/16** (*relevant document can be located at Trust Board 2007 - 2022 including packs from 2016/Trust Board Pack 2016/2. 24 March 2016/006. Trust Board Minutes 28 January 2016 - Draft (3) – FINAL*) **24/3/16**, (*relevant document can be located at S21 11 of 2022 Attachments, 20. 20160324 TB Public*

Minutes) with one specific example being the Infection Prevention and Control team who attended the meeting on **27/8/15** (*relevant document can be located at S21 No 11 of 2022 Attachments, 21. 20150827 Performance report a*) to provide a 'deep dive' into performance in 2014/15 and providing assurance that all, cases of C-Difficile have a Root Cause Analysis (RCA) undertaken to identify and promote shared learning.

10.4 The degree of engagement with particular clinicians and teams was also influenced by emerging issues, opportunities and risks. As an example, in 2015/16 as interim CEO I engaged on an initially intensive and then regular (I believe this was weekly/then fortnightly) basis with clinical staff in both Craigavon and Daisy Hill EDs, acute medicine and medical and surgical AMDs and CDs. This was in response to a significant and complex risk to sustaining a 24/7 Emergency Department service at Daisy Hill Hospital that I refer to in more detail in paragraph 30.4. I have also been reminded by reference to emails (*20150608 E Mtg re Blue Skies Pilot with SHSCT and HSCB – Urology plus 2 attachments A and A1 can be located at S21 No 11 of 2022 Attachments, 22. 20150608 E Mtg re Blue Skies Pilot with SHSCT and HSCB – Urology, 23. 20150608 E Mtg re Blue Skies Pilot with SHSCT and HSCB – Urology A, 24. 20150608 E Mtg re Blue Skies Pilot with SHSCT and HSCB – Urology A1*) provided to me by the Trust Public Inquiry Team that I supported the urology team to present their ideas to address capacity gaps in the service through innovative ways of working to Mr Dean Sullivan, HSCB Director of Commissioning, and some of his regional team at a meeting on 8/6/15. This was called "Blue Skies Pilots". I believe this meeting was attended by myself, the Director of Acute Services, Debbie Burns, and some of her management team, Mrs Trouton and Mrs Martina Corrigan, and by a number of urology clinical staff with the presentation being led by one of the newer consultants in the team, Mark Haynes.

10.5 During 2015/16 I recall I led quarterly Performance assurance meetings with my corporate Directors and each operational service Director and their senior teams to review performance across quality, access, workforce and finances and

to identify action plans and support required. This usually included Assistant Directors, some of whom were clinical. Senior clinical staff including AMDs and CDs could also email me with information they wished to share or to seek support or direction. I have not accessed any specific evidence of these meetings or any such emails from the Trust Public Inquiry Team at the time of submitting this section 21 notice response.

11. Please also set out the details of any weekly and monthly scheduled meetings with those staff members (referred to by you at 6, 7 and 8), and how long those meetings typically lasted. If a minute was taken of such meetings, please provide all minutes of any meeting which referenced urology services during your tenure from January 2015 until March 2016.

11.1 For factual accuracy please note I was not the CEO from January 2015 and I am responding to this question only as the interim CEO of the Trust from 1/4/15 to 31/3/16 and not in my prior roles. For reference, in all other roles I met my direct reports and line manager in weekly team meetings lasting approx. 2-3 hours, in monthly one to one meetings lasting approximately 90 minutes, plus regular calls and email communication.

11.2 I am not clear whether the Inquiry is asking for details of scheduled meetings on a 1:1 basis with my direct reports and the Chair as my line manager or all meetings we attended together. Regular scheduled meetings that would have involved my Director team and the Chair would have included Board and Committee meetings with regular meetings with Directors including weekly SMT meetings and I have summarised these below. A more comprehensive list of meetings attended by the Chief Executive, Chair and Directors would need to be advised by the Trust Public Inquiry Team with reference to Mrs Elaine Wright, the Executive Assistant to the Chief Executive's office and Mrs Sandra Judt, Board Assurance Manager.

- a. SMT monthly Governance meetings – approx.. 3.5 hours;
- b. Quarterly Governance committee meetings – approx. 4.5 hours;

- c. Public and Confidential Board meetings – 8 meetings of each held in 2015/16 lasting approx.. 6-7 hours in total;
- d. One to one meetings monthly with my Directors lasting approx. 1.5 hours;
- e. My one to one with the Trust Chair monthly lasting approx. 1-2 hours plus an ad hoc weekly or more frequently check in discussions estimated at approx. 1 hour per week;
- f. Meetings with the Chair of each Committee after each meeting to review the effectiveness of the meeting and follow up on key issues and actions. This lasted approx. 1.5 hours;
- g. Three Trust Board workshops and development day in 2015/16 lasting all day;
- h. Attendance by the Chair and myself at formal accountability meetings twice a year with DHSSPS officials. In 2015/16 these occurred on 16/6/15 and 3/12/15;
- i. Meetings with the Chief Executive of the HSCB on occasion.

11.3 With respect to minutes, access to minutes of all scheduled Board, SMT and Committee meetings which referenced urology services during my tenure in 2015/16 should be sourced from the Trust Public Inquiry Team to ensure this is comprehensive. I have endeavoured to be as thorough in my response as possible in the context of the time constraints I face and have reviewed the following as relevant in 2015/16:

- a. 38 sets of notes from the Trust SMT meetings in 2015/16 none of which included the word urology;
- b. Minutes from 8 confidential and 8 public Board meetings in 2015/16. Only one meeting specifically referenced urology (24/3/16) with an extract included at my response to question 41 below;
- c. 8 sets of minutes from Governance Committee meetings in my tenure 1/4/15-31/3/16. Where these reference urology, I believe I have included them in my response to question 55;
- d. Minutes from the year end (2014/15) accountability meeting with DHSSPS on 16/6/15 attended by myself and the Chair (*relevant*

document can be located at S21 No 11 of 2022 Attachments, 25. 20150616 Mid Year Strategic Accountability Meeting - Mins from 16 June 2015 A2) Reference to urology is covered in my response to question 41. Although a mid-year accountability meeting was held on 3/12/15, I the Trust Public Inquiry team have been unable to locate these at the time of my submission. I refer further to this in my response to question 41.

11.4 I have referenced several sets of minutes that cover urology service issues throughout this response, primarily from scheduled Board, Committee and SMT meetings, but I cannot attest that this is fully comprehensive in terms of all meetings internally and externally as there were many discussions about elective access performance that would have included urology among several other challenged specialties. I can confirm that I am not aware of any scheduled meetings or indeed informal meetings internally or externally attended by me, about clinical governance concerns within the urology service or any staff member within that service.

11.5 With respect to minutes of one-to-one meetings with my senior management team, and my one-to-one meetings with the Chair, no formal minutes appear to have been kept for these meetings as I have not been able to access same from the Trust Public Inquiry Team at the time of submitting this response. I do have evidence of a meeting arranged with Mrs Esther Gishkori, as Director of Acute Services from September 2015-March 2016, and Mr Kieran Donaghy, Director of Human Resources and Organisational Development (*relevant documents can be located at 26. 20150723 E and diary - Mtg with EG and 27. 20150723 E and diary - Mtg with EG A*), 28/7/15 to agree her objectives from September 2015 to March 2016 as part of an agreed 6-month trial period following her appointment. This included the following specific objectives related to urology:-

“Implement the Service Development Proposals which have been presented to HSCB for 2015/16 as follows: -

d) Ensure that the Urology Team and T&O Team “blue sky thinking” plans are kept alive and expand and maximise the regional opportunities in Urology” and “Evidence that the Urology and T&O Teams have addressed backlog issues (it is accepted this will not be completed) and are still leading the way in terms of regional performance and meeting new demand by March 2016”.

12. Please explain how you, as Chief Executive, assured both yourself and the Board that the clinical governance systems in place during your tenure were adequate. How did you ensure that the Board was appraised of both serious concerns and current performance given the applicable standards of clinical care and safety? What is your view of the efficacy of these systems in place, if any?

12.1 The overarching approach to assurance regarding the clinical governance systems in place in 2015/16 that I was responsible for as interim CEO and Accountable officer are set out in detail in paragraphs 1.11-1.12, 1.18-1.23 and 1.24-1.51.

12.2 In summary, assurance to myself and the Board was achieved through an integrated governance framework comprised of the following key elements:

- a. Committee structures with the Governance Committee as the overarching strategic Committee responsible for providing assurance to the Board on all aspects of governance (except financial control, which was the remit of the Audit Committee).
- b. The Board Assurance Framework as an integral part of the Trust’s governance arrangements compiled in conjunction with all Directorates. The Assurance Framework for my tenure in 2015/2016 defined the organisation’s objectives, identifying risks to their achievement, highlighting the key controls through which these risks were to be managed and the sources of assurance about the effectiveness of these controls internally and from external independent bodies. It set out the sources of evidence which the Board used to be assured of the

soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes. Two Board Assurance Framework Reports were presented to Trust Board in my tenure at 11/6/15 and 24/11/15 (*the relevant document can be located at S21 No 11 of 2022 Attachments, 28. 20151126 Board Assurance Framework*)

- c. The Corporate Risk Register (CRR), which was complementary to the Assurance Framework. A high-level summary of the Corporate Risk Register was included with the Board Assurance Framework to provide the Board with information on other significant risks that are under active management and review. The CRR was reviewed by SMT monthly and Governance Committee on a quarterly basis.
- d. A system for Risk Management underpinned by the Controls Assurance Standard for Risk Management which I was responsible for as Chief Executive, and the 201809 Risk Management Strategy (*located at, Ongoing Discovery May 2022/Document Number 2 iii a/ 201809 Risk Management Strategy*) and procedures for the identification and management of risk within the organisation.
- e. Embedded structures for Clinical and Social Care Governance structures. 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. Directorate Risk Registers were in place within the Trust and informed the Corporate Risk Register.
- f. The approach to CSCG was shaped by professional standards and learning lessons from key internal and external reports including reporting of incidents, scrutiny of risk associated with the provision of clinical and Social Care, safe systems of care delivery, the reporting of

serious adverse incidents and the lessons learned from the same. More detail on evidence of this is covered in my response to questions 7 and the Trust also developed a 20141001 Incident Management Procedure (*located at S21 No 11 of 2022 Attachments, 29. 20141001 Incident Management Procedure*) in 2014 to ensure clarity on roles, responsibilities and processes for identification, reporting, review, monitoring and learning from all incidents.

- g. Development during 2015/16 of a Quality Improvement Framework (QIF) to drive continuous quality improvement in the Trust and strengthen assurance processes as the foundation of our QI efforts.
- h. Benchmarking with UK peer hospitals for key indicators of efficiency and safety. Evidence of this assurance for 2015/16 is noted in the minutes of Trust Board 26/5/16 (*located at Trust Board 2007 - 2022 including packs from 2016/Confidential Trust Board Pack 2016/8. 25.08.2016/3ib) Approved Confidential minutes - 26th May 2016*) which was following my departure from the Trust but reflecting retrospective reporting. This indicated that for the fifth year in succession, the Southern Trust's acute hospital network, had been officially named as one of the Top 40 performing hospitals in the UK. The Trust was also ranked in the top five in the UK for Patient Safety, at the CHKS Awards held on 10th May (see paragraph 1.42).

12.3 As set out in my response to paragraphs 7.2-7.7, my assurance on how clinical governance systems operated was founded on the model for integrated clinical and social care governance in Structures for Clinical and Social Care Governance Consultation document Period (December 2010) "A System of Trust" (relevant document can be located at S21 No 11 of 2022 Attachments, 11.20150410 E and Reports Draft Paper Governance - RCSCG CONSULTATION DRAFT 4 A2). Pages 21-30 of this document set out the processes that were the central components of Clinical and Social Care Governance systems and part of patient and client safety and quality reporting. These included:

- a. Complaints Process;
- b. Incident management processes (for which Datix was introduced into the Trust from 2010 as a basis for effective incident management, analysis, and learning);
- c. Standards and Guidelines for Patient Safety and Quality process;
- d. Risk Management process;
- e. Registered and Unregistered Workforce Standards, Quality, Training and Education;
- f. Clinical Indicators and Clinical Audit processes;
- g. Effectiveness and Evaluation to audit quality and safety indicators at a corporate level;
- h. Litigation;
- i. Morbidity and Mortality processes;
- j. Managing Poor Professional Conduct and Performance.

12.4 Assurance was also secured through the Corporate Co-ordination and Overview roles established in April 2011 within the Chief Executive's Office. The role of the Assistant Director of Clinical and Social Care Governance, who in my tenure was Mrs Margaret Marshall, was to provide a corporate view to integrate the various strands of Clinical and Social Care Governance within the Trust across the 3 core components of Corporate Co-ordination & Overview Role (Chief Executive's Office); Operational Directors and their teams; and Professional Executive Directors and their teams. Under these arrangements resources to support the governance agenda were strengthened in 2011 in each directorate with the introduction of Governance Co-ordinator roles. This re-alignment of resources was targeted at addressing governance issues more closely to frontline patient or client care, as promptly as possible and by those directly involved in service delivery.

12.5 In April 2015, as Interim Chief Executive, I personally requested a review of the outcomes of the 2010 Review of CSCG that had resulted in the governance systems in "A System of Trust". The 2015 review aimed to provide Trust Board, Governance Committee and the Senior Management Team (SMT), with an assurance that these arrangements remained effective and robust in the following areas:

- a. Providing clarity and transparency of function.
- b. Driving Quality and Safety.
- c. Providing adequate assurances to the SMT, Trust Board, Professional Bodies and the Public, on areas relating to risk, patient safety and non-compliance.
- d. Taking cognisance of recent external reviews.

12.6 An update on this review with recommendations and an Action Plan was presented by Mrs Marshall and myself to the Governance Committee on 8/12/15 in a paper, "Revisit of Clinical and Social Care Governance Arrangements (CSCG)" *(located at S21 No 11 of 2022 Attachments, 30. 20151208 Approved Governance Committee Minutes Item 8i) CSCG Revisit)* with an associated presentation that I have not accessed. The scope of the review covered strengths and weaknesses of the Trust's CSCG Assurance Framework in structure, communication flows, clarity of roles and functions and effective mechanisms in place to review learning across the whole system to inform SMT strategy in respect of patient safety priorities and risk. This review did not include operational governance arrangements within Directorates as set out in "A System of Trust". The review took learning from the key themes within several external reviews including the Berwick Report, the Francis Report, the Donaldson Report and the Portlaoise Hospital Report as well as themes from a series of internal audits which focused on elements of the Trust's CSCG arrangements from 2009 – 2015. As a result of this 2015 Review, recommendations were approved by SMT and Governance Committee, to strengthen and improve clinical and social care governance arrangements in 5 key areas:

- a. Agreeing and reporting in a dashboard, a range of integrated CSCG quality indicators to inform SMT, Governance Committee and Trust Board on matters of patient safety, risk and Quality Improvement.
- b. Strengthening capability (systems) and capacity (analysis/trending) to provide the type and depth of organisational intelligence/information required to adequately inform the organisations CSCG, Risk, Safety and Quality Improvement priorities. Evidence of this dashboard report being progressed for

- key clinical quality indicators and trend analysis including SAls, incidents, complaints and standards and guidelines is included in the Minutes of the Governance Committee meeting 4/2/16 for item 8 Incident, Complaints, Patient Safety Report (*relevant document can be located at S21 No 11 of 2022 Attachments, 31b(viii). 20160204 Approved Governance Committee minutes*)
- c. Agreeing a Clinical and Social Care Audit Plan linked to key safety priorities.
 - d. Clarifying the forum to provide Executive and Non-Operational Directors assurance of independent 'expert' oversight, challenge, and scrutiny in respect of learning from SAls and strengthening the opportunity for trends and learning from SAls to be considered corporately.
 - e. Incorporating a dedicated Governance Agenda into the SMT meeting schedule for 2016.

12.7 Assurance to myself and the Board was also secured through standard schedules of reporting into Governance Committee and Trust Board. These reports were also discussed before Committee and Board meetings and further developed when required, by the SMT. I have reviewed all agendas and minutes from these meetings in 2015/16 to support me in providing an informed response to the inquiry questions. Governance Committee included dedicated sections for clinical and social care governance and professional governance reports from Executive Directors with regular assurance reports evidenced in the 2015/16 meetings (*all agendas and minutes from confidential and non-confidential Governance Committee meetings 2015/16 located in S21 No 11 of 2022, 31a (i-iv) Confidential Governance Committee and 31b (i-viii) Non Confidential Governance Committee including the following:*

- a. Confidential meetings covered SAls and Adverse Incidents with a "Summary of SAI recommendations report forwarded to HSCB" for the prior quarter at every meeting and the non-confidential meeting also included an SAI Report excluding details of individual cases. As set out in my response to question 16, HSCB SAI Learning Reports were also discussed at least annually when issued by HSCB
- b. Corporate Risk Register was reviewed quarterly (after monthly review at Senior Management Team).

c. Medicines Governance report was reviewed quarterly.

d. Incidents and Complaints management and update on those complaints being handled by the Ombudsman were reported quarterly.

e. A Standards and Guidelines compliance report was presented bi-annually. *An example of this is located in S21 11 of 2022 Attachments, 31b(iv) 20150908 Approved Governance Committee Minutes)*

f. RQIA status update report providing assurance on follow up action plans from recommendations from inspections and as evidenced in my response to question 10; assurance on other inspections such as the Trust cervical screening service, were also reported.

g. As also covered in my response to question 10, clinical staff also attended the committee to highlight good practice, risk, learning from review and provide assurance on quality of services.

h. Medical Director Report covering medical appraisal and revalidation, Healthcare acquired infection and Infection and Prevention Control assurance plus an Annual Mortality Report for the Trust that was benchmarked with peer organisations in the NHS (*relevant document can be located at S21 No 11 of 2022 Attachments, 31b(v). 20151208 Approved Governance Committee Minutes)*

i. Quarterly report on compliance with core and professional quality indicators for AHPs.

12.8 Public Trust Board meetings included dedicated sections for Patient and Client Safety and Quality of Care and for Operational Performance Reporting. Assurance reports evidenced in the 2015/16 meetings under these areas of focus included the following: (all agendas and minutes from confidential and non-confidential Trust Board meetings 2015/16 *located in S21 No 11 of 2022, 32a(i-xx). Trust Board Confidential and 32b(i-xviii). Trust Board Non*

Confidential folders) Board Assurance Framework referred to in 12.2 discussed biannually;

- a. Monthly Medical Director Report covering medical appraisal and revalidation, Healthcare acquired infection, and Infection and Prevention Control assurance, medical education and training including visits by NIMTDA;
- b. Executive Director of Social Work report covering, as examples, unallocated childcare cases and adult safeguarding plus and Annual Report on Discharge of Delegated Statutory Functions and Corporate Parenting;
- c. Executive Director of Nursing reports on nursing quality indicators and performance;
- d. A Trust Annual Quality Report (*relevant document can be located at S21 No 11 of 2022 Attachments; 32b(xii). 20151022 TB Public Minutes*)
- e. Minutes of the Governance Committee and feedback from the most recent meeting was provided by the Non-Executive Director Chair of Governance Committee at every meeting;
- f. The Mid Year Assurance Statement used for accountability meetings between the Chair and Chief Executive went to the Board for approval annually (*relevant document can be located at S21 No 11 of 2022 Attachments, 32b(xii). 20151022 TB Public Minutes*)
- g. The Annual Report and Statement of Governance was approved by the Board. Key aspects of this report relevant to governance are set out in paragraphs 1.11-1.12, 1.18-1.51
- h. Monthly Performance Reports covering all Ministerial and commissioning standards and targets which for 2015/16 were set out in full in the HSCB and PHA Commissioning Plan (*relevant document can be located at S21 No 11 of 2022 Attachments 35. Commissioning Plan 2015-16_0*)

12.9 Confidential Trust Board meetings' reporting included discussion on the

Corporate Risk Register which was reviewed quarterly followed detailed discussion at Governance Committee.

12.10 Assurance to me as interim Chief Executive also derived from monthly SMT dedicated Governance meetings. The SMT Terms of Reference (*located at S21 No 11 of 2022 Attachments, 36. SMT Terms of Reference*) have been provided to me by SHSCT and set out the arrangements for the SMT to meet with staff from the Governance department in attendance as a Governance Management Board. I have reviewed agendas and some minutes from SMT meetings in 2015/16 which confirmed my recollection of this dedicated governance approach by the senior team. Following my review of CSCG during 2015/16, I convened a specific SMT Governance meeting once a month rather than a dedicated section within the general SMT meeting. Agendas and minutes from 27/1/16 (*located at S21 No 11 of 2022 Attachments, 37. SMT Governance Agenda 27 January 2016 and 38. SMT Governance Notes 27 January 2016*) 24/2/16 (*located at S21 No 11 of 2022 Attachments, 39. SMT Agenda 24 February 2016 and 40. SMT Notes 24 February 2016*) and 2/3/16 (*located at S21 No 11 of 2022 Attachments, 41. SMT Agenda 2 March 2016 and 42. SMT Notes 2 March 2016*) evidence this with monthly topics covering a comprehensive review of all papers for Governance Committees, review of planned and completed internal audits (for example, into complaints 27/1/16), and ensuring processes were effective and continually developing (for example, presentation of a new database for tracking Trust compliance with Standards and Guidelines was discussed at the 27/1/16 meeting). Regional letters were also discussed, for example, the SMT Agenda 24 February 2016 (*located at S21 No 11 of 2022 Attachments, 39. SMT agenda 24 February 2016*) discussed a letter from Dr McBride, Chief Medical Officer, regarding development of the complaints process following the Donaldson review.

12.11 The Board was appraised of serious concerns and current performance in respect of clinical governance systems through the reports in 12.3 to 12.8, as well as through direct contact should issues arise that required a more urgent briefing to Board members. As interim Chief Executive, I contacted the Chair as my first point of contact regarding any serious concerns, with follow up with the Board usually at confidential Board meetings. Having reviewed the minutes of all Trust Board meetings

in 2015/16, early alerts were made in the confidential meeting by a number of operational Directors throughout the year:

26/3/15, relevant document can be located at S21 11 of 2022 Attachments, 32a(ii). 20150326 Confidential Minutes

28/5/15, can be located at S21 11 of 2022 Attachments, 32a(iv). 20150528 Confidential Minutes

24/9/15, can be located at S21 11 of 2022 Attachments, 32a(x). 20150924 Confidential Minutes

22/10/15, can be located at S21 11 of 2022 Attachments, 32a(xii). 20151022 Confidential Minutes

26/11/15 can be located at S21 11 of 2022 Attachments 32a(xiv). 20151126 Confidential Minutes)

12.12 In terms of my view of the efficacy of these systems, this remains as was stated in the Annual Report and Accounts for the Year ended 31 March 2016 (located at S21 11 of 2022 3.

20160425_MonthlyPerfReportApril(MarchPerf)_TB_V1_0_LLappin) – see paragraph 1.52, and the specific statement made by the Accountable Officer :-

“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”.

13. During your tenure, was the Board appraised of those departments within the Trust which were performing exceptionally well or unsatisfactorily and, if so, how was this done? Was there a committee which was responsible for overseeing performance? If so, where did it sit in the managerial structure and hierarchy and how did the Trust Board gain sight of these matters?

13.1 The core means of appraising the Board of performance was through the monthly Performance Reports presented to every public Trust Board meeting. These reports provided the Board with information relating to achievement against Service and Budget Agreement (SBA) for core levels of commissioned activity; performance against the Commissioning Plan standards and targets for 2015/2016; and a range of other important related indicators which the Board identified as impacting on the Trust's overall performance for example, access times for clinical reviews beyond 'clinically indicated' timescales in acute and mental health Consultant-led outpatients; Planned repeat procedures: and plain film and diagnostic reporting. On a biannual basis, the Performance Report also included a further annex reporting against the regionally defined Indicators of Performance. Our practice was to provide a summary cover sheet to the Report drawing attention to key areas of risk or improvement. An example of the extensive nature of the Report can be seen in the Monthly Performance Report for October 2015 presented to public Board on 26/11/15 (*Relevant documents located at S21 11 of 2022, 46. 20151126 Performance Report a and 47. 20151126 Performance Report b*).

13.2 Trust Board agendas also included standing items for Chair's Business and Chief Executive's Business reflecting achievements of individual members of staff and/or teams. Feedback and learning, including from service users, to improve services was also presented by individual teams to the Board. Evidence of this approach can be seen as an example in the minutes of public Trust Board meetings on 28/5/15 and 27/8/15 (*relevant documents can be located at S21 No 11 of 2022 Attachments, 32b(iv). 20150528 TB Public Minutes and 32b(viii). 20150827 TB Public Minutes*)

13.3 Examples of deeper dives into performance on particular clinical services that included areas of strong or under performance are included in paragraph 10.3 from Governance Committee and 13.2 from Trust Board.

13.4 As referenced in paragraphs 1.38-1.42, Board approval of the Annual Report and Accounts for 2015/16 also summarised for the Board the annual position on performance assured through the following sources of Independent Assurance - Internal Audit; RQIA; External Review/Benchmarking; Licensing and other Regulatory bodies.

13.5 The Trust held an Annual Quality Improvement event from 2014/15 and issued a continuous improvement newsletter at least 4 times per year, initiated by myself in 2011 in my role as Director of Performance and Reform. The annual event and newsletter provided a means for staff to showcase and share examples of service improvement with the inaugural event on 18/6/14 having over 70 posters and 19 presentations on the day and opened by the Trust Chair.

13.6 During my tenure there was no committee of the Board specifically for performance. Trust Board was responsible for overseeing overall performance and, as referenced on pages 32-38 of the Annual Report and Accounts for 2015/16 (*relevant document can be located at Trust Board 2007 - 2022 including packs from 2016/Trust Board Pack 2016/4. 9th June 2016/006c. SHSCT DRAFT ANNUAL REPORT AND ACCOUNTS 2015-16 2nd June 2016*). Each Board committee also took a lead on specific areas of performance.

14. Please provide details of any specific training you received in respect of any aspects of clinical governance, patient care and safety or any other risk factors relevant to the Trust's operational functioning.

14.1 As referenced in para 3 of 20150325 Ltr RP292 letter to P Clarke re Acting Accounting Officer - Appointment Letter (*located at S21 No 11 of 2022 Attachments, 4. 20150325 Ltr RP292 letter to P Clarke re Acting Accounting Officer – Appointment Letter*) I was required as a new Chief Executive, to attend training delivered by the Chief Executives Forum which I did on 16/6/15. This provided tailored development and input for those undertaking the role of Accounting Officer. I do not recall any specific training regarding clinical governance or patient safety and care, however, I would say that, when I took up the role of interim Chief Executive in April 2015, I had 24 years' experience of working in health and social care and understood the need to achieve good clinical and social care governance and assurance on the quality of patient safety and care through a combination of factors including having effective systems and processes such as risk management and SAI reporting, creating a

culture of openness and learning, not blame, and developing leaders to promote this culture.

15. How, as the accountable officer, did you ensure that all Board members were kept up to date on clinical governance best practice?

15.1 The Governance Committee was the overarching strategic Committee responsible for providing assurance to the Board on all aspects of governance (except internal financial control). The Committee was comprised of the CEO (me), all Non-Executive Directors, members of the Senior Management Team and the Director of Pharmacy and the Assistant Director of Clinical and Social Care Governance attended all meetings.

15.2 I believe the detail I have set out in my response to questions 12 and 16 evidences the breadth of the approach I took as accountable officer to support Board members to be open to learning and best practice on matters relating to clinical governance and generally. In 2015/16, in addition to Governance Committee and Trust Board meetings, two Board workshops were held at which members explored strategic issues and planned service developments and the Trust Board held a Development Day on 12 November 2015 which provided members with the opportunity 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. Further detail on these Board workshops and development day can be accessed from Mrs Sandra Judt, Board Assurance Manager.

16. How did you ensure that learning from clinical governance failures which may have been identified as a result of investigations were raised during Board discussions? Please illustrate your answer with examples, if applicable. Were any such issues concerning urology services raised with the Board?

16.1 Learning from failures and promoting a “just”, not a “blame”, culture was integral to the Trust system of governance as referenced in paras 1.15, 1.20, 1.45-1.47, 12.3-12.6 and 13.2.

16.2 With respect to learning specifically from investigations, learning from SAls was discussed at Board and/or Governance Committee meetings. Evidence of this approach is as follows:

- a. The Donaldson Report referenced in paragraph 1.49, was raised by the Chair at the confidential meeting of the Trust Board on 29/1/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 48. 20150129 Confidential Minutes (1)*) advising that this matter would be a substantive item on the Directors workshop agenda on 26/2/15. Although this is before my tenure as interim chief executive, the Donaldson report learning was a substantive matter for all HSC organisations and I picked up the work commenced under the tenure of Mrs McAlinden, Chief Executive to 31/3/15. The minutes of the public Board meeting of 28/5/15 can be located at S21 No 11 of 2022 Attachments, 32b(iv). 20150528 TB Public Minutes
- b. for example, refer to the substantial engagement of Trust staff in developing a response to the Donaldson Report and the scope of the review of Clinical and Social Care Governance I initiated in 2015/16 (detailed in my response to question 12) included recommendations from the Donaldson Report and other external reviews.
- c. Minutes of the Governance Committee meeting 3/2/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 49. 20150203 Approved Governance Committee Minutes*) HSCB SAI Learning Report for 1 April – 30 September 2014 where members discussed how learning had been disseminated across the region and received assurance that learning is shared with individual directorate meetings and also at SMT for corporate learning. Agreement was also reached that a summary of the top tips from regional Learning Lessons Newsletter would be made easily available to Trust staff.
- d. Incident and Complaints management and SAI reports were presented at every Governance Committee meeting and a summary of SAI recommendations arising from SAI Investigation Reports forwarded to HSCB was discussed annually. In

2015/16 this was discussed in minutes of the confidential Governance Committee meeting 8/9/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 31a(iv). 20150908 Confidential Governance Committee Minute*)

e. One of the outcomes of the review of Clinical and Social Care Governance I initiated in 2015/16 (as detailed in my response to question 12) was the development of a dashboard report across key clinical quality indicators including SAls, incidents, complaints and standards and guidelines. Minutes of the Governance Committee meeting 4/2/16, (*located at S21 No 11 of 2022 Attachments, 31b(vii). 20160204 Approved Governance Committee Minutes*) for item 8 Incident, Complaints, Patient Safety Report, reflects the development of trend analysis to better inform learning and areas for improvement.

16.3 I do not recall, nor has a review of the minutes of all Governance committee meetings in 2015/16 indicated, that any clinical governance failures in urology services were raised in these discussions.

17. Was it a requirement of your role that you undertook annual continuing professional development? If not, did you undertake such training anyway? In any event, please provide details of any training undertaken by you in your role as the CEO when you took up post?

17.1 The JD for myself as interim Chief Executive (*located at S21 No 11 of 2022 Attachments, 1. Chief Executive JD 2015. Paula Clarke*) does not specify annual continuing professional development as a requirement, however, this was good practice and something I endeavoured to do. I have referred to the training provide to me as a new accounting office in paragraph 14.1 and, from the information I have been able to access from the SHSCT public inquiry team to date, I attended a number of events to support my ongoing development as a leader including:

- HSC Complaints learning event (June 2015);
- Attendance at NICON (NI Confederation) conference.

18. Were you aware of any avenues for sharing best/worst practice between Chief Executives of health care Trusts in NI, health care providers in the Republic of Ireland and NHS Trusts throughout the UK? If not, do you consider that the sharing of information in this way would assist in maintaining and enhancing clinical governance and overall patient care? Whether you agree or not, please explain your answer.

18.1 My recollection for my tenure as Interim CEO, alongside references made in the Statement of Governance in the SHSCT Annual Report and Accounts for 2015/16, and other documents I have reviewed in responding to the Inquiry, is that the following avenues enabled sharing of learning across Health and Social Care providers. These are examples only and I am not suggesting this is a fully comprehensive list:

- a. Monthly meetings between Trust and HSCB Chief Executives.
- b. Monthly Trust Chief Executive meetings.
- c. Regional and local Transformation Programme Boards to work together to implement 'Transforming Your Care'.
- d. Forums such as the Regional Children's Service Planning Project Board that included HSC partners, community/voluntary sector and other statutory agencies such as Education.
- e. Reports widely available from organisations such as Kings Fund, Health Foundation, Clinical Quality Commission (CQC).
- f. Publicly available RQIA reports and the role of RQIA to provide 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.
- g. National and NI Chief Medical Officer Annual Reports.
- h. Page 59 of the 2015/16 SHSCT Annual Report and Accounts references that the Donaldson Review in 2014 examined the HSC in its entirety in respect of its openness and transparency; appetite for inquiry and learning; and approach to redress 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 (and as mentioned already above), the Minister announced a number of actions

in 2015/16 which focussed on elements of Clinical & Social Care Governance as follows:

- i. The use of Serious Adverse Incidents and Adverse Incidents to improve patient safety and reduce risk;
- ii. The deaths of children from natural causes should not be classified as an SAI; and
- iii. The introduction of a regional morbidity and mortality review system.

In response to this learning, the Trust participated 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.

- i. Complaints Annual Learning event organised by HSCB (commenced in 2014).
- j. Conferences and events held by NICON (the NI Confederation), which was linked to the NHS Confederation, securing access to national learning documents and events.
- k. Cooperation and Working Together (CAWT) – a partnership between HSC services in NI and ROI facilitating cross-border collaborative working, the Management Board of which I was a member. This body supported training and development of health and social care staff and sharing of learning as one island and internationally. Examples during my tenure included an all-island transplant conference in September 2015 and the development of a Cross Boarder Senior Nurses and Midwives forum.
- l. Evidence included in paragraph 16.2 above of HSCB biannual SAI Learning Reports.

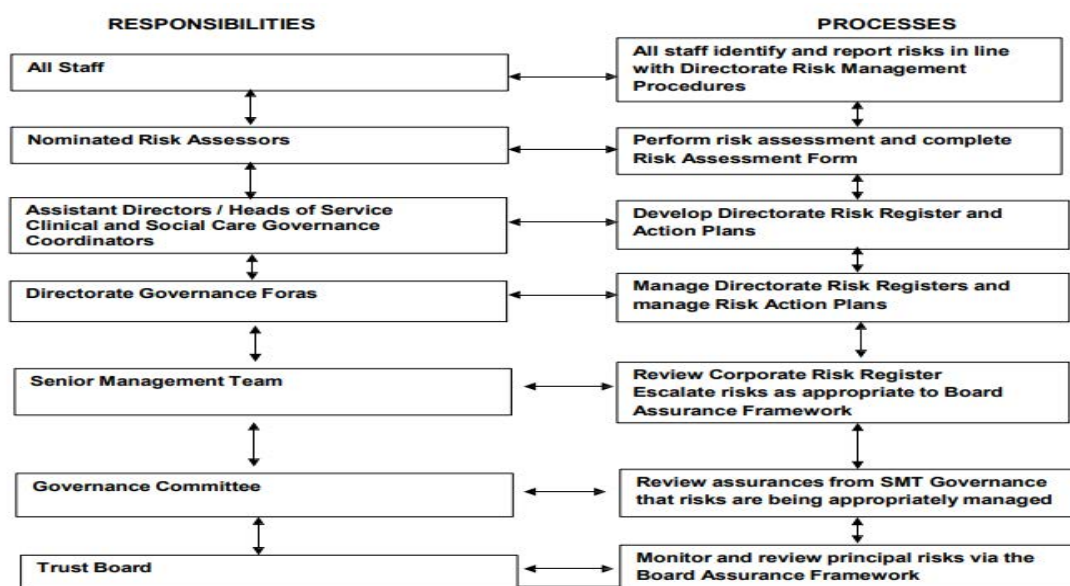
18.2 My view as interim Chief Executive, in 2015/16 and now, remains that sharing information openly and transparently of best and worst practice is essential in building a culture in health and social care for continuous improvement with a focus on learning, not blame.

19. What is your view of the adequacy of the risk management arrangements in

the Trust during your time in post?

19.1 My recollection is that risk management arrangements were adequate during my tenure. This view is supported by reminding myself of the following key assurances:

- a. The overall processes and assurances for risk management as reported in the Annual Report and Accounts for 2015/16 and referenced in paragraph 1.24-1.29.
- b. Internal Audit review of the Trust risk management systems in 2015/16, which secured a satisfactory level of assurance.
- c. A comprehensive Risk Management Strategy (*located at, Ongoing Discovery May 2022/Document Number 2 iii a/201809 Risk Management Strategy*) was in place developed in January 2014. This makes clear that the Trust approach to risk was to understand what might prevent us from achieving our objectives (the risk) and be able to respond to try to reduce the chance of each risk happening or reducing the consequences if it does occur. Managing risk is not about totally eliminating risk, as this is not possible within a health and social care environment. The strategy sets out governance arrangements for risk and roles and responsibilities in detail with an overview summary provided below:-



Risk Management Strategy – January 2014
7

- d. Paragraphs 12.3-12.10 demonstrate the effective operation of the Governance Committee in overseeing risk management.

20. Did you consider that the training and development for staff at all levels, including at senior management and Board level, encouraged a culture of reporting and learning from incidents? Please explain your answer. During your time, was the Board made aware of any problems in this area and, if so, what was done about it

20.1 I believe a culture of reporting and learning from incidents was a focus for the Board and senior management team during my tenure in 2015/16. Evidence of this includes the governance structures as set out in my response to question 12, including dedicated governance teams in each operational Directorate 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 and who were a source of advice and training for staff.

20.2 I also refer to the 20141001 Incident Management Procedure (*located at S21 No 11 of 2022 Attachments, 29. 20141001 Incident Management Procedure*), developed by the Trust in in 2014 to ensure clarity on roles, responsibilities and processes for identification, reporting, review, monitoring and learning from all incidents for staff across the Trust at all levels and included responsibility for all managers to undertake Training Needs Analysis. My response to questions 15 and 16 provides evidence of the Board development and actions to ensure reporting and learning from incidents and in paragraph 79.2 I provide more information about the approach to reporting in the Acute Directorate which included a monthly Governance meeting, chaired by the Director for Acute Services and Morbidity and Mortality meetings in each Acute Division. Further evidence of the need to learn and improve, and of the Board awareness of problems with respect to whistleblowing, is set out in my response to question 77.

20.3 With respect to specific training and development for staff at all levels, I believe

raising concerns and incident reporting was part of the Trust's portfolio of training for staff which included mandatory training such as fire safety and I think that whistleblowing/raising concerns was part of the mandatory training which was required for all staff, from Trust Board to frontline. This information could be confirmed by reference to the Human Resources Team at the Trust. Section 8 of the Trust Annual Report and Accounts for 2015/16 summarises the internal audits completed in the year of my tenure and provides satisfactory assurance on the complaints and whistleblowing, risk management and fraud processes. These audits considered awareness and training for Trust staff and paragraph 1.28 refers specifically to a recommendation from Internal Audit to improve training and awareness for all staff in risk management which was being actioned in 2016.

21. How was the Board assured, if at all, that there was a continued focus on reflective learning from the things that go wrong and celebration of the things that go well?

21.1 I refer to my response to questions 10, 12, 13 and 16, and specifically paragraphs 10.2 and 13.2-13.5, that evidence recognition and learning from things that go well, and my response to question 16, that addresses learning from investigations.

22. As former CEO, what is your view of the efficacy of the quality and safety monitoring systems that were in place in the Trust and executed through your operational teams during your tenure? Are there specific aspects of these systems that you found particularly helpful and are there parts of these systems that required improvement? If yes, please explain. What changes did you put in place or attempt to put in place to augment the assurance that was in place, and what direct observations and conversations did you have with clinical staff on the ground to see for yourself what the issues and problems were and what services are providing excellence?

22.1 I refer to my responses under questions 7 and 12 and the detailed overview of governance which includes quality and safety monitoring systems in paragraphs 1.9-

1.52. This includes my view that, as formally approved in the Annual Report for 2015/16 governance statement, these systems were sound and effective. In addition, the Trust submitted an Annual Quality Improvement Plan (QIP) to the PHA which included the quality indicators identified in the HSCB/PHA Commissioning Plan. For 2015/16 these included, for example, improvements in falls, pressure ulcers, venous thrombosis embolism assessments, and Early Warning Scores (EWS).

22.2 With respect to aspects of the Trust quality and safety monitoring systems that I found particularly helpful, I would refer to the opportunities provided for clinical and professional teams to present their services and provide assurance on the quality and safety of these services and learning from review and user feedback to Trust Board or Governance Committee. Examples of these are included in paragraphs 10.3 and 12. In addition, I believe that the leadership walks undertaken by the Chair and NEDs, which were reported to Governance Committee biannually in 2015/16, were good practice. The report for the period January to September 2015 is provided in *Leadership Walkabouts - Summary report Jan-Sep 2015 Final (relevant document can be located at S21 No 11 of 2022 Attachments, 51. Leadership Walkabouts - Summary report Jan-Sep 2015 Final)*, demonstrating how this informal engagement enabled Board members to talk with front line staff about issues in the organisation by asking a series of structured questions including a focus on: -

- a. What works well/doesn't work well;
- b. Challenges faced;
- c. Ideas for improvement;
- d. Commendations/Complaints;
- e. User engagement;
- f. Team meetings/Staffing issues;
- g. Training and Supervision;
- h. Audits;
- i. Incident reporting;
- j. Risks;
- k. Infection prevention and control.

22.3 A report was completed within 14 days of each visit and shared with the Chair, as well as the person who conducted/assisted in the walk round. Issues identified (if any) were escalated to me as interim Chief Executive and I would address them with the relevant Director. A response to the issues raised was required within a three-week timeframe, with assurance also provided back to the Chair by either explaining the issue or assurance that remedial action has been taken to address concerns. This process also enabled Board members to offer appreciation and encouragement where performance is excellent. It is my view that these more engaging and personal contacts augmented the suite of formal reporting into Trust Board and Committees and encouraged a culture of speaking-up to highlight good practice or raise concerns.

22.4 With respect to parts of these systems that required improvement, my view is that continuous improvement is part of good practice and an ongoing process of review and questioning. Evidence of my leadership in this regard, and the changes I initiated, is provided in my response to question 12 above through the approach I took to undertaking a review of CSCG arrangements. Evidence is also provided in the continued focus on Quality Improvement that I led in my role as Director of Performance and Reform from 2009 to March 2015, and continued in 2015/16 by leading on the Board objective to develop a Quality Improvement Framework (QIF) that would strengthen assurance processes as the foundation of the following QI efforts; increase co-ordination and prioritisation of efforts to innovate and improve our services; enhance monitoring and measurement of the outcomes and experiences of those using our services; and most importantly ensure we listened, learned and acted on what we heard. Further detail regarding the QIF can be accessed from Mrs Aldrina Magwood, Acting Director of Performance and Reform in 2015/16.

22.5 The opportunity for me to directly observe and discuss issues with services or recognise excellence are referred to in my response to questions 10 and 13.

23. How much time did you spend talking to your Senior Management Team and the Trust Board about clinical governance issues generally? This might helpfully be expressed as a percentage of daily/weekly hours.

23.1 I estimate that, based on the formal meetings below, I spent approximately 40-50% of my weekly time engaging with my SMT and Trust Board members on issues of clinical governance.

- a. SMT monthly Governance meetings – approx. 3.5 hours with the majority of time relating to clinical and social care governance issues.
- b. Quarterly Governance committee meetings – approx. 4.5 hours with approx. 80%-90% of time relating to clinical and social care governance issues.
- c. Public and Confidential Board meetings – 8 meetings of each held in 2015/16. Together these meetings lasted approx. 6-7 hours in total on each of the 8 occasions, with an estimated 40% of the agenda time spent on issues relating to clinical governance and patient quality and safety.
- d. One to one meetings monthly with my Directors lasting approx. 1.5 hours with an estimated 50% of this time spent on issues relating to clinical governance and patient quality and safety for professional and operational Directors.
- e. My one to one with the Trust Chair monthly lasting approx. 1-2 hours plus ad hoc weekly, or more frequent, ‘check in’ discussions estimated at approx. 1 hour per week. I estimate that approx. 40% of our time together related to issues of clinical governance and patient quality and safety.
- f. Meetings with the Chair of the Governance Committee after each meeting to review the effectiveness of the meeting and follow up on key issues and actions. This lasted approx. 1.5 hours, four times in 2015/16 with approx. 80% of time on these matters.
- g. Three Trust Board workshops and a development day in 2015, each lasting all day with an approximate 33% of the day spent on issues relating to clinical governance and patient quality and safety.

24. How did staff generally inform you about or engage you in conversations regarding clinical governance issues? Was it your usual experience that they generally do so informally, or in writing, or both?

24.1 Clinical governance issues were largely raised with me via formal reporting into SMT Governance and onto Governance Committee and Board as required as set out in my response to question 12. The opportunity for staff to raise issues in person or via email or a letter was promoted through my informal walkabouts and visits to teams. However, I can't recall any specific examples of this given that it was over 6 years ago and my recollection is that issues were more often raised formally.

25. How would you describe the methods which you deployed to ensure that you got to know that what is expected of people in terms of compliance with clinical governance standards and arrangements was actually being carried out? Did you consider these methods successful? It would assist if you could illustrate your answer with examples.

25.1 The methods I used to secure assurance on compliance with clinical governance standards and arrangements are set in detail in paragraphs 1.30-1.42 and 7.2-7.8 and my full response to question 12. Specifically, I would refer to the information included in the Board Assurance Framework that set out the wide range of assurance from internal and external sources including, for example, the Regulation and Quality Improvement Authority, Internal and External Auditors, Royal Colleges and Professional Councils and supplemented from non-independent sources such as performance management, self-assessments and internal workstreams on national audits. As an example, internal auditors independently verified compliance with the Controls assurance standards as substantive for both Governance and Risk Management in 2015/16, as stated in the Annual Report and Accounts for 2015/16. Other methods included informal and formal engagement with teams as set out in my response to question 10 and from the NED Leadership walks as set out in paragraph 22.2.

25.2 I have no evidence to indicate that these methods were not successful in my tenure. I accept that, following my period as Trust Chief Executive, issues will have

arisen regarding matters of clinical governance under my tenure, but no system of governance is completely failsafe and lessons will always be being learnt.

26. Please provide examples of a number of issues that were escalated through to the Trust Board or Trust Board Committees where there were patient quality and safety concerns. The examples can come from any department, but we would be particularly interested to hear about any issues from urology. You should describe the route by which those concerns passed through the clinical governance structures and the route by which the Board then agreed a plan to improve matters and then sought assurance that the issues had been resolved. Did you as CEO have any concerns about these processes? If so, what changes, if any, did you make to improve assurance and ownership at all levels in the Trust?

26.1 I have reviewed all Governance Committee and Trust Board minutes for 2015/16 and the issues escalated through these routes relating to patient safety and quality are as reflected in the Corporate Risk Registers (CRR) and the SAI reports that were presented to the Governance Committee quarterly and discussed in the confidential section.

26.2 Risks were included under sections that related to the Trust Corporate Objectives including the Corporate Objective to Provide Safe High Quality Care. An example of the breadth of issues with actual or potential risk that the Trust was managing in my tenure is reflected in the Corporate Risk Register as at 30/11/15 presented and discussed at Governance Committee on 8/12/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 52. 20151208 CRR*). The total number of risks being managed at corporate level was 22 of which none were assessed as extreme risks, 12 were high risk, 10 medium and 0 low risk. Those under the Corporate Objective to Provide Safe High-Quality Care included the 12 high risks and 7 of the medium risks.

26.3 None of these risks related to urology service issues as a single concern. The urology concerns included under the Corporate Risk Registers in 2015/16 related to the following risks as at 8/12/15, and these are further addressed in my response to question 55:-

- a. High Risk to Achievement of Elective Commissioning Plan Standards and Targets indicates that areas of risk highlighted to Health and Social Care Board formally include Urology (OP Review Backlog) as one of 6 clinical specialities and that the Trust will continue to re-direct internal resources to areas of greatest risk as funding becomes available or as operationally feasible.
- b. High Risk relating to Out-Patient Review and Planned Treatment Backlogs indicated that at 1 November 2015, there were a total of 20,627 patients waiting in excess of their clinically indicated timescale for review out-patient appointment of which 44% (9155 people) were waiting in excess of 6-months past their clinically indicated timescale. The longest waits were noted to be in Urology extending back to 2011/12. It was assured that all patients for 2011/12 and 2012/13 had been validated and those waiting from 2011/12 have all been offered an appointment date. It was noted that no non-recurrent funding had been received from HSCB in 2015/16 for the outpatient review backlog.
- c. High Risk to ability to recruit/retain Consultant medical staff for specific specialties which excludes urology under risks in Consultant Medical Staff but indicates risk for SAS grade doctors (staff, associate specialist and specialty doctors) in 6 clinical services, including urology.

26.4 These concerns had been routed from the initial identification of risk to delivery in the Trust Delivery Plan for 2015/16. Specialty specific risks would have been included on clinical Departmental risk registers and escalated onto the Acute or other relevant operational Directorate Risk Register. The Corporate Risk Register included identification of the lead Director for managing the risk and provided assurance to Governance Committee and Trust Board (via the Board Assurance Framework) on the key controls in place and further actions planned to continue to reduce and mitigate the risk. Routing of concerns regarding patient quality and safety was

supported through the 201809 Risk Management Strategy (*relevant document can be located at, Ongoing Discovery May 2022/Document Number 2 iii a/201809 Risk Management Strategy*) and the Incident Management Procedure, (*relevant document can be located at S21 No 11 of 2022 Attachments, 29. 20141001 Incident Management Procedure*)

26.5 The discussion at Governance Committee on 8/12/15 on the outpatient backlog risk, and specifically urology, demonstrates the challenge members provided to seek assurance that a plan was in place to make improvements:

“Dr Mullan drew members attention to page 12 and asked about longest waits, some going back to 2011/12. Mrs Magwood (Acting Director of Performance and Reform) 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 (interim Chief Executive) 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”

26.6 My recollection of the main issue presenting risk to patient quality and safety in my tenure was the risk to sustaining the Emergency Department at Daisy Hill Hospital as a 24/7 unit. I have set out the detail of this risk and how I addressed this, including how this was routed through governance processes in my response to question 30.

26.7 I had no concerns that I recall about these processes, however, as set out in paragraphs 12.3-12.6, I did take steps to strengthen clinical and social care governance processes through a review that took account of learning from national external reviews. This included strengthening capability (systems) and capacity (analysis/trending) to provide the type and depth of organisational

intelligence/information required to adequately inform the organisations' safety and quality improvement priorities.

27. In respect of your role, please detail your lines of engagement with the Trust Board, to include all formal and informal avenues.

27.1 As interim Chief Executive my lines of engagement with Trust Board included the following formal and informal avenues:-

- a. Board and Committee meetings;
- b. Board workshops and development days (3 held in 2015/16);
- c. Meetings with the Chair and the NED chairing Committees after each meeting;
- d. My one-to-one meetings, formal and informal, plus sometimes daily contact by phone, with the Chair;
- e. Attendance by the Chair and myself at formal accountability meetings twice a year with DHSSPS officials and meetings with the Chief Executive of the HSCB on occasion;
- f. Attendance by Trust Board members at celebration events such as Trust Excellence awards and the Annual Quality Improvement event.

28. Who on the Trust Board had responsibility for clinical governance and patient safety during your time in post? Please explain the Board oversight of clinical governance and patient safety generally, including the name(s) of and duties of any *Board Assurance Manager* during your tenure.

28.1 As interim Chief Executive of the Trust in 2015/16 I was responsible for clinical governance and patient safety. I discharged my duties through the clinical and social care governance arrangements set out in detail in paragraphs 1.11-1.52, and 7.2-7.8. Key within this is that there was clarity on the role of Operational Directors as responsible and accountable for patient safety and quality and for implementing agreed workforce standards and providing assurance to the executive functions that action is taken to ensure a workforce of an acceptable standard in order to deliver safe, high quality care. Operational Directors were responsible and accountable for all aspects of CSCG reporting through SMT Governance, and me as its Chair, and via

this body through to Trust Board. Professional Directors for Social Work, Nursing and AHPs and Medical were responsible for providing expert advice and support professionally, providing assurance on compliance and reporting on standards for the registered workforce. The Medical Director, as the designated Responsible Officer, had specific responsibilities covered in paragraph 7.8; details of these individuals during my tenure are covered in paragraph 6.2.

28.2 Board oversight and assurance of clinical governance and patient safety generally has been set out in detail in my full response to question 12.

28.3 The Board Assurance Manager during my tenure was Mrs Sandra Judt. Her duties are set out in the Job Description for this role Board Assurance Manager SANDRA JUDT (*relevant document can be located at S21 No 11 of 2022 Attachments, 53.* Board Assurance Manager SANDRA JUDT)

29. How did you let the Board know if problems regarding clinical governance arose? Did you utilise both formal and informal methods of contact and, if so, who was your point of contact and why? Did you think the mechanisms for doing this were good enough and, if not, what would have improved them?

29.1 As interim Chief Executive, I sought to ensure that the senior team adopted an open and transparent approach to raising issues of actual or potential risk and concern. This was achieved primarily through the suite of reporting into Governance Committee and Trust Board as I have set out in paragraphs 12.7-12.10. As I state in paragraph 12.11, the Board was appraised of serious concerns at as early a stage as possible, with examples of operational Directors raising early alerts formally in the confidential Board meetings on 26/3/15 (*relevant document can be located at S21 No 11 of 2022 Attachments 54. SMT Notes 18 March 2015*), 28/5/15 (*relevant document located at S21 No 11 of 2022 Attachments, 55. SMT Notes 27 May 2015*), 16/9/15 (*relevant document can be located at S21 No 11 of 2022 Attachments 56. SMT Notes 16 September 2015*), 22/10/15 (*relevant document can be located at S21 No 11 of*

2022 Attachments, 57. SMT Notes 21 October 2015) and 26/11/15 (relevant document can be located at, Trust Board 2007 - 2022 including packs from 2016/Confidential Trust Board Pack 2016/1. 28.01.2016/Draft Confidential minutes - 26 11 2015). Should it have been necessary, a more urgent briefing could have been given to Board members, for example, through an email communication or through the Chair. I don't recall specific examples of this in 2015/16 but this issue could be followed up by the Inquiry with the Board Assurance Manager, Mrs Sandra Judt.

29.2 As interim Chief Executive, I contacted the Chair as my first point of contact regarding any serious concerns as my line manager. I would also escalate concerns to the Permanent Secretary and/or the HSCB Chief Executive as I was also accountable to them. This contact would usually have been via a telephone call initially, followed up with formal communication as required. I believe this was the route I followed with respect to the Daisy Hill Hospital risks mentioned in my response to question 30.

29.3 I do believe these mechanisms were good enough as they were both formalised and pragmatically informal should contact be required for an urgent issue or an emergent potential risk as opposed to an actual problem.

30. Describe the most significant clinical governance/clinical risk challenges which you faced during your tenure as Chief Executive, and explain how you addressed them?

30.1 The most significant clinical governance and risk challenges during my tenure are included in the Corporate Risk Registers. My response to question 19 includes reference to the Risk Management Strategy (*relevant document can be located at S21 No 11 of 2022 Attachments, Ongoing Discovery May 2022/Document Number 2 iii a/201809 Risk Management Strategy*) introduced from January 2014 with a clear process to escalate risks from team to Board level where these could not be managed locally or needed corporate oversight. These processes underpinned how I addressed these risks and included risk registers that were developed at all levels based on a standardised Trust Risk Assessment Form that included:-

- a. Risk title and description (including location and local details);
- b. Potential for harm;
- c. Summary of current control measures;
- d. Initial risk rating;
- e. Action plan;
- f. Nominated person responsible for each action;
- g. Review date and monitoring arrangements.

30.2 It was expected that a risk action plan was developed to document the management actions and controls to be adopted. The system of management for Clinical and Social Care Governance is set out in my response to question 12. This included an Assistant Director of CSCG who reported to me as interim Chief Executive plus CSCG Co-ordinator's and teams for the operational Directors who supported the development and maintenance of risk action plans for Directorate/Departmental risk registers. On my delegated authority as Chair of SMT Governance, the Board Assurance Manager was responsible for maintaining risk action plans for the Corporate Risk Register.

30.3 My response to question 26 summarises the position for the Corporate Risk Register as at 30/11/15, presented and discussed at Governance Committee on 8/12/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 52. 20151208 CRR*) The total number of risks being managed at corporate level at this time was 22, of which none were assessed as extreme risks, 12 were assessed as high risk, 10 as medium risk, and 0 as low risk. With respect to clinical governance/clinical risk challenges specifically, I recall some of these in more detail than others and have referred to the high risk associated with achieving elective care standards and targets for access times throughout this report. The high risk associated with outpatient reviews beyond clinically indicated timescales and the sustained focus of the Trust in managing and addressing these risks is included in my response to question 54.

30.4 I would state categorically that the most significant challenge to delivery of safe, high quality clinical services during my tenure was to sustain the Emergency Department at Daisy Hill Hospital as a 24/7 unit as a result of a number of complex factors including consultant and middle grade recruitment and retention. This was escalated formally as a risk onto the Corporate Risk Register at 30/9/15 having been noted on the CRR as discussed at the Governance Committee Meeting on 8/9/15 as a potential new risk. The CRR presented and discussed at Governance Committee on 8/12/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 52. 20151208 CRR*) and on 4/2/16 (*relevant document can be located at S21 No 11 of 2022 Attachments, 58. 20160204 CRR*) included the following two relevant risks and associated controls and actions plans:

- a. Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital;
- b. Inability to recruit/retain Consultant medical staff for specific specialties which included Emergency Medicine with specific reference to Daisy Hill Hospital.

30.5 This risk first came to my attention through escalation from the Acting Director of Acute Services, Mrs Debbie Burns, and the Clinical Director for Emergency Medicine, Mr Seamus O'Reilly, in mid-April 2015 who raised concerns regarding the level of overnight medical cover at Daisy Hill Hospital ED. I recall that I took these concerns very seriously and responded as a matter of urgency and rapidly established a Senior Oversight Group chaired by myself as CEO with a weekly action plan to address risk management and mitigating actions. A brief timeline of these initial actions is provided to the Inquiry in 20150507 DHH ED Timeline A1 (*relevant document can be located at S21 No 11 of 2022 Attachments, 59. 20150507 DHH ED Timeline A1*) I recall, but have no evidence, that I alerted the Trust Chair of these concerns and took the first formal opportunity to brief the Board in confidential session on 28/5/15. The minutes of the following confidential Trust Board meetings and SMT meetings demonstrates the focus given to this high risk and the key actions I led, as Interim Chief Executive, to manage this risk: -

- a. Trust Board (confidential)

- i. 28/5/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 32a(iv). 20150528 Confidential Minutes*)
 - ii. 11/6/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 32a(vi). 20150611 Confidential Minutes*)
 - iii. 27/8/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 32a(viii). 20150827 Confidential Minutes*)
 - iv. 24/9/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 32a(x). 20150924 Confidential Minutes*)
 - v. 22/10/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 32a(xii). 20151022 Confidential Minutes*)
- c. SMT (primarily under Confidential section)
- i. 1/7/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 61. SMT Notes 1 July 2015*)
 - ii. 22/7/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 62. SMT Notes 22 July 2015*)
 - iii. 5/8/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 63. SMT Notes 5 August 2015*)
 - iv. 12/8/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 64. SMT Notes 12 August 2015*)
 - v. 23/9/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 65. SMT Notes 23 September 2015*)
 - vi. 30/9/15 (*relevant document can be located at S21 No 11 of 2022 Attachments 66. SMT Notes 30 September 2015*)

30.6 These minutes attest to my personal leadership, along with the Medical Director and Director of Acute Services, to engage transparently with clinical staff in both Craigavon and Daisy Hill Hospitals and to action all possible mitigating measures, most of which came at financial risk. A summary of the key actions included additional measures to recruit and stabilise the medical workforce in ED and additional support to junior staff in the ED in the out of hours period, ongoing recruitment of 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, and appointment of additional Emergency Nurse Practitioners and additional Band 6 Clinical Sisters. These actions secured the service throughout 2015/16 and beyond, however, significant concerns remained regarding the sustainability of the current service model and the risk remained as a high risk on the Corporate Risk Register when I left the Trust on 31/3/16. Further work and investment were carried forward into this service with a full review being undertaken and reported in a Daisy Hill Hospital Pathfinder Project on 20th December 2017. This can be sourced publicly online.

30.7 I would also highlight that, given the significance of this risk and its potential impact on service provision at surrounding acute hospitals as well as in the context of the political scrutiny regarding services at Daisy Hill Hospital, I briefed DHSSPS, HSCB and PHA senior representatives at an early stage (in April 2015) and involved HSCB and PHA management and clinical senior leaders in my Senior Oversight Group. Evidence of the scrutiny on this matter, and some political acceptance of the actions taken by myself and the Trust, is accessible at an Adjournment debate in the Stormont Assembly on 22/9/15 (*relevant document located at S21 11 of 2022 Attachments 66a. plenary-22-09-2015*), with part of the statement by Dominic Bradley MLA being as follows:

“...I believe that this restriction of hours, reduction of hours and closure at night cannot be allowed to happen. I do take the word of the trust that it is making every effort to deal with this situation. There is a problem with recruitment of staff at the middle-grade level needed to sustain the service, but I want to see the Minister and his Department at central level lending support and assistance to the trust to ensure that it can recruit the people it needs to keep the emergency department in our hospital open.

I have met the previous chief executive, Mrs McAlinden, and the current acting chief executive, Mrs Clarke, and the executive team. As I said, I appreciate the efforts they are making to address this problem, but, without the help of the Department and the Minister, there is only a certain amount they can do. The Southern Trust has already engaged in recruitment

exercises on a continual basis on some 16 separate occasions, yet it has not managed to attract the staff that it needs. In such a situation, there needs to be ministerial involvement in order that attractive packages can be put together to ensure that we are able to attract the level of staff needed.

A detailed action plan has been drawn up by the trust and has been agreed. This will support the continued provision of emergency care overnight, but only on a short-term basis. We want a sustainable service that will continue into the future and which will not be threatened by staff shortages. As I said, we do welcome the efforts that are being made by the trust, but the service remains extremely vulnerable to any further loss of medical staff."

30.8 I believe this example provides evidence of the seriousness with which myself, the senior management team and clinical leaders, and the Trust Board responded to matters of clinical risk and dealt with this effectively within the constraints of the overall HSC environment.

31. Did you engage in any program with a view to improving any aspect of clinical governance or clinical risk management during your tenure as Chief Executive? If so, fully explain the steps which you took as part of this program and outline any changes which resulted.

31.1 I have set out the review of clinical and social care governance arrangements I undertook in 2015/16 in my response to question 12.

32. What percentage of the time at Trust Board was taken up with care quality and patient safety concerns and what emphasis was placed on receiving assurance that any such issues were resolved?

32.1 The assessment I have made of time dedicated to clinical governance issues at Trust Board only (i.e., excluding committees) in my response to question 23 indicates that Trust Board spent approx. 40% of the agenda time on issues relating to clinical governance and patient quality and safety.

33. Was it your experience while in post that the Board had taken appropriate actions in relation to quality and safety concerns and sought to prioritise resources appropriately for these actions to be effective?

33.1 Yes, my experience as interim Chief Executive was that the Board did act appropriately to address concerns relating to quality and safety and to prioritise resources towards required actions. I refer to the 2015/16 Financial Plan paragraphs 1.5-1.6 and to my response to question 40 for evidence contributing to my view.

34. Do you have any knowledge of, or personal experience of, matters regarding clinical governance and patient safety not having been dealt with properly by the Trust and/ or the Trust Board during your tenure? If so, please provide full details, including setting out whether any failure to properly act has been admitted to and addressed, and any subsequent lessons identified and implemented - and if not, why do you think that did not happen?

34.1 During my tenure I had no knowledge or recollection personally of any failure to deal properly with clinical governance and patient safety matters. As I have already stated, myself and my senior team, working with the Chair and non-executive Directors, set out to create a culture of transparency and learning.

34.2 Had I been aware of any matters not being dealt with properly, it would have been incumbent on me as Accountable Officer to challenge this and I can confirm I had no requirement to do so in 2015/16, nor has anything other than the matters pertaining to this Urology Services Inquiry, been brought to my attention since that time.

34.3 I am now aware, in 2022, of new information relating to urology services and specifically the practice of Mr Aidan O'Brien and I address my understanding and reflection on these matters in my responses to questions 83, 98, 103 and 118.

35. Please set out what you considered to be the challenges in terms of learning

the lessons from clinical governance and safety issues, and how staff were appraised of these and encouraged to reflect and learn? Are there any examples of this where minutes and presentations, if any, can be provided and where improvements have been put into place and embedded as demonstrated by audit?

35.1 In my view, the challenges in terms of learning the lessons from clinical governance and safety issues when I was the Interim Chief Executive included the continuous need to focus on creating a culture of openness, a “just” and learning culture where staff felt able to raise issues, identify risks, and be supported in managing those risks while accepting that risk cannot be completely eliminated in the delivery of health and social care. This was the focus of the Francis Review, and the Donaldson review referenced at paragraph 16.2. Essential in creating a learning culture was the approach adopted by line managers across a very large and complex organisation. I believe the open recognition that this culture did not exist everywhere in the Trust in my tenure is apparent in the whistleblowing and raising concerns survey and the response and minutes of the Board meeting on 26/11/15 to this, including actions taken to improve, as detailed in my response to question 77.

35.2 Other challenges to learning derived from the need to take decisions about the priority for investment in actions that would have contributed to adopting lessons learned. As I set out in paragraphs 1.3-1.7 the Trust faced a very challenging financial context and delivery plan in 2015/16 with an explicit need to balance the statutory duties to break even and deliver safe, quality care through difficult decisions.

35.3 Staff were appraised of learning from issues and encouraged to reflect and learn through a variety of methods including but not limited to:

- a. The Incident Management Procedure, referred to in my response to question 12, was introduced from October 2014 which was to support all staff in the identification, reporting, review, monitoring and learning from all incidents which resulted in or had the potential to result in injury or harm and to *“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.” This procedure includes a section (4.0) on *Reviewing, Monitoring and Learning from Incidents* which required that all incidents were reviewed on a weekly basis by the service areas’ Incident Review Team who would help ensure the development and agreement of learning and action plans as appropriate. All incidents categorised as moderate, major or catastrophic required a time-bound action plan which had to include relevant learning points that had to be communicated and actioned within teams. Assistant Directors were to be informed of any immediate learning which could minimise the risk of further reoccurrence of the incident.

- b. The development in 2015/16 of a Quality Improvement Framework (QIF), as referenced in my response to question 22, with a focus on ensuring we listened, learned and acted on what we heard from staff and service users.
- c. Morbidity and Mortality reviews in each clinical Directorate and in divisional teams.
- d. Reflective learning embedded into the requirements for medical and nurse revalidation – the latter was introduced in late 2015/16.
- e. NED Leadership walks raised discussion on reporting risks and getting feedback and I would also have had similar discussions on my walkabouts.
- f. Disseminating learning from high profile safety and clinical governance issues and investigations. Examples from discussions at Board or Governance Committee include the reference in paragraph 16.2 to sharing learning from regional SAls within individual directorate meetings, at SMT and agreement to provide an easily accessible top

tips from the regional Learning Lessons Newsletter to all Trust staff and to the wide engagement of staff in responding to the Donaldson Report. A discussion at confidential Board on 24/9/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 32a(x). 20150924 Confidential Minutes*) recorded in the minutes also refers to the vigilance of the Board to Hospital Acquired Infection risks and impact on patient safety. Following an outbreak involving 3 cases of CPE, a Board member asked about sharing the learning and was assured by Dr Wright, Medical Director, and Mr Rice, Director of Mental Health and Disability and Director of Nursing, that they were issuing a joint letter to all clinical staff to reinforce adherence to infection control practices. This action was also reflected in the Board Assurance Framework document presented to Trust Board on 29/11/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 28. 20151126 Board Assurance Framework*)

35.4 Examples of improvements put in place across the Trust, many coming from lessons learned, can be accessed in the quarterly QI newsletters from 2015/16.

Located in S21 No 11 of 2022, 66b. CI Newsletter Issue 16 and 66c.

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35.5 I would also refer to the attendance at Governance Committee and Trust Board by staff from a number of services across the Trust during my tenure to present on their service challenges and successes. Some of these are included in paragraph 10.3 and I would specifically highlight the 8/9/15 Governance Committee meeting attended by Dr Hogan, Associate Medical Director of Integrated Maternity and Women's Health Services, Dr Sim Consultant Obstetrician/Gynaecologist, and Dr McCracken, Consultant Obstetrician, where the minutes indicate the team reflected taking learning from the Morecambe Bay Report which highlighted failings within a maternity unit in England. The presentation given by the team can be accessed from Sandra Judt, Board Assurance Manager, and any audits or regulatory reviews that demonstrate the embedding of these lessons in the unit could be accessed from one of the three consultants named above.

36. Did you and the Trust Board identify and share lessons learned from adverse incidents, complaints, litigation and public inquiries, etc., concerning clinical governance and patient care and safety, both regionally and nationally? Whether your answer is yes or no, please explain. Do you consider it practicable that such lessons learned are shared and, if not, what needs to change to allow that to happen in a meaningful way?

36.1 I believe my response to questions 15, 16, 18 and 35 addresses the sharing of learning and my views on the importance and practicalities of such sharing.

37. How would you describe the "risk appetite" of the Trust and the Trust Board while you were Interim Chief Executive? Was there, as part of the risk management strategy and process within the Trust, an annual Board appraisal of risk appetite in relation to quality and safety, operational performance and finance?

37.1 I would describe the risk appetite of the Trust and Trust Board in my tenure as both considered and proportionate. Examples of the approach the Board took to managing the balance of risks to quality, safety, operational performance and finances are included in my response to question 40 and in my response to question 30 regarding actions taken at financial risk to maintain 24/7 ED services at Daisy Hill Hospital.

37.2 On a biannual basis, the Board Assurance Framework discussed at biannually Trust Board, (*relevant document can be located at S21 No 11 of 2022 Attachments, 28. 20151126 Board Assurance Framework*), set out the principal areas of risk to the delivery of the Trust's Corporate Objectives and identified the systems of control and actions for the management of these risks. In considering this assurance document the Board was specifically asked to consider whether all the principal risks had been identified, whether the current controls and assurance systems were sufficient, and if the action planned was considered sufficient/acceptable. This drew out an assessment of risk appetite in the context of the Trust Risk Management Strategy and

its definition of risk appetite as being:

“...defined as the amount of risk that an organisation is willing to take in the pursuit of its corporate objectives. Factors such as the external environment, relative benefit, stakeholders, innovation, policies and business systems will all influence an organisation’s Risk Appetite. This strategy explains the framework used within the Trust to ensure risk is clearly identified, considered and managed within the context of organisations ‘Risk Appetite’ at all levels of the organisation.”

I also refer to this Strategy in my response to question 19.

37.3 I do recall the topic of risk appetite being a discussion point at Board workshops and development days but I don’t recall, nor have I been provided with any evidence by the Trust, that there was a specific process to assess and test risk appetite. In my Executive Director role since April 2016 in an NHS Foundation Trust, I do participate in a best practice assessment of risk appetite. This is undertaken approximately every two years and uses the Good Governance Institute framework and methodology *which can be located at S21 11 of 2022 Attachments 71. GGI-Board-Guidance-on-risk-appetite-2020.*

38. Were you, as Interim CEO, able to assure the Board that high standards of professional practice were maintained? How did you seek to gain this assurance? Did this involve nurses, allied health professionals, doctors, technicians, and managers?

38.1 Assurance on maintenance of high standards of professional practice was secured through the overall clinical and social care governance systems as detailed in paragraphs 1.30-1.42, 7.2-7.8, 12.1-12.10. Reporting into Trust Board and Governance Committee is detailed in my response to question 12 and specifically refers to the Reports of the professional Executive Directors including assurance on professional practice for medical, nursing, AHP, Social Work and other clinical professional staff. I believe reporting on general systems of staff appraisal for the non-

registered workforce was included in the Director of Human Resources reports into Trust Board. My one-to-one meetings with Directors also provided an opportunity for informal discussions about any issues of professional practice.

38.2 Specific assurance was also secured through the processes for managing high professional standards. In reviewing Structures for Clinical and Social Care Governance Consultation Period (December 2010) “A System of Trust,” (*relevant document can be located at S21 No 11 of 2022 Attachments, 11. 20150410 E and Reports Draft Paper Governance - RCSCG CONSULTATION DRAFT 4 A2*) I was reminded of the Trust processes for managing poor professional performance and conduct for all staff including clinical, nurse, AHP, social work and all employees. This is set out in Appendix 3 of “A System of Trust”. I have also referred in my response to question 83 to the Trust Guidelines for Handling Concerns about Doctors’ and Dentists’ Performance

39. How were you assured as to how clinical appraisal was managed in the Trust? What assurance does the Board receive in this regard? Did you have any concerns about this during your tenure?

39.1 Reporting into Trust Board and Governance Committee is detailed in my response to question 12 and specifically refers to the Reports of the Medical Director that included assurance on the medical appraisal processes. I have included evidence of this in my response to question 91, including reference to the 20140701 Policy - Southern Trust Appraisal Scheme for Medical Staff (*relevant document can be located at S21 No 11 of 2022 Attachments, Relevant to MDO/reference no 2t/20140701 Policy - Southern Trust Appraisal Scheme for Medical Staff*). My one-to-one meetings with the Medical Director offered the opportunity for any issues to be raised and discussed. I have no recollection of any such concerns being raised with me or to the Trust Board during my tenure and I had no concerns about the processes.

40. Did the Trust Board ever raise the issue of budget allocation and the prioritisation of risk, or seek to establish whether you, and they, were content

that an acceptable risk prioritisation/budget allocation balance had been struck?

40.1 It is my belief that during my tenure, the Trust Board was very aware of the ongoing need to manage the balance of its dual statutory duties to provide safe, high-quality care and break even financially. I have given some examples of the Board recognition of the difficult decisions this balance sometimes required below.

40.2 I refer to public Board minutes from Minutes of a confidential meeting of Trust Board held on Thursday, 26th March 2015 (*relevant document can be located at S21 No 11 of 2022 Attachments, 32a(ii). 20150326 Confidential Minutes*) at 9.30 a.m. in the Boardroom, Trust Headquarters, Craigavon under AOB section 11 that states:-

“At this point, Mrs Clarke reminded members of detailed discussion at the Trust Board meeting in October 2014 when approval was given to commit funding at financial risk to address clinical risks. This action had been taken in the context of expected further funding from HSCB and the Trust financial position. Mrs Clarke outlined areas of clinical risks now emerging due to lack of Q1/2 elective funding into 2015 and sought Trust Board approval to proceed at financial risk for the month of April 2015 only. This risk is mitigated by the expectation of diagnostic funding from HSCB which has been advised verbally. Key areas are CT; Endoscopy; Symptomatic Breast and MRI. Members approved the commitment of funding during April 2015 for the areas of risk on the basis that this action is highlighted formally to HSCB and their commissioning intent from the end of April is clarified. Mrs Clarke agreed to write to HSCB Chief Executive.”

40.3 At this meeting the Chair also reported under Matters Arising that she and myself had met with the Chair and Chief Executive of HSCB, Mr Ian Clements and Mrs Valerie Watts, on 11/3/15 and had raised the Trust Board's concerns about the timing of funding allocations. Throughout 2015/16, the Monthly Performance Reports and Corporate Risk Registers also reflected the continued highlighting of the need for additional recurrent and non-recurrent funding to address issues regarding patients waiting longer than the prevailing standards for new appointments, for treatment, and for reviews within clinically indicated timescales.

40.4 A comprehensive illustration of how the Board considered the balance between risk prioritisation and funding was in development of the 2015/16 Financial Plan (Draft Financial Plan 2015/16) and the 2015/16 Trust Delivery Plan. This is covered in paragraphs 1.5-1.6 including a clear statement that:-

“The Southern Trust has been advised it needs to deliver £13m in cash savings during 2015/16 as part of this wider health and social care financial settlement. Within the constraints of the statutory duty to breakeven financially, the Southern Trust remains mindful of its statutory duty to provide safe, high quality care which is effective, efficient, accessible and responsive to the needs of our patients and clients. However, balancing the requirements of both these statutory duties means difficult decisions are required. Where some degree of service change is required the Trust will ensure that best practice is applied and followed and necessary alternative capacity is available to support any proposed shifts in activity.”

41. Please provide all notes and minutes of any meetings with the Trust Board, Trust Committees, any Trust or Departmental Staff or any third party or health body in which the problems with Urology Services were discussed during your time in post.

41.1 I am responding to this question for the year 2015/16, being my tenure as interim Chief Executive of the Trust and based on documents provided by SHSCT Public Inquiry Team. I refer to my response to question 11 and repeat that I have endeavoured to be as thorough in my response as possible in the context of the time constraints I face and have reviewed the notes and minutes below as relevant in 2015/16.

- a. 38 sets of notes from the Trust SMT meetings in 2015/16, none of which included the word urology.
- b. Minutes from 8 confidential and 8 public Board meetings in 2015/16. The minutes of the meeting of 24/3/16 appear to be the only reference specifically

to urology as follows: 20160324 TB Public Minutes (*relevant document can be located at S21 No 11 of 2022 Attachments 32b(xviii). 20160324 TB Public Minutes*) item 9i:

“Mrs Magwood presented the Performance Report and advised that the format continues to be refined. She stated that the report reviews performance against the Trust’s Service and Budget Agreement (SBA) as at end of January 2016 and performance against Commissioning Plan Standards and Targets as at end February 2016. Members discussed the report in detail. In relation to SBA, Mrs Magwood noted that corporately month end January performance is good against the profiled level of activity in the majority of areas expected at this time of the year, however some specialty areas are not expected to deliver the full level of commissioned activity by March 2016. She particularly highlighted the fact that improvement plans have been implemented in key specialties where performance was not in line with profiled activity and stated that end of January performance confirms return to normal tolerances for Paediatrics and Cardiology New Outpatients. General Surgery and Urology remain challenging.”

- c. 8 sets of minutes from Governance Committee meetings in my tenure from 1/4/15 until 31/3/16. Where these reference urology, I believe I have included in my response to question 55.
- d. Minutes from the year end (2014/15) accountability meeting with DHSSPS on 16/6/15 attended by the Chair and me (*relevant document can be located at S21 No 11 of 2022 Attachments, 25. 20150616 Mid Year Strategic Accountability Meeting – Mins from 16 June 2015 A2*) which record that:-

“In relation to elective care SHSCT accepted the need for a continued focus on performance, and also highlighted the issue of demand exceeding capacity. Paula Clarke advised that treatment pathways and theatre schedules are being reviewed, but there are regional staff

shortages in a number of specialties (urology), which need to be addressed on a regional basis."

I refer to this discussion in my response to question 57.

- e. I have not been able to access minutes from the mid-year accountability meeting with DHSSPS at the time of this submission, however, I note that in the mid-year assurance statement submitted formally to DHSSPS (and approved through Trust Board 27/10/15), in advance of this meeting that reference is made to urology performance against the access standards for outpatients, inpatients and day cases. This is in the context of several services not meeting access standards with no specific highlight given to urology (*relevant document can be located at S21 No 11 of 2022 Attachments, 68. 20151022 MidyearassuranceSHSCTFinal*)

41.2 I have referenced several sets of minutes that cover urology service issues throughout this response, a number from outside my tenure as interim Chief Executive where relevant, for example, at paragraph 57.3 in respect of minutes from January 2015. For 2015/16 I cannot attest that I am providing a fully comprehensive position in terms of all meetings internally and externally as there were many discussions about elective access performance that would have included urology among several other challenged specialties. One such example is referenced in paragraph 54.9, where a paper discussed at the SMT meeting on 29th April 2015, sets out actions being taken to invest at financial risk on a short-term basis to mitigate clinical risk / governance concerns for several acute services, including urology outpatient review backlog longest waits. The paper provides evidence of correspondence and a meeting between myself, as Chief Executive, and Debbie Burns, as Director of Acute Services, with Mrs Valerie Watts, Chief Executive of HSCB, and Mr Dean Sullivan, HSCB Director of Commissioning, escalating these risks. I have not had access to any notes or minutes from said meeting. I am also aware, from emails provided to me relating to urology in 2015/16, of the following meetings with HSCB that I do not believe I attended. Access to any notes or minutes could be sourced via Heather Trouton who was involved in both communications.

a. Regional meeting for urology services 30/4/15 called by Dean Sullivan was to have been attended by Debbie Burns, Heather Trouton, Martina Corrigan, Mr Michael Young (Consultant Urologist), Mr Mark Haynes (Consultant Urologist), Mr Aidan O'Brien (Consultant Urologist) or Mr Anthony Glackin (Consultant Urologist) (*relevant document can be located at S21 No 11 of 2022 folder, 69. 20150401 E and Diary Urology Services Mtg on 30 April 2015*)

b. November 2015 references to a "Regional review of urology and OP gynae regional work stream" (*S21 No 11 of 2022 folder, 70. 20151208 E Regional Review of Urology and OP Gynae Regional Workstream A1*)

I refer back to the Trust Public Inquiry Team to continue to try to confirm that "all notes and minutes" have been provided to the USI. I can confirm that I do not recall any meetings, internally or externally, attended by me about clinical governance concerns with the urology service or any staff member within that service.

41.3 With respect to minutes of one-to-one meetings with my senior management team, and my one-to-one meetings with the Chair, no formal minutes appear to have been kept for these meetings as I have not been able to access same from the Trust Public Inquiry team at the time of submitting this response. As mentioned above, I do have evidence of a meeting arranged with Mrs Esther Gishkori, as Director of Acute Services from September 2015-March 2016, and Mr Kieran Donaghy, Director of Human Resources and Organisational Development (*relevant documents can be located at S21 No 11 of 2022 Attachments, 26. 20150723 E and diary - Mtg with EG and 20150723 E and 27. 20150723 E and diary - Mtg with EG A*) on 28/7/15 to agree her objectives from September 2015 to March 2016 as part of an agreed 6-month trial period post her appointment. This included the following specific objectives related to urology: -

"Implement the Service Development Proposals which have been presented to HSCB for 2015/16 as follows: - d) Ensure that the Urology Team and T&O Team "blue sky thinking" plans are kept alive and expand and maximise the regional

opportunities in Urology” and “Evidence that the Urology and T&O Teams have addressed backlog issues (it is accepted this will not be completed) and are still leading the way in terms of regional performance and meeting new demand by March 2016”.

42. Do you consider that the Board operated efficiently and effectively during your tenure? If not, please describe your experiences.

42.1 Yes, I do believe that the Board operated effectively and efficiently during my tenure as interim Chief Executive in 2015/16 and endeavoured to keep developing to provide good leadership for the 14,000 staff in the Trust. In 2015/16, two Board workshops were held at which members explored strategic issues and planned service developments and a Development Day was held on 12 November 2015 which provided members with the opportunity 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. As referenced in paragraphs 12.1-12.2, the Trust benchmarked with UK peer hospitals for key indicators of efficiency and safety and in 2015/16 remained as one of the Top 40 performing hospitals in the UK for the fifth year in succession, including in the top five in the UK for Patient Safety.

43. Was it your view that the Board was, individually and collectively, motivated to address concerns regarding governance and clinical and patient safety as they arose within Urology Services or more generally? Did they always follow up on concerns raised? Were meetings conducted in an open and transparent manner? What was your experience of the Boards appetite for identifying concerns and implementing lessons learned?

43.1 It is and was at the time of my tenure as interim Chief Executive, my view that Board members were individually and collectively motivated to address concerns raised, including any concerns re governance and clinical and patient safety. It was also my experience that the Board equally had a strong appetite to identify concerns and implement lessons learned. With respect to urology services, I have set out at

paragraphs 26.3-26.5, the urology concerns included under the Corporate Risk Registers in 2015/16 and the important challenge Board members brought to ensure these were being addressed.

43.2 My view is based on my recollection of the personal commitment of Board members to do the right thing and create a culture of openness and speaking up. I believe the open recognition that this culture did not exist everywhere in the Trust in my tenure is evidenced in the whistleblowing and raising concerns survey and the response and minutes of the Board meeting on 26/11/15 regarding this, including actions taken to improve (as detailed in my response to question 77) as well as in the support from Board members in Governance Committee to the review I initiated in 2015 into Clinical and Social Care Governance in the Trust as per my response to question 12. Other reasons for my view include the approach to actively seeking to take learning from investigations (as set out in my response to question 16); evidence of addressing concerns robustly such as the Daisy Hill Hospitals' risks (see my response to question 30); commitment to spend at risk to address clinical risk concerns (as referenced in my response to question 40); and in the evidence of Board member challenges on issues of risk, governance, and safety throughout Board minutes in 2015/16.

43.3 Concerns were always followed up in my experience and opportunities to ensure this was happening included follow up through matters arising/action logs and progress reports into formal meetings, as well as one-to-one meetings between myself and the Chair and, as set out in my response to question 11, between the Chair of Committees with the Chair and myself. Examples of concerns being followed via reports included complaints, RQIA and SAI reporting into Governance Committee as well as the review of the Corporate Risk Register quarterly, and the Board Assurance Framework, bi-annually into Board. The process for following up issues/concerns from Leadership walks was also robust, as set out in my response to question 22.

43.4 The Chair and I held a shared position that the default for Board discussions was that this should happen in public boards unless there were good reasons to hold confidential discussions. It was my experience that Board meetings often ran well

over time in the interests of ensuring due regard was given to hearing all views and being open and transparent. Board meetings in public were advertised to encourage public attendance and transparency and minutes were available on the Trust public-facing internet site. Speaking rights were granted to members of the public via a defined process through the Board Assurance Manager, for example, at the 22/10/15 Board meeting when strategic decisions were being made on the Future of Statutory Residential Homes for Older People. From around October 2015, the Chair also made it her practice ask each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles as professional advisors to the Board. This attests to meetings being conducted in an open and transparent manner.

44. Explain how your performance was appraised, to include how often and by whom, and how this was recorded. How were your performance targets evaluated?

44.1 As interim Chief Executive I had a performance review and annual appraisal with my line manager who, in 2015/16, was Chair of the Board, Mrs Roberta Brownlee. This included setting annual objectives to deliver the objectives and priorities for the Trust in the year ahead, discussing progress at monthly one to one meetings, and the Chair completing an evaluation of my performance as part of the annual appraisal process. This process was used to report to the Remuneration Committee. However, as I left the Trust on 31/3/16, it has been confirmed that no such appraisal was completed or reported to Remuneration Committee for my tenure. I have not been able to access from the Trust public inquiry team at the time of submitting this response evidence of objectives agreed with the Chair when I took up post from 1/4/15.

44.2 I am unclear if the reference to "your performance targets" is the same as my personal objectives. I would therefore add, for clarity, that the performance of the Trust was closely monitored by the commissioning body, the Health and Social Care Board, and the Chair and myself attended two meetings with the Permanent Secretary of DHSSPS (Mr Richard Pengelly in 2015/16) and/or his team as formal accountability review meetings. These were at mid-year and year end. I attended the year end meeting for the year

ended 2014/15 on 16/6/15 and believe the mid-year meeting for 2015/16 was held on 3/12/15 but I have not been able to access any evidence of this nor minutes from the Trust public inquiry team at the time of submitting this response. A “ground clearing” meeting held with DHSSPS officials to agree the agenda was held on 25/11/15 reflecting the focus for discussion on assurance with audit reports, financial plans and performance against ministerial targets (*relevant document can be located at S21 No 11 of 2022 Attachments, 72. 20151125 Diary Ground Clearing Meeting Agenda*) The mid-year assurance statement discussed at this meeting, and which was required to be approved by Trust Board, was discussed at the Board meeting on 22/10/15, and has been provided as supporting evidence (*relevant document can be located at S21 No 11 of 2022 Attachments, 68. 2015102 MidyearassuranceSHSCTFinal*)

45. Please explain how, if at all, the consideration of clinical risk within an area/specialty influenced how you allocated annual budgets for Departments? If you did prioritise clinical risk, what methodology did you use and what criteria did you apply? In other words, how, if at all, did you reflect clinical risk in budget allocation?

45.1 I refer to my response to question 49 to provide the wider context to allocation of budgets at a specialty level. I do not recall the detail of the budget setting process below Directorate level and advise that, for a comprehensive response, the Inquiry could consider seeking further detail from the Director of Finance in 2015/16, Mr Stephen McNally, and the Director of Performance and Reform with responsibility for coordinating the Trust Delivery Plan, Mrs Aldrina Magwood.

45.2 Based on what I can recall, and with reference to documents provided to me or sourced online, I have summarised how I believe clinical risk was considered in the Trust planning processes:

- a. Budgets were generally rolled forward annually with adjustments for a number of factors including inflationary uplifts and additional recurrent allocations made by commissioners into specific services.
- b. Commissioners could also make funding allocations during the year as the quarterly Departmental monitoring rounds were completed. The HSC organisations, through HSCB, would submit clinical risk information to support these monitoring round bids for more funding. This, for example, happened in 2015/16 where clinical risk associated with extending waiting times for elective care resulted in non-recurrent funding being allocated for Quarter 4 that supported additional capacity, including in the independent sector, to be sourced. This was referenced in the Monthly Performance Reports to Trust Board.
- c. Directors were responsible for managing their own budgets with, I believe, some degree of autonomy to commit funding to address issues or risks that they could manage within their budget, e.g., by making savings elsewhere to offset investments.
- d. The Trust planning processes were supported by dedicated financial and planning managers who worked with service teams to identify savings and investment plans for consideration. I believe this included identifying priorities for additional funding consideration that the Trust submitted to commissioners on a standard template called an Investment Proposal Template (IPT). This covered the rationale for investment and any risk it was addressing.
- e. This process was supported by an approach for developing business cases internally. The Annual Report and Accounts for the year ended 31 March 2015 (available publicly online) refer to Trust Guidelines on Business Case Development and Approvals being approved by SMT in May 2014. I recall that the process sought to ensure that projects necessary to support service improvement and address risks and other drivers for change followed a standardised approach. An equality

screening exercise and, where necessary, formal consultation processes including an Equality Impact Assessment were part of this approach.

- f. Criteria for assessing clinical risk were based on the Trust Risk Management Strategy which included a risk impact/consequence model (known as the 5x5 matrix) which was a regional model used across all HSC organisations.

- g. The Trust Risk Management Strategy makes clear that the Corporate Risk Register was shared with the Department of Health mid-year and year end at the Trust's accountability meetings and states on page 25 that:

"... where the resolution of a risk includes funding implications that cannot be contained within the available budgets, a business case should be developed as part of the Trust's business planning process."

46. During your tenure, was it your experience that Departments or specialities sought an increased budget allocation to reflect their specific risk and, if so, what was your response? Please provide specific examples to explain your answer.

46.1 In reviewing minutes from the SMT meetings in 2015/16 and Trust Board there are a number of examples of the processes I have set out in my response to question 45, being used by Departments to seek and secure increased financial allocations. I have provided several of these to demonstrate this was a process used throughout the year:

- a. SMT Notes 8 July 2015 (*relevant document can be located at S21 No 11 of 2022 Attachments, 73. SMT Notes 8 July 2015*). Cases approved included Home Oxygen

Therapy IPT; Establishment of a Minor Stream in CAH ED; Physiotherapy, OT and SW Support within ED; Radiology Services 7 days a week.

- b. 30/9/15 SMT Notes 30 September 2015 (*relevant document can be located at S21 No 11 of 2022 Attachments, 66.* SMT Notes 8 September 2015) A Summary IPT Report was presented by Mrs Magwood which included 12 cases for investment totalling over £1m. These were discussed and finally approved at the meeting on 7/10/15.
- c. SMT Notes 17 February 2016 IPTs (*relevant document can be located at S21 No 11 of 2022 Attachments, 74.* SMT Notes 17 February 2016) for Non-Obstetric Ultrasound and Plain Film Reporting were approved.
- d. 20160324 TB Public Minutes (*relevant document can be located at S21 No 11 of 2022 Attachments, 32b(xviii).* 20160324 TB Public Minutes) A summary of proposals with a capital/revenue value in excess of £300,000 that had been developed between 28/1/16 – 24/3/16 was discussed. It was noted that each project had a risk management process in place to identify and seek to manage/mitigate any impact should these not proceed to delivery following consideration by commissioners.

47. Did you have any personal knowledge whether such a system, which permitted budgetary requests specific to risk management, existed before your time in post?

47.1 Yes, as Director of Performance and Reform from 2009-2015 I was responsible for the Trust corporate planning processes and believe that the processes I recall and have set out in my response to question 45 applied. These processes would have been kept under review to improve and adapt as required in the wider regional planning context and commissioning direction.

48. Are you aware of other Trusts or health care providers who take or apply this risk/budget allocation approach or model?

49.

48.1 I recall that the approach adopted to budget setting and risk assessment was standardised across HSC providers in Northern Ireland in 2015/16 and set within the context of the HSCB Commissioning Plan, as set out in my response to question 49.

50. How, if at all, did you satisfy yourself that the approach taken to risk in allocating budgets was acceptable?

49.1 I recall that the Trust budget was allocated by the HSCB under the Commissioning Plan. This included allocations for programmes of care such as Acute, Mental Health, Elderly Care, etc. along with agreed levels of service to be delivered. This was set out in a formal Service and Budget Agreement. In 2015/16 the Commissioning Plan 2015/16 (*relevant document can be located at S21 No 11 of 2022 Attachments 35. Commissioning Plan 2015-16_0*) section 4 sets out the very challenging financial context for the region and the fact that the Southern area was not being funded in line with its population requirements as assessed under the capitation formulae and that this was an issue to be redressed over time. The Plan states that over £100m of additional key service pressures regionally were identified during the commissioning process of which only £8m was able to be included in the financial plan as these were deemed fully inescapable. The other pressures, which included approx. £45m to address elective care delivery, were not funded and were being fed into DHSSPS monitoring bids. The Plan advises that a comprehensive assessment had been undertaken by Local and Regional Commissioning Leads to identify any significant risk associated with these unfunded service pressures. This assessment acknowledged that the level of funding available to invest in elective care services in 2015/16 was likely to result in a significant and rapid increase in the number of patients waiting and in the length of time they wait for a first outpatient appointment, and for inpatient or day case treatment. The latter was certainly what I experienced in SHSCT which affected a number of services including urology.

49.2 I set this regional position out as context for the approach taken in my tenure to budget-setting and assessing risks across the breadth of services the Trust provided. I believe the Draft Financial Plan approved by the Trust Board in March 2015, and referenced in paragraphs 1.5 and 1.6, provided myself and the Board with assurance

that the approach adopted in allocating budgets did take due account of risk. As examples of this assurance, I refer to two extracts from the Plan:

- a. *“Vacancy Control Measures – The Trust implemented a range of vacancy control measures in 2014/15 and it is proposed that these measures continue during 2015/16. The main aspects will include targeting a significant reduction in flexible workforce spend and delaying recruitment. The majority of these workforce measures will be opportunistic; however, the Trust will continue to ensure that it concentrates resources on the most critical services to avoid risk to patient and client safety and quality of care. The Trust will continue to ensure close monitoring of these actions and target vacancy control on a rolling basis to minimise impact on any one service..”*

- b. *“Temporary change to the operational hours of South Tyrone Hospital (STH) children’s ambulatory paediatric unit. In November 2014, following the Southern Trust announcement of plans to save £2.9m by the end of March 2015 the hours of operation of the STH ambulatory service were temporarily changed from 9am - 5pm to 9am - 1pm from Monday to Friday. Paediatric advice lines for GPs and other health and social care staff remain accessible at Craigavon and Daisy Hill Hospitals from 9am to 10pm. The Trust has maintained regular monitoring of activity levels within the unit at STH and the ambulatory service at CAH to assess the impact and manage any risks. This analysis has demonstrated that on average 5 less patients are being seen per week at with approximately 1 additional patient per week seen in the ambulatory unit in CAH from the Dungannon area. The Trust proposes to continue these temporary measures during 2015/16.”*

49.3 Below Trust-level planning, assurance on management of risk was with each Director. The Trust Financial Plan was reflected into the setting of Directorate and service budgets approved by Trust Board at its meeting on 28/5/15. Minutes from this meeting (*relevant document can be located at S2I No 11 of 2022 Attachments, 32b(iv). 20150528 TB Public Minutes*) indicate that Stephen McNally, Director of Finance, tabled a paper to set the SHSCT Financial Resource Budget (ST601/15), advising that, following agreement in principle of the Board to the proposed resource

budget of £557.4m, a detailed resource budget would be confirmed to all budget holders together with a paper on the financial framework within which Resource Budgets must be managed. Further detail on this could potentially be accessed from Mr McNally.

Urology services/Urology unit: Staffing

I refer to Question 3 paragraph 2 of the instant section 21 Notice (No.11 of 2022) in which it is stated that “*All questions asked in this notice refer to the period of your tenure as Interim Chief Executive*”. In answering the questions below I have responded in my earlier roles with SHSCT only where this is relevant to the question asked and where I have specific recollection of some potentially relevant information. When I refer to my earlier roles, I mean my roles back to 2009, i.e., acting DPR from September 2009, and then substantive DPR from March 2011 to March 2015. I would like to state that I have little recollection of the specifics of many matters given the passage of time (some 12-13 years in the case of events in 2009/2010) but I have responded as fully as I can, with reference to what I believe to be the most relevant documents to the TOR of the Inquiry

51.The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

50.1 The evidence I have been provided with by the SHSCT Public Inquiry Team to help me recall my involvement during 2010, when the implementation plan was being developed, is included in the following most relevant documents:

- a) HM700 - ltr to Trust Dir Acute re Urology Review Implementation.pdf (*relevant document can be located at S21 No 11 of 2022 Attachments, 76. HM700 - ltr to Trust Dir Acute re Urology Review Implementation*) from Hugh Mullen, Director of Performance Management and Service Improvement HSCB, dated 27/4/10 that I was copied into as a Trust Director of Performance;
- b) Email from Emma Stinson 23/4/10 including papers for the first Urology Steering Group Meeting held on 13th May 2010 (*relevant document can be located at S21 No 11 of 2022 Attachments, 77. Steering Group Meeting - 13th May 2010*) which I was invited to;
- c) Team South Implementation Plan v0.2 (June 2010) (*relevant document can be located at S21 No 11 of 2022 Attachments, 78. Team South Implementation Plan v0.2*) and Team South Implementation Plan V0.3 (09 Nov 10) (*relevant document can be located at S21 No 11 of 2022 Attachments, 79. Team South Implementation Plan V0.3*)
- d) Investment Proposal Template for the Southern LCG (December 2011) and the associated Urology Team South Business Case (Approved SHSCT SMT 8 Feb 12) *Urology Revenue IPT Feb 2012 (relevant document can be located at S21 No 11 of 2022 Attachments, 80. Urology Revenue IPT Feb 2012)*

50.2 My role in the Trust from September 2009 to March 2015 was as Acting Director of Performance and Reform (to March 2011) and then substantive Director to 31 March 2015. My involvement in the implementation of the Team South Urology service was primarily to support the operational Director of Acute Services with responsibility for urology services, Dr Gillian Rankin, in developing a business case and associated implementation plan in response to the regional review recommendations and then securing approval of this business case from HSCB. I have been reminded of this in evidence provided by the Trust Public Inquiry Team including an email from me on 17/4/10 to Sandra Waddell, Head of Planning in Acute Services in my team, setting out a range of actions to develop the business case (*relevant document can be located at S21 No 11 of 2022 Attachments, 81. FW for action - FW Urology Review*) I would also have been in regular discussion with commissioners (in HSCB and the Southern Local Commissioning Group) as part of annual planning processes responding to the HSCB Commissioning Plan and

Ministerial standards and targets, in agreeing additional recurrent or non-recurrent funding to address gaps in clinical service capacity. Further information on this involvement is included in my response to question 53 below.

50.3 From reviewing the documentation from 10-12 years ago I am reminded that I was a member of the Team South Urology Steering Group which served as a Project Board that oversaw a project structure to establish the Team South service. This was chaired by Dr Rankin. Mrs Sandra Waddell (Head of Planning - Acute Services in 2010) supported the Project Team, which was chaired by Mrs Heather Trouton (Acting Assistant Director of Acute Services – Surgery & Elective Care in 2010).

50.4 I have requested but have not been provided with any minutes or update reports into or from the Steering Group following the inaugural meeting on 13/5/10.

52. What, if any, performance indicators were used within the urology unit at its inception?

51.1 I have reviewed the documents referenced in paragraphs 50.1 b) to d) above, provided by the SHSCT Public Inquiry Team and note that these refer to the following performance indicators:

- a. The implementation plan, Nov 2010 section 3, refers to *“the Trust’s intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.”*
- b. The Investment Proposal Template advises that the HSCB Performance Management and Service Improvement (PMSI) directorate was working with Trust management and clinicians across each of the Trusts setting up urology units to agree a range of service quality indicators and clinical quality indicators.

51.2 I have no further information on the detail of the development of these specific indicators, however, the urology service before and after implementation of Team South was assessed on an on-going basis against the extant performance targets set by the HSCB. In 2010/11 these were called Priority for Action (PfA) Standards and Targets. Performance was reported at each Public Board against these targets and compliance with elective access targets was also the subject of regular performance meetings with HSCB and DHSSPS, as performance across all Trusts was reported regionally in HSCB public meetings. As an example of reporting, on 24th June 2010 when Team South was in the process of being set up, the Performance Report to the Trust Board (ST 256/10) (*relevant document can be located at S21 No 11 of 2022 Attachments, Trust Board 2007 - 2022 including packs from 2016/ 20100624 Performance Report to TB*) advised publicly on the following position against the urology elective access targets applying during May 2010:-

- a. Page 12 “*OPs - 1633 OPs Confirmed waiters >9 weeks: ...401 Backstop (all seen within 17 weeks) 138 x Urology, 21 x Urology ICATS, > 17 week: 9 x urology Diagnostics – 81, 14 Urodynamic*”.

51.3 This meant that there were 1633 people waiting on an outpatient assessment more than the target of 9 weeks. 401 people were waiting between 9 and 17 weeks, which was the accepted longest “backstop” target agreed with the HSCB where services had an accepted challenge in meeting demand, of whom 138 were in urology consultant services and 21 in urology ICATs services. 9 people waited longer than 17 weeks for a urology outpatient appointment and 81 people waited longer than 17 weeks for a diagnostic assessment, of whom 14 were in urodynamics. The same report also reported on in-patient and day-case waiting time performance as follows;

- a. “*IP/DCs - 1079 Inpatient / Daycases – Confirmed >13 weeks: 13 Week backstop but within 17 Week: 70 Uro, Backstop >17 Week: 114 Uro,*”.

51.4 This meant that 1079 people were waiting longer than the target of 13 weeks for an inpatient or day case procedure. 70 people were waiting between 13 and 17

weeks for urology treatment, which was the accepted longest “backstop” target agreed with the HSCB where services had an accepted challenge in meeting demand. 114 people waited longer than 17 weeks.

53. Was the '*Integrated Elective Access Protocol*' published by DOH in April 2008, or any previous or subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants and staff in the SHSCT? If yes, how and by whom was this done? If not, why not?

52.1 It is my understanding that the '*Integrated Elective Access Protocol*' published by DOH in April 2008 remained extant for the whole period I worked at the Trust from March 2008. As Director of Performance and Reform (acting from September 2009, substantive March 2011 to March 2015), my performance team was in a support role to the operational Directorates who were responsible for ensuring the requirements of the Protocol were being applied. I had no responsibility for outpatient booking and referrals as this function had transferred out of the portfolio of the Director of Performance and Reform before I took up post in September 2009. I did not personally disseminate the IEAP, having only joined the Trust in March 2008 as an Assistant Director of Performance Improvement. I had a brief discussion with Mrs Lesley Leeman, who was my Head of Performance in 2008, to remind me about the IEAP processes at that time and how this was disseminated, and she confirmed that training had been led by the Operational Service Managers within Acute Services and this had primarily targeted admin and booking staff. Specific information regarding dissemination to urology consultants and to wider staff across the Trust might be best sought from the Director of Acute Services in 2008 (Mrs Joy Youart) and the Director of Performance and Reform at that time (Mrs Mairead McAlinden).

52.2 I have been reminded by reference to documents provided to me by the Trust Public Inquiry Team that, in January 2015 when I was Director of Performance and Reform, the HSCB had completed a short pathway review to “*assess the systems and processes currently in place for the booking of outpatient services regionally to ensure they support the consistent application of the Integrated Elective Access Protocol*”

(IEAP).” The performance against chronological management at speciality level within each Trust was analysed and those specialties with a higher percentage of routine new outpatients being seen out of chronological order were selected for review. In addition, specialties where there was a particular concern regarding patients currently waiting over 9 weeks were also selected for review. Five specialties were identified for review across the region including urology. The report from this audit was sent to Mrs Aldrina Magwood as Acting Director of Performance and Reform in June 2015/16 by Mr Michael Bloomfield, HSCB Director of Performance and Corporate Services (*relevant document can be located at S21 No 11 of 2022 Attachments, 82. MB334 - ltr to Aldrina Magwood re Review of OP booking processes*).

52.3 With respect to training and understanding of staff, section 6 of the report states that *“Staff are aware of the IEAP and were able to show examples of local policies and procedures to follow. There is an ongoing process for refresher training on IEAP, which will include specific training for all relevant staff on correct recording of clinical priority type.”* This provides some evidence that dissemination was achieved, particularly for booking staff, noting that one of the report recommendations was that *“All booking staff should receive refresher training on the IEAP standards on a regular basis.”* Further information on this review is provided in my response to question 53.

54. How, if at all, did the 'Integrated Elective Access Protocol' (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of that protocol or any previous or subsequent protocol? What action, if any, was taken (and by whom) if time limits were not met?

53.1 The urology service was the same as any other clinical service and was expected to operate under the IEAP. Responsibility for management, oversight and governance of urology was as set out in my response to questions 7 and 8 above. The Director of Acute Services and her service operational team were responsible for managing, overseeing, and governing the urology service to comply with extant

standards and guidelines which would have included the IEAP and the access targets stated at section 4.0 of the Protocol (*relevant document can be located at, Relevant to Acute/ Document Number 6/ 20080430 No.6 Integrated Elective Access Protocol*) and the prevailing commissioning plan access targets in each year. Detail of how the IEAP was specifically delivered within urology services might be more completely answered by the Head of Service for urology services Mrs Martina Corrigan and Mrs Katherine Robinson (Head of the Booking Centre).

53.2 I recall that compliance with time limits for urology services against the Protocol was monitored through performance reporting within an overall performance management framework (*relevant document can be located at S21 No 11 of 2022 Attachments, 83. Performance Framework Version2 PROGRESS REPORT JUN09*). As advised in my response to question 51, performance on the access targets was reported at every public board meeting and compliance with elective access targets was also the subject of regular performance meetings with HSCB and DHSSPS as performance across all Trusts was reported regionally in their Board meetings. I recall that compliance with the IEAP was an ongoing issue for assurance from operational Directors into Performance Reporting that I became responsible for as Director in September 2009. An example of this can be referenced in the Monthly Performance Report for October 2015 presented to public Board on 26/11/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 46. 20151126 Performance Report a*). The covering template to the report summarises SMT discussion and challenge and specifically refers to assurance being sought on adherence to the IEAP, strict chronological management and DNA/CNA practices as well as to assurance sought on ongoing validation of waiting lists by service leads.

53.3 In 2015/16, during my tenure as interim Chief Executive, the pathway review completed by HSCB and referenced in paragraph 52.2 assessed the systems and processes in place for the booking of outpatients in urology services against the Integrated Elective Access Protocol (IEAP) with a specific focus on performance against chronological management. Key findings from that report were as follows:

- a. Regarding Triage times, it was reported that, "*For the majority of urology*

referrals, daily triage is now achieved, but there is a long-standing issue with turnaround time from one consultant and referrals not returned from triage continues to be a key issue for booking staff."

- b. Regarding clinic templates it was reported generally that clinic templates *"are carved out to new urgent, new routine and review slots in line with best practice."* For Urology specifically it was reported that *"since December 14, all clinic slots are designated red flags. Unallocated slots are notified to the Referral and Booking Centre who book with patients from the PTL, selecting urgent patients first, and then proceeding to routines. Urgent patients are mostly being booked within 4-6 weeks, but the waiting time for new routine patients is currently at 40 weeks."*
- c. With respect to chronological management, it was reported that, *"in some specialties, e.g. urology and ophthalmology, the Referral and Booking Centre will be contacted by referrers with information about a change in clinical priority and a second referral usually sent in. Staff will administer this on the system, retaining the patient's original date but amending the clinical priority and appointment type. This can mean that sometimes urgent patients will appear to have waited longer than routines."*
- d. Regarding booking processes, it was reported that, *"The process for booking new routine and review patients is in line with regional guidance. In the new urology model, all patients are now telephone booked."*

53.4 The relevant recommendations from this process and noted in 1 and 2 below:

Prioritisation of referrals: Daily Triage for Red Flags Within 3 working days for other referrals	1. Where the 3-day turnaround standard is not being met, a process should be agreed with clinicians whereby the referrers' priority is accepted and the booking staff proceed to book urgent appointments. 2. The areas outlined with particular challenges with late triage / missing referrals should be escalated as a matter of urgency. 3. A process should be put in place to ensure that all staff who book or make changes to appointments make the correct amendment to clinical priority type.	By the end of September 2015

53.5 I have some recollection of being generally aware of the issues raised in this report regarding daily triage and that the reference to turnaround time for one consultant referred to Mr O'Brien, as well as a general awareness of the recommendation that I believe was made by HSCB to five Trusts in the region, to agree a process for using the referral priority grading for a patient where the 3-day turnaround standard was not being met. I have not seen, nor do I recall, any escalation of the issues in this report formally into SMT, Board or to me as interim Chief Executive and expect I was aware as the review commenced when I was Director of Performance and Reform, and through informal discussions/one to one meetings with the extant Acting Director of Acute Services, Debbie Burns and Acting Director of Performance and Reform, Aldrina Magwood. As interim Chief Executive, I would reasonably have expected that follow up on the recommendations was the responsibility of these two Directors and the incoming Director of Acute Services, Mrs Esther Gishkori from August 2015, working together. I refer to this matter again in my response to questions 96 and 97.

53.6 If IEAP time limits were not being met there were a range of actions taken. These actions were the responsibility of the urology operational service team and information on this could be sought from Mrs Martina Corrigan, Head of Urology Services. With respect to improving performance against the access targets, actions were reported at a corporate level in the Monthly Trust Performance Reports. This usually included actions to improve performance within existing capacity as well as actions to identify gaps between the capacity of the team to deliver and the demand for assessment and treatment, and secure support from commissioners to invest to close those gaps. Examples of both types of actions, that I have seen reference to in the documents provided to me by the Trust Public Inquiry Team, include moving procedures normally undertaken as an in-patient admission to a day case admission (as proposed for the TURP procedure in the April 2010 baseline assessment against Regional Review of Adult Urology Services update (item 11 in the paper included in papers in 50.1b above). Addressing the lack of capacity for urology services regionally and locally to achieve elective standards was part of the Regional Review. As at June 2010, the Performance Report to the Board (ST 256/10) (*relevant document can be located at S21 No 11 of 2022 Attachments*, Trust Board 2007 - 2022 including packs

from 2016/20100624 Performance Report to TB) advised publicly that there were actions being taken to address capacity gaps for a number of services including urology. Page 34 states:

“The Trust will be meeting with HSCB to discuss specialty specific areas where it has identified capacity gaps; some of these capacity gaps were partially met through agreed investment in 2009/10, including ophthalmology and endoscopy and some of which are new capacity gaps which have been defined more recently including general surgery and rheumatology. In relation to recurrent investment allocated in 2009/10 the Trust continues to progress implementation plans to secure sustainable service solutions. Further to the outcome of the review of urology services, circa £1.19m has been allocated for the implementation of urology services in Team South. This includes the combined Southern and Fermanagh area of the Western Trust. An implementation plan is being progressed detailed our proposals against the review recommendations and will include a proposed service model. This will be submitted to HSCB in June”.

53.7 Similar action is reflected in 2013 and 2015 in paragraph 54.9.

55. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust’s plan to deal with this backlog.

I. What is your knowledge of and what was your involvement, if any, with this plan

54.1 My involvement with the overall Team South Implementation Plan is as set out in my response to question 50. With respect specifically to addressing outpatient review backlogs, my knowledge comes from review of the documents provided to me as I did not recall this level of detail from some 12 years ago. I have noted that the Team South Implementation Plan v0.2 (*relevant document located at S21 11 of 2022*

Attachments 78. Team South Implementation Plan v0.2) refers to “a substantial backlog of patients awaiting review at consultant led clinics. The total number of patients is 4,037. The Trust’s plan to deal with this backlog has been included as Appendix 2”. The Team South Implementation Plan v0.3 (09 Nov 10) (relevant document located at S21 11 of 2022 Attachments, 79. Team South Implementation Plan v0.3) refers to “a substantial backlog of patients awaiting review at consultant led clinics. The trust has submitted a plan to deal with this backlog and implementation of this plan is in progress”. Section 4 in both reports advises of the assumption that separate funding would be provided to clear the review backlogs so the cost of these actions is not included in the Team South Business Case. Appendix 2 in the June 2010 Plan sets out a brief summary of actions, including identifying patients who may be at risk and require an urgent review; identifying patients who require a consultant reassessment in an agreed timeframe; cleansing lists to ensure that there are no duplicate open requests for the same issue. The Specialty Nurses had agreed to coordinate the process by reviewing patient centre letters and results.

54.2 In my role as Director of Performance and Reform, I was responsible for reporting on overall performance to Trust Board, supporting operational Directors in targeting improvement support, and in negotiating with commissioners for additional capacity. I do not recall this specific backlog plan nor anything about my direct involvement in its implementation. Delivery of a service plan for managing backlogs for review patients was the responsibility of the Director of Acute Services, Dr Gillian Rankin in 2010, and her team.

II. How was it implemented, reviewed and its effectiveness assessed?

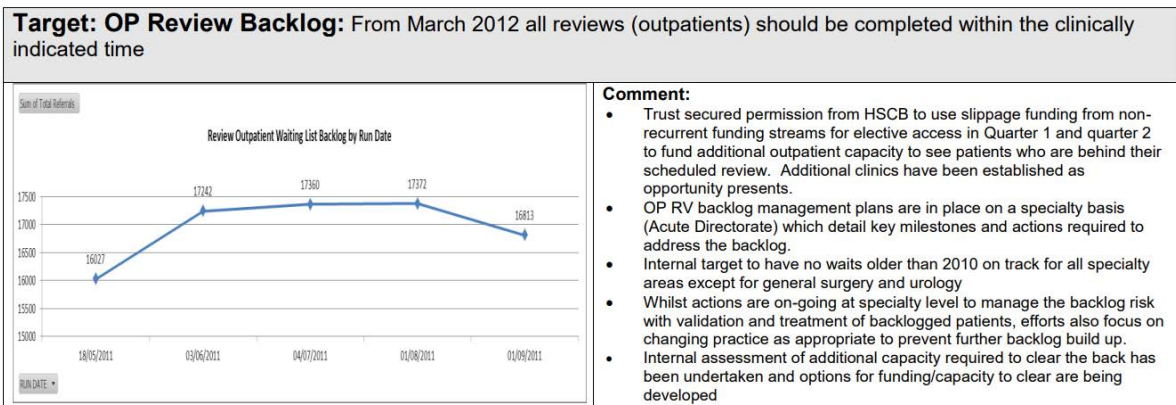
54.3 Responsibility for implementing the action plan within urology, including recruiting staff and accessing independent sector capacity, was with the Assistant Director for Acute Services (Surgery) who was Heather Trouton in the period 2010-2016, under the direction of Dr Gillian Rankin, Director of Acute Services (January 2010-March 2013). Detail regarding implementation monitoring processes would require to be raised with these people. I would have expected that implementation progress and impact would have been reported into the Team South Implementation

Steering Group, of which I was a member. I have requested, but at the time of submitting this statement I have not received, minutes or update reports into or from the Steering Group following the inaugural meeting on 13/5/10. I cannot therefore confirm if such updates were brought to the meeting at this at this time.

54.4 With regard to reviewing progress and effectiveness, this was the responsibility of the Director of Acute Services. I do recall, but have not located evidence, that Dr Rankin reported into SMT on progress with backlog reduction plans and that this matter was also a regular topic of discussion at Governance Committee. My understanding of this 2010 backlog plan for urology comes from my perspective as Director of Performance and Reform responsible for reporting on overall performance to Trust Board not as the Director leading the implementation actions. From the review I have been able to complete of some of the substantial number of documents provided by the SHSCT Public Inquiry Team going back to 2010 (such as, e.g., monthly Trust Board minutes and monthly performance reports), I am reminded of the ongoing focus on addressing the outpatient review backlog across several clinical specialities, including urology as provided below, and in paragraph 54.9

54.5 The newly established CORPORATE PERFORMANCE DASHBOARD for August 2010, reported to Trust Board on 30/9/10 (*relevant document can be located at S21 No 11 of 2022 Attachments, 84. 20100930 TB Confidential Minutes*) by myself as acting Director of Performance and Reform, reported on the position with review backlogs April to September 2010 and outlined actions to address this.

54.6 This reporting and discussion by Board continued into 2011/12 when the HSCB established a new target that, from March 2012, all reviews (outpatients) should be completed within the clinically indicated time. The position and actions at 29/9/11 were reported as follows in the Corporate Performance Dashboard September 2011 (*relevant document can be located at S21 No 11 of 2022 Attachments, 85. 20120929 Performance Dashboard B*) for all specialties affected, not only urology:-



54.7 This reporting indicates that, while implementation of the specific 2010 backlog reduction plan may have been effective, this impact was not sustained.

III. What was your role, if any, in that process?

54.8 My role is as set out at 54.1 and 54.2

IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

54.9 I refer to my response under 52.2 above regarding my knowledge of the plan and the fact that any positive impact on backlog review patient waiting times was not sustained. During my tenure as Director of Performance and Reform and as interim Chief Executive in 2015/16, timely access to assessment, treatment and review within the urology service continued to be a challenge reported to the Trust Board in monthly Performance Reports and discussed with commissioners and DHSSPS in relation to compliance with access standards and targets. As referenced in my response to question 55, the impact of these issues on patient care was recognised in the Corporate Risk Register. I have provided three examples to demonstrate that the Trust maintained transparency on these challenges and the actions to continue to address the issues over the years from 2010, however, a full review of every performance report from 2010 could be undertaken by the Trust Public

Inquiry Team should this be relevant: -

- a. Trust Board public meeting 26/9/13 minutes (*relevant document can be located at Trust Board 2007 - 2022 including packs from 2016/20130926 TB Public Minutes*) “*Urology: Mrs Clarke stated that Urology continues to present an ongoing risk which is the subject of regular discussion with the Health and Social Care Board and they have accepted the workforce constraints affecting this area of performance. Given the regional challenges with this specialty, agreement has been reached to reconvene the regional process.*” The actual Performance Report (*relevant document can be located at S21 No 11 of 2022 Attachments 86. 20130926a Performance Report to TB*) presented at this meeting includes the following detail that refers to a number of specialties not just urology.
 - i. “*The majority of clinical specialty areas will achieve the maximum waiting time for outpatients of 15-weeks by the end of September with the Trust projecting that 4 areas including urology will not achieve this position. This relates in part to medical staffing issues*”. Further urology was noted as one of 2 Inpatients/day case specialty areas that would not achieve a maximum wait of 26 weeks. This is noted as due to staffing issues and significant volumes of urgent/red flags patients creating long waits for routine patients. Urodynamics was the only area of diagnostics noted as expected to exceed the 9-week maximum waiting time by September 2013.
 - ii. This projected overall position had been recognised by HSCB as good in regional comparisons, with a low number of specialty areas not attaining the target access times but key performance risks remained which were attributed to a number of common factors across services including; recurrent investment not yet been completed nor embedded in systems to allow teams to routinely achieve the required level of performance; impact of disproportionate lost core capacity associated with bank holidays and the summer leave period; impact of sickness, maternity and other absences in

the medical workforce and associated challenges in securing backfill capacity in general and within current funded resources; continued pressures on demand in some areas including nonelective demand, urgent and red flag referrals.

- iii. During August it was reported the Trust had successfully recruited to the vacant Consultant Urology post. The report advises the Trust *“has a plan in place to improve performance and a meeting arranged in September with the Commissioner to review this in the context of the regional challenges with this specialty”*
 - iv. Urology remained the area of internal focus for 62-day cancer diagnosis and treatment with the report advising performance was affected by the overall manpower issues being experienced in this specialty area, which had been discussed with the commissioner.
 - v. Actions referenced to address this situation included the Trust securing capacity in NHSCT for a cohort of long wait urology patients and appointment of the replacement 5th consultant post which would increase capacity in Q3/4. The Trust had discussed challenges in securing and retaining staff with the commissioner and was developing plans to increase capacity in the short term.
- b. On 29th April 2015, a paper was tabled by the Director of Acute Services, Debbie Burns, at SMT (*relevant document can be located at S21 No 11 of 2022 Attachments*, 3. 20150427_ContingencyOptionsASDSMT_Paper_V1_0_LLappin) This set out the actions being taken to invest at financial risk to the Trust on a short-term basis, to mitigate clinical risk / governance concerns for several acute services, including urology outpatient review backlog longest waits. The paper provides evidence of both correspondence, and a meeting, between me (as Chief Executive) and Debbie Burns (as Director of Acute Services) with Mrs Valerie Watts, Chief Executive of HSCB and Mr Dean

Sullivan, HSCB Director of Commissioning escalating these risks which resulted from *“lack of commissioned capacity in the context of reduced levels of non-recurrent funding anticipated in Q1/2”*. The paper identifies that because of this escalation, some non-recurrent funding had been agreed for April 2015, but contingency options were proposed for consideration should funding not be available to continue to manage this risk from May 2015. Specific issues for urology services set out were:

- i. *“Out-patient review waiting list backlog – 2925 patients past their clinically indicated timescale for review @ 1/4/15”. Actions were to “Continue patient validation exercise to clear 2012 and Re-validate urgent within 2013 2014 patients”.*
- ii. Contingency options being considered should funding not be provided from May 2015 included:
 - *“Option 1: Due to the clinical/ward-based commitments around maintaining red flag and cancer pathway and long IP/DC waits in excess of 80 weeks and the new operational OP model no immediate options present to displace consultant medical staff work within this speciality. Engagement required with clinicians to ascertain any options for displacement of other work.*
 - *Option 2: Stand down newly agreed blue-sky model which is reliant upon MD (sic multidisciplinary) working and revert to traditional OP model utilising Nurse-Specialists to undertake additional review capacity. Comment/Impact: Inability to test blue sky model as agreed with commissioner; Loss of morale and longer-term sustainability within specialty; Unacceptable to clinic team”*
- iii. Notes from the meeting do not detail the discussion but confirm that

“Members considered the performance issues identified and discussed and agreed those to proceed and those to be escalated to the Commissioner. Mr Gibson agreed to progress.” Further detail on the actions taken can be secured from Mr Simon Gibson, Assistant Director Acute Services, who was representing Mrs Debbie Burns, Director of Acute Services, at this SMT meeting.

- c. The Monthly Performance Report presented to Trust Board public meeting on 26/11/15 cover sheet sets out that there were continued issues with backlogs in reviews with the Trust recognising the importance of maintaining visibility of this issues by stating:
 - i. *“While not formal commissioning plan targets, this report also considers a range of other important related indicators which impact on the Trust’s overall performance including Reviews and Reporting beyond ‘clinically indicated’ timescales. This Report further set out performance on Acute Outpatient Reviews as follows:*
 - ii. *“Acute Outpatient reviews - Patients waiting beyond their clinically indicated timescales: Lead Director – Mrs Esther Gishkori, Director of Acute Services (Not a formal CP target)” indicating that of the 20,626 patients waiting for review appointments beyond their clinically indicated date at 1 November 2015 the majority of these, 18,313 relate to Acute consultant outpatient services, with approximately 1598 paediatrics and 715 ICATs.*
 - *44% of those waiting are in excess of 6-months;*
 - *15% are waiting between 3 – 6 months; and*
 - *41% are waiting less than 3-months for a review.*
 - iii. *Longest Trust waits are in urology, with 472 patients waiting from 2012/13. All these patients have been validated and a significant proportion will have been made previous offers which were*

unsuitable for the patient. Capacity has been put in place to address this long waiting cohort over the next few months. Internal redirected resource will provide capacity to target over 5000 of our longest waits across a range of specialty areas before the end of March which will minimise the volume of patients waiting beyond their clinically indicated timescale for review”.

iv. Actions to Address the overall backlog in review, not only for urology in the report included:

- *“Arrangements in place to minimise risk and ensure reviews with high clinical priority take place in accordance with the clinically indicated timescale.*
- *Trust undertook a data and patient validation programme to review patients waiting beyond their clinically indicated date. This was resourced internally by the Trust until March 2015.*
- *The Trust has highlighted the on-going emergent risk in the clinical pathway from review patients waiting beyond their clinically indicated timescale to HSCB. HSCB acknowledging the issue but have currently no additional resources available to support this. HSCB have indicated that should additional monies become available they would be happy to consider this, and*
- *The Trust in the interim continues to re-direct internal resources to this area as it becomes available or where clinical risk is identified.”*

54.10 The reasons presented in these reports as to why outpatient review backlogs remained an issue after 2010 provide the basis for my understanding of why the 2010 Implementation Plan did not fully achieve its aims.

56. As far as you are aware, were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

55.1 My responses to questions 41, 53 and 54, exemplify a sustained focus on issues with capacity and performance against access standards in urology services. I have reviewed a sample of Corporate Risk Registers from 2010/11, when the Implementation Plan was being developed and progressed, and more specifically from my tenure as interim Chief Executive in 2015/16.

55.2 The Corporate Risk Register was discussed at Governance Committee meetings 4 times per year and the Board Assurance Framework (BAF) biannually at Trust Board. The following issues of relevance to the Inquiry are reflected in these Risk Registers and associated minute extracts where relevant.

55.3 The Corporate Risk Register as at June 2010 presented to Governance Committee on 7/9/10 (*relevant document can be located at S21 No 11 of 2022 Attachments, 87. 20100907 CRR a*). This refers to a moderate rated risk to ongoing achievement of Access Targets and review appointments. No specific reference is made to urology services, however, the actions include a reference to Heads of Service meeting with relevant consultants on a monthly basis.

55.4 The Corporate Risk Register for August 2015 presented to Governance Committee on 8/9/15: (*relevant document can be located at S21 No 11 of 2022 Attachments, 88. 20150908 CRR*) – The first two risks summarised below refer specifically to Urology.

- a. High Risk to Achievement of Elective Commissioning Plan Standards and Targets indicates that areas of risk highlighted to Health and Social Care Board formally include Urology (OP Review Backlog) as one of 6 clinical specialities and that the Trust will continue to re-direct internal resources to areas of

greatest risk as funding becomes available or as operationally feasible.

- b. High Risk to ability to recruit/retain Consultant medical staff for specific specialties excludes urology under risks in Consultant Medical Staff but indicates in SAS Medical Staff in 6 clinical services including urology. This is further covered in my response to question 57.

A further risk relating to Out-Patient Review and Planned Treatment Backlogs is on this August 2015 Risk Register as a high risk but does not specify urology. Detail on the specialty position for reviews was provided in Monthly Performance Reports (see response to question 54). It was noted that no non-recurrent funding had been received from HSCB in 2015/16 for the outpatient review backlog.

55.5 The Corporate Risk Register presented to Governance Committee on 8/12/15: *(relevant document can be located at S21 No 11 of 2022 Attachments, 52. 20151208 CRR)* recorded: -

- a. *"High Risk to Achievement of Elective Commissioning Plan Standards and Targets indicates that areas of risk highlighted to Health and Social Care Board formally include Urology (OP Review Backlog) as one of 6 clinical specialities and that the Trust will continue to re-direct internal resources to areas of greatest risk as funding becomes available or as operationally feasible.*
- b. *High Risk relating to Out-Patient Review and Planned Treatment Backlogs indicates that at 1 November 2015, there were a total of 20,627 patients waiting in excess of their clinically indicated timescale for review out-patient appointment of which 44% (9155 people) were waiting in excess of 6-months past their clinically indicated timescale. The longest waits were noted to be in Urology extending back to 2011/12. It was assured that all patients for 2011/12 and 2012/13 had been validated and those waiting from 2011/12 have all been offered an appointment date. It was noted that no non -recurrent funding had been received from HSCB in 2015/16 for the outpatient review backlog.*
- c. *High Risk to ability to recruit/retain Consultant medical staff for specific*

specialties excludes urology under risks in Consultant Medical Staff but indicates in SAS Medical Staff in 6 clinical services including urology”

55.6 The discussion at Governance Committee on the outpatient backlog risk, and specifically urology, has been referenced in my response to question 26 but replicated here for ease. The minutes of the Governance Committee meeting indicate discussion regarding longest waits for outpatient review appointments as follows:

“Mrs Magwood (Acting Director of Performance and Reform) 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 (interim Chief Executive) 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”

55.7 The Corporate Risk Register presented to Governance Committee 4/2/16 (relevant document can be located at S21 No 11, 58. 20160204 CRR) recorded:

- a. *“High Risk to Achievement of Elective Commissioning Plan Standards and Targets indicates that areas of risk highlighted to Health and Social Care Board formally include Urology (OP Review Backlog) as one of 6 clinical specialties and that the Trust will continue to re-direct internal resources to areas of greatest risk as funding becomes available or as operationally feasible.*
- b. *High Risk relating to Out-Patient Review and Planned Treatment Backlogs indicates an improving position. As at 1 January 2016, there were a total of 18,065 patients waiting in excess of their clinically indicated timescale for review out-patient appointment with 41% (7407 people) waiting in excess of 6-*

months past their clinically indicated timescale. The longest waits were again noted to be in Urology extending back to 2012/13 with all patients for 2012/13 having been validated and those waiting from 2012/13 had all been offered an appointment date. It was noted that no non-recurrent funding had been received from HSCB in 2015/16 for the outpatient review backlog.

- c. High Risk to ability to recruit/retain Consultant medical staff for specific specialties excludes urology under risks in Consultant Medical Staff but indicates in SAS Medical Staff in 6 clinical services including urology."*

55.8 The role of the Director of Acute Services for governance and management is set out in paragraph 7.2-7.7 above. This includes ensuring that a sound system of governance was in place supported through the managerial and clinical operational leads and including incidents, complaints, risk register, patient safety and clinical indicators. Equally the Trust (*relevant document can be located at Ongoing Discovery May 2022/Document Number 2 iii a/201809 Risk Management Strategy*) sets out roles and responsibilities for managing and reporting risk. It was therefore predominantly the role of the operational Director to ensure issues and risks in urology were raised at the appropriate level within the Trust, however, the Director of Performance and Reform was responsible for providing the Board with the Monthly Performance Reports and highlighting any key risk to the achievement of the Trust's objectives. Information regarding the specific minutes of meetings and Risk Register content within the Acute Services Directorate should be accessed through the Director of Acute Services at the time the Implementation Plan was in development in 2010/11, Dr Gillian Rankin, and during my tenure as interim Chief Executive, Mrs Debbie Burns to August 2015 and Mrs Esther Gishkori from August 2015.

57. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

56.1 I refer to my responses in paragraph 1.7, question 51, paragraphs 53.3 and

54.9, and question 96, that demonstrate that issues in fully meeting access standards and reviewing outpatients within clinically indicated timescales within urology services persisted, despite the implementation of the Regional Implementation Plan approved by the Minister in March 2010.

56.2 This performance, among other clinical services, was the focus of on-going Trust Board scrutiny as well as regional discussion and action from 2010 until I left the HSC system on 31/3/16. As examples, paragraph 1.7 extract from the 2015/16 Trust Delivery Plan, refers to another regional review and implementation process being progressed for urology by the HSCB by December 2015 and minutes of the Trust Board meeting of 28/5/15 indicate discussion on outpatient reviews under the Monthly Performance Report with myself as interim Chief Executive advising:-

“..that the Trust will continue to take actions to seek to reduce the review backlog. Where delays are indicating emerging areas of clinical risk, the Trust will continue to highlight this capacity gap to the Health and Social Care Board. In April and May the Trust has highlighted the ongoing emergent risk in the clinical pathway from review patients waiting beyond their clinically indicated timescale to HSCB and sought an agreed position on the way forward.”

56.3 The HSC BOARD PERFORMANCE REPORT – 2015/16 End of Year Assessment (relevant document located at S21 11 of 2022 Attachments 89. Item-7-HSC-Board-Performance-Report-15-16-EOY-Assessment) also reflected persistent regional issues with performance against the 62 day cancer treatment target over 2015/16. This reported that despite SHSCT being the second highest performer regionally, with an 88% achievement position for this overall target, that HSCB recognised capacity gaps in urological services stating:

“As previously reported, the majority of patients actively waiting longer than 62 days are on the urological, skin, lower GI and upper GI cancer pathways – at end of March 2016, 91% (443 of 486) of patients waiting more than 62 days were on a red flag pathway across these tumour groups. Given the ongoing workforce and capacity issues in these tumour

sites, a number of specialty-specific regional groups involving representation from the HSCB, PHA and Trusts have been established and work is being taken forward in these fora to develop innovative long-term solutions to these issues. In parallel, the HSCB is continuing to meet with all Trusts on a monthly basis via the cancer service improvement and AD forum to share best practice across the region and identify opportunities for delivering improved performance pending implementation of long-term solutions.”

56.4 While I have focussed my response on persistent problems with timely access to urology services, I would add that the 26 Regional Implementation Plan recommendations in 2010 did, however, cover a wide range of actions including, for example, addressing clinical workforce requirements, modernising and redesigning service delivery and improving admission pathways and protocols. Detail on the degree to which all of these recommendations were achieved could be provided by Heather Trouton, as Project Lead for the Team South implementation.

58. Do you think the urology unit was adequately staffed and properly resourced during your tenure? If that is not your view, can you please expand noting the deficiencies as you saw them?

57.1 I have no recollection of specific issues of staffing in the unit being escalated directly to me in my tenure as interim CEO in 2015/16 and therefore have no reason to believe the unit was not adequately staffed or resourced. As noted in paragraph 1.7, the TDP for 2015/16 confirms that all consultant urology posts were filled. Having reviewed the Corporate Risk Registers for August 2015 and February 2016 presented to Governance Committee on 8/9/15, 8/12/15 and 4/2/16, I was reminded of a high Trust risk to recruit/retain Consultant medical staff for specific specialties. This excluded urology as a Consultant Medical Staff risk but indicates risk with SAS (middle grade) Medical Staff in 6 clinical services, including urology.

57.2 The key controls noted that a detailed action plan was in place in the Human

Resources Directorate and this could be accessed from the then Director, Mr Kieran Donaghy or the Trust Public Inquiry Team if required. I believe this risk was linked to an email provided to me by the SHSCT inquiry team. I was copied into this email on 28/9/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 90. 20150929 E General Surgical Situation*) from Heather Trouton Assistant Director of Acute Services and Mr Eamon Mackle, AMD to Mrs Esther Gishkori, Director of Acute Services and Dr Richard Wright, Medical Director highlighting a risk to emergency cover in general surgical services due to a gap in middle grades. It was noted this impacted on urology inpatient out of hours cover. This was not a specific staffing gap in urology medical staff and was appropriately escalated to the Director of Acute Services and the Medical Director to support risk management.

57.3 I also note that in the minutes from the year end (2014/15) accountability meeting with DHSSPS on 16/6/15, attended by myself and the Chair (*relevant document can be located at S21 No 11 of 2022 Attachments, 25. 20150616 Mid-Year Strategic Accountability Meeting - Mins from 16 June 2015 A2*) it is recorded that:-

“In relation to elective care SHSCT accepted the need for a continued focus on performance, and also highlighted the issue of demand exceeding capacity. Paula Clarke advised that treatment pathways and theatre schedules are being reviewed, but there are regional staff shortages in a number of specialties (urology), which need to be addressed on a regional basis.”

I believe this comment reflected my concern at urology staffing issues in the Northern HSC Trust impacting on SHSCT as reflected in the Confidential Board minutes 29/1/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 48. 20150129 Confidential Minutes*) under item ‘3ii) Elective Care – Under-delivery of Core Capacity Volumes’ recorded as follows:

“At this point, Mrs McAlinden provided the context around the NHSCT Urology service and the recent media coverage. She informed members of Commissioner-led discussions which had taken place at a regional level to agree what the other Urology networks could undertake to address the NHSCT gap. She advised that

there was a proposal that the Southern Trust would accept referrals from Cookstown and surrounding area, which Mrs Burns had not accepted and set out the reasons for this. She advised that Mrs Clarke and Mrs Burns had subsequently met with the HSCB and it was agreed that the Trust would provide some limited support, but only on a temporary basis to end of March 2015."

57.4 I recognise that this position regarding the performance of the urology service in meeting standards for timely access to assessment, treatment and follow-up indicate that there were potentially insufficient resources to meet demand. I do not recall the detail of the contributing factors to urology performance, however, noted that as set out in paragraph 1.7, the TDP for 2015/16 did indicate that the issues were primarily related to high volumes of cancer and urgent referrals, and urgent surgery work being prioritised and impacting on access for routine patients, not specifically about staffing shortfalls.

57.5 Further detail on the performance assessment for urology services could be provided by Mrs Lesley Leeman, Assistant Director of Performance in 2015/16 and Mrs Heather Trouton, Assistant Director of Acute Services. The Inquiry should also note that the assessment of capacity required to meet population demand was the role of the HSCB and the Southern LCG as commissioners. Capacity to effectively meet urology demand across the region was an on-going issue being reviewed again in 2015/16 by HSCB establishing a Regional Planning and Implementation Group for urology. It is my understanding that the SHSCT representatives into this process were Mrs Esther Gishkori, Director of Acute Services and Mrs Heather Trouton, Assistant Director of Acute Services, along with the consultant team.

57.6 I recall that the Director of Human Resources reported at all public Trust Board meetings in 2015/16 which I believe set out the Trust's top recruitment challenges/risks as well as key workforce productivity information. In reviewing the minutes from the discussion at Trust board meetings in 2015/16 I note nothing was flagged for urology services staffing specifically and further information regarding urology staffing issues in 2015/16 could be sought from Mrs Heather Trouton, Mrs Martina Corrigan and Mr Eamon Mackle.

59. Were you aware of any staffing problems within the unit during your tenure?

If so, please set out the times when you were made aware of such problems, how and by whom.

58.1 I have no recollection nor have I seen anything more than I have advised in my response to question 57 to indicate that I was appraised as the interim Chief Executive in 2015/16 of staffing problems in the urology unit.

60. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

59.1 I have no recollection, nor have I seen anything beyond the information provided in my response to question 57 above, to indicate there were staffing problems in the urology unit in my tenure as interim CEO in 2015/16. If staffing vacancies and challenges existed, this was the responsibility of the Head of Service to manage and address. Such actions would include, for example, prioritising the team capacity, securing bank or locum cover if possible, paying for overtime or additional medical planned activity time, as well as developing a proposal and business case for any underlying recurrent capacity gaps requiring an increase in the team complement. Detailed knowledge is held by the operational management team at that time and I refer the Inquiry to the Assistant Director for Surgery (Mrs Heather Trouton), the Head of Service (Mrs Martina Corrigan), the Associate Medical Director (Eamon Mackle) and the Clinical Directors (Robin Brown and Sam Hall).

61. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

60.1 As covered in my response to question 57, I was not directly appraised as the interim Chief Executive in 2015/16 of staffing problems in the urology unit. From my responses to questions 54 and 55, I was aware (through performance reports to Trust

Board and the corporate risk register), of the challenges with long waits for urology assessment and treatment, however, there is no specific reference to staffing problems as a factor in this under performance. Detailed knowledge is held by the operational management team at that time, and I refer the Inquiry to the Assistant Director for Surgery (Mrs Heather Trouton), the Assistant Director for Cancer and Clinical Services (Mr Ronan Carroll), the Head of Service (Mrs Martina Corrigan), the Associate Medical Director (Eamon Mackle) and the Clinical Directors (Robin Brown and Sam Hall)

62. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

61.1 Unless changes in roles, duties and responsibilities were required as a result of a Board or senior management team identified risk or action, I would not as interim CEO in 2015/16 be expected to be aware of this level of service detail. This knowledge is held by the operational management team at that time and I refer the Inquiry to the Assistant Director for Surgery (Mrs Heather Trouton), the Head of Service (Mrs Martina Corrigan), the Associate Medical Director (Eamon Mackle) and the Clinical Directors (Robin Brown and Sam Hall)

63. Did your role change in terms of governance during your tenure? If so, explain how and why it changed with particular reference to urology services, as relevant?

62.1 My role as interim CEO in 2015/16 did not change in terms of governance overall or with reference to urology services

64. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff.

63.1 I would not, as interim CEO in 2015/16, be expected to be aware of this level of service detail. In a generic sense I am aware that acute clinical services were supported by administrative staff in a number of roles such as medical secretaries, ward clerks, operational management teams and booking teams. Detailed knowledge is held by the operational management team at that time and I refer the Inquiry to the Assistant Director for Surgery (Mrs Heather Trouton), the Head of Service (Mrs Martina Corrigan), the Associate Medical Director (Eamon Mackle) and the Clinical Directors (Robin Brown and Sam Hall)

65. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

64.1 I refer to and repeat my answer to question 63.

66. Were any concerns raised with you about the adequacy and/or availability of administrative staff for urology clinicians? Are you aware of such concerns having been raised with any other staff? If so, please explain and provide any documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.

65.1 I confirm that to my recollection, no concerns were raised with me as interim CEO about administrative staff for urology clinicians nor am I aware of such concerns being raised with other staff. I refer the Inquiry to the operational management team at that time including the Director of Acute Services (Mrs Debbie Burns/Mrs Esther Gishkori), the Assistant Director for Surgery (Mrs Heather Trouton), the Head of Service (Mrs Martina Corrigan), the Associate Medical Director (Eamon Mackle) and the Clinical Directors (Robin Brown and Sam Hall) as being better placed to answer this.

67. Did administrative staff within urology services ever raise any concerns directly with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in

response.

66.1 I can confirm that, to my recollection, no concerns were raised with me as interim CEO by administrative staff in urology services.

68. Who was in overall charge of the day to day running of the urology unit during your tenure? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person/ those persons answered.

67.1 As interim Chief Executive, I would not be reasonably expected to know the details of all of the clinical services staff who ran the day-to-day clinical service units. While I recall a number of the staff in the urology unit during my tenure, such as Shirley Tedford, one of the lead nurses, reliable information about the day to day running of the Unit should be accessed from Mrs Martina Corrigan, Head of Service for Urology from September 2009 and still in post when I left SHSCT on 31/3/16.

69. What, if any role did you have in staff performance reviews?

68.1 On the basis that this question relates to staff performance reviews associated with urology services, my role, as interim CEO, was confined to appraising the performance of my direct reports being the Directors of the Trust. This included setting objectives for the year ahead and discussing progress with those objectives at regular one to one review meetings.

68.2 As an example, in paragraph 41.3 above, I refer to the objectives I set and agreed with Mrs Esther Gishkori as Director of Acute Services from September 2015-March 2016 which included the following specific objectives pertinent to urology services:-

“Implement the Service Development Proposals which have been presented to HSCB for 2015/16 as follows:- d) Ensure that the Urology Team and T&O Team “blue sky thinking” plans are kept alive and expand and maximise the regional

opportunities in Urology.”

68.3 *The measure of success to be used was “ Evidence that the Urology and T&O Teams have addressed backlog issues (it is accepted this will not be completed) and are still leading the way in terms of regional performance and meeting new demand by March 2016”.*

70. Was your own role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

69.1 Yes, I had a performance review and annual appraisal with my line manager who, in 2015/16, was Chair of the Board, Mrs Roberta Brownlee. I refer to my response to question 44 and that I have not been able to access evidence of this appraisal or objectives from the SHSCT public inquiry team at the time of submitting this section 21 notice. I am not aware of any specific documents that relate to the conduct of performance reviews for the Chief Executive and would expect the Director of Human Resources and Organizational Development (Mr Kieran Donaghy during my tenure) may be able to provide this detail.

Engagement with unit staff

71. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

70.1 As interim CEO in 2015/16, my engagement with staff in the urology unit was not part of any scheduled set of meetings. My engagement with clinical staff and the

Head of Service for urology is set out in my response to questions 9 and 10, and my responsibilities for urology services are as set out in my response to question 7.

72. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

71.1 As interim CEO in 2015/16, I had no scheduled meetings with staff in the urology unit.

73. Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?

72.1 To my recollection, there were no such meetings with me in 2015/16 and any informal meetings would have been as set out in my response to question 10 and, as such, were not about safety or governance concerns.

74. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

73.1 I have no recollection nor evidence of either good or poor working relationships within the urology team that would allow me to respond in an informed way. However, the absence of such evidence indicates there were no serious issues of concern escalated to me as interim Chief Executive regarding working relationships.

Complaints

75. Please describe your role, and the role of members of the management team, should a complaint about clinical governance and/or patient safety be made by (i) member of staff, (ii) a patient, or (iii) anyone else, and provide an

overview of how any such complaint was handled and your role in the process. It would be helpful if your answer referred to a specific example/s, preferably from urology, if any.

74.1 I have reminded myself of the Trust Policy for the Management of Complaints (*relevant document can be located at S21 No 11 of 2022 Attachments, 90a. Policy for the Management of Complaints 2013*) updated during my tenure as interim Chief Executive in July 2015. This sets out in detail in section 2 the roles and responsibilities for managing complaints raised by anyone about any matter applicable to all services provided by the Trust with the exception of complaints relating to Children's Services, under the Children (NI) Order 1995, for which alternative procedures were in place. A summary of the specific roles for myself and the senior management team was as follows:

- a. The Chief Executive is responsible for ensuring that the complaints procedure is effective, and our approach ensures that appropriate investigations and actions have been completed before a response is sent following the formal investigation of a complaint. Responsibility for managing the requirements of this policy is delegated to the Assistant Director of Clinical and Social Care Governance.
- b. It is role of the Assistant Director of Clinical and Social Care Governance (CSCG) to work with the Trust's operational, executive and corporate Governance Leads and support leads on the ongoing development of systems and procedures to monitor the implementation and effectiveness of changing professional, clinical and operational practice in improving the safety and quality of care, which takes due regard of evidence-based practice, lessons learned from reviews, complaints, incidents, accidents and public inquiries, and to provide recommendations and advice to SMT Governance on the Governance Action Plan and priority areas for action. The Assistant Director of CSCG also ensures that a 'Lessons Learned' strategy and process is in place.

- c. Executive Directors role is to refer any professional issues, about which they have concerns to the relevant professional body.
- d. Operational Directors are responsible and accountable for the proper management of accurate, effective and timely responses to complaints received in relation to the services they manage. This responsibility also includes the prompt instigation of local investigations at an appropriate level determined by the seriousness of the complaint.
- e. It is the responsibility of all Trust Directors, Assistant Directors, Service Heads and Senior Managers to utilize the information and trends from complaints within their governance processes to ensure learning and improvement, and to develop and monitor action and learning plans in response to issues identified from complaints. It is the role of the Assistant Director, in complaints where concerns are raised about clinical treatment and care, to share and agree the proposed draft response to the complaint with the relevant clinician prior to it being submitted to the Director for approval.

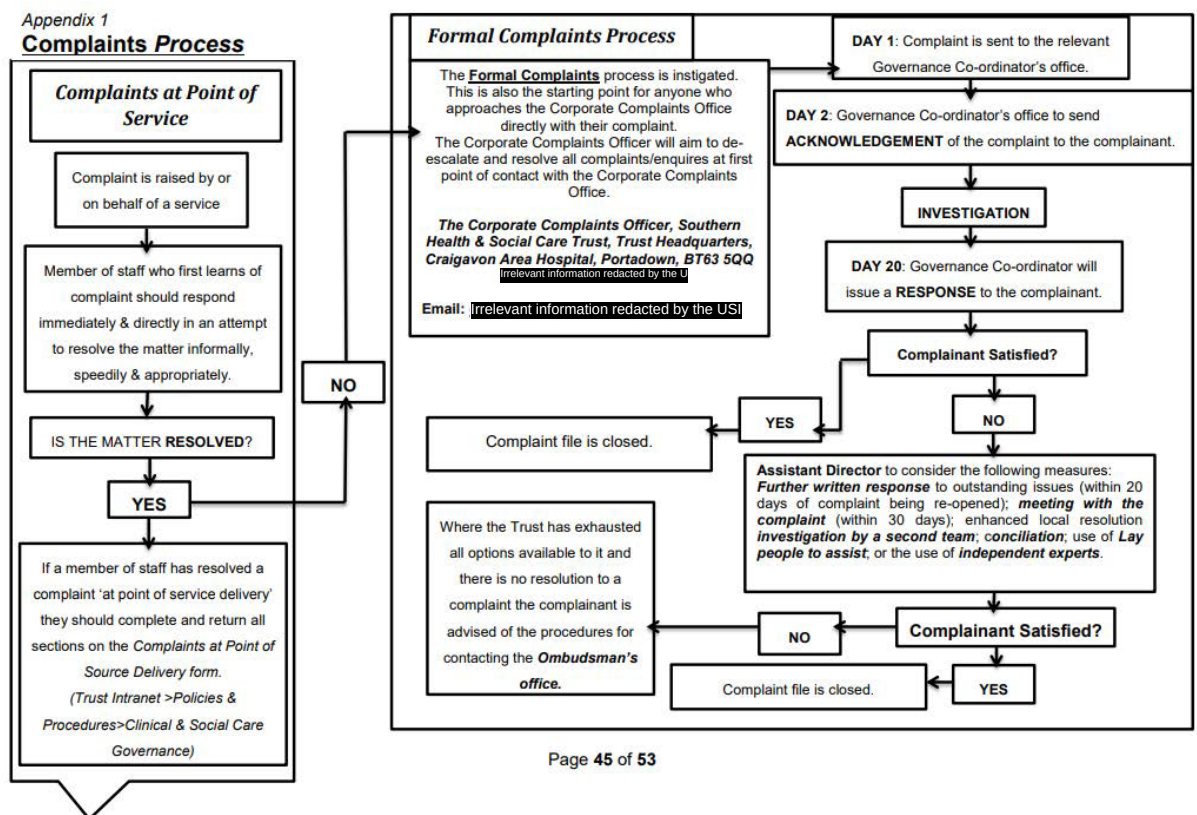
74.2 Section 4, 'Handling Complaints' steps through the process for receipt of and responses to a complaint and further clarifies the following roles:

- a. Where serious governance issues are identified on receipt of the complaint it must be shared with the relevant Director.
- b. Where a complaint involves clinical/professional issues, the draft response must be shared by the Assistant Director with the relevant clinicians/professionals to ensure the factual accuracy of the response and to ensure those staff agree with and support the draft response. Should further work be required on the action and learning plan it is the responsibility of the Assistant Director to initiate this within their division and report back to the relevant Governance Co-ordinator.

- c. All final responses are to be forwarded to the relevant Lead Director for approval by day 18.

74.3 The Trust Policy makes clear that issues may be raised in a complaint that the Trust needed to address but which did not fall within the scope of the Policy and would be handled via other procedures the Trust had in place. As examples these included staff grievances; investigation under the disciplinary procedure or by one of the professional regulatory bodies; a criminal investigation; protection of vulnerable adults; coroner's cases; legal action.

74.4 An overview of how a complaint was handled is included in section 4 and Appendix 1 of the Trust Policy. The summary in Appendix 1 is provided below. Unless a complaint came directly into me or was particularly complex and serious, I did not get involved in responding. I don't recall any detail but do recall that some complaints were discussed with me by the relevant Director if they required advice or support.



74.5 With regard to an example from urology services, I refer to the following two complaints that I did not recall but was reminded of through documents provided to me by the Trust Public Inquiry team. I would highlight that this is not specifically a complaint about “clinical governance and/or patient safety” as referenced in this question but is pertinent. Please note this complaint and several others are also covered in my response to question 96.

- a. On 15 October 2015 an emailed letter and a consent form was received by the CEO office from Micelle O'Neill, MLA, in relation to a patient named Personal Information redacted by the USI. This is in line with the Trust Complaints Policy section 3.6 that required consent when complaints were made by third parties. *(relevant documents can be located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 - Paula Clarke - previous CE/20151026-email complaint Personal Information redacted by the USI attachment 1 and 20151026-email complaint Personal Information redacted by the USI attachment 2)*
- b. The information provided was that this patient had been waiting since September 2014 for an operation under Mr O'Brien's care and, despite attempts made to contact Mr O'Brien, she had not received a response to any follow up communication. Ms O'Neill asked specifically “*how long the waiting list is for Personal Information redacted by the USI*” and “*are there any vacant posts in the urology department and are these being filled by locums.*”
- c. My office escalated this to the Acute Directorate who, in line with section 4.2.2 of the Trust Policy, were responsible for investigating and co-ordinating a response.
- d. I do not have evidence of the process within the acute team to respond to this complaint. This detail can be accessed from the Director of Acute Services office.
- e. A response *(relevant document can be located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 - Paula Clarke - previous CE/20151026-email complaint Personal Information redacted by the USI)* was issued to Michelle O'Neill's office on 26 October 2015 from Rosin Farrell in the Clinical

and Social Care Governance Team within Acute Services, within the 20-day timeline for responding to complaints, which advised that:

- i. [Personal Information redacted by the USI] was currently waiting 59 weeks for her procedure (i.e. this confirmed she was known to the team and on the waiting list).
 - ii. *"Waiting times for urology has increased significantly and the Urology team are giving priority to their cancer patients which there is a high demand for and our current waiting time for urgent non-cancer patients ... is regrettably now 80 weeks".*
 - iii. *"There are six consultant urologists and no vacancies within the urology team".*
- f. On 10 February 2016, an email was received into my office from the office of the CEO of the Western HSC Trust (Elaine Way), which forwarded an email from Arlene Foster, MLA, dated 8 February 2015. Ms Foster's email was in relation to [Personal Information redacted by the USI], a patient from Fermanagh, who was under Mr O'Brien's care in the South West Acute Hospital, Fermanagh. [Personal Information redacted by the USI] had been assessed in February 2014 but in or around January 2016, elevated readings associated with his prostate cancer revealed that the cancer had spread, and he was told that he required chemotherapy. As he had not heard anything, [Personal Information redacted by the USI] contacted Mr O'Brien's secretary. He was told that there was no record on *"the City Hospitals system"* (*relevant document can be located at* Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 - Paula Clarke - previous CE/20160211-email constituent Enquiry). A consent form was received on 11/2/16 as required under the Trust Policy.
- g. My office escalated this to the Acute Directorate who, in line with section 4.2.2 of the Trust Policy, were responsible for investigating and co-ordinating a response.
- h. This was escalated on 11th February to the Director of Acute Services, Esther Gishkori, with my personal request as CEO to *"please treat this as*

urgent as sounds as if something has gone wrong if not on cancer tracker pathway”.

- i. In line with paragraph 2.6 of the Trust Complaints Policy, the Clinical and Social Care Governance Team in the Acute Directorate followed this up immediately and collated a response which was well within the 20 day timeframe for responding to a complaint.
- j. I do not have evidence of the process within the acute team to respond to this complaint. This detail can be accessed from the Director of Acute Services office.
- k. A response (*relevant document can be located at S21 No 11 of 2022 Attachments, 91. 20160212 E Arlene Foster MLA re [Personal Information redacted by the USI]*) was issued by David Cardwell in the Clinical and Social Care Governance Team Directorate of Acute Services (doc 24 in evidence retrieved from archives egress folder), on 11 February 2016 to the office of Arlene Foster MLA as follows:
 - *“Thank you for your email of 8 February 2016 in relation to [Personal Information redacted by the USI]. I am advised that Mrs Corrigan, Head of Urology for the Southern Trust has looked into this matter. She has confirmed that the referral to Dr K Rooney, Consultant Oncologist, at the Belfast Trust, was sent on 1 February 2016 along with a letter to the patient, from Mr O’Brien, Consultant Urologist, advising him of the referral. In this instance if [Personal Information redacted by the USI] has not received an appointment then the Belfast Trust would be best placed to advise on their plans for [Personal Information redacted by the USI] treatment. If you require any further information, please do not hesitate to contact us”.*

76. Please explain your understanding of how the management of clinical governance operated between clinical, nursing and other Directors and Departments, and detail your involvement in any of those processes.

75.1 I have set out my understanding of the roles of operational and professional Directors in paragraph 1.27 and my responses to questions 7 and 12.

77. During your tenure, did you think the relative responsibility for different aspects of clinical governance was clearly allocated between the relevant professional members of your senior team? Did you have cause to question or improve this? Was there a clear demarcation of particular responsibilities and, if so, how was this communicated within the senior team? Was it clearly set out or did it cause issues?

76.1 I refer to my responses to questions 7 and 12 above which set out the relative responsibilities for clinical governance and the approach I took to improving clinical and social care governance arrangements during 2015/16. I believe the demarcation of roles was clear and had been communicated to the senior team, (who I am interpreting as the Directors/SMT), through “A System of Trust” which was reviewed when I commenced post in April 2015 and would therefore have been available to all Directors in post at that time. The JDs, as set out in paragraph 6.2, for all operational service and professional Executive Directors also reflects key responsibilities for clinical governance.

76.2 The review of CSCG I initiated in 2015/16, did identify the absence of an up-to-date Integrated Governance Strategy, and I was reminded in a review of the agenda for the SMT Governance meeting of 24/2/16 (*relevant document can be located at S21 No 11 of 2022 Attachments 39. SMT Agenda 24 February 2016*), that the target date to complete this was June 2016, with the work being led by Mrs Margaret Marshall, AD for CSCG and Mrs Sandra Judt, Board Assurance Manager. While this is not explicitly included as a recommendation “Revisit of Clinical and Social Care Governance Arrangements (CSCG)”, (*relevant document can be located at S21 No 11 of 2022 Attachments, 30. 20151208 Approved Governance Committee Minutes Item 8i) CSCG Revisit*) reported into Governance committee on 8/12/12, it did identify as an area of questioning in the review “*Has SMT set out and agreed an Organisational Governance Strategy which provides clarity on roles and functions across all Directorates?*”. The feedback from interviews and focus groups indicated

that *“it was timely to agree and set out the organisation’s Governance Strategy/Framework and stakeholder opinion gathered through process, should inform content. Connections and connectivity to the Trust’s Quality Improvement Framework will need to be considered with the organisation’s Governance Strategy/Framework.”*

76.3 I have no recollection, nor evidence, of any issues arising regarding clarity of roles during my tenure.

78.What is your view of how the complaints and whistle-blowing procedures, etc. operated and did you make any improvements in those areas? Have there been incidences where a member of staff or members of staff or a patient or anyone else raised concerns about how effective those procedures were and what was your response to that?

77.1 From recollection I believe the complaints and whistle-blowing procedures operated effectively, while accepting there is always scope for improvement.

77.2 I have refreshed my recollection of the following documents provided to me by the SHSCT Public Inquiry team to help me respond – *(relevant document can be located at, Relevant to HR/reference no 2i/Ref 2i - YOUR RIGHT TO RAISE A CONCERN (Whistleblowing) Regional HSC Framework)* the Trust Whistleblowing Policy and Procedure for Raising Concerns at work, refreshed and approved by SMT March 2015 *(relevant document can be located at S21 No 11 of 2022 Attachments, 93. 20151029 email WHISTLEBLOWING POLICY 2)* and the Trust Policy for the Management of Complaints *(relevant document can be located at S21 No 11 of 2022 Attachments, 90a. Policy for the Management of Complaints 2013)* covered in question 74.

77.3 To ensure ongoing focus and improvement, the Complaints Policy was updated during my tenure as interim Chief Executive in July 2015 and I do not recall, nor have I seen any evidence in the documentation provided to me by the Trust Public Inquiry team, that concerns were raised with me about the effectiveness of the Trust Complaints Processes. As further assurance, Section 8 of the Trust Annual Report

and Accounts for 2015/16 summarises the internal audits completed in the year of my tenure and provides satisfactory assurance on the complaints and whistleblowing and fraud processes.

77.4 In terms of improvements, the Board and myself, as interim CEO, sought to provide a culture of openness where issues of concern could be raised to improve the quality of care and endeavoured to ensure the complaints and raising concerns processes operated effectively. As an example of this, the Francis Report – ‘Freedom to Speak Up’ was published in February 2015 and I was reminded, in reviewing the minutes of the confidential Board meeting on 26/11/15 (*relevant document can be located at S21 11 of 2022 Attachments 32a(xiv). Confidential Minutes*) that in April 2015, the Trust invited staff to complete a ‘Raising Concerns - Whistleblowing Survey’ via Survey Monkey online which focused on seeking staff views on the Trust’s Whistleblowing Policy and Procedure for Raising Concerns and how comfortable and confident staff are about raising a concern internally. The purpose of this was to ensure staff views were incorporated into the review of the Trust’s Whistleblowing Policy and Procedure for Raising Concerns, and how it was implemented in practice. The survey results, reported to the Board in 20151126 Whistleblowing Survey Results, (*relevant document can be located at S21 No 11 of 2022 Attachments, 94. 20151126 Whistleblowing Survey Results*) indicated that a high proportion of the 1050 staff members (8% of the workforce) who responded were not confident or comfortable enough to speak up freely. A detailed action plan was included in the report into SMT and the Board to drive improvement in this position and recognising the need for wider cultural change. This included designation of Dr Wright, Medical Director, as the Executive Director lead with operational responsibility for raising concerns arrangements within the Trust, identifying a Non-Executive Director lead to act as independent voice and Board level champion for those who raise concerns, a plan to revise the Policy and Procedures by April 2016 and to undertake a comprehensive communications and training plan to ensure ongoing visibility and implementation of the revised policy to all staff at all levels in the Trust. Evidence of immediate follow-up can be seen in the issue of the extant Whistleblowing and Raising Concerns Policy to all consultant staff in the Surgery Directorate by Mrs Heather Trouton on 29/10/15 (*relevant document can be located at S21 No 11 of 2022 Attachments, 93. 20151029*

email WHISTLEBLOWING POLICY 2)

Governance – generally

79.What was your role in relation to the Directors Human Resources and Organisational Development, the Assistant and Associate Directors, the Head of Service for Urology, the Medical and Clinical Directors, consultants and other clinicians in the urology unit, including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.v

78.1 My role as interim CEO in 2015/16 in relation to the role of my Directors and their teams, clinical and managerial, and the postholders during my tenure is set out in my response to questions 6 and 7.

78.2 In summary, as interim Chief Executive of the Trust in 2015/16 I was responsible for the overall management and performance of the Trust including clinical governance and patient safety. I discharged my duties through my senior management team with specific responsibilities for clinical and social care governance arrangements set out in detail in my response to question 7. These arrangements provided clarity on the role of Operational Directors being responsible and accountable for patient safety and quality and for implementing agreed workforce standards and provide assurance to the executive functions that action was taken to ensure a workforce of an acceptable standard to deliver safe, high quality care.

78.3 Operational Directors were responsible and accountable for all aspects of CSCG to SMT Governance and its chair the Chief Executive, and via this body through to Trust Board. The AMD and AD were responsible and accountable for all aspects of CSCG within their area to the Operational Director. Professional Directors for Social Work, Nursing and AHPs and Medical were responsible for providing expert advice and support professionally, providing assurance on compliance and reporting on

standards for the registered workforce. The Medical Director as the designated Responsible Officer had specific responsibilities covered in paragraph 7.8 above.

78.4 I was supported in my role specifically for clinical and social care governance, by the Assistant Director of Clinical and Social Care Governance, who in my tenure was Mrs Margaret Marshall. Her role was to provide a corporate view to integrate the various strands of Clinical and Social Care Governance within the Trust across the 3 core components of Corporate Co-ordination & Overview Role (Chief Executive's Office); Operational Directors and their teams; and Professional Executive Directors and their teams. The governance agenda within each directorate was supported through Governance Co-ordinator roles who reported into the relevant Director

80. Who oversaw the clinical governance arrangements of the urology department and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately? Please explain and provide documents relating to any procedures, processes or systems in place on which you rely on in your answer.

79.1 As referenced in 78.1 above, Operational Directors were responsible and accountable for all aspects of CSCG in their services. For urology services this was under the Director of Acute Services (postholders set out in paragraph 6.2), with the Medical Director having defined responsibilities as the designated Responsible Officer as covered in paragraph 7.8.

79.2 How I assured myself that this was being done appropriately is set out in detail in my response to question 12. In addition to that detail, the one to ones I held with the Director of Acute Services and the Medical Director provided an opportunity to discuss how well processes were working. I have not been able to access any notes from these discussions in 2015/16 to evidence or remind me if this was explicit. I do recall however that there was a monthly Governance meeting chaired by Director of Acute Services for her Directorate and Mrs Martina Corrigan, Head of Urology Service confirmed this when we met on 8/6/22. She also reminded me that a separate Morbidity and Mortality meeting was held within each Division and the Surgery Division

meeting included urology consultants. Further detail on the clinical governance arrangements of the urology department should be accessed from Mrs Corrigan and from the Clinical Director, Mr Robin Brown.

81. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

80.1 The quality of services in urology as part of the total clinical services delivered by the Trust was overseen at Board level through a range of methods. This is detailed in my response to questions 12, 13 and 22. With respect to specific assurance on the quality of services in urology, this was the responsibility of the Director of Acute Services and the Medical Director as per their respective responsibilities covered in paragraphs 7.2 - 7.8.

82. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing performance metrics?

81.1 As interim Chief Executive I did not oversee performance metrics directly within urology services. Oversight for myself and the Trust board was via the Monthly Performance Report, which was the responsibility of the Director of Performance and Reform to co-ordinate and report, and the suite of reporting into Trust Board and Governance Committee and into SMT from professional and operational Directors. These are detailed in paragraphs 12.7-12.10 and 13.1. The Director of Acute Services and her team were responsible for the oversight of delivery against performance metrics.

83. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

82.1 I assured myself of the quality of services in urology as part of the assurance process for all clinical services delivered by the Trust through a range of methods.

This is detailed in paragraphs 12.1-12.2, 12.7-12.10 and my response to questions 13 and 22.

84. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

83.1 As interim CEO issues of concern relating to any service, including urology, could be brought to my attention through a number of avenues. Externally this could be through emails, phone calls or letters into my office directly from patients, families or people acting on their behalf with consent, usually elected representatives. I was reminded of examples of such issues regarding timely access to urology services, some designated as complaints, on reviewing emails provided to me by the inquiry team and have given detail of these in paragraph 96.4.

83.2 Concerns could also have been raised by other organisations such as RQIA, Patient Councils, external reviews or benchmarking undertaken by a professional body. The performance monitoring role of the HSCB and the DHSSPS for delivery of health and social care services across the region also provided the opportunity for specific issues of concern with any service to be raised with the Trust CEO.

83.3 Internally, concerns could be raised with me as interim CEO through line management escalation through one of the Directors, or by any member of staff contacting me directly in person or by phone, email or letter. The Trust's Whistleblowing Policy and Procedure for Raising Concerns and Complaints Policy were in place for this process. The Leadership walks undertaken by Non-Executive Directors and reported to Governance Committee biannually in 2015/16 as an assurance mechanism, also provided staff with the opportunity to raise issues as referenced in paragraph 22.2 as well as via my Chief Executive visits to teams as referenced in my response to question 10.

83.4 The systems and processes in place for dealing with concerns raised depended on the concern but included the Trust Complaints policy, the Whistleblowing Policy, Managing High Professional Standards and Trust Guidelines for Handling Concerns about a Doctor Doctors' and Dentists' Performance. Identification of concerns was also supported via the processes in place for risk management and clinical and social care governance as detailed in my responses to questions 12 and 19.

83.5 With respect to the efficacy of these systems and processes, to my recollection and informed by the documents I have been able to review in drafting my statement to the Inquiry, as they pertain to my tenure as interim CEO in 2015/16, I have no reason to believe that these were not effective generally. This is reflected in my statement of assurance on internal governance in the 2015/16 Annual Report and Accounts (*relevant document can be located at S21 No 11 of 2022 Attachments, 13. ANNUAL_REPORT_AND_ACCOUNTS_2015-16*) as referenced in paragraph 1.52 and supported by the independent assurances gained for internal audits achieving satisfactory assurance in 2015/16 for Complaints Management, Whistleblowing and Fraud processes, Risk Management and Clinical and Social Care Governance.

83.6 With specific regards to the efficacy of MHPS processes, I would refer to my response to section 21 Notice No.42 of 2022, question 11, where I have reflected on these issues, having now seen the Investigation Report from MHPS Case Investigator Dr Neta Chada and the Determination from Case Manager D Ahmed Khan. I note that Dr Khan recorded 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".

83.7 I also note that 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 makes clear that responsibility for triage of referrals was Mr O'Brien's. The 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:

"...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 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".

83.8 The impression that I have formed, based on this new information to me in 2022, is that the effectiveness of the MHPS Framework and related 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 they were implemented as effectively as they should have been.

85. Did those systems or processes change over time? If so, how, by whom and why?

84.1 Systems and processes should be reviewed in the light of feedback, new information locally, regionally, or nationally, and informed by best practice. I do not however recall details of all policy reviews completed in 2015/16 but refer to my response to question 74, noting the Trust Complaints policy was updated in July 2015, and my response to question 77, reflecting changes to the Trust Whistleblowing policy and to the fact that following my departure from the Trust on 31/3/16, the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance, were updated in October 2017.

86. How did you ensure that you were appraised of any concerns generally within the unit?

85.1 My response to questions 79, 82 and 83 cover how I sought to ensure I was appraised of any concerns generally within the urology unit and the role of other Trust personnel in ensuring this.

87. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary? If yes, please explain.

86.1 My response to question 79 and with specific reference to paragraphs 12.1-12.2 and 12.7-12.10 and my response to questions 13 and 22, together, set out the approach I took to ensure governance systems overall were adequate and the role of other Directors in respect of this assurance. During my tenure as interim CEO I have no recollection of having any concerns that governance issues in the urology unit were not being identified, addressed and escalated as necessary.

88. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

87.1 I have assumed this question relates to concerns raised regarding urology services during my tenure as interim Chief Executive. No concerns of clinical governance that I recall were escalated to me or through Trust Board level governance reports and the Corporate Risk Register. More generally I refer to my responses to questions 54 and 55 for risks and performance concerns for urology services.

89. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

88.1 Detail of patient data collected within individual clinical services such as urology would not reasonably be expected to be known by the Chief Executive and I therefore believe that this information should be sought elsewhere, e.g., from Mrs Martina Corrigan, Head of Urology services during my tenure. From a more general perspective I was aware that clinical services collected data on patient referrals and treatment via the Patient Administration System and clinical data included morbidity and mortality reviews undertaken within the acute directorate as referenced in paragraph 1.50 and my response to question 79. Patient experience and feedback was also collected and used in consultant appraisal and revalidation as set out in my response to question 91 and through complaints reporting as covered in question 74.

90. What is your view of the efficacy of those systems? Did those systems change overtime and, if so, what were the changes?

89.1 As per my response to question 88, I do not have sufficient detailed knowledge of these systems to comment on the efficacy, nor am I aware of any changes to these systems within the urology unit. I therefore believe that this information should be sought elsewhere e.g., from Mrs Martina Corrigan, Head of Urology services during my tenure.

91. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

90.1 In paragraph 1.22, I refer to information regarding the responsibility of Heads of Service to make teams aware of targets relevant to their services. This paragraph (1.22) further indicates that each Directorate had an annual work plan with key deliverables from the Strategic Plan and the Trust Delivery Plan set out with actions, owners and timescales. This provided the framework for performance objectives for individuals and for teams and was the responsibility of each Director to oversee for

their services. During my tenure as interim Chief Executive in 2015/16 I agreed objectives with each Director and expected these to be cascaded through their teams down to specialty teams. Objectives I set and agreed with Mrs Esther Gishkori as Director of Acute Services from September 2015 to March 2016, specific to urology are covered in questions 11 and 68.

90.2 In preparing this statement, I was reminded of the existence of the Consultant Job Planning Framework 2009 (*relevant document can be located at S21 No 11 of 2022 Attachments, 95. Consultant Job Planning Framework 2009*) and the fact that this sets out that objectives were an essential part of the job plan for every consultant and should be tailored to reflect local development plans and priorities. Undertaking this process was the responsibility of the operational Director and the AMD. Monthly Performance Reports in 2015/16 included monitoring of performance against Service and Budget Agreements (SBA) with the HSCB as commissioner. These agreements set out commissioned levels of activity for all clinical services and I recall that these were based on a capacity modelling approach that included an assessment of consultant activity that should be able to be delivered in a clinical session. This capacity planning was a core part of job planning. Heads of Service worked with their clinical teams to agree these templates and monitor performance. Information about how this operated could be accessed from Mrs Martina Corrigan, Head of Urology Services and Mr Robin Brown, Clinical Director.

90.3 I have no recollection, nor any evidence to indicate, that these processes for setting objectives operated otherwise than effectively in 2015/16.

92. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

91.1 I believe the cycle of appraisal for consultants worked well during my tenure as interim Chief Executive and was governed under the 20140701 Policy - Southern Trust Appraisal Scheme for Medical Staff (*relevant document can be located at, Relevant to MDO/reference no 2t/20140701 Policy - Southern Trust Appraisal Scheme for Medical Staff*) that I was reminded of in the documents shared with me by the SHSCT

public inquiry team). This document sets out clearly the various roles and responsibilities, including that the Chief Executive is personally accountable to the Trust Board for overseeing the appraisal process, and operating this system through the Medical Director and Associate Medical Directors, who were accountable for ensuring any necessary action arising from the appraisal process was undertaken. The Medical Director was responsible to ensure the necessary links existed between the appraisal process and other Trust processes concerned with clinical governance, quality and risk management and the achievement of service priorities. My assessment of this system working well is based on the evidence below.

91.2 As referenced in my response to paragraph 7.8, as required under “The Medical Profession (Responsible Officers) Regulations (NI) 2010”, the Medical Director role, as Responsible Officer, requires revalidation of doctors within a 5-year cycle i.e. 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 investigation of complaints, concerns, patient safety incidents and other available indicators that can be reliably related to the performance of the individual doctor. 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 on 11/6/15 to Trust Board confirming the Trust has achieved 100% completion rates as at 31 December 2014 for the 2013 appraisal round, which equates 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 (*relevant document located at S21 11 of 2022 Attachments 32b(vi). 20150611 TB Public Minutes*).

91.3 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 Medical Director Report to Trust Board 28/1/16 and minutes of TB public on 28/1/16 (*relevant documents can be located at S21 No 11 of 2022 Attachments 96. 20160128 MD Report TB and 32b(xvi). 20160128 TB Public Minutes*), 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. Comparisons were drawn between the 2012 and 2013 analyses and findings indicated that the Trust's comprehensive medical appraisal and revalidation processes were very well received by the medical workforce. Reference to this audit is also made in the 8/12/15 Governance committee minutes (*relevant document can be located at S21 No 11 of 2022 Attachments, 31b(v). 20151208 Approved Governance Committee Minutes*).

91.4 With respect to job planning, I recall there was an annual process under the responsibility of the Associate Medical Directors reporting to the operational Director and professionally to the Medical Director. The Consultant Job Planning Framework 2009 (*relevant document can be located at S21 No 11 of 2022 Attachments, 95. Consultant Job Planning Framework 2009*) referenced at paragraph 90.2 sets out the detail of the process to be followed. I have no reason to believe this operated otherwise than effectively during my tenure.

93. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your time in post, including the name(s) and role(s) of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your

tenure.

92.1 In my response to questions 6, 7, 8, 78 and 83, I have set out the management and accountability for matters of patient risk and safety, governance, the names and roles of people involved, and the avenues and processes for raising and dealing with concerns. I also refer to my response to question 12 that provides a comprehensive overview of the clinical governance systems in place in my tenure and Board assurance relating to serious concerns and performance.

92.2 The following Trust policies and guidelines, relevant to processes for identifying and addressing concerns and which have been referenced as source documents for the Inquiry team throughout my statement, include the following:

- a. Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance (16th September 2010), reflecting the requirements of Maintaining High Professional Standards in the Modern HPSS. Section 2.0 and Appendix 6 "Role Definitions" in the Trust Guidelines describe roles and responsibilities under the screening, informal and formal processes following concerns being raised about the conduct, clinical performance, and health of medical and dental employees. It is not feasible to provide names of those who might be involved in this process in 2015/16 as this could have covered a wide variety of AMD and Clinical Directors. The Directors involved would have been as set out in my response to question 6.
- b. Complaints Policy as referenced in my response to question 74.
- c. Whistleblowing and Raising Concerns Policy referenced in my response to question 77.
- d. Risk Management Policy referenced in my response to question 19.
- e. Medical appraisal and revalidation as referenced in my response to question 1.

94. Did you feel supported in your role by the Trust Board and general management and medical line management? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

93.1 As interim CEO of the Trust in 2015/16, I did feel supported in my role by all members of the Board and the Directors and their leadership teams responsible for general and medical line management. I had a good relationship with my Chair, Mrs Roberta Brownlee, and felt supported by her in my step up to the interim Chief Executive role.

93.2 The many achievements of, and challenges faced by, the Trust as set out on pages 4-22 of the Annual Report and Accounts for the Year ended 31/3/16 (*relevant document can be located at S21 No 11 of 2022 Attachments, 3. 20160425_MonthlyPerfReportApril(MarchPerf)_TB_V1_0_LLappin*), demonstrate how the collective effort of the Board of Directors working with and through our 14,000 staff, was able to deliver quality health and social care services and make improvements in these services. I was privileged and proud to have had the opportunity to lead the Trust during this year.

93.3 I do not have any specific examples relating to urology services from my year as interim CEO that I feel particularly demonstrate support, or otherwise, from the Board and wider teams. An example of support that I would give is with respect to a significant and complex risk to sustaining a 24/7 Emergency Department service at Daisy Hill Hospital as covered in my response to question 30 and I would highlight that successful management of this risk, during my tenure, was only possible through the commitment and dedication of clinical and managerial teams and the support of the Board.

Concerns regarding the urology unit

95. The Inquiry is keen to understand how, if at all, during your tenure you liaised with and had both formal and informal meetings with:

- i. The Trust Board
- ii. The Chair of Trust Board - the Inquiry understands this to have been Roberta Brownlee
- iii. The Medical Directors - the Inquiry understand these to have been John Simpson and Richard Wright.
- iv. The Directors of Acute Service - the inquiry understands these to have been Debbie Burns and Esther Gishkori.
- v. The Director of Human Resources and relevant Human Resources personnel - (please name)
- vi. The Assistant Directors - the inquiry understands these to have been Heather Trouton and Ronan Carroll.
- vii. The Associate Medical Directors - the inquiry understands this to have been Eamon Mackle and Mark Haynes (Surgery) and Charlie McAlister and Damian Scullion (Anaesthetics)
- viii. The Clinical Directors, the inquiry understands this to have been Robin Brown and Sam Hall.
- ix. The Head of Service, namely Martina Corrigan,
- x. The consultant urologists in post.
- xi. The Nurse Managers - the inquiry understands this to have been Shirley Tedford and Gillian Henry.

The Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to urology services concerns.

Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc. Your answer should also include any individuals not named in (i) - (xi) above but with whom you interacted on matters falling with the Inquiry's Terms of Reference.

(i) Trust Board.

94.1 My response to question 12 addresses assurance and engagement with the Board on matters of clinical governance and serious concerns generally. The overall engagement and approach to governance generally is set out in paragraph 1.8-1.52. My responses to questions 11, 23 and 27 identify scheduled and informal meetings with members of Trust Board and my SMT. Any matters of concern related to urology were about access performance as addressed in my response to questions 54, 55 and 96.

(ii) The Chair of Trust Board - the Inquiry understands this to have been Roberta Brownlee

94.2 I confirm the Chair of the Board was Roberta Brownlee during my tenure. My liaison with the Chair is covered in the same responses as for Trust Board in paragraph 94.1. I do not recall, nor have I seen, any evidence to indicate that my one-to-one meetings with the Chair included urology specific concerns.

(iii) The Medical Directors - the Inquiry understand these to have been John Simpson and Richard Wright.

94.3 I confirm the Medical Directors during my tenure were John Simpson and Richard Wright for the periods set out in paragraph 6.2. Meetings with all my SMT are as set out in my responses to questions 9, 11 and 23. I engaged with my SMT on matters of governance generally as set out in paragraphs 12.7-12.11. My response to question 7 sets out the distinct roles and responsibilities for the operational management and governance of urology services. Paragraph 7.8, specifically covers the role and responsibility of the Medical Director as the designated Responsible Officer. I do not recall having any specific meetings with either Medical Director regarding concerns in urology services of a general or patient safety nature. They would have been involved in discussions at Trust Board and Governance Committee that included urology, as referenced in 94.1

and involved in relevant SMT discussions, as addressed in my response to question 54.

(iv) The Directors of Acute Service - the inquiry understands these to have been Debbie Burns and Esther Gishkori.

94.4 I confirm the Directors of Acute Services during my tenure were Debbie Burns and Esther Gishkori for the periods set out in my response to question 6. Meetings with all my SMT members are as set out in my responses to questions 9, 11 and 23. I engaged with my SMT on matters of governance generally as set out in paragraphs 12.7-12.11. My response to question 7 sets out the distinct roles and responsibilities for the operational management and governance of urology services. My engagement with these individuals in matters of governance generally and urology specifically is through their involvement in discussions at Trust Board and Governance Committee that included urology, as referenced in 94.1 and from involvement in relevant SMT discussions, as addressed in my response to question 54. I refer also to my response to questions 11 and 68 where I set out objectives agreed with Esther Gishkori for her first 6 months in post and which included urology related objectives. I also refer to question 53 that identifies my general awareness of issues relating to triage in urology services associated with Mr O'Brien, and my belief this awareness was from informal discussions with Debbie Burns and/or Aldrina Mgwood. This was not discussed formally with me as a matter of governance concern.

(v) The Director of Human Resources and relevant Human Resources personnel - (please name)

94.5 The Director of Human Resources during my tenure was Mr Kieran Donaghy and, as a member of SMT and of Trust Board and Governance Committee, my liaison with him in matters of governance generally, and urology specifically is the same as for the Medical Directors at 94.3 above. I do not recall any meetings with Mr Donaghy regarding governance concerns in urology. I did

not liaise with or have formal or informal meetings Human Resources personnel relating to urology governance generally nor any specific concerns relating to patient safety.

(vi) The Assistant Directors - the inquiry understands these to have been Heather Trouton and Ronan Carroll.

94.6 I confirm the Assistant Directors for Surgery and for Cancer and Clinical Services during my tenure were Heather Trouton and Ronan Carroll respectively. My response to question 8 sets out the aspects of my roles and responsibilities for the operation and governance of urology services as interim Chief Executive relative to other roles including Assistant Directors, Clinical Director, Associate Medical Director and Head of Urology Service. I do not recall, nor have I seen any evidence to indicate, that I liaised with either individual (Ms Trouton or Mr Carroll), in my tenure regarding matters of concern with urology governance generally or specifically, other than any discussions associated with the challenges in access performance which were not governance matters. I have referred in paragraph 10.4 to a “Blue skies” meeting about the future vision for urology services that I believe Heather Trouton attended and in 10.5 to my recollection of holding quarterly performance review meetings with each operational Director and their team where both ADs would have been in attendance. I do not recall issues of urology governance being raised at these meetings and have requested, but not accessed, any minutes that may have existed from the Trust public inquiry team at the point of submitting my response.

(vii) The Associate Medical Directors - the inquiry understands this to have been Eamon Mackle and Mark Haynes (Surgery) and Charlie McAlister and Damian Scullion (Anaesthetics)

94.7 I confirm that Eamon Mackle and Charlie McAlister were Associate Medical Directors during my tenure for Surgery and Anaesthetics respectively, but I do not recall Mark Haynes or Damian Scullion being in the AMD role during that time (2015/16). My engagement, both formal and informal, with Mr Mackle and Mr

McAllister was as for my general clinical team engagement set out in my response to question 10. My response to question 8 sets out the aspects of my roles and responsibilities for the operation and governance of urology services as interim Chief Executive relative to other roles including Associate Medical Directors. I do not recall, nor have I seen any evidence to indicate, that I liaised with either individual in my tenure regarding matters of concern with urology governance generally or specifically although I would have engaged with them considerably on other matters of governance such as the significant and complex risk to sustaining a 24/7 Emergency Department service at Daisy Hill Hospital referenced at paragraph 10.4.

(viii) The Clinical Directors, the inquiry understands this to have been Robin Brown and Sam Hall.

94.8 I confirm that Robin Brown and Sam Hall were the relevant Clinical Directors during my tenure. My engagement, both formal and informal, with Mr Brown and Mr Hall was as for my general clinical team engagement set out in my response to question 10. My response to question 8 sets out the aspects of my roles and responsibilities for the operation and governance of urology services as interim Chief Executive relative to other roles including Clinical Directors and Associate Medical Directors. I do not recall, nor have I seen any evidence to indicate, that I liaised with either individual in my tenure regarding matters of concern with urology governance generally or specifically although as with the AMDs, I would have engaged with them considerably on other matters of governance and particularly with Robin Brown, regarding the significant and complex risk to sustaining a 24/7 Emergency Department service at Daisy Hill Hospital referenced at paragraph 10.4

(ix) The Head of Service, namely Martina Corrigan,

94.9 I confirm the Head of Service for urology in my tenure was Martina Corrigan. As stated at paragraph 9.2, I did not, as interim CEO, have any regular schedule of engagements or meetings in place with Martina Corrigan

or any Heads of Service as their line management arrangements were under the relevant Director. I did try to establish a working culture of an open-door policy and encouraged staff to feel able to come directly to me with any issues, ideas or concerns but do not recall any such approach by the Urology Head of Service in my tenure as Interim CEO. To remind myself of some information in support of a more complete response to the inquiry, I met Mrs Corrigan on 8th June 2022 and she confirmed her recollection was that she had not met me for any specific reason nor on a regular basis in 2015/16. My response to question 8 sets out the aspects of my roles and responsibilities for the operation and governance of urology services as interim Chief Executive relative to other roles including the Head of Urology Service. I have referred in paragraph 10.4 to a “Blue skies” meeting about the future vision for urology services that I believe Martina Corrigan attended.

(x) The consultant urologists in post.

94.10 I do not recall all of the consultant urologists in post during my tenure. Michael Young and Aidan O’Brien were the consultants I would have known most given they had both been working in SHSCT for a long period and I would have engaged with them as part of service developments, such as the Team South implementation plan as covered under my response to question 50. I have also referred in paragraph 10.4 to a meeting about the future vision for urology services that I believe Mark Haynes attended having led on this vision. As set out in my response to question 70, as interim CEO in 2015/16, my engagement with staff in the urology unit was not part of a scheduled set of meetings and engagement with clinical staff in urology would have been as set out in paragraphs 10.1 to 10.4. I do not recall, nor have I seen any evidence to indicate, that I liaised with any of the consultant urologists in post in 2015/16 regarding matters of concern with urology governance generally or specifically

(xi) The Nurse Managers - the inquiry understands this to have been Shirley Tedford and Gillian Henry.

94.11 I confirm the Nurse Managers in urology in my tenure were Shirley Tedford and Gillian Henry. As set out in my response to question 70, as interim CEO in 2015/16 my engagement with staff in the urology unit was not part of a scheduled set of meetings and engagement with clinical staff in urology would have been as set out in my response to question 10. I do not recall, nor have I seen any evidence to indicate, that I liaised with any of the nurse managers in 2015/16 regarding matters of concern with urology governance generally or specifically.

95. Can you explain from your perspective how you understood Urology Services was supposed to operate from a clinical governance and patient care and safety perspective during your time in post compared to how it did in fact operate?

95.1 From my perspective as interim CEO in 2015/16, Urology services would have been expected to operate in line with the extant clinical and social care governance and patient safety policies and guidelines for the Trust during 2015/16 as I have set out in my response to questions 12, 13 and 22.

95.2 It is only retrospectively, as a result of information now available to me in the context of this Inquiry and referenced in my response to questions 83, 98, 103 and 118, that I am now aware that one consultant urologist, Mr O'Brien, did not operate in line with the extant processes. The issues of "patient care and safety" myself and the Board were aware of during my tenure were related to underperformance against access standards; they were not the issues in respect of Mr O'Brien.

96. Can you identify in what aspects you considered Urology Services to be operating adequately and in what respects it was failing to do so? If your understanding changed over time, please explain this within your answer.

96.1 As interim Chief Executive in 2015/16, I do not recall, and have not seen

any evidence that was available to me during 2015/16, to indicate that the urology service was failing to operate adequately in delivering safe and effective care. In my response to question 100, and at paragraph 10.4, I refer to the positive approach being adopted by the urology team to continue to improve and seek support for their vision for the service through a “blue skies pilot”, something I consider to be commendable.

96.2 The aspect of the service that I would describe as not operating adequately during my tenure as interim Chief Executive, was with respect to the challenges in delivering timely assessment and treatment for new outpatient, inpatient/day-case and outpatient review access targets to all patients in the service in line with the regional standards and Trust priorities. For context, the waiting times for several clinical services during 2015/16 were not meeting the regional access standards by a considerable amount of time. I have provided significant evidence throughout this response of these access performance issues as reported in public Board meetings via the Monthly Performance Report. Two further examples are as follows:

- a. In the Monthly Performance Report for October 2015 presented at the public meeting of the Board on 26/11/15, waits of 115 weeks for inpatient or day case urology treatment along with a number of other clinical services with long waits ranging between 39 and 78 weeks, were reported.
- b. Information provided in the MHPS Investigation Report completed by Case Investigator Dr Neta Chada, referenced in my response to question 83 also includes information at page 41, section 9 on urology waiting times in April 2015 and April 2016 as follows:

	NEW OUTPATIENTS			SURGICAL PROCEDURES		
	RED FLAG	URGENT	ROUTINE	RED FLAG	URGENT	ROUTINE
APRIL 2015	14 DAYS	16 WEEKS	53 WEEKS	48 DAYS	82 WEEKS	97 WEEKS
APRIL 2016	26 DAYS	40 WEEKS	73 WEEKS	65 DAYS	119 WEEKS	124 WEEKS

96.3 As referenced in paragraphs 55.1-55.7 the impact of these performance issues on patient care was recognised in the Corporate Risk Register.

96.4 This underperformance was also highlighted for me in several queries and complaints that I did not recall but have been reminded of through the process of responding to this Inquiry. This reminder has come from the Trust Public Inquiry team providing me with evidence of communication into my office, as interim Chief Executive in 2015/16, that referenced Mr O'Brien. These complaints were regarding urology patients under Mr O'Brien's care during my tenure and are summarised below. For accuracy, however, it would be important to acknowledge that other complaints were also received into my office regarding access times for a number of clinical services with long waiting times in 2015/16 (i.e., not only urology):

- a. A complaint was made into my office via email on 8 June 2015 by a patient, Personal Information redacted by the USI, regarding a 7-month delay for a second surgery under the care of Mr O'Brien. In response to this complaint, Mr O'Brien wrote to me via email on 15 June 2015 and advised that he had "*patients awaiting admission since October 2013 never mind October 2014*" and confirmed Personal Information redacted by the USI had recently been given a date for surgery (*relevant document can be located at S21 No 11 of 2022 Attachments, 98. 20150615 E* Personal Information redacted by the USI *re Wait for Surgery*)
- b. 20150529 Enquiry 4758 Personal Information redacted by the USI (*relevant document can be located at Relevant to Acute/Document No 29 and Document No 34 and Document No 57/Enquiries/Enquiries 2015/20150529 Enquiry 4758* Personal Information redacted by the USI) and 20150811 E Jo Anne Dobson MLA re Personal Information redacted by the USI (*located at S21 No 11 of 2022*

Attachments, 99. 20150811 E Jo Anne Dobson MLA re Personal Information redacted by the USI Two emails were received into my office by about a patient, Personal Information redacted by the USI who was under the care of Mr O'Brien. The first was on 29/5/15 from Margaret Ritchie MP and the second on 10/8/15 from Jo-anne Dobson, MLA. These elected representatives advised that Personal Information redacted by the USI had been treated with a stent for kidney stones which had not worked and was waiting for follow up surgery since July 2014. He had been told this was a priority and was likely to take place in February but he had not received a date yet. A response appears to have been made by the complaints team in the Acute Directorate on 26/6/15 advising that Personal Information redacted by the USI was on the waiting list for surgery but that waiting times had significantly increased due to concentrating on cancer patients and that Personal Information redacted by the USI had been added to the cancellation list, i.e. to be contacted at short notice, should another patient cancel. An addendum on 28/9/15 noted Personal Information redacted by the USI had his procedure on 7/9/15.

- c. On 19th October 2015, Personal Information redacted by the USI, Councillor, emailed my Personal Assistant in the CEO Office, Elaine Wright, setting out that his mother, Personal Information redacted by the USI, had been assessed by Mr O'Brien on 23 May 2015 and had been referred for surgery but that she had not received any communication following up on this since then. This was escalated to the Director of Acute Service's Office. Emma Stinson, Personal Assistant to Esther Gishkori (the then Director of Acute Services) responded on 27 October 2015 to confirm that Personal Information redacted by the USI was listed on the system as waiting. She advised that she had notified the complaints team and that she had asked Martina Corrigan (Head of Urology) and Mr O'Brien for their response. 20151102-email for response Personal Information redacted by the USI (*relevant document can be located at S21 No 11 of 2022 Attachments, 100.* 20151102-email for response Personal Information redacted by the USI) On the back of this response from Emma Stinson, on 2nd November, I asked Elaine Wright, my PA, to advise Councillor Personal Information redacted by the USI that his mother's case was being progressed and to come back to us with any other concerns. At the time of responding to this section 21 Notice, I have not received any evidence

of any further response made.

- d. On 15 October 2015 an emailed letter and a consent form was received by the CEO office from Michelle O'Neill, MLA, in relation to a patient named [Personal Information redacted by the USI] 20151026-email complaint [Personal Information redacted by the USI] attachment 1 (*relevant documents can be located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 - Paula Clarke - previous CE/20151026-email complaint* [Personal Information redacted by the USI] attachment 1), and 20151026-email complaint [Personal Information redacted by the USI] attachment 2). This patient had been waiting since September 2014 for an operation under Mr O'Brien's care and, despite attempts made contact Mr O'Brien, she had not received a response to any follow up communication. Ms O'Neill asked specifically "how long the waiting list is for [Personal Information redacted by the USI]" and "are there any vacant posts in the urology department and are these being filled by locums". A response 20151026-email complaint [Personal Information redacted by the USI] [Personal Information redacted by the USI] (*relevant document can be located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 - Paula Clarke - previous CE/20151026-email complaint* [Personal Information redacted by the USI]), was issued to Michelle O'Neill's office on 26 October 2015 from the Clinical and Social Care Governance team within Acute Services which advised that:
- i. [Personal Information redacted by the USI] *was currently waiting 59 weeks for her procedure.*
 - ii. *"Waiting times for urology has increased significantly and the Urology team are giving priority to their cancer patients which there is a high demand for and our current waiting time for urgent non-cancer patients ... is regretfully now 80 weeks". "There are six consultant urologists and no vacancies within the urology team".*
- e. On 10 February 2016, an email was received from the office of the CEO of the Western HSC Trust (Elaine Way), which forwarded an email from Arlene Foster, MLA, dated 8 February 2015 (*relevant document can be located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 - Paula Clarke - previous CE/20160211-email constituent*

Enquiry) Ms Foster's email was in relation to [Personal Information redacted by the USI], a patient from Fermanagh, who was under Mr O'Brien's care in the South West Acute Hospital, Fermanagh. Mr [Personal Information redacted by the USI] had been assessed in February 2014 but in or around January 2016, elevated readings associated with his prostate cancer revealed that the cancer had spread and he was told that he required chemotherapy. As he had not heard anything, Mr [Personal Information redacted by the USI] contacted Mr O'Brien's secretary. He was told that there was no record on "the City Hospitals system". This was escalated on 11th February to the Director of Acute Services, Esther Gishkori, with my personal request as CEO to *"please treat this as urgent as sounds as if something has gone wrong if not on cancer tracker pathway"*. A response was issued by David Cardwell in the Clinical and Social Care Governance Team Directorate of Acute Services (*relevant document can be located at S21 No 11 of 2022 Attachments, 91. 20160212 E Arlene Foster MLA re Mr [Personal Information redacted by the USI]*), on 11 February 2016 to the office of Arlene Foster MLA as follows; *"Thank you for your email of 8 February 2016 in relation to Mr [Personal Information redacted by the USI]. I am advised that Mrs Corrigan, Head of Urology for the Southern Trust has looked into this matter. She has confirmed that the referral to Dr K Rooney, Consultant Oncologist, at the Belfast Trust, was sent on 1 February 2016 along with a letter to the patient, from Mr O'Brien, Consultant Urologist, advising him of the referral. In this instance if Mr [Personal Information redacted by the USI] has not received an appointment then the Belfast Trust would be best placed to advise on their plans for Mr [Personal Information redacted by the USI]'s treatment. If you require any further information please do not hesitate to contact us"*.

96.5 In addition to the access performance issues in urology services, I now recall from documents provided to me by the Trust Public Inquiry team that in 2015/16, during my tenure as interim Chief Executive, a pathway review was completed by HSCB in five Trusts in the region to assess the systems and processes in place for the booking of outpatients in several services against the Integrated Elective Access Protocol (IEAP) with a specific focus on performance against chronological management. This included urology services and I have set out more detail on this review and its findings in my response to questions 52 and 53. Key findings from that report, relevant to my response to this question, relate

to triage times, where HSCB reported that:

“For the majority of urology referrals, daily triage is now achieved, but there is a long-standing issue with turnaround time from one consultant and referrals not returned from triage continues to be a key issue for booking staff.”

The report recommendations from HSCB for all services reviewed included

“..Where the 3-day turnaround standard is not being met, a process should be agreed with clinicians whereby the referrers’ priority is accepted, and the booking staff proceed to book urgent appointments” and “the areas outlined with particular challenges with late triage/missing referrals should be escalated as a matter of urgency”.

96.6 As stated in my response to question 53, I have some recollection of being generally aware of issues raised in this report regarding daily triage and that the reference to turnaround time for one consultant referred to Mr O’Brien as well as a general awareness of the recommendation regarding the priority grading for a patient where the 3-day turnaround standard was not being met. I have not seen, nor do I recall any escalation of the issues in this report formally into SMT, Board or to me as interim Chief Executive and expect I was aware as the review commenced when I was Director of Performance and Reform, and through informal discussions/one to one meetings with the extant Acting Director of Acute Services, Debbie Burns and Acting Director of Performance and Reform, Aldrina Magwood.

96.7 As interim Chief Executive, I would reasonably have expected that follow up on the recommendations was the responsibility of these two Directors and the incoming Acute Director of Acute Services, (from August 2015), Mrs Esther Gishkori, working together.

96.8 In my response to questions 54 and 56, I have indicated that the issues

regarding access performance in urology services continued over a long period of time from 2010 until my tenure ended on 31/3/16, despite the examples given of actions being taken to seek to improve this position. Since leaving the Trust on 31/3/16, I have become aware through the process of responding to this section 21 Notice of the investigations under the Managing High Professional Standards Policy into the practice of Mr O'Brien. My response to questions 83, 98 and 118 sets out my reflection on this information and the retrospective view I have now formed of failings in the urology service during my tenure that I was not aware of during my tenure.

97. During your tenure, please describe the main problems you encountered or that were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:

- a) What were the concerns raised with you, when were they raised and who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns**
- b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?
- c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not?
- d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements and how was this done? Please provide all relevant documents.
- e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?**

- f) If you were given assurances by others, please name those individuals and set out the assurances they provided to you. How did you test those assurances?**
- g) Were the systems and agreements put in place to rectify the problems within urology services successful?**
- h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.**

97.1 From what I can recall, and from the documents provided to me by the SHSCT team that I have been able to review as part of the process of responding to this Inquiry, the main problems I encountered or that were brought to my attention with respect to urology services during my tenure as interim Chief Executive in 2015/16 were the waiting times for patients to be assessed, treated and reviewed within clinically indicated timelines. This is covered in my response to questions 52, 54, 55 and 96 and I believe these responses also address the specific matters as set out in a) to h).

97.2 With respect to the specific issue regarding triage times that I have identified in paragraph 96.5-96.7, I now address the specific matters in a)-h) below as relevant:

- a) I have not seen, nor do I recall, any escalation of the issues in this report formally into SMT, Trust Board or to me as interim Chief Executive but I do have some recollection of being generally aware of issues regarding daily triage and that the reference to turnaround time for one consultant referred to Mr O'Brien, as well as a general awareness of the recommendation that I believe was made by HSCB to five Trusts in the region, to agree a process for using the referral priority grading for a patient where the 3-day turnaround standard was not being met. As indicated above, I believe my recollection most likely comes from the fact the review commenced when I was Director of Performance and Reform (in January 2015) and/or from informal discussions or one to one meetings with the extant Acting Director of Acute Services, Debbie Burns and Acting Director of Performance and

Reform, Aldrina Magwood but I do not recall any specific meetings or escalation to me formally about this issue.

- b) As these issues were not raised as concerns internally or by HSCB to me, my reasonable expectation as a Chief Executive was that follow up on the recommendations of an operationally facing report was the responsibility of these two Directors (Mrs Burns and Mrs Magwood) and the incoming Acute Director of Acute Services, (from August 2015), Mrs Esther Gishkori, working together.
- c) Similarly, I am not aware of any specific operational assessment completed to assess any risks to patient care and safety resulting from this triage review.
- d) As a result of the position I have set out in a)-c), I was unaware of any specific system or process actions taken in response to the HSCB report.
- e) As a result of the position I have set out in a)-c), I had no reason to assure myself on such systems and processes.
- f) and h). As a result of the position I have set out in a)-c), I was not aware of being given any specific assurances by others nor agreeing performance indicators to measure success
- g) With respect to systems and agreements being successful, as stated at d) I was unaware of any such systems or actions. I reflect, in paragraph 98.4, on information I am now aware of from the MHPS Reports that are relevant to this triage issue.

98. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

- (a) properly identified,**
- (b) their extent and impact assessed,**
- (c) the potential risk to patients properly considered?**

98.1 No issues of concern were raised with me other than the access performance issues I have referenced in my response to question 96 and 97. With respect to these performance concerns, I do believe that the evidence included in my response to questions 54 and 55, gives assurance that myself and the Trust Board were aware of the issues through the Monthly Performance Reports and the Corporate Risk Register, that they had been properly identified and their extent and impact assessed including the potential risk to patients. The risk assessments reported in the CRR were at a Trust level covering risks to access standards for outpatient, day case and inpatient assessment and treatment and specifically for outpatient review backlogs and planned procedures. Further detail of the risk assessment specifically for urology services in 2015/16 would be included on the Acute Directorate and Surgical Division risk registers and could be accessed from Heather Trouton, Assistant Director of Acute Services in 2015/16.

98.2 Issues I recall being generally aware of relating to triage have also been set out in my response to questions 96 and 97. At that time in 2015/16 I had no reason to believe that these issues had not been properly identified, their extent and impact assessed and the potential risk to patients properly considered. This belief was reasonable, given the independent review completed by HSCB and subsequent report and recommendations and the fact that I have seen no evidence to indicate that there was any internal, formal escalation of these findings. I reflect on this belief in paragraph 98.4.

98.3 At no time during my tenure as interim CEO in 2015/16 were concerns regarding deficiency in practice of any staff member in the urology team raised with me or escalated to me under the Trust Guidelines for MHPS or any other policy. I am however, (in the context of my preparation of this response to the Inquiry), now aware through documents provided to me relating to MHPS investigations undertaken by the Trust after I left the Trust on 31/3/16, and covered in my response to question 83, that

concerns were raised formally on March 23rd 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 and Elective Care, 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.

98.4 Having now seen the MHPS Reports referenced in paragraph 83.6-83.8, I note the following:

- a. The findings of Dr Khan as Case Manager 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."*
- b. The findings in Dr Chada's report, as Case Investigator, in section 6 that:
 - i. *"...a decision was taken during 2015 to introduce a default process whereby all patients were placed on the waiting list according to the GP categorisation of urgency if the referral was not received back from the consultant urologist. This default process was agreed by the Director of Acute Services at the time, Mrs D Burns and a number of other senior Trust staff according to some witnesses interviewed."*
 - ii. In Section 8 of Dr Chada's report that: *"It is evident that many witnesses were aware Mr O'Brien was not undertaking triage as per*

the agreed process in 2014 and 2015 but there is little evidence to highlight clearly the actions taken by managers or senior clinicians to address the concerns with him during that period”

iii. 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: “..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 was a missed opportunity by managers to fully review and understand the extent of the issues”.

98.5 Based on this new information to me at this point in time, I now consider that the concerns raised formally on 23rd March 2016 in the letter to Mr O’Brien from Mr Eamon Mackle and Mrs Heather Trouton, which I was unaware of in March 2016, did not fully identify the extent of the issues nor their impact and potential risk to patients. It is my understanding that these concerns were not escalated formally under MHPS until 30 December 2016 following further information from an SAI investigation.

99. What, if any, support was provided to urology staff (other than Mr. O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q114 will ask about any support provided to Mr. O'Brien).

99.1 During my tenure as interim CEO I was unaware of any concerns raised that would have required support to be provided to urology staff.

100. Was the urology department offered any support for quality improvement initiatives during your tenure?

100.1 I do not recall any specific support being offered to support urology services for quality improvement initiatives. I would refer to the “Blue Skies Pilot” opportunity presented to the HSCB Director of Commissioning and his team on 8/6/15 set up by

myself and referenced in paragraph 10.4

Mr. O'Brien

101. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

101.1 I am responding in respect of my tenure as interim Chief Executive in 2015/16 during which time I had no direct responsibility for Mr O'Brien. As a medical consultant Mr O'Brien was responsible within the management arrangements of the Directorate of Acute Services and professionally to the Medical Director. From what I can recall, any contact I had with Mr O'Brien was infrequent and informal occurring through the engagement processes with clinical staff I have set out in response to question 10.

102. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

102.1 I had no involvement in the formulation and agreement of Mr O'Brien's job plan(s) as that responsibility was with the Clinical Director and AMD.

103. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?

103.1 I refer to and repeat my responses to questions 83, 96 and 98, with specific reference to paragraphs:

- a. 83.6-83.7, 98.3 and 98.4 which relate to concerns regarding Mr O'Brien's practice that I only became aware at this point in time in 2022 from the MHPS Investigation Reports
- b. 96.4 relating to queries/complaints regarding access times for care under Mr O'Brien received into my office in 2015/16
- c. 96.5-96.7, 97.2 and 98.2 which relate to my general awareness of some issues relating to triage within urology services and Mr O'Brien that I recall being generally aware of in 2015/16 but which were not raised as issues of concern with me.

104. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

104.1 I have no recollection, nor any evidence to indicate, that I was involved in any discussions about concerns regarding Mr O'Brien.

105. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

105.1 Given my response to question 104, this question is not applicable to me

106. Did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? If so:

- (i) **what risk assessment did you undertake, and**
- (ii) **what steps did you take to mitigate against this? If none, please explain.**

If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person and, if known, any steps taken

106.1 Given my response to question 104, this question is not applicable to me

107. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr. O'Brien and others, given the concerns identified.

107.1 Given my response to question 104, this question is not applicable to me

108. Did you ever speak to or contact Mr. O'Brien, either formally or informally, regarding the concerns raised, or any proposed actions or plans, or about any matter falling within the Inquiry's Terms of Reference? If so, please provide full details.

108.1 I can confirm I have never spoken or contacted Mr O'Brien regarding any concerns raised during or after my tenure in the SHSCT

109. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

109.1 Given my response to question 104, this question is not applicable to me

110. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

110.1 Given my response to question 104, this question is not applicable to me

111. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

111.1 Given my response to question 104, this question is not applicable to me

112. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

112.1 I have no recollection, nor any evidence to indicate, that Mr O'Brien raised any concerns with me as interim Chief Executive in 2015/16. I have a general recollection of Mr O'Brien expressing frustration at the long waiting times for patients, as did other consultants across a number of clinical services. This issue was a high-profile matter for Trust Board and operational managers, as evidenced throughout my response above.

113. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:

- (a) outline the nature of concerns you raised, and why it was raised**
 - (b) who did you raise it with and when?**
 - (c) what action was taken by you and others, if any, after the issue was raised**
 - (d) what was the outcome of raising the issue?**
- If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?**

113.1 At no time during my tenure with SHSCT did I raise concerns about the

conduct/performance of Mr O'Brien as I had no cause to do so.

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

114.1 Given my response to questions 104 and 112, this is not applicable to me.

115. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

115.1 Given my response to questions 104 and 112, this is not applicable to me. For accuracy I refer to my response to questions 26, 54 and 55 that address the access and waiting time risks included in the Corporate Risk Register during my tenure.

116. Did you communicate in any way, either formally or informally, with your predecessor Chief Executive, Mairead McAlinden, or your successor, Francis Rice, in relation to any issues of concern regarding urology services, such as patient safety, clinical risk or governance issues? If so, please provide all details and any relevant documentation.

116.1 I can confirm that I had no reason to communicate in any way with my predecessor Chief Executive, Mairead McAlinden, or my successor, Francis Rice, in relation to any issues of concern regarding urology services.

Learning

117. What was the position regarding the concerns raised regarding urology by the end of your tenure? Had concerns of which you were made aware been

addressed to your satisfaction? If so, please explain. If not, why not?

117.1 The only concerns I was aware of regarding urology services in my tenure as interim CEO of SHSCT were those relating to performance against access standards which I believe I have already covered in sufficient detail earlier in this statement.

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

118.1 In my response in paragraphs 83.6-83.8 and 98.3-98.5, I refer to concerns regarding urology services and specifically, the practice of Mr O'Brien, that I was unaware of during my tenure. The information I am now aware of in 2022 derives from the MHPS Investigation Reports and Case Manager's Determinations, covered in these paragraphs. The governance concerns in these reports relate to the Terms of Reference for the formal Report by Dr Khan and pertain to:

- a. triage of patient referrals by Mr O'Brien;
- b. tracking and storage of Mr O'Brien's patient notes;
- c. dictation of outpatient clinic outcomes by Mr O'Brien;
- d. scheduling of private patients within clinical priority by Mr O'Brien;
- e. the extent to which line managers were aware of these matters prior to December 2016.

118.2 With hindsight, and now knowing that patients came to harm as a result of the deficiencies in the practice of Mr O'Brien identified in these Reports, I would have to say that I could have been made formally aware of the escalating concerns in the period prior to the letter of 23/3/16 being issued to Mr O'Brien by Dr Mackle and Mrs Trouton. The fact that I was on annual leave from 14/3/16 and left the Trust on 31/3/16 is, I believe, a factor in my not knowing about this.

118.3 Regarding whether I should have been made aware, I base my view on the content of these MHPS Reports and appreciate that I may not have access to all relevant information. I would say that, to some extent, the growing evidence relating to the practice of Mr O'Brien over 2014 and 2015/16 that the MHPS Reports outline were being managed at the appropriate level within the Acute Services Directorate. An example of this is in the fact that the HSCB independent review of IEAP practices addressed in my response to question 53, which recommended something akin to a default process for recording referrals not triaged within 3 days, provided a sense of assurance that mitigating actions were under control, hence a belief that there was no reason to report these triage delays and associated mitigating actions at an organisational level. My assessment, based on hindsight, and having seen the investigation reports, is that these governance concerns did not come to my attention as acute clinical and operational managers were acting in good faith to try and resolve issues locally and taking actions to address the immediate problem rather than dig sufficiently into the root cause and assess the actual or potential impact and risk to patients.

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

119.1 My awareness of the issues within urology services that "went wrong" relate entirely to the practice of Mr O'Brien and the findings of the MHPS Reports referenced in my response to questions 83, 98, 103 and 118. As I left the Trust and moved to England at the end of March 2016, I was not part of these investigations and had no awareness of them until I was required to respond to the Inquiry under this section 21 Notice. Acknowledging that I may not have all the relevant information that came to light following my departure from the Trust, I have expressed my view in my responses in paragraphs 83.6-83.8, 98.3-98.5 and in my response to question 118.

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

120.1 As I left the Trust and moved to England at the end of March 2016, I was

not part of the identification of the governance concerns within urology services and specifically relating to the practice of Mr O'Brien, nor the approach adopted to ensure learning was identified, acted on and shared. I therefore cannot legitimately respond beyond my response to question 118.

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

121.1 I refer to my responses to questions 118 and 119.

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

122.1 As I left the Trust and moved to England at the end of March 2016, I was not aware of nor part of the identification of the governance concerns within urology services that commenced with the letter to Mr O'Brien by Mr Eamon Mackle and Mrs Heather Trouton on 23rd March 2016. As I was unaware of the concerns, I cannot say I made mistakes in handling these direct MHPS concerns. I also refer to my response to questions 118 and 119.

122.2 On reflection, I have considered the approach adopted to putting in place the "default" triage process, where patients not triaged by the consultant within 3 days were put on the Patient Administration System based on the GP referral rating. This process is referenced in the MHPS report completed by Dr Chada, as covered in my response to question 98, and is also referenced in my response to questions 53

and 116, noting that this approach was recommended by the HSCB following their review of IEAP practices. My experience from clinical feedback was that GP referral ratings were generally considered to be accurate and, if anything, the long waiting times that had developed for some services in 2015/16 had resulted in GPs increasing urgent referrals. I have now reflected that, both the HSCB recommendation and the belief that GPs were more likely to upgrade a referral where there were long waits, contributed to a missed opportunity to fully assess the risks in this process and put in place counter-measures or mitigating actions. This could, for example, have included an audit of a percentage number of referrals that had not been triaged every month to test the accuracy of the GP referral, or by setting a backstop target, where referrals added to the system based on the GP referral rather than consultant triage, still had to be triaged by a consultant within, say, 4 weeks.

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

123.1 As I have stated in my response to questions 12, 22 and 83, I believe the governance arrangements during my tenure as interim Chief executive in 2015/16 were effective. I had no concerns about these governance arrangements during my tenure however as set out in paragraphs 12.3-12.6, I did aim to continuously improve on these arrangements and undertook a review during my tenure.

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

124.1 I do not have anything to add.

Statement of Truth

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

Signed: Personal Information redacted by the USI

Date: ____15th July 2022_____

Section 21 11 of 2022

Witness Statement: Paula Clarke

Table of Attachments

Attachment	Document Name
1	Chief executive Job Description
2	Item 09 - 05 - SHSCT Draft Financial Plan 2015-16 PDF
3	20160425_MonthlyPerfReportApril(MarchPerf)_TB_V1_0 Personal Information redacted by the USI
4	20150325 Ltr RP292 letter to P Clarke re Acting Accounting Officer - Appointment Letter
5	20150325 Ltr RP292 letter to P Clarke re Acting Acc Officer - Accounting Officer Memorandum A1
6	Assistant Director JD Performance and Reform
6a-6g	JDs for all Directors
7	PandR Organisational Chart 16.01.14
8	Org Chart - Dec 2016
9	Office of the Chair Jan 2016
10	ACUTE Organisational Chart December 2015
11	20150410 E and Reports Draft Paper Governance - RCSCG CONSULTATION DRAFT 4 A2
12	ro-guidance-doctors-employers
13	ANNUAL_REPORT_AND_ACCOUNTS_2015-16
14	20160122 Diary Medical Forum Meeting A2
15	20150203 Approved Governance Committee Minutes
21	20150827 Performance Report a
22	20150608 E Mtg re Blue Skies Pilot with SHSCT and HSCB - Urology
23	20150608 E Mtg re Blue Skies Pilot with SHSCT and HSCB - Urology A
24	20150608 E Mtg re Blue Skies Pilot with SHSCT and HSCB - Urology A1
25	20150616 Mid Year Stratgic Accountability Meeting - Mins from 16 June 2015 A2
26	20150723 E and diary - Mtg with EG
27	20150723 E and diary - Mtg with EG A
28	20151126 Board Assurance Framework
29	20141001 SHSCT Incident Management Procedure
30	20151208 Approved Governance Committee Minutes Item 8i) CSCG Revisit
31a(i-iv)	Confidential Governance Committee
31b(i-viii)	Non Confidential Governance Committee
32a(i-xx)	Trust Board Confidential.
32b(i-xviii)	Trust Board Non Confidential
35	Commissioning Plan 2015-16_0
36	SMT Terms of Reference
37	SMT Governance Agenda 27 January 2016
38	SMT Governance Notes 27 January 2016
39	SMT Agenda 24 February 2016
40	SMT Notes 24 February 2016
41	SMT Agenda 2 March 2016
42	SMT Notes 2 March 2016
46	20151126 Performance Report a
47	20151126 Performance Report b
48	20150129 Confidential Minutes (1)
49	20150203 Confidential Governance Committee Minutes

51	Leadership Walkabouts - Summary report Jan-Sep 2015 Final
52	20151208 CRR
53	Board Assurance Manager SANDRA JUDT
54	SMT Notes 18 March 2015
55	SMT Notes 27 May 2015
56	SMT Notes 16 September 2015
57	SMT Notes 21 October 2015
58	20160204 CRR
59	20150507 DHH ED Timeline A1
61	SMT Notes 1 July 2015
62	SMT Notes 22 July 2015
63	SMT Notes 5 August 2015
64	SMT Notes 12 August 2015
65	SMT Notes 23 September 2015
66	SMT Notes 30 September 2015
66a	plenary-22-09-2015
66b	CI Newsletter Issue 16
66c	20150911_Sept newsletter_Final version_bmc
68	20151022 MidyearassuranceSHSCTFinal
69	20150401 E and Diary Urology Services Mtg on 30 April 2015
70	20151208 E Regional Review of Urology and OP Gynae Regional Workstream A1
71	GGI-Board-Guidance-on-risk-appetite-2020
72	20151125 Diary Ground Clearing Meeting
73	SMT Notes 8 July 2015
74	SMT 17 February 2016
76	HM700 - ltr to Trust Dir Acute re Uology Review Implementation
77	Steering Group Meeting - 13th May 2010
78	Team South Implementation Plan v0.2
79	Team South Implementation Plan v0.3
80	Urology Revenue IPT Feb 2012
81	FW for action - FW Urology Review
82	MB334 - ltr to Aldrina Magwood re Review of OP booking processes
83	Performance Framework Version2 PROGRESS REPORT JUN09
84	20100930 TB Confidential Minutes
85	20110224 Performance Dashboard B
86	20130926a Performance Report to TB
87	20100907 CRR a
88	20150908 CRR
89	Item-7-HSC-Board-Performance-Report-15-16-EOY-Assessment
90	20150929 E General Surgical Situation
90a	Policy for the Management of Complaints 2013
91	20160212 E Arlene Foster MLA re Mr [Redacted] Personal Information
93	20151029 email WHISTLEBLOWING POLICY 2
94	20151126 Whistleblowing Survey Results
95	Consultant Job Planning Framework 2009
96	20160128 MD Report TB
98	20150615 E [Redacted] re Wait for Surgery Personal Information
99	20150811 E Jo Anne Dobson MLA re [Redacted] Personal Information redacted by the USI
100	20151102-email for response [Redacted] Personal Information redacted by the USI

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 relevant¹ subject AND have a minimum of 5 years' experience in a senior management² role in a major complex organisation³
- 2) Have at least 3 years' experience of managing major change programmes addressing significant⁴ 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 significant⁴ 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 significant⁴ 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 organisation³, 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 appointment⁵. 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

1. Introduction

In response to the Assembly budget settlement, the Department of Health, Social Services and Public Safety, (DHSSPS), has developed a draft plan to deliver financial balance in 2015/16 and address unavoidable/inescapable cost pressures and commitments. This final budget settlement gave the DHSSPS some £150m of additional resources compared to 2014/15 and includes an expectation that all Arms' Length Bodies (ALBs) need to achieve significant savings in order to finance such cost pressures and commitments. The Southern Trust has been advised it needs to deliver £13m in cash savings during 2015/16 as part of this wider health and social care financial settlement.

Within the constraints of the statutory duty to breakeven financially, the Southern Trust remains mindful of its statutory duty to provide safe, high quality care which is effective, efficient, accessible and responsive to the needs of our patients and clients. However, balancing the requirements of both these statutory duties means difficult decisions are required. Where some degree of service change is required the Trust will ensure that:

- best practice is applied and followed;
- necessary alternative capacity is available to support any proposed shifts in activity.

The ability to expand and develop new services in 2015/16 will be restricted and there will be a need to consolidate some of our existing services to ensure safe, effective care and value for money is achieved. This paper sets out how we propose to deliver the £13m savings target. These proposals will be subject to public consultation and equality screening, as appropriate and in line with Departmental and organisational legislation and guidance.

2. Southern Trust Financial Context 2015/16

The Trust's financial plan for 2015/16 is set in the context of the Southern Trust's overall position with respect to performance, relative efficiency and significant demographic pressures compared with the rest of the region:

- **Performance:** We continue to deliver against the majority of our Service and Budget volumes, uplifted for additional activity to deliver non-cash releasing efficiency savings.
- **Efficiency:** We can demonstrate through external benchmarking that we retain our position as one of the most efficient Trusts in NI and within the UK Top 40 hospitals.
- **Demography:** We have seen local population growth of 18% between 2000 and 2011 compared with the NI average of 7% and we have further projected growth of 15% by 2023 compared to the NI average of 7%.

Furthermore, the Trust's savings requirements for 2015/16 are set in the context of what has already been achieved as part of the current comprehensive spending review (CSR) period as well as emerging pressures within our hospital and community services.

3. Southern Trust Savings Target for 2015/16

The HSCB has confirmed that the Southern Trust is required to deliver **£13m** cash release savings for the financial year 2015/16. Within the context outlined above, delivering £13m savings presents a significant task for the Trust. Our primary focus in 2015/16 will be to continue to aim to deliver on plans that achieve safe, quality and efficient care in a sustainable and financially recurrent way to achieve a degree of stability however the Trust will also be required to continue with a number of shorter term contingency measures (non-recurrent actions) to secure the level of savings required during this financial year.

To this end, we will continue to protect the Trusts' most critical services as a priority. This includes ensuring we deploy skilled staff to best effect in service areas where demand is high and they can be most effective and ensuring the most efficient approach to service delivery that maintains the quality and level of services available to service users.

The Trust's plans fall into the following broad categories and described in greater detail in the sections below:

	Savings Plans	£'000s
1.	Savings in 2015/16 from existing plans (SECTION 4)	1,400
	Hospital services for older people: flexible use of non-acute beds	180
	Assumed continued closure of Skeagh House residential facility	300
	Modernisation of day services	250
	Drumglass children's residential facility	518
	Traffic Management Strategy/Car parking	152
2.	Savings from maintaining 2014/15 contingency plans in 2015/16 (SECTION 5)	360
	Closure of Armagh MIU	200
	Reduced operational hours at STH Paediatric Ambulatory clinics	160
3	Savings from New Recurrent Plans for 2015/16 (SECTION 6)	4,000
	Reform of Domiciliary care / 'live monitoring'	1,300
	Range of Workforce Measures	2,600
	Review of Contracts with external providers	100
4.*	Savings from recurrent plans that will deliver beyond 2015/16 (SECTION 7)	3,000
5.	Savings from Contingency Measures – vacancy control, G&S, (SECTION 8)	4,240

**Note: The Trust will be required to achieve a total of £7,240m in contingency during 2015/16 to bridge those proposals outlined in Section 7.*

4. Savings Planned in 2015/16 from Existing Plans

The Trust has developed a number of strategic plans during 2012-2015 for which associated implementation in 2015/16 is planned to secure £1.4m cash release savings as follows:

- **Hospital Services for older people:** the Trust will continue in 2015/16 to use our non-acute beds in Loane House, Dungannon and Lurgan Hospital flexibly throughout the year. This means stepping up and down the number of beds available in line with high and low periods of demand.
- **Skeagh Residential Home:** The Trust has developed a proposed strategy for statutory residential homes and awaits approval from HSCB on this plan. In the interim, Skeagh House Residential home in Dromore is currently temporarily closed as a result of landslip in March 2013 which required the Trust to evacuate all residents to ensure their health and safety. The Home remains unusable as a result of the land slip and the continued instability of the hill above it on which the Barban Hill development was constructed in recent years. The former residents of Skeagh House have settled into alternative accommodation and staff re-deployed to other services. The Trust has engaged Legal Services with respect to establishing liability, securing an agreed solution and stabilising the slope. The current advice has indicated the matter could take some time to resolve legally therefore the savings associated with the temporary closure are assumed for 2015/16.
- **Day Services Modernisation:** Following the HSCB Public Consultation on Day Opportunities and the support given for this approach, the Trust working in partnership with service users will continue to enhance and develop the range of day opportunities available in local communities including the on-going provision of care and support within Day Centres for people with complex healthcare needs and challenging behaviours.
- **Residential care for Children and Young People:** the Trust has enhanced intensive foster care and outreach services within the Trust over recent years. These developments have reduced demand and enabled flexible utilisation of beds within residential care facilities. As a result, Drumglass children's residential facility in Dungannon has not been required for over 18 months and staff have been redeployed to other front line services. **It is the Trusts intention to progress local engagement and a targeted consultation with key stakeholders over the coming months to move to a permanent closure of this facility in 2015/16.**
- **Traffic Management Strategy/Car Parking:** The Trust's Traffic Management Strategy ensures safe, secure and suitably accessible car parking for patients, visitors and staff. This provision includes both free and fee-paying, depending on the needs and choice of individuals. The Trust has introduced revised Car Parking Charges on both Acute hospital sites at Craigavon Area Hospital (CAH) and Daisy

Hill Hospital (DHH). This uplift still represents value for money when compared with other Trusts in the region.

5. Savings Planned in 2015/16 from Temporary / Contingency Plans Implemented in 2014/15

In October 2014, following the October Monitoring Round the DHSSPS received £80m additional funding however, this fell short of the levels required to maintain existing services during 2014/15 and the Minister advised the NI Assembly that there would be consequences for the provision of health and social care services and it would not be possible to maintain current levels of service provision in the absence of the required funding.

In late 2014, the Regional Health and Social Care Board approved Trust plans to step down a number of services so that funds could be released to support priority front line services. All Trusts implemented a range of contingency proposals to address the difficult financial position, minimising as far as possible, any potential negative impact on patient and client care, and at all times putting the safety of patients and clients as our first priority.

As part of these measures, the Minister required assurance from Trusts that where changes were implemented alternative arrangements were put in place to maintain safety and mitigate the impact of patient flow. The Trust is proposing a number of these actions are continued as part of the 2015/16 financial plan as follows:

- **Temporary closure of Armagh Minor Injuries Unit.** The MIU was temporarily closed in November 2014, following the Southern Trust announcement of plans to save £2.9m by the end of March 2015. The Trust has closely monitored the impact of the temporary closure to ensure that risks are minimised. It is clear that most people who decide they need advice or treatment for a minor injury are going to the MIU at South Tyrone Hospital. This demand has been absorbed at STH without pressure on existing resources with on average 7 patients attending per hour and 99.9% assessed and treated within 4 hours of arrival.

The experienced Emergency Nurse Practitioner staff who worked in the Armagh unit have been based in the Emergency Department at Craigavon Hospital helping to manage the significant increase in demand in this main emergency site. It has been important during these busy winter months that our experienced nursing staff are available to see and treat as many patients as possible in our busiest units.

It is proposed that the temporary closure of Armagh MIU will be extended beyond the end of March 2015 and that the Trust will liaise with the HSCB and the Department to commence a public consultation before the end of May 2015 to decide on the longer-term future of the service.

- **Temporary change to the operational hours of South Tyrone Hospital (STH) children's ambulatory paediatric unit.** In November 2014, following the Southern Trust announcement of plans to save £2.9m by the end of March 2015 the hours of operation of the STH ambulatory service were temporarily changed from 9am - 5pm to 9am - 1pm from Monday to Friday. Paediatric advice lines for GPs and other health and social care staff remain accessible at Craigavon and Daisy Hill Hospitals from 9am to 10pm. The Trust has maintained regular monitoring of activity levels within the unit at STH and the ambulatory service at CAH to assess the impact and manage any risks. This analysis has demonstrated that on average 5 less patients are being seen per week at with approximately 1 additional patient per week seen in the ambulatory unit in CAH from the Dungannon area.

The Trust proposes to continue these temporary measures during 2015/16. The longer term plan for the unit will be subject to further discussion with the commissioner in the context of wider plans under the Trust's 'Changing for Children' strategy.

6. Savings from New Plans to be implemented in 2015/16

As part of the overall planning process for the HSC budget for 2015/16 the Trust has discussed a range of new proposals, both recurrent and non-recurrent, to contribute to securing financial break-even. The following summarises those plans where HSCB support has been confirmed:

- **Reform of Domiciliary Care Services** - on-going measures to bring domiciliary care spend in line with commissioned levels will continue during 2015/16. This will include testing new approaches such as 'Live Monitoring' and reviewing our current approach to service delivery and testing opportunities to improve the safety, quality, effectiveness and experience of service users during 2015/16. Any reform of the existing service model will be progressed in line with recommendations from the Regional Review of Domiciliary Care which is being led by the HSCB.
- **Workforce Measures:** Savings opportunities for 2015/16 include vacancy control, absence management and reductions in overtime and agency costs. There will also be a strong focus on securing savings from management and administration expenditure. In addition, the Trust will participate in collaborative working with the wider HSC sector to progress areas where there is evidence to support working differently across the region.
- **Review of Contracts with external providers:** The Trust proposes through its regular review of contracts provided by external providers, including voluntary and community groups, to identify areas for cost reduction and opportunities for new ways of working.

7. Savings from Plans Beyond 2015/16

The Trust 3 year strategic plan “Changing for a Better Future” identified a number of proposals for service change in support of our key priority of ensuring the safety and quality of our services and identifying opportunities to improve patient experience and quality of care. These plans included proposals to transform a number of areas of care delivery to enhance access to a range of care options locally, improve safety and outcomes for patients and ensure best use of public funding and scarce specialist staff resources.

During 2014/15 the Trust brought forward and publically consulted on a number of these proposals including:

- Modernisation of in-patient acute and rehabilitation stroke services through the development of a specialist acute stroke unit at Craigavon Area Hospital.
- Consolidating all inpatient non-acute hospital services for older people at Daisy Hill and Craigavon Area hospitals
- Development of a new, fit for purpose unit for Dementia Assessment Inpatient Care on the Craigavon Area Hospital site

The Trust’s change plan for statutory residential care provision in the southern area is currently under consideration by the HSCB.

These service changes are dependent on key enablers including access to capital development funding and the need for us to build confidence that new community based services that are in place are working well before any major changes could take place. The efficiency opportunity from these plans is therefore two to three years away from being realised and the Trust will therefore be required to implement non-recurrent contingency measures in the interim period. These are further outlined below.

8. Savings from Temporary/ Contingency Plans in 2015/16

Contingency arrangements are generally viewed as one-off actions designed to bridge the period between the date on which income is lost and the point at which the Trust is able to implement permanent measures of cost reduction equal to the amount of lost income, (thereby ensuring achievement of the statutory duty to break-even).

Contingency arrangements can be required for a number of consecutive years, the period is determined by the time it takes to identify and fully implement the range of permanent measures.

Over recent years, the Southern Trust has worked with a range of independent experts to explore all possible areas of savings and to date no new significant savings opportunities have been identified that can be implemented by Trust only implementation. However,

further system wide opportunities do exist and the Trust is reliant on commissioner led system wide reform to address the underlying financial gap in a recurrent and sustained way.

As a direct result of the above the Trust has become heavily reliant upon non-recurrent contingency measures in order to secure year-end financial breakeven. The 2015/16 financial year will be no exception to this as the Trust will be required to achieve a total of £4.24m savings through a range of measures. These will fall into two main categories:-

- **Vacancy Control Measures** – The Trust implemented a range of vacancy control measures in 2014/15 and it is proposed that these measures continue during 2015/16. The main aspects will include targeting a significant reduction in flexible workforce spend and delaying recruitment. The majority of these workforce measures will be opportunistic; however, the Trust will continue to ensure that it concentrates resources on the most critical services to avoid risk to patient and client safety and quality of care. The Trust will continue to ensure close monitoring of these actions and target vacancy control on a rolling basis to minimise impact on any one service and seek to sustain commissioned levels of activity where these have been agreed.
- **“Discretionary” Goods and Services** – all areas of discretionary spend such as staff travel, printing and stationery, books and publications, training, estates maintenance and non-essential goods and services will continue to be closely managed to minimise spend. The Trust will also continue to pursue best value for money on all resources procured.

9. Equality Screening

In developing our Financial Plan the Trust has adhered to its Section 75 statutory equality duties. In the interest of openness and transparency the Trust will publish quarterly equality screening outcomes reports and will publish same on its website.

Whilst some of the proposals in the Trust’s Financial Plan have been screened out with mitigation, others will be subjected to on-going screening and will be kept under review. Others, such as those outlined in Section 7 above have already been subjected to equality screening, equality impact assessment and public consultation. The Trust will also take account of the Human Rights Act and the need to act in a way that is compatible with the European Convention on Human Rights as well as pay due regard to the impact of service changes on rural areas.

The Trust is mindful of the advice issued by the Equality Commission for NI in December 2014 on how to apply the Section 75 equality duties to budget processes. In particular the Trust notes the requirement for an *assessment of overall budget proposals at strategic*

level - to provide evidence of the *cumulative impacts* of the overall range of proposals presented by HSC Trusts and what impacts they might collectively have on the section 75 categories. *The Trust will work with the HSCB to ensure that local area impacts or the impact of central decisions are appropriately consolidated and assessed on a region-wide basis.*



REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 28 April 2016
Title:	Monthly Performance Management Report
Lead Director:	Aldrina Magwood Acting Director of Performance and Reform
Corporate Objective:	➤ Provide safe high quality care ➤ Maximise independence and choice for our patient and clients ➤ Support people and communities to live healthy lives and to improve their health and wellbeing. ➤ Make best use of resources.
Purpose:	For Information
	High Level Context: 1. Critical to the Trust's performance is achievement of our <u>Service and Budget Agreement (SBA)</u> for core levels of commissioned activity in the first instance. This report reviews performance against the SBA as at the end of February 2016. ➤ Corporately Month End February performance is showing good performance against the profiled level of activity in the majority of areas expected at this time in the year, however some specialty areas are not expected to deliver the full level of commissioned activity by March 2016. 2. This report reviews performance at the end of March 2016 against the <u>Commissioning Plan Standards and Targets for 2015/2016</u>. The Trust Delivery Plan includes our internal assessment of achievability of the Commissioning Plan Standards and Targets as the start of the year. As at March 2016 the Trusts internally assessment of performance highlights a number of areas where performance is not in line with the initial assessment or achievable or partially achievable with resources. These areas include ➤ Carers Assessments, Direct Payments and Cancelled out-patient appointments where the target was based on historically good Trust performance relative to the region leaving achievement of the target more challenging; ➤ 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; ➤ Elective in-patient/day cases targets where assessed performance was subject to availability of timely additional resources to facilitate creation of additional in-year capacity. ➤ Adult mental health services including dementia, and psychological therapies where there was workforce challenges in-year.

- Adoption timescales which was impacted by adoption of a higher number of older children

3. While not formal Commissioning Plan targets, this report also considers a range of other important related indicators which impact on the Trust's overall performance including:

- Reviews beyond 'clinically indicated' timescales (Acute & Mental Health Consultant led outpatients);
- Reporting timescales – plain film and diagnostics (non-DRTT modalities; and
- Planned repeat procedures.

Note: The Commissioning Plan Direction, with goals and targets for 2016/17, has not been finalised and as such the Trust will continue to report on the current 2015/16 targets into the next period.

Key Issues

(1) Service and Budget Agreement (SBA) – Achievement of commissioned levels of activity

The delivery of access times is reliant in part upon the delivery of agreed levels of commissioned activity, as per the SBA. Whilst corporately month-end February performance is showing good performance against the profiled level of activity in the majority of areas, expected at this time in the year, some specialty areas are not expected to deliver the full level of commissioned activity by March 2016.

The following key actions are in place:

- Improvement plans implemented in key specialities where performance was not in line with profiled activity to ensure these return to profile.
- Proposals have been submitted to HSCB to adjust SBA volumes where these do not reflect the current service model. Whilst agreements have been secured for the majority, one remains outstanding, Urology, for agreement by year-end.;
- The Trust has engaged with HSCB and SLCG to provide mitigating information on specific specialty areas where manpower issues (Orthopaedic ICATS, General Surgery, Diabetology, Endoscopy) or lack of demand (Orthodontics, Colposcopy, Community Dentistry) is impacting on the delivery of SBA levels. These areas will not return to the profiled performance required by March 2016; and
- Trust has submitted improvement plans to HSCB, to seek improved SBA performance in Quarter 1 of 2016/17, for Endocrinology, Gastroenterology and Urology NOP; General Surgery in-patients and day cases (IP/DC) and Endoscopy.

(2) Commissioning Plan Targets - Elective Access

As previously reported, access times continue to increase particularly for routine patients, and the ability to maintain standards has become increasingly challenging related to:

- Demand exceeding commissioned capacity – Regionally an increase in referrals is estimated at 6% year on year;
- Recurrent investment is insufficient to address all capacity gaps in

elective areas; and

- The in-year timing of non-recurrent funding allocations from HSCB, to address capacity gaps, has limited the Trusts ability to optimise additional capacity options.

The following key actions are in place:

- Available capacity continues to be prioritised to red flag (cancer) referrals and urgent patients. The Trust is experiencing increasing demand for red flag referrals which has impacted on capacity for routine waits making the access time longer in some areas. There is currently no related increase in confirmed cancer diagnoses resulting from the increase 'red flag' referrals;
- Strict chronological management to ensure routine patients are treated in turn;
- Measures to minimise lost capacity from those who do not attend or cancel their appointments/procedures on the day;
- Provision of monthly information to General Practitioners to ensure referrers and patients are aware of current and projected waiting times by specialty, and
- Continued focus on the provision of activity in accordance with Service and Budget Agreement (SBA) commissioned volumes

The Trust formally highlighted risks to the HSCB in early 2015/2016 and has assessed elective areas where there is emergent risk in the clinical pathway for 2016/2017. These areas will be prioritised against a sum of non-recurrent funding which has been made available by the HSCB for additional in-house capacity to be undertaken in Q1/2 2016/17 to address elective waits and patient safety issues.

Summary of elective access areas:

- **Diagnostics (CP 16)** – Additional non recurrent funding has been provided in 2015/16, predominantly to Imaging and Endoscopy. This will see improved access times at March 2016 for imaging with the majority of waits anticipated below 21-weeks, notwithstanding any increases in urgent demand. Exceptions include specialist areas for CT colonography and fluoroscopy where ability to provide additional capacity is limited.

Endoscopy presents with the longest wait for routine diagnostics and projects a longest routine wait of 46 weeks at the end of March. Demand in this area is greater than capacity which is recognised by HSCB and investment in additional training posts for nurse Endoscopists has been made. HSCB funding for additional capacity facilitated an additional 2300 procedures outside the SBA. Capacity in the Independent Sector has been extremely limited this year. Capacity continues to be prioritised for red flag, urgent patients and urgent planned/screening patients.

HSCB has indicated it will seek to provide additional non-recurrent funding in Q1/2 for additional capacity in diagnostics to continue to improve access. Formal communication of this is awaited.

- **Out-Patients (CP 15)** – Non-recurrent funding from the November

2015 Monitoring Round was initially directed by the HSCB to specific areas where access issues presented a regional priority and subsequently to areas where there was opportunity to create additional capacity. Within the Trust Pain Management and the visiting service of Ophthalmology received additional support initially in line with regional direction. The Trust continues to re-direct internal resources, as available, to speciality areas where urgent or long waits present emergent clinical risk and to reviews beyond clinically indicated timescales.

Routine waits beyond 18-weeks, which is the maximum wait on the current target, include routine Symptomatic Breast and Paediatric NOP. Further out-patients are anticipated to be waiting in excess of 26-weeks in Cardiology, Endocrinology; Diabetes; ENT; Gastro-enterology; Ortho-Geriatrics; General Surgery; Gynaecology; Haematology; Neurology; Orthopaedics; Respiratory; Pain Management; Rheumatology; and Urology.

- **In-Patient/Day Cases (CP17)** – Non-recurrent funding from the November 2015 Monitoring Round was initially directed by the HSCB to specific areas where access issues presented a regional priority and subsequently to areas where there was opportunity to create additional capacity. Within the Trust Pain Management, General Surgery and Orthopaedics received additional support. The Trust continues to re-direct internal resources as available to a wider range of specialty areas.

Routine waits beyond 26-weeks, which is the maximum wait on the current target, also include Cardiology, ENT and Gynaecology. Further waits in excess of 52-weeks are anticipated in Breast Surgery; General Surgery, Orthopaedics, Pain Management and Urology.

It is important also to note that other factors influence the time a patient may wait including the clinically defined urgency of the procedure and the capacity within the required sub-specialist area.

- **Mental Health Out-Patients (CP22)** – Non recurrent funding has not been directed to this area to date and pressures prevail in Psychological Therapies and Dementia/Memory Services. The Trust has re-directed internal resources as available and where capacity can be secured.
 - **Psychological Therapies** - Workforce challenges continue in Psychological Therapies with pressures felt both locally and Regionally. An internal review of current arrangements is on-going. Some short-term internal additional capacity has been secured and this is impacting on reduced access times currently.
 - **Dementia Services** - Are subject to capacity analysis via a Regional exercise which has identified capacity gaps. Regional work on the new model of service delivery is not complete and investment has not been allocated as yet to increase capacity. The Trust has developed options to improve capacity in 2016/2017 as a short term measure.

- **Allied Health Professionals (CP9)** – Non-recurrent funding available

from the November 2015 Monitoring Round to improve capacity for AHPs could not be utilised due to the inability to secure short term temporary additional capacity. The Trust has continued to re-direct internal resources to AHPs as available throughout the year.

- Regional review of capacity and demand has concluded and an indicative view of capacity gaps has been agreed and is with HSCB for finalisation. This will then inform future commissioning arrangements in 2016/2017
- Routine waits beyond 26-weeks, as previously reported, continue to present in Dietetics (paediatrics) Speech & Language Therapy; Occupational Therapy (both elderly/adult and paediatric services) and Podiatry.

(3) Commissioning Plan Targets - Unscheduled Care (CP 5, CP 12 and CP 21)

➤ **Emergency Department** - Emergency Department (ED) performance against the 4-hour and 12-hour standards continues to be challenging locally and regionally.

- Performance in March, against the 4-hour target, remained relatively static. ED attendances were generally higher in both Craigavon Area Hospital and Daisy Hill Hospital.
- Trust has achieved throughout the year a position above 90% for those treated, discharge or admitted within 6 hours.
- Throughout the month there were peaks in attendances and admissions creating high runs of demand. This coupled with periods of decreased discharge levels impacted on general system flow as there is a low tolerance for a mismatch admissions and discharges which increases the risk of breach of the 12-hour standard.
- There was a total of 10 breaches of the 12-hour standard in March, which is an improved position from February (22).
- Throughout the month additional 'Winter' beds and additional flexible bed capacity were in place to respond to the periods of heightened unscheduled care pressures. This, in addition to a range of additional resources put in place to manage anticipated peaks in the mid-March/Easter holiday period, enabled the Trust to continue to optimise patient flow during this busy period.
- Maintaining a safe standard of care remains a priority and monitoring of quality ED standards are in place.

Note: In the first two weeks of April high levels of ED demand, which peaked at over 300 attendances on two occasions, and runs of high levels of emergency admissions, has seen significant pressure on unscheduled care services results in system flow issues and a level of 12-hour breaches beyond that experienced to date.

➤ **Discharges/Whole Systems Flow** – Whilst performance against complex discharges is good, performance against non-complex discharges has decreased throughout the year.

- Discharge performance is a key tenant of patient flow and improvement plans are being brought forward to review and improve this as part of the workplan of the new corporate

unscheduled care improvement operational group. Some interim actions are in place including provision of additional junior medical staff to focus on pharmacy/prescribing activities which can delay simple discharges.

- The Trust has escalated the risk associated with the continuance of heightened unscheduled care pressures outside the normal 'Winter' period to the HSCB and sought engagement of the management of this shared risk. The Senior Management Team has agreed in the first instance to extend the additional resources put into place for Winter into the month of April to manage risk associated with the high level of demand and ongoing pressures.

(4) Health Care Acquired Infections (HCAI) (CP20)

Detailed information on HCAI and infection prevention and control arrangements is included in the Governance Report.

(5) Reviews and Reporting beyond clinically indicated timescales

- **Reviews beyond clinically indicated timescales** - There has been a reduction in the volumes of patients waiting for review appointments beyond their clinically indicated timescales in all consultant-led areas.
 - The total waits have reduced by an estimated 9000 patients from the peak in August 2105 to the latest March 2016 position. This was associated predominantly with the re-direction of internal resources to this area, as they were available to increase capacity.
 - In Q1/2 2016/17 HSCB has allocated a fixed non-recurrent funding amount to the Trust to create additional in-house capacity for elective area. The Trust has included in this further capacity targeted toward reviews waiting the longest time across a range of specialty areas.
 - Longest consultant out-patient waits continues to present in Urology and plans are in place to target capacity to improve this in-year.
- **Imaging Reporting** - As indicated in previous reports to Trust Board, performance against diagnostic reporting turnaround targets is challenging related to recruitment challenges/vacancies in Consultant manpower which continue to affect Radiology services.
 - Recruitment within the wider EU is being explored.
 - The Trust continues to target current capacity to urgent films
 - Additional capacity for plain film reporting has been established via the Independent Sector and timescales for reporting are being monitored robustly.
 - An Investment template proposals (IPT) for 2016/2017 to increase capacity for reporting with specialist trained radiographers has been submitted to HSCB and will go some way to addressing the capacity gap for reporting if supported.
- **Planned Repeat Activity** – Capacity is not in place to ensure all procedures which require a planned repeat to be performed for screening or other purposes is undertaken within their clinically indicated timescales. This predominantly related to endoscopy and is in part due to the high volume of red flag and urgent patients which

	are absorbing the capacity available. Arrangements are in place therefore to separate those patient requiring planned repeat procedures into urgent and routine and as such initial focus is on seeing those urgent planned patients. This position is being monitored by the Endoscopy Users Group closely. Summary: Other key risks affecting performance remain, and have been reported previously, relating to a number of common factors including : • Although the position improved somewhat in 2014/2015, recurrent investment has not been secured for all services with a recognised capacity gap; • The on-going impact of workforce controls related to Trust financial contingency plans; • Particular issues relating to sickness, maternity and other absences in the medical workforce and associated challenges in securing backfill capacity in general and particularly in relation to middle grade medical staff; • Continued pressures on demand in some areas including non-elective demand, urgent and red flag referrals; and • The need to allocate appropriate levels of capacity for service areas not subject to regional standards/targets e.g. review appointments and planned repeat procedures.
	Senior Management Team Challenge • Review of the reduced performance position and challenge to continue to deliver the agreed SBA levels; • Discussion regarding the need for continued re-direction of temporary internal resources to address key pressures including emergent clinical risk in element areas and ongoing pressures on unscheduled care services into 2016/17; • Ongoing formal engagement with HSCB around the management of shared risk around emergent clinical risk; • Agreement to give priority to addressing patients waiting beyond their clinically indicated review timeline and acceptance that this may impact further on access for new patients but this risk to be balanced specialty by specialty; • Assurance sought on adherence to the IEAP in particular strict chronological management and DNA/CNA practices; • Assurance sought on ongoing validation of waiting lists by service leads; • Agreement to ensure co-ordinated focus on whole system flow and including look-back from peak pressure days/periods to ensure learning as part of ongoing management of unscheduled care, and • Agreement to review how the Trust supports and manages staff to deal compassionately and appropriately with complaints and queries about increasing waiting times.

PERFORMANCE MANAGEMENT REPORT

COMMISSIONING PLAN STANDARDS/TARGETS FOR 2015/2016

**April 2016 Report for
March 2016 Performance**

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1.0 CONTEXT

This report forms part of the Trust's Performance Management Framework and sets out a summary of Trust performance rolling from 2014/2015 into 2015/2016 against:

- Health and Social Care Commissioning Plan Standards/Targets

Indicators of Performance for 2015/2016 have been defined and will be reported against six-monthly in line with HSCB arrangements.

2.0 REPORTING

Qualitative and quantitative updates on performance against the Commissioning Plan Standards/Targets are presented in this performance report under the themes of Ministerial Priority:

- To improve and protect health and well-being and reduce inequalities; through a focus on prevention, health promotion, anticipation and earlier intervention;
- To improve the quality of services and outcomes for patients, clients and carers through the provision of timely, safe, resilient and sustainable services in the most appropriate setting;
- To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long-term conditions;
- To promote social inclusion, choice, control, support and independence for people living in the community, especially older people and those individuals and their families living with disabilities;
- To improve the productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities;
- To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across all our services;

The level of performance, based on the current and anticipated progress, will be assessed as follows:

Green (G)	Standard/target achieved/on track for achievement – Monitor progress to ensure remains on track
Yellow (Y)	Standard/target substantially achieved/on track for substantial achievement – Management actions in place/monitor progress to ensure standard/target remains on track
Amber (A)	Standard partially achieved/limited progress towards achievement of target – Management actions required
Red (R)	Standard/target not achieved/not on track to achieve – Management actions/intervention required
White (W)	Not assessed (due to lack of baseline; target; or robust data)

The performance trend, representing the direction of progress during the financial year, will be indicated by the arrows below:

↑	Performance improving

↓	Performance decreasing

↔	Performance static

YEAR-END INTERNAL ASSESSMENT OF PERFORMANCE AGAINST COMMISSIONING PLAN STANDARDS/TARGETS 2015/2016

SUMMARY:			
Of the 45 Commissioning Plan Standards/Targets the Trust achieved the following breakdown by RAG status:			
Green (G)	Target Achieved	6 (15%)	16 (41%)
Yellow (Y)	Target substantially achieved, or narrowly missed	6 (15%)	
Amber (A)	Target partially achieved	4 (11%)	
Red (R)	Target not achieved	17 (44%)	
Unassessed (U)	Target cannot yet be assessed	6 (15%)	

2015/2016 Commissioning Plan Targets & Standards – Snapshot Dashboard – March 2016 and Year-End Assessment

No.	Target Area	TDP RAG Rating	Target	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Internal Year-End Assessment	Year-End RAG
5.	Unplanned Admissions - reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions (reported 3 months in arrears)	R	-5%	Sep +13% Cum +11%	Oct 0% Cum +9.9%	Nov +3.3% Cum +9.9%	Dec +0.8% Cum +9.5%	9.5% (cumulative April to December) – unvalidated)	R
6.	Unplanned Admissions - ensure that unplanned admission to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.	R	TBC	+13.7%	N/A	N/A	N/A	+11% (cumulative April to December) – unvalidated)	R
7.	Carers' Assessments - secure a 10% increase in the number of carers' assessments offered.	A	838 March 2016	Q2:15/16 606	Q3:15/16 693	Q4: 15/16 N/A		-21% achieved in Quarter 3 (-145 carers short of target) Quarter 4 not yet available	R

No.	Target Area	TDP RAG Rating	Target	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Internal Year-End Assessment	Year-End RAG
8.	Direct Payments - secure a 10% increase in the number of direct payments across all PoC.	A	816 March 2016	Q2 15/16 -1.5%	Q3 15/16 -1.5%	Q4 15/16 +5.6% (+42)		-5.6% Achieved (-32 clients short of target) at 31 March 2016 – unvalidated	Y
9.	AHPs - no patient will wait longer than 13 weeks from referral to commencement of AHP treatment. (volumes over 13 weeks)	R	0	3727	3859	3629	3459	3459 patients in excess of 13-weeks (at 31 March 2016) – unvalidated Dietetics 90; Physiotherapy 1062; Occupational Therapy 377; Speech & Language Therapy 112; and Podiatry 1441	R
10.	Hip Fractures - 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. (no. breaches; R:regional ave)	A	95%	65.7% (12)	94.7% (2)	89.7% (3)	96.6% (1)	90.9% (cumulative April to March) – validated	A
11.	Cancer Services - *all urgent breast cancer referrals should be seen within 14 days; (no.breaches; R:regional ave) *at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; *at least 95% of patients urgently referred with a suspected cancer	A	100%	45.1%	88%	100%	100%	100% (cumulative April to March) – unvalidated	Y
		A	98%	100%	100%	100%	100%	100% (cumulative April to February) – unvalidated	G
		A	95%	91.2%	85.9%	89.6%	N/A	89.6% (cumulative April to February) – unvalidated	A

No.	Target Area	TDP RAG Rating	Target	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Internal Year-End Assessment	Year-End RAG
	should begin their first definitive treatment within 62 days.								
12.	Unscheduled Care - 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hour (R: Regional Ave; A: attendances) *no patient attending any Emergency Department should wait longer than 12 hours.	A	95%	78.8% 75% R 12446A	75.4% 74% R 12612 A	76.9% 74% R 12651 A	76.7% 14,128 A	Trust 80.1% (cumulative April to March – 126044 out of 157394) – validated - CAH = 72% (58310 out of 80996) - DHH = 82.7% (41419 out of 50076)	R
		A	0	3	48	22	10	93 (cumulative April to March – 0.1% of total attendances) – validated	Y
14.	Emergency Readmissions - secure a 5% reduction in the number of emergency readmissions within 30 days.	A	Trend (CHKS) reporting performance lower than peer(Trust 5.6 % Dec 14 – Dec 15; Peer 6.6%)					+5.6% (cumulative December 2014 – December 2015 – CHKS information) – unvalidated (Note: Benchmarked CHKS performance shows Trust performing better than Peer)	U
15.	Elective Care – Outpatients *60% of patients wait no longer than nine weeks for their first outpatient appointment *no patient waits longer than 18 weeks. (volume)	R	60%	35.8%	33.8%	38.44%		38.55% <9-weeks (cumulative April to February) – unvalidated	R
		R	0	14,736	14,855	12,521		12521 patients waiting in excess of 18-weeks (at 29 February 2015) – unvalidated	R
16.	Elective Care – Diagnostics *no patient waits longer than nine weeks for a diagnostic test (volumes) I:	R	0	4125 I 1250NI	4193 I 1517NI	3103 I 1596 NI		Imaging – 3103 in excess of 9-weeks (at 29 February 2016) – unvalidated Non-Imaging – 1596 in excess of 9-weeks (at 29 February 2016) – unvalidated	R

No.	Target Area	TDP RAG Rating	Target	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Internal Year-End Assessment	Year-End RAG
	imaging, N-I: non imaging *all urgent diagnostic tests are reported on within two days of the test being undertaken.							Endoscopy – 738 in excess of 9-weeks (at 29 February 2016) – unvalidated	
		R	100%	75.1% I 95% NI	77.8% I N/A	N/A I N/A		DRTT Urgent Imaging – 77.7% (cumulative April to February) – unvalidated DRTT Urgent Non-Imaging – 87.5% (cumulative April to February) – unvalidated	R
17.	Elective Care – Inpatient/Daycases *65% of inpatients and daycases are treated within 13 weeks and *no patient waits longer than 26 weeks.(volumes)	A	65%	56.5%	55.4%	56.3%		56.3% <13-weeks (cumulative April to February) – unvalidated	R
		A	0	1709	1690	1522		1522 patients waiting in excess of 26-weeks (at end February 2015) – unvalidated	R
19.	Stroke Patients - ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis.	G	13%	Sep 5.13%	Oct 10%	Nov 11%	Dec 16% Cum 13%	13% Trust (cumulative April to December) – unvalidated	G
20.	Healthcare Acquired Infections - secure a reduction of 20% in MRSA and <i>Clostridium difficile</i> infections compared to 2014/15.	W	MRSA 5	0 Cum 2	0 Cum 2	0 Cum 2	0 Cum 2	MRSA 2 – validated	G
		W	C Diff 32	6 Cum 47	2 Cum 49	3 Cum 52	2 Cum 54	C Difficile 54 – validated	R
21.	Patient Discharge – *ensure that 99% of all learning disability (LD) and mental health (MH) discharges take place within 7 days of the patient being assessed as	A	99%	50% LD	50% LD	100% LD	0% LD	Learning Disability 80% - 20 out of 25 (cumulative April to March) – unvalidated	Y
		G	99%	96.2% MH	95.87% MH	96.5% MH	95.3% MH	Mental Health 94.2% - 1100 out of 1167 (cumulative April to March) – unvalidated	A
		A	0	0 LD	0 LD	0 LD	1 LD Cum: 1		Y

No.	Target Area	TDP RAG Rating	Target	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Internal Year-End Assessment	Year-End RAG
	medically fit for discharge, with *no discharge taking more than 28 days; *90% of complex discharges from an acute hospital take place within 48 hours, with *no complex discharge taking more than seven days; and *all non-complex discharges from an acute hospital take place within six hours.	A	0	2 MH	1 MH	1 MH	2 MH Cum: 21		R
		A	90%	90.1%	94.9%	100%	100%	48-hours – 95.8% - 1218 out of 1274 (cumulative April to March) – unvalidated	G
		A	100%	98.7%	100%	100%	100%	7-days – 98.72% - 1296 out of 1313 (cumulative April to March) – unvalidated	G
		A	100%	90.8%	90%	91.5%	92.8%	6-hours – 92.4% - 24670 out of 26896 (cumulative April to March) – unvalidated	A
22.	Mental Health Services – *no patient waits longer than nine weeks to access child and adolescent mental health services; *nine weeks to access adult mental health services; * nine weeks to access dementia services; and *13 weeks to access psychological therapies	G	0	0	0	0	0	CAMHS – 0 patients in excess of 9-weeks (at 31 March 2016) – unvalidated	G
		A	0	102	100	90	81	Adult Mental Health – 81 patients in excess of 9-weeks (at 31 March 2016) – unvalidated	R
		G	0	111	105	86	69	Dementia – 69 patients in excess of 9-weeks (at 31 March 2016) – unvalidated	R
		A	0	107	82	35	10	Psychological Therapies – 10 patients in excess of 13-weeks (at 31 March 2016) – unvalidated	Y
23.	Children in Care – Placement Change - ensure that the number of children in care for 12 months or longer with no	A	85%	Annual Reporting – information in respect of 2014/15 not yet available					U

No.	Target Area	TDP RAG Rating	Target	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Internal Year-End Assessment	Year-End RAG
	placement change is at least 85%.								
24.	Children in Care-Adoption within 3 years - ensure that a three year time frame for 90% of children who are adopted from care.	G	90%	Annual Reporting – 25% 2014/2015 - information in respect of 2015/16 not yet available					U
25.	Patient Safety - ensure that the death rate of unplanned weekend admission does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.	A	Not >0.1%	-0.1%	1.7%	0.7%	-1.2%	Variance of 0.6 % in death rate (cumulative April to March) – unvalidated	R
26.	Normative Staffing - implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.	A		A report detailing the end of year compliance for 2015/2016 is currently being collated for submission to the HSCB by 18 May 2016. This data will be submitted to Trust Board via the Executive Director of Nursing Report.					U
27.	Excess Beddays - reduce the number of excess bed days for the acute programme of care by 10%.	R		Trend (CHKS) reporting performance 16% compared to 15.5% HES peer average (December 2013 – December 2015 – CHKS data) – unvalidated					U
28.	Cancelled Appointments - reduce by 20% the number of hospital cancelled Consultant-Led outpatient appoints in the acute programme of care which resulted in the	A	< 4335	582 (2.9%)	412 (2.3%)	540 (2.9%) 5015 Cum	N/A	+20.75% above profiled target (cumulative April to February) – unvalidated	R

No.	Target Area	TDP RAG Rating	Target	Dec 2015	Jan 2016	Feb 2016	Mar 2016	<u>Internal</u> Year-End Assessment	Year-End RAG
	patient waiting longer for their appointment. (Volumes & % rate in month)								
29.	Delivering Transformation – Safe transfer of £83m from hospital/institutional based care into primary, community and social care services	W	The Trust contributes to this target by implementing commissioned community based schemes, e.g. Acute Care at Home/Re-ablement. A Regional methodology has been agreed to facilitate identification and measurement of the shift left funding transfer into primary, community and social care services.						U

2015/2016 Corporate Indicators of Performance (Non-CP Target) – February 2016

Corporate Indicators of Performance (No CP Target)	Nov 2015	Dec 2015	Jan 2016	Feb 2016	March 2016
OP Review Backlog – Volume of patients waiting beyond clinically indicated timescales	18,803 Acute/CYP/ OPPC 744 –MHD	18,065 Acute/CYP/ OPPC 994 –MHD	16,987 Acute/CYP/ OPPC 1045 - MHD	16,013 Acute/CYP/ OPPC 734 - MHD	13,090 Acute/CYP/ OPPC 859- MHD
Unallocated Cases – number of unallocated child care cases (T: total; >40: volume over 40 days)	37 T 15>40	40 T 13>40	38 T 9>40	72 T 28>40	44T 17>40
GP OOH - % Urgent calls triaged within 20 mins; % Routine calls triaged within 60 mins	90.06% U 42.22% R	88.38% U 43.81% R	87.12% U 39.5% R	86.23% U 46.64% R	80.88% U 36.72% R
Service & Budget Agreement % variation against apportioned Month-end SBA.	Position @ 31 January 2016 New Outpatients +1%, Review Outpatients +3% Diagnostics +9%, Births 0%, Non-Elective Inpatients +57% Day Cases +1%, Elective Inpatients -15%		Position @ 29 February 2016 New Outpatients +1%, Review Outpatients +4% Diagnostics +10%, Births -1%, Non-Elective Inpatients +59% Day Cases +1%, Elective Inpatients -14%		

MINISTERIAL PRIORITY: TO PROVIDE HIGH QUALITY, SAFE AND EFFECTIVE CARE; TO LISTEN TO AND LEARN FROM PATIENT AND CLIENT EXPERIENCES; AND TO ENSURE HIGH LEVELS OF PATIENT AND CLIENT SATISFACTION

CP 5: UNPLANNED ADMISSIONS: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care

By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas. (Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Heart Failure, Asthma and Stroke)

Baseline: Increase of 13.5% April – December 2014 compared to 2012/2013 baseline

Target: 5% reduction (Cumulative Admissions 1917)

TDP Assessment: Unlikely to be achieved/affordable

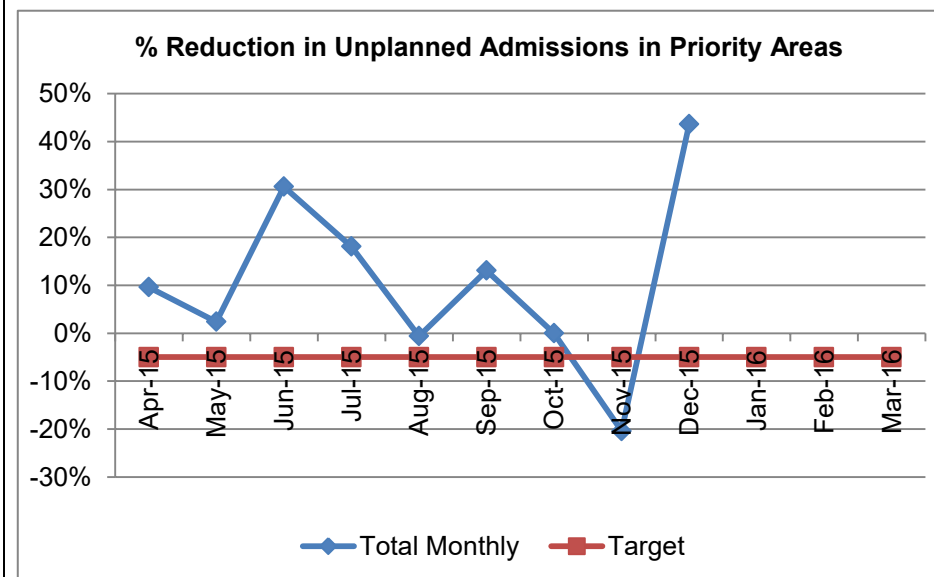
Comments: Reporting three months in arrears

Reduction in the number of unplanned hospital admissions for people with the identified conditions will depend on arrangements being in place to support service users to manage their condition in a primary/community setting. At the end of March 2015 this target was not achieved with +23.4% against a target of -5%.

The target is profiled based on the actual presentation of conditions in 2013/2014, minus 5%. Cumulatively at 31 December 2015 there were 138 (+9.5%) more admissions for the target cohort than the same period in the baseline year.

From 1 April 2015 to 29 February 2016 The Trust had a total of 46,080 non-elective FCEs, which is an increase of 30% (+10,740) for the 11-month period in 2014/2015 (35,340). This general increase in non-elective admissions, for all patients, makes this target challenging in the face of this increasing trend.

Table 5a shows variability in the ongoing performance against the target for each of the specified long term conditions with COPD being the only specialty which has shown a reduction in December, -1.4% (-1 patient) and cumulatively to date has shown a 2% reduction (-11 patients). The remaining conditions all demonstrated an increase in admissions in December compared to the baseline year with heart failure showing a significant increase in admissions, 170.8% (+41 patients). There were also increases in Diabetes, Asthma and Stroke admissions in December compared to a reduction in November and these have



contributed to the large spike in total monthly admissions. Cumulatively to date all specialties are showing a 9.5% (+138 patients) increase on admissions compared to the baseline year.

It should be noted that unplanned admissions for primary stroke and acute asthma are unlikely to reduce due to clinical best practice. However, a range of initiatives are in place around these and the other condition areas to ensure the necessary supports in place to increase the management of these conditions in a community/primary care environment.

Stroke

- The Trust has focused support in place post stroke for 6-months to seek to avoid secondary presentations of stroke;

Heart Failure/COPD/Asthma

- Established arrangements in place for known Heart Failure and COPD patients including self-management plans, good education and awareness provided by Community Team;
- Identification and follow-up of Heart Failure and COPD patients who have been admitted to CAH / DHH;
- Established pulmonary rehabilitation plans and maintenance support programmes in place, particularly focused on 'frequent flier' patients who may have had multiple admissions due to COPD/anxiety issues, and
- Respiratory Care pilot focused on prevention of a range of respiratory conditions;

Diabetes

- Established arrangements in place for known Diabetic patients managed by the Community Team through self-management plans and Nurse-Led Community Clinics and access to Community based Diabetic Nurse Specialist support;
- The Trust is reviewing its diabetic services and has shared a revised pathway and recommendations for improvement with SLCG, and
- Investment template proposals have been submitted to SLCG for increased diabetic nurse specialist capacity in DHH and in the community.

Further initiatives including development of the Acute Care at Home model & Re-ablement model will continue to support the management of unplanned admissions at home.

Table 5(a): Breakdown by Condition

Month of Discharge	COPD	Diabetes	Heart failure	Asthma	Stroke
April	3.8%	72.7%	-11.8%	88.9%	9.3%
May	-20.3%	33.3%	-2.7%	85.7%	24.3%
June	31.5%	116.7%	45.5%	50.0%	4.3%
July	34.8%	62.5%	5.7%	100.0%	-11.9%
August	-19.3%	0.0%	15.2%	0.0%	11.6%
September	7.4%	42.9%	32.1%	-7.1%	4.7%
October	-7.1%	27.3%	19.4%	17.6%	-15.6%
November	-26.9%	-16.7%	27.8%	-40.0%	-40.0%
December	-1.4%	90.0%	170.8%	44.4%	36.8%
Cumulative Total (Target -5%)	-2%	38.1%	26.3%	26.0%	0.8%

Cumulative position for all conditions April – December 2015 + 9.5%

	Monthly Position:												Cum Assess from Apr 2015	Trend
	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15		
Target Admissions	175	159	181	158	162	140	131	147	145	165	181	148	T 1378	
Actual Admissions	254	233	185	182	174	192	163	154	173	174	152	224	A 1588	
% Achievement				9.6%	2.4%	30.6%	18.1%	-0.6%	13.1%	0%	-20.4%	43.6% cum 9.5%	R	↓

CP 6: UNPLANNED ADMISSIONS: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care

During 2015/2016, ensure that unplanned admission to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/2014 levels. (New target area)

Baseline: 2994 (April 2013 to March 2014)

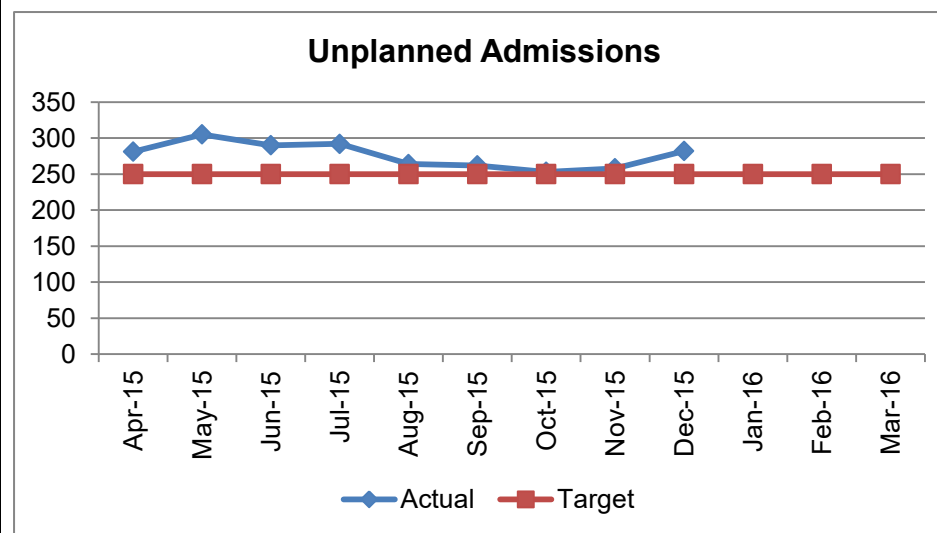
TDP Assessment: Unlikely to be achieved/affordable

Target: Unplanned admissions do not exceed 2013/14 levels

Comments: Reporting three months in arrears

This target seeks to analyse the number of unplanned admissions to hospital of adults (aged 18 and over) with acute conditions (ear/nose/throat infections, kidney/urinary tract infections, heart failure) that would usually be managed in Primary Care. The drivers for this are to provide high quality care and only referring patients when it is clinically appropriate to do so. The performance measurement against this target also aims to identify any emerging patterns and review these with reference to available care pathways and the capability and access with Primary Care Services to see and treat patients. This is an outcome based target which requires input from other partners including primary care and public health to progress.

Baseline data for 2013/2014 demonstrates a total of 2233 unplanned admissions for the specified acute conditions at December 2013. At December 2015 there were a total of 2487 unplanned admissions, for the cumulative period April to December 2015. This represents a performance of +11% (+254) against the comparative 2013/2014 9-month period. If the volumes demonstrated in the April to December 2015 period continue through to the end of the financial year then the estimated total unplanned admissions will be 3316. Based on this estimated level of unplanned admissions this would demonstrate a performance of +11% (+322) at year-end. This target is not on track to achieve the performance sought.



Monthly Position:												Cum Assess Dec 2015	Trend
Jan 2014	Feb 2014	Mar 2014	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015		
254	234	273	281	305	290	292	264	262	253	258	282		
-	-	-	14.7%	15.1%	27.8%	9.0%	1.5%	12.9%	-1.2%	11.2%	13.7% cum +11%	R	↓

CP 7: CARERS' ASSESSMENT: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care**By March 2016, secure a 10% increase in the number of carers' assessments offered. (No change in target)****Baseline:** 762 @ 31 March 2015 (all programmes)**TDP Assessment:** Partially Achievable/ Achievable with Additional resources**Target:** 762 + 76 = 838**Comments: Reporting quarterly (Quarter 4 data is not available until the end of April).**

The Trust's baseline and target was set based on the volume of carer's assessments undertaken in the Quarter 4 (January to March 2015). In this period additional assessments in Physical & Sensory Disability and in Child & Adolescent Mental Health Services resulted in the total number of assessments being offered higher than the previous periods. It is also of note that the target for the Sothorn Health and Social Care Trust (SHSCT) (838) is the highest in the region, which ranges from 393 in WHSCT to 795 in NHSCT.

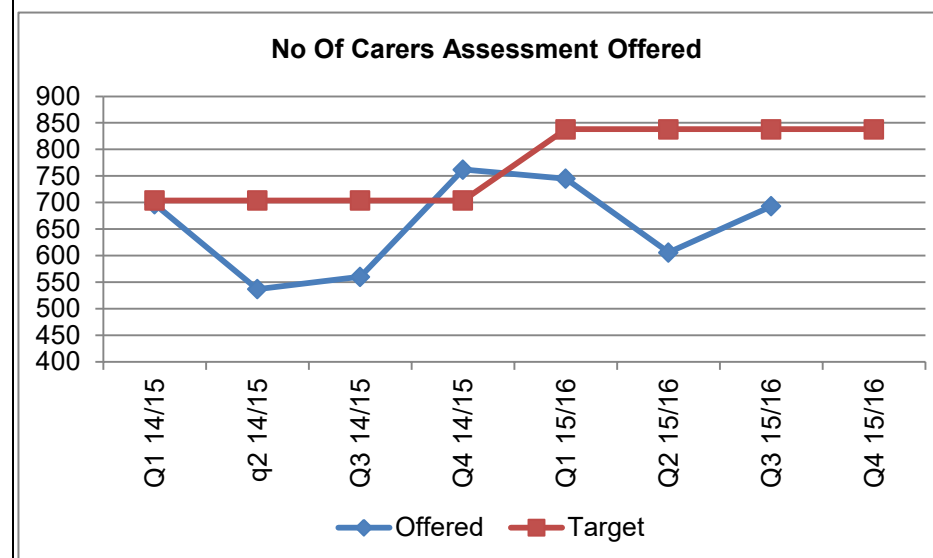
Trust performance in Quarter 3 has increased from Quarter 2 and is +24% above the level achieved in Quarter 3 2014/2015. Quarter 4 consistently has seen the strongest performance throughout the past years due in part to the opportunity presented by maximisation of cash grant resources for carers with identified needs. It is anticipated that this year will be similar although, as indicated, achievement of the target remains challenging.

Regional performance is not comparable as targets are set on an individual Trust basis.

It is anticipated that the roll out of the NISAT 'V4 Carers Assessment/Support Planning' will lead to more robust recording of carers assessment offers and detail of need met in support plans and identified 'unmet need'. Funding allocated for Self Directed Support in-year should provide an increase in the number of offers.

Actions to Address:

- The Trust has established a 'Carers Reference Group' at which



each Directorate is represented by a 'Champion'; • All Directorates have a commitment to Carers within PPI plans; • Promotion of the uptake/offer of carer's assessments will be re-enforced as part of the training and operational processes, and • The Carers Action plan includes increased focus on ownership of carers and carer's assessments.							
Quarterly Position:						Cum Assess	Trend
	Quarter 4 (Jan to Mar 2015)	Quarter 1 (Apr to Jun 2015)	Quarter 2 (Jul to Sept 2015)	Quarter 3 (Oct to Dec 2015)	Quarter 4 (Jan to Mar 2016)		
Offered	762 (+58 above target)	745 (-93 below target)	606 (-232 below target)	693 (-145 below target)	N/A	R	↑

CP 8: DIRECT PAYMENTS: Lead Director – Mr Francis Rice, Director of Mental Health and Disability

By March 2016, secure a 10% increase in the number of direct payments across all programmes of care. (Change in target from 5% to 10%)

Baseline: 695 active and 47 ceased direct payments @ 31 March 15 (742)

TDP Assessment: Partially achievable/ achievable with additional resources

Target: Increase by 10% 816

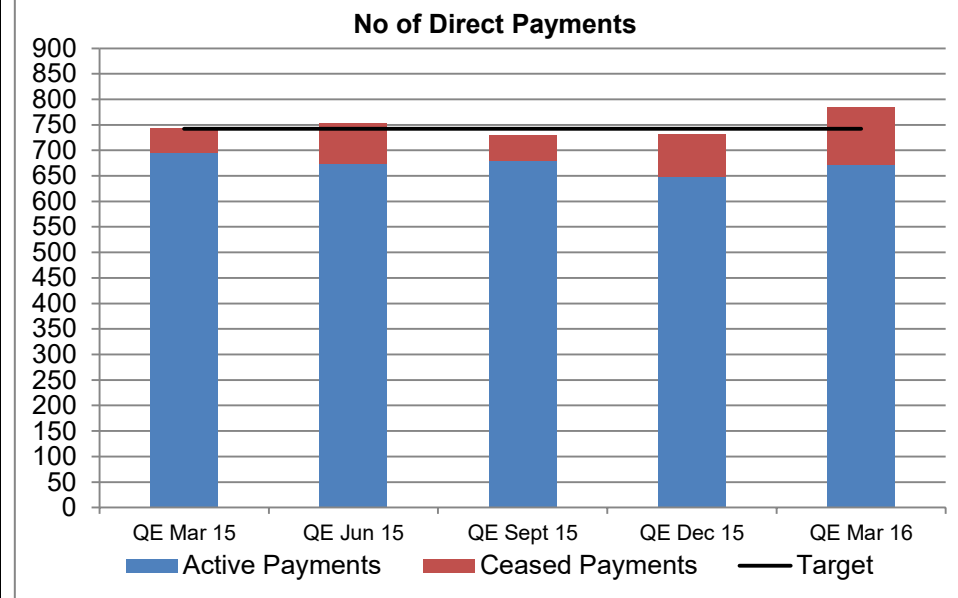
Comments: Reported one-month in arrears

This target is made up of active payments and payments which were previously made and ceased within the quarter. It is of note that the target for the SHSCT (816) is the highest in the Region which ranges from 485 in WHSCT to 686 in NHSCT.

Regional performance is not comparable as targets are set on an individual Trust basis, however, the trend against individual targets demonstrates only one Trust on-track against their profiled target at the end of Quarter 3 and Regionally there was a 0% decrease at this point.

Action

- The Trust will continue to promote Direct Payments and to roll out training to staff on the new guidance; and The Trust will also continue with the introduction of Self Directed Support payments.



	Quarterly Position:						
	QE March 2015	QE June 2015	QE Sept 2015	QE Dec 2015	QE March 2016	Cum Assess	Trend
Trust Total	742	753	731	732	784	Y	↑
Trust Ceased	47	79	51	83	113		
Trust Active	695	674	680	649	671		

Of the 671 active offers split across the programmes of care is as follows:

Physical and sensory disability 138, Mental Health 50, Learning Disability 315 and Elderly 168

* Children with disabilities included in the Learning Disability category

SHSCT Performance Report April 2016 (for March Performance Data)

CP 9: ALLIED HEALTH PROFESSIONALS: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care

From April 2015, no patient waits longer than 13-weeks for referral to commencement of AHP treatment. (Change in target from 9-weeks to 13-weeks)

Baseline: 1436 >13 weeks @ 31 March 15

TDP Assessment: Unlikely to be achieved/affordable

Standard: 0 waits over 13 weeks

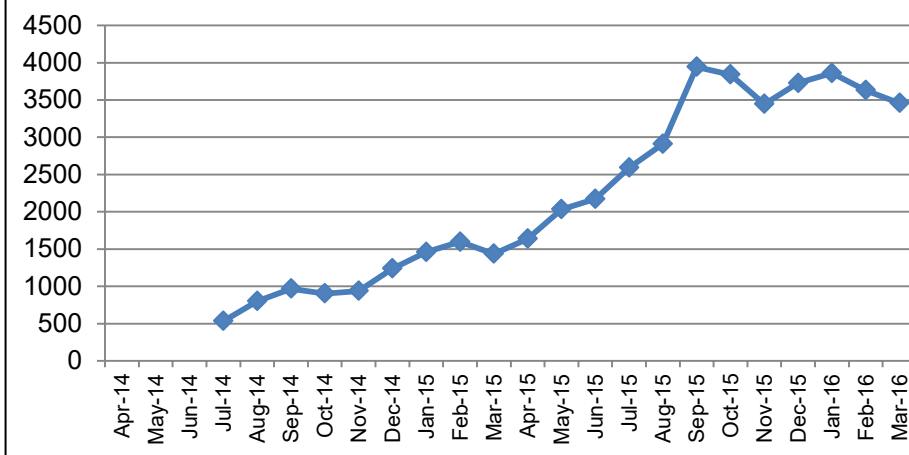
Comments:

The volume of patients waiting in excess of 13-weeks has decreased between February and March by 170 patients with most significant decreases demonstrated in Speech & Language Therapy, Physiotherapy, Dietetics and Podiatry services. Breakdown of waits by Profession can be seen in Table 9(a).

January regional performance demonstrates a total of 14,282 patients waiting in excess of 13-weeks, excluding BHSCT. Volumes range from 332 (SET) to 6817 (Northern). SHSCT accounts for 3859 of the available regional volume of patients waiting in excess of 13-weeks.

- **Dietetics** – There continues to be a high levels of demand for paediatric services. Inequitable waiting times had been demonstrated across the localities associated with long-term sick leave. To ensure an equitable waiting time for all patients a Trust-wide waiting list has been created which should facilitate the reduction in unequitable waits. Early outcomes from the regional demand and capacity exercise indicate a capacity gap in paediatrics, and to a less extent adult services.
- **Occupational Therapy (Paediatrics)** – The service has been impacted by capacity issues in Core and Special School Services, with required levels of capacity redirected appropriately to the Special Schools demand. Early outcomes from the Regional demand and capacity exercise indicate no significant capacity gap in elective services.
- **Occupational Therapy (Adult)** – There is an inequality in access times across the localities due to lost capacity within one ICT. Available capacity continues to be focused to urgent patients, which therefore demonstrate the increase in access times for routine patients.
- **Podiatry** – The Regional demand and capacity exercise has

No Waiting in Excess of 13-Weeks from Commencement of Treatment



demonstrated a capacity gap, however, the level of capacity gap may be understated when the ongoing high level of reviews beyond the clinically indicated timescale are considered.

Capacity, in the first instance, is directed to urgent patients.

The service has been impacted by loss of temporary staff and is expecting further impact from maternity and sick leave.

Therefore, an increase in access times and review backlog is anticipated as a consequence.

- **Physiotherapy** – The initial impact of new capacity had seen a month on month reduction in volumes waiting over 13-weeks.
- **Speech & Language Therapy** – Three temporary staff have been in place since mid-November which has contributed to a reduction in the numbers waiting over 13-weeks. March has demonstrated a significant reduction in waiters over 13-weeks associated with the additional temporary staff.

Reviews and treatments beyond their clinically indicated timescale has become an increasing challenge throughout the range of AHP areas. Internal resources have been re-directed, as available, to focus on areas of accrued backlog. Whilst this has led to significant improvement and is welcomed, challenges remain associated with the ability to attract temporary/additional capacity with the necessary skills. Regional recruitment waiting lists have a limited number of candidates available and candidates are less interested in short-term temporary work.

The Regional demand and capacity exercise is concluded and proposals for capacity gaps, which should inform future investment are with commissioners for consideration.

Actions to Address:

- On-going focus on urgent waits and planned reviews in areas with manpower and demand issues; arrangements have been established for reporting of these patients monthly to increase visibility and action planning;
- Executive Director of AHP and the Assistant Director for CYPS have provided input into a review of Special Schools;
- Redirection of internal resources into 2016/2017 is required, in the first instance, to see reviews that are waiting beyond their

Table 9(a)

Profession	Access Time (end March)	Volume over 13 weeks & change in position +/- from February	% of total waits within profession
Dietetics	29-weeks	90 (-14)	8.34%
Occupational Therapy	47-weeks	377 (-2)	26.9%
Orthoptics	11-weeks	0 (-4)	0%
Physiotherapy	25-weeks	1062 (-30)	18.1%
Podiatry	38-weeks	1441 (-8)	50.2%
Speech & Language	33-weeks	112 (-112)	38.7%

clinically indicated timescales; - Internal review of AHP on-going with fortnightly Director-led meetings; and - Trust has highlighted temporary recruitment challenges to PHA/HSCB and has convened an internal meeting to consider challenges.														
	Monthly Position:												Cum Assess	Trend
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16		
>13 weeks	1638	2032	2173	2591	2910	3944	3840	3446	3727	3859	3629	3459	R	↑

CP 10: HIP FRACTURES: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for in-patient treatment for hip

Baseline: 91.5%

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 95%

Comments:

On-going trauma pressures have resulted in the cancellation of elective orthopaedic surgery to facilitate the treatment of the clinically urgent trauma cases. In 2014/2015 there were a total of 106 elective orthopaedic operative cases cancelled/slots lost to facilitate trauma cases. This pressure has continued into 2015/2016 with a total of 171 elective orthopaedic operative cases cancelled up to 31/03/16. The Division predict this trend will continue with on-going trauma pressures.

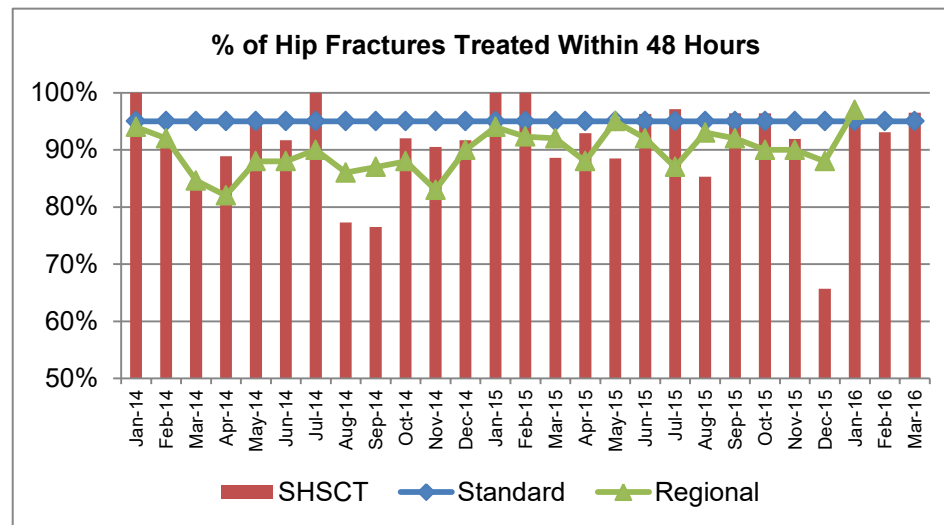
In March there was only 1 case not treated within 48 hours. This was associated with continued higher level of demand for general trauma, and a requirement for Specialist services.

The Trust's performance in January was 95% which was below the Regional average of 97% (latest position available). Cumulatively, year to date, the Trust is achieving 90.9% and whilst this is below the target of 95% it should be noted that the Regional average is only 91%.

The Trust has implemented the Trauma & Orthopaedics Investment and 3 out of 4 permanent Consultants are in post. In lieu of a 4th post the Trust has secured a Locum Consultant. In the context of the ongoing demand for trauma this 4th consultant has a trauma focused job plan which has been agreed with HSCB to assist in the management of this demand. Referrals for the Newry & Mourne patients, which had been diverted to BHSCT, have now been repatriated to the SHSCT (excluding spines; foot & ankle; paediatrics).

Actions to Address:

- The Trust continues to work with the HSCB to develop a 'blue-sky' model to address future service demand and is initiating pilot work in-year. This model will release of staff to commence nurse led fracture clinics, training of surgical theatre assistant and additional



- theatre capacity with specialty doctor working parallel to consultant staff;
- The Trust is bring forward a position paper for HSCB to define the impact of trauma demand and potential options, and
 - On a daily basis the clinical team ie. Consultants; Junior Medical Staff; and Trauma Co-Ordinator meet, to present each trauma case, and agreed on the clinical priority of the cases the trauma list for that day.

	Monthly Position:												Cum Assess	Trend
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov-15	Dec-15	Jan-16	Feb 16	Mar 16		
Trust	92.9% (26 out of 28)	88.5% (23 out of 26)	96.3% (26 out of 27)	97.1% (33 out of 34)	85.3% (29 out of 34)	96.4% (27 out of 28)	96.4% (27 out of 28)	91.9% (34 out of 37)	65.7% (23 out of 35)	94.7% (36 out of 38)	93.1% (27 out of 29)	96.6% (28 out of 29)	Y	↑
Regional	88%	95%	92%	87%	93%	92%	90%	89%	88%	97%	N/A	N/A		

CP11: CANCER CARE SERVICES: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, all urgent breast cancer referrals should be seen within 14-days. (No change in target)

Baseline: 82.7%

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 100%

Comments:

Investment has been secured to increase capacity in this area recurrently. There are however ongoing challenges with the ability to secure the specialists skills required to maintain this level of capacity in 2016. The Trust is currently working with one specialty breast surgeon and one specialist radiologist in this area due to vacancies.

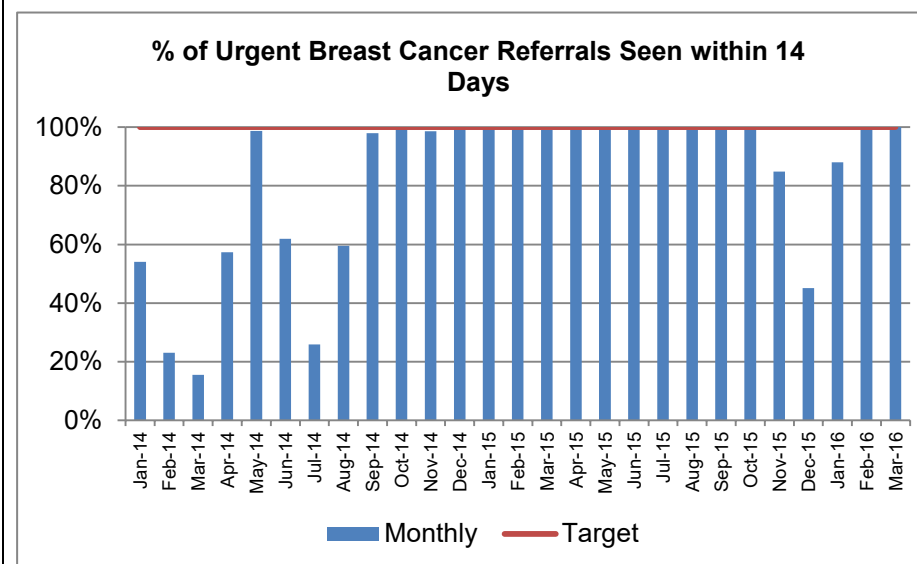
Interim arrangements have been put in place with BHSCT to secure some additional interim breast surgery capacity and discussions are ongoing at a regional level to secure an interim arrangement to provide cover for specialist radiology.

It is of note that routine demand, which is outside this target, is 16% (+522 patients) higher in the period April – March 2015/16 compared to the same period in 2014/15. This is impacting on routine access time which increased to 20 weeks at the end of March and is predicted to be 24 weeks at the end of April if the trend continues. There is no subsequent increase in confirmed cancers in the same period.

Demand for urgent red flag referrals spiked in October and November at 42% above the available capacity resulting in decreased performance in November and December. Whilst demand typically increases in this period annually associated with the breast awareness campaign this year's demand has been significantly higher and has been mirrored in the other Trusts. Regionally, in January, 71% of breast cancer referrals were seen within 14 days.

In mid-January the Trust returned to a position whereby all red flag cancer referrals were seen within 14 days and this position has been sustained in March seeing a 100% compliance in-month.

It is anticipated that performance in April will decrease due associated with later internal referrals and reduced operational capacity due to vacant posts.



As at 15 April 2016 there are 17 confirmed breaches of the 14-day standard with 4 further anticipated breaches.

Actions to Address:

- Trust will work to implement the additional resources required to establish this increase capacity recurrently;
- Increasing demand has been highlighted to the HSCB and will be monitored closely to establish if this is a longer term trend, and
- The Trust has secured radiology support from NHSCT and breast surgery interim capacity from BHSCT

Monthly Position:												Cum Assess	Trend
Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016		
100% (255 out of 255)	99.6% (269 out of 270)	100% (243 out of 243)	100% (282 out of 282)	99.2% (236 out of 238)	100% (248 out of 248)	100 % (255 out of 255)	84.9% (242 out of 285)	45.1% (124 out of 275)	88% (228 out of 259)	100% (263 out of 263)	100% (261 out of 261)	Y	↔

CP 11: CANCER CARE SERVICES: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31-days of a decision to treat. (No change in target)

Baseline: 99%

TDP Assessment: Partially achievable/achievable with additional resources

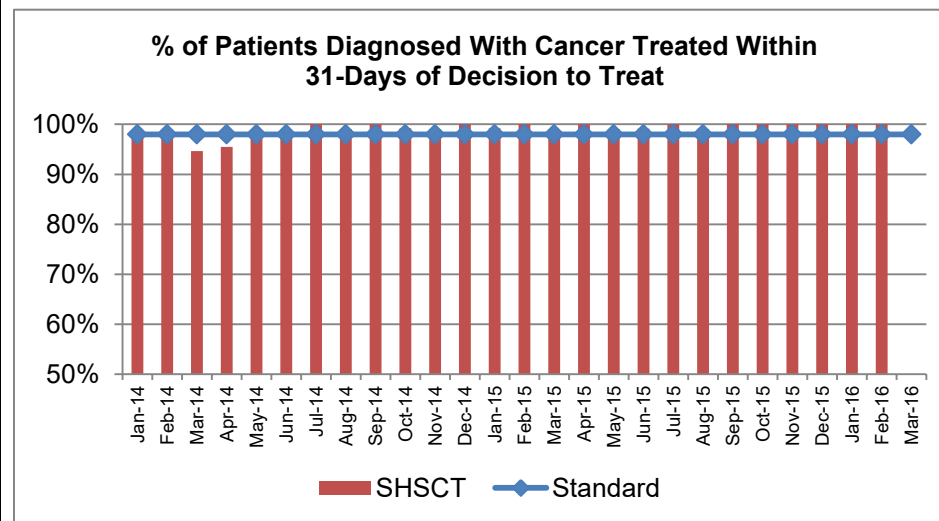
Standard: 98%

Comments: Reporting one month in arrears.

Performance against the 31-day standard is based on completed waits ie. Those patients that have had their cancer confirmed and who have received their first definitive treatment. Performance against this target has been consistently high.

January Regional performance demonstrates an average of 93% and a range of performance from 90% (BHSCT) to 100% (SHSCT). The Southern Trust has a performance of 100% in January and is the highest performing Trust.

March performance shows a continuation of the 100% achievement against this target.



Monthly Position:												Cum Assess	Trend
Mar 2015	Apr 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016		
98.35%	100%	99.03%	99.13%	100%	99.03%	100%	100%	100%	100%	100%	100%	G	↔

CP 11: CANCER CARE SERVICES: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2014, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62-days. (No change in target)

Baseline: 85.3%

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 95%

Comments: Reporting one month in arrears.

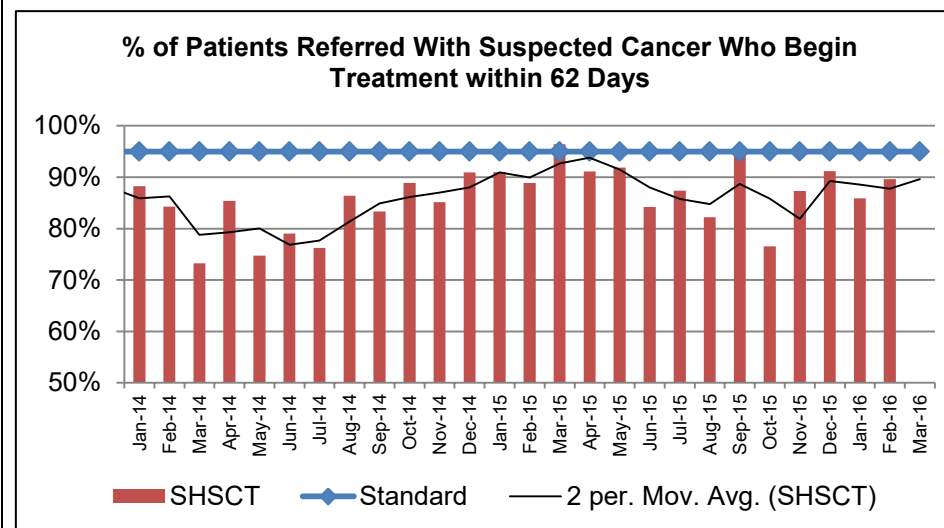
Performance against the 62-day standard is based on completed waits ie. those patients that have had their cancer confirmed and who have received their first definitive treatment.

62-Day: In February there were 6.5 patients in excess of the 62-day standard (8 inter-Trust transfer and 2 internal). Key issues relate to:

- Increased referrals in some specialties with a total increase of 21% (+2447 referrals) from the same period last year; and
- Delay in radiology special investigations (ultrasound) due to medical manpower issues associated with vacancy and sickness.

Performance in January (85%) remains above the Regional average of 63%, with the Trust, cumulatively, the second best performing Trust in the Region (88%) behind WHSCT (91%). Performance ranges from 59% (BHSCT) to 91% (WHSCT).

Day-85: In February there was 1 85 day breach and the un-validated position for March shows 0 85 day breaches.



Monthly Position:												Cum Assess	Trend
Mar 2015	Apr 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016		
96.43%	91.11%	91.84%	84.21%	87.37%	82.22%	95.16%	76.54%	87.3%	91.2%	85.9%	89.6%	A	↑

CP 12: UNSCHEDULED CARE: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department. (No change in target)

Baseline: Trust – 83.8%

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 95%

Comments:

Performance continues to be challenging locally and regionally with heightened unscheduled care pressures throughout March and into April.

Performance in March against the 4-hour target remained consistent compared to previous month and across the year the Trust has maintained a position of over 90% treated, discharged or admitted within 6 hours.

- Daisy Hill Hospital (DHH) - Overall ED attendances and admissions in March were much higher than February (increase of 518 attendances and 65 admissions in March).
- Craigavon Area Hospital (CAH) - Attendances in March were higher than both the January and February periods.

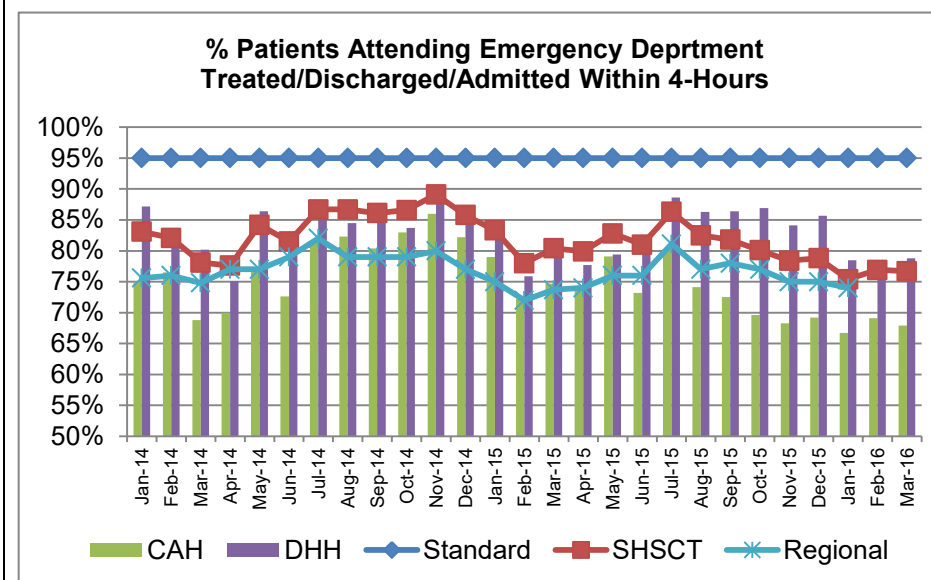
75% of patients were seen in SHSCT within 4-hours in January 2016 (latest available) compared to a Regional average of 74%. Performance ranged from 69% in NHSCT to 78% in SEHSCT. Cumulatively the SHSCT is the highest performing Trust in the Region with 81% of patients being seen within 4-hours to date compared to a Regional average of 77%.

Emergency Department

- Renewed focus on key aspects of the 60-minute plan and other key flow indicators including triage time; and
- Improvement work focused on throughput in the minor stream.

Patient Flow

- Sustained management and clinical focus in and out of hours to maintain focus and support staff;
- Daily patient flow processes with the objective of pulling discharges forward and working towards having the hospital settled by 8.00pm;
- Opening of 17 additional medical beds initiated (w/c 16 November) and flexing up of available beds throughout the system which should assist with flow issues;
- Increase capacity for psychiatric liaison input into CAH site;



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- Discharge management and flow with expansion of community based services including Intermediate Care Services (ICS), Re-Ablement, Specialist Chronic Condition Community Teams and roll out of the Acute Care at Home (AC@H) model which, whilst facilitating early discharge, is having a significant impact on admission avoidance for appropriate cases;
- New pilot for engagement with AC@H team for stable patients over 80-years of age prior to admission in ED to consider appropriateness for management at home via AC@H ED.; and
- Expansion of the paediatric ambulatory service model on CAH site.

Whole System Focus

- Winter pressures plan developed and reviewed at SMT weekly;
- On-going work with Alamac, assessing performance across the pathway and initiation of whole system teleconferencing, (Mon, Wed and Friday) with relevant Assistant Directors and key staff to explore interface across the pathway;
- Better use of information with support of Alamac to link Acute and Community indicators to provide early indication of pressures and predict trends over key holiday periods, assisting pro-active planning/escalations;
- Corporate unscheduled care escalation arrangements have been reviewed in line with new regional unscheduled care guidance.

Forward Look Actions

- The Trust has established an unscheduled care operational improvement group to provide oversight to a range of cross programme actions to improve this area. This will feed into the Locality Network Group and regional structures
- An unscheduled care plan for 2016/2017 is in development.

	Monthly Position:												Cum Assess	Trend
	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016		
Trust 4-Hour	79.9% (10427 out of 13043)	82.8% (11026 out of 13324)	81% (11317 out of 13966)	86.3% (11232 out of 13018)	82.5% (10945 out of 13266)	81.8% (10800 out of 13200)	80.1% (10557 out of 13190)	78.4% (9842 out of 12,553)	78.8% (9812 out of 12446)	75.4% (9514 out of 12,612)	76.9% (9728 out of 12651)	76.7% (10,387 out of 14,128)	R	↓
Trust 6-Hour	93.2% (12154 out of 13043)	95.5% (12731 out of 13324)	94.07% (13138 out of 13966)	96.4% (12553 out of 13018)	94.6% (12549 out of 13266)	94% (12414 out of 13200)	92.7% (12,232 out of 13190)	91.9% (11,545 out of 12553)	91.8% (11,425 out of 12446)	90% (11,353 out of 12,612)	91.12% (11,528 out of 12,651)	90.3% (12755 out of 14,128)		
CAH 4-Hour	74.2% (4850 out of 6533)	79.1% (5376 out of 6794)	73.2% (5194 out of 7092)	80.2% (5289 out of 6593)	74.1% (4950 out of 6683)	72.5% (4869 out of 6716)	69.6% (4755 out of 6836)	68.3% (4488 out of 6574)	69.2% (4638 out of 6703)	66.7% (4434 out of 6649)	69.1% (4575 out of 6620)	67.9% (4894 out of 7,205)	R	↓
CAH 6-Hour	91.1% (5951 out of 6533)	94.8% (6442 out of 6794)	90.9% (6447 out of 7092)	94.1% (6206 out of 6593)	91.3% (6100 out of 6683)	89.9% (6043 out of 6716)	87.7% (5996 out of 6836)	87.4% (5743 out of 6574)	88.1% (5907 out of 6703)	85.57% (5690 out of 6649)	87.5% (5794 out of 6620)	85.7% (6,174 out of 7,205)		
DHH 4-Hour	77.7% (3236 out of 4167)	79.4% (3393 out of 4272)	82.3% (3499 out of 4249)	88.6% (3740 out of 4222)	86.3% (3708 out of 4296)	86.4% (3492 out of 4044)	86.9% (3591 out of 4132)	84.1% (3311 out of 3936)	85.7% (3405 out of 3974)	78.5% (3223 out of 4106)	78.4% (3183 out of 4061)	78.8% (3639 out of 4,618)	R	↔
DHH 6-Hour	92.7% (3862 out of 4167)	94.4% (4033 out of 4273)	95.7% (4066 out of 4249)	98.2% (4144 out of 4222)	96.9% (4162 out of 4296)	97.2% (3932 out of 4044)	97.1% (4014 out of 4132)	95.5% (3759 out of 3936)	96.6% (3839 out of 3974)	92.7% (3806 out of 4106)	92.7% (3764 out of 4061)	92.6% (4276 out of 4,618)		
Regional Average	74%	76%	76%	81%	77%	78%	77%	75%	75%	74%	74%	N/A		

CP 12: UNSCHEDULED CARE: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, no patient attending any Emergency Department should wait longer than 12 hours. (No change in target)

Baseline: 14

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 0

Comments:

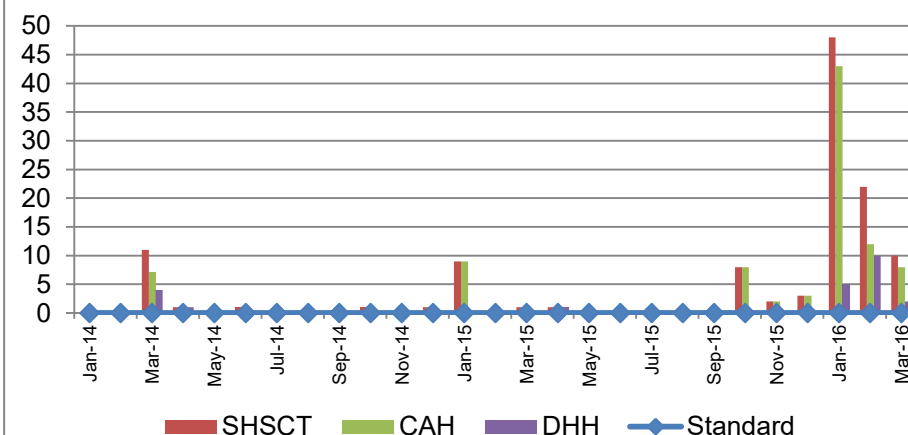
10 patients breached the 12-hour standard in March, predominantly in clusters of high whole system pressure periods.

- In CAH there were 8 breaches of the 12-hour standard – 1 breach on 8th, 2 on the 14th and 15th and 5 on the 22nd and 23rd March when there were higher levels of attendances and admissions (22nd & 23rd occurring between St Patrick's & Easter Bank Holidays).
- In DHH there were 2 breaches of the 12-hour standard – both on 9th March when there were higher levels of attendances and admissions.

January Regional performance (545) demonstrates a large increase (+252 patients from December) in patients waiting greater than 12-hours from October (226) and November (291).

From 1 to 11 April 2015 there has been 55 breaches of the 12-hour standard – 47 in CAH (4 - 8 April) and 8 in DHH (6 - 8 April).

Number of Patients Waiting Over 12-Hours in Emergency Department



	Monthly Position:												Cum Assess	Trend
	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016		
Trust	1	0	0	0	0	0	8	2	3	48	22	10	R	↑
CAH	0	0	0	0	0	0	8	2	3	43	12	8	R	↑
DHH	1	0	0	0	0	0	0	0	0	5	10	2	R	↑

GP OUT OF HOURS: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care**Not a formal CP target - GP Out of Hours Standards are:****Urgent triage (UT)** 90% within 20 minutes**Urgent face to face (UF2F) appointment** 90% within 2-hours**Routine triage (RT)** 90% within 60 minutes**Routine face to face (RF2F) appointment** 90% within 6-hours**Comments:**

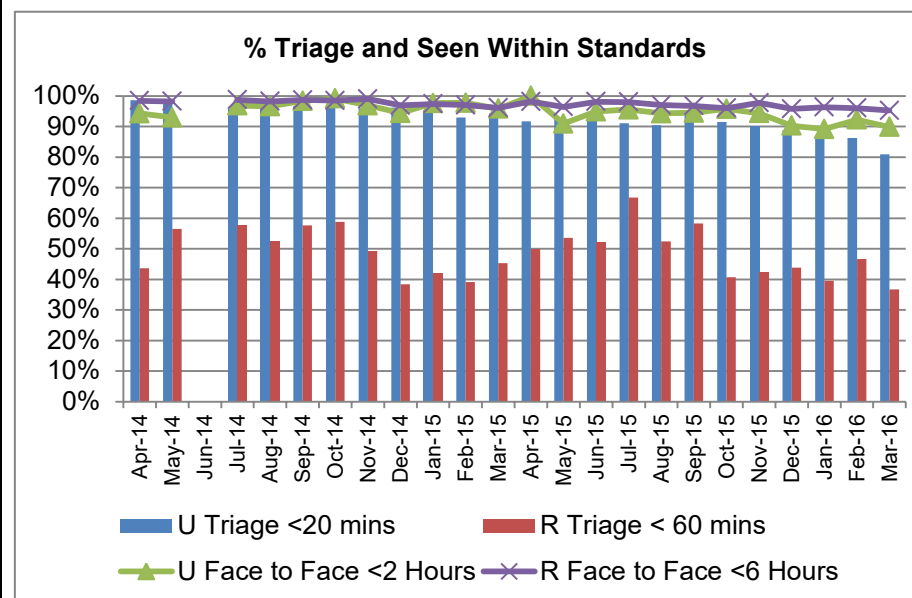
In order to reflect the totality of pressures on the 'unscheduled system' information on GP Out of Hours performance has been included. The ability to maintain adequate service provision and standards for triage relate to ongoing challenges presented in filling vacant GP shifts.

The Trust has recruited and trained nurses to undertake nurse triage, as Nurse Triage Advisors and 5 nurses are working as Nurse Practitioners.

Pressures continue in January, February and March related to ability to cover shifts with an early alert raised to HSCB on occasions where cover was limited. In March 33.6% of GP shifts were unfilled which equated to 209 shifts (out of 622 shifts). The 209 unfilled shifts equates to 1014 hours of unfilled clinical capacity. Efforts to recruit additional GPs and Locum staff have not been successful and long term sickness for 'red eye' night shift cover has compounded the position. Whilst the volume of calls can be challenging at times the complexity of individual cases which consume GP time is a key factor relating to system pressures.

Performance times are monitored closely.

- **Urgent Triage** - The percentage of urgent patients triaged within twenty minutes has further decreased to 80.88% at end of March which equated to 403 patients not triaged within 20 minutes compared to 223 in February. The number of patients waiting greater than 60 minutes for urgent triage has increased from 23 to 51.
- **Routine Triage** - The percentage of routine patients triaged within sixty minutes has significantly decreased at the end of March by almost 10% to 36.72%. This equated to 4160 patients not being triaged within 60 minutes (compared to 2841 in February), of which 305 patients waited 8 - 9 hours; 143 patients waited 9 - 10 hours and 833 patients waited over 10 hours.
- **Face to Face** – The percentage of urgent patients seen within two hours has decreased to 89.83% with 55 patients being seen after two hours.



The percentage of routine patients seen within six hours has remained fairly static, at 95.19% although the number waiting greater than 6 hours increased to 131 in March from 86 in February.

Actions to Address:

- A 6-month pilot has been developed to enable Pharmacists to undertake triage, at weekends and bank holidays for medication related calls. The pilot commenced on 28 February 2015 and is being formally evaluated. Feedback to date, from the GPs, has been positive and the pilot has been extended to March 2016 to provide support in the winter pressure period;
- A capacity and demand analysis has undertaken and the outworking of this exercise will inform future planning;
- The Trust is exploring a pilot of enabling IT equipment to support Out of Hours processes including remote triage. Preparatory work for a pilot of remote triage has been done including testing of equipment; a proposal is being presented to the Senior Management Team outlining benefits and residual risks;
- Proposals to address winter pressures have been prepared; and Enhanced payment rates have been offered to seek to attract GP cover, which has had variable success.

	Monthly Position:												Cum Assess	Trend
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16		
UT <20 mins	91.68%	92.57%	92.18%	91.01%	90.38%	93.97%	91.46%	90.06%	88.83%	87.12%	86.23%	80.88%	R	↓
No. >20 mins	129	126	102	117	128	85	144	177	230	287	223	403		↓
RT <60 mins	49.86%	53.6%	52.08%	66.75%	52.37%	58.31%	40.68%	42.22%	43.81%	39.5%	46.64%	36.72%	R	↓
No. >60 mins	3047	3079	2432	1791	2554	1966	3171	3206	3280	3872	2841	4160		↓
UF2F <2 hrs	100%	90.91%	94.87%	95.55%	94.25%	94.5%	95.75%	94.32%	90.23%	89.15%	92.25%	89.83%	Y	↓
No. >2 hrs	0	2	13	13	20	18	19	26	56	51	31	55		↓
RF2F <6 hrs	98.15%	96.41%	98.11%	97.99%	96.97%	96.74%	96%	97.73%	95.75%	96.32%	95.98%	95.19%	G	
No. >6 hrs	49	109	42	49	69	47	66	57	117	102	86	131		↓

CP 14: HOSPITAL RE-ADMISSIONS: Lead Director – Mrs Esther Gishkori, Director of Acute Services**By March 2016, secure a 5% reduction in the number of emergency re-admissions within 30 days. (No change in target)****Baseline:** 13% above target profile**TDP Assessment:** Partially achievable/achievable with additional resources**Target:** 5% reduction**Comments: Reporting three months in arrears.**

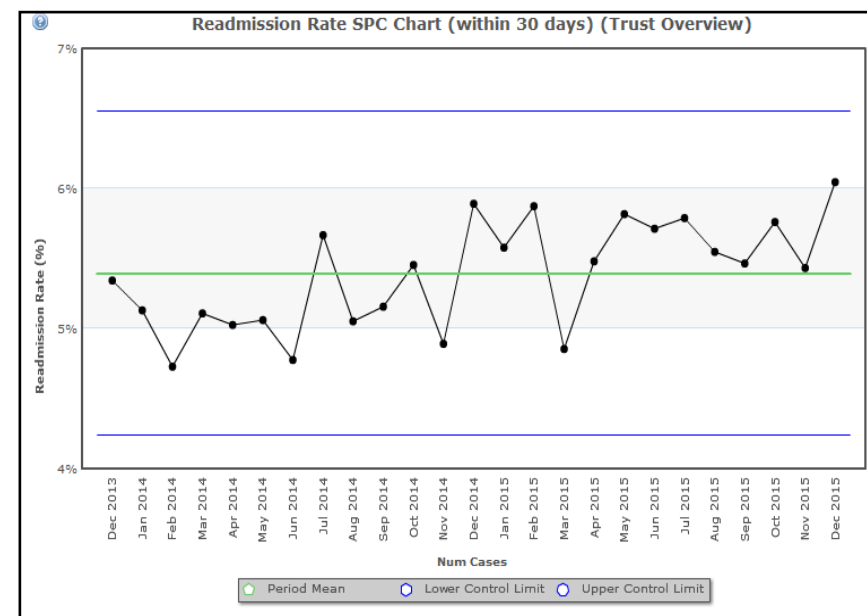
Regional performance data for 2015/2016 is not currently available. CHKS, the comparative benchmarking system, measures re-admissions against the top hospital Peers. Whilst this definition and the comparators are slightly different from those used by HSCB this is a useful guide to performance against our Peers and in providing assurance regarding appropriate patient care.

CHKS indicates the Trusts re-admission rate of 5.6% over the last 12 reportable months (December 2014 – December 2015) which is below the Peer average of 6.6% for the same period. Longer term trending on the chart demonstrates the pattern of re-admission over the last two years, which averaged a similar re-admission rate of 5.4% against a peer of 6.7% from December 2013 – December 2015) with no specific change in the average.

Re-admission rates over the last reported seven months are consistently above the average rate but still within the normal control limit. Where re-admission rates are significantly above the normal variation, analysis is being undertaken to identify specialty areas where the pattern is outside that expected for review with Associate Medical Directors to identify any patterns and, or emerging themes and to consider if any further analysis is required.

Actions to Address:

- A detailed analysis of re-admissions, including analysis of the top 10 condition groups, has been undertaken and discussed with clinicians and GP Fora; this analysis will be undertaken routinely every six months;
- An analysis of the December 2015 peak, which is above the normal variation, is required and will be undertaken to review/identify any patterns/emerging themes.



CP 15: ELECTIVE CARE – OUT-PATIENTS: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, at least 60% of patients wait no longer than 9-weeks for their first out-patient appointment and no patient waits longer than 18-weeks. (Change in target from 80% to 60% <9-weeks and maximum wait from 15 to 18-weeks)

Baseline: 47.4% <9-weeks and 1436 >18-weeks

TDP Assessment: Unlikely to be achieved/affordable

Standard: 60% <9-weeks

0 >18-weeks

Comments: Excludes visiting services - Oral Surgery, Ophthalmology, Paediatric Cardiology and Paediatric Dentistry.

March 2016 data not yet available.

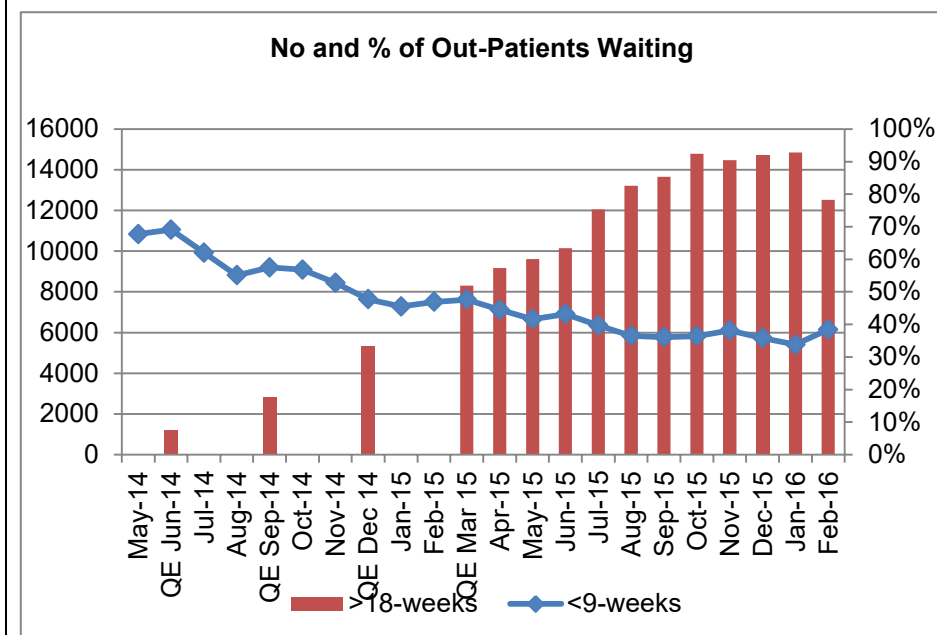
At the end of February there were 12,521 patients waiting over 18-weeks including the specialties identified in Table 15a, this is a decrease of 2334 patients compared to January.

The percentage of total patients waiting less than 9-weeks has increased to 38.4% compared to 33.8% of patients seen within 9-weeks in January. This performance is higher than the Regional performance, where the Regional average indicated 30% waiting < 9-weeks. When the Trust excludes all visiting services from its total activity this performance improves further to 41%.

Regionally in January there were 164,683 patients waiting greater than 9-weeks for an OP appointment, the SHSCT accounted for 13.7% of this (22,606). In January there were 121,857 patients waiting >18 weeks Regionally of which SHSCT accounted for 12.2% (14,855 patients).

Key prevailing issues include:

- A range of specialty areas where capacity is insufficient to meet demand associated with residual capacity gaps and impacted by a general increase demand;
- A general increase in red flag demand, which is impacting on the access times for urgents and further reducing the amount of routine capacity that can be provided;
- Financial situation which reduced the level of non-recurrent funding provided in 2014/2015 for additional capacity which resulted in accrued increased access times; this was compounded by timeliness of funding which became available from the November Monitoring round which limited the lead in time for creating additional capacity; and



- A number of specialty areas are currently underperforming against SBA at this stage in the year. Whilst the majority will recover, to within normal tolerances, by March 2016 exceptions include Dermatology, Diabetes/Endocrinology; Orthopaedic ICATs, and Urology.

In November HSCB allocated additional funding for additional elective out-patient capacity in Pain Management and the visiting services of Ophthalmology to be undertaken in Quarter 4. This funding sought to provide an equality of wait for specialties across the Region. A contract has been placed in the Independent Sector and these patients are currently being transferred for assessment.

Funding has also been diverted to provide additional capacity in-house to areas where long waits present potential clinical risk, including Haematology, Paediatrics, Cardiology, Thoracic Medicine, Neurology, Gynaecology, ENT, Rheumatology and Gastroenterology.

Actions to Address:

- Focus remains on the prioritisation of capacity to red flag and urgent cases;
- Review of performance for routine, urgent and core SBA activity undertaken with bi-weekly & monthly performance meetings. These meetings review and challenge the SBA performance and access delivery and are utilised to agree remedial action required to improve the areas of underperformance;
- Internal recovery plans in place for any areas identified as underperforming against SBA by more than -5% which the normal tolerance for variation;
- Acute, OPPC and CYP Directorates working to implement recommendations from the HSCB audit of out-patient management which will improve chronological management;
- Information on access times is shared monthly with General Practice to ensure referrers and patients are aware of current access times, and
- Procurement activities designed to secure additional capacity in the Independent Sector in line with announcement of additional in-year non recurrent funding have been concluded.

Table 15(a)

Speciality	Access time (end March)	Volume over 18 weeks & change in position +/- from February (not available)	SBA position as at 29/02/16**
Dermatology (Includes ICATS)	19 weeks		Under-performing by 7%
Urology (Includes ICATS)	71 weeks		Under-performing by 9%
Ortho-Geriatrics	55 weeks		Over-performing by 26%
Neurology	55 weeks		Over-performing by 7%
Orthopaedic (Consultant Led)	58 weeks		Under-performing by 9%
Cardiology (Cons Led & ICATS)	40 weeks		In balance 0%
Orthopaedic ICATS	29-weeks		Under-performing by -14%
ENT (Cons Led)	36 weeks		Over-performing by 11%
General Surgery	36 weeks		Under-performing by 5.5%
Pain Management	44 weeks		Under-performing by 3%
Endocrinology	72 weeks		Under-performing by 28%
Diabetology	55 weeks		Under-performing by 10%
Rheumatology	67 weeks		Over-performing by 4%
Gynaecology	28 weeks		Under-performing by 2%
Gastroenterology	51 weeks		Over-performing by 18%
Haematology	14 weeks		Over performing by 31%
Paediatrics	26 weeks		Over performing by 10%

**** SBA position at 29 February 2016 is inclusive of activity undertaken through internally redirected resources (IRR).**

A summary of actual access times for March 2016 is attached in Appendix 2.

	Monthly Position:													Trend
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Cum Assess	
<9-wks	44.5% (13839)	41.6% (13320)	43.2% (14168)	39.7% (13405)	36.5% (12692)	36.1% (12510)	36.4% (12799)	38.1% (13262)	35.8% (12294)	33.8% (11555)	38.44% (12,551)		R	↑
>18-wks	29% (9173)	30% (9616)	31% (10148)	36% (12057)	38% (13216)	39% (13664)	42% (14787)	42% (14475)	43% (14736)	43% (14855)	38% (12521)		R	↑

Note: Historic data for volumes in excess of 18-weeks is only available on a quarterly basis.

OUT-PATIENT REVIEWS – Patients waiting beyond their clinically indicated timescales: Lead Director – Mrs Esther Gishkori, Director of Acute Services (Not a formal CP target)

Comments: Excludes Visiting Services - Oral Surgery, Ophthalmology, Paediatric Cardiology, Paediatric Dentistry and Paediatric Neurology.

Of the 13,090 patients waiting for review appointments beyond their clinically indicated date, at 1 April 2016, the majority of these (11,449) relate to Acute Consultant Out-Patient services with 927 Paediatrics and 707 ICATS.

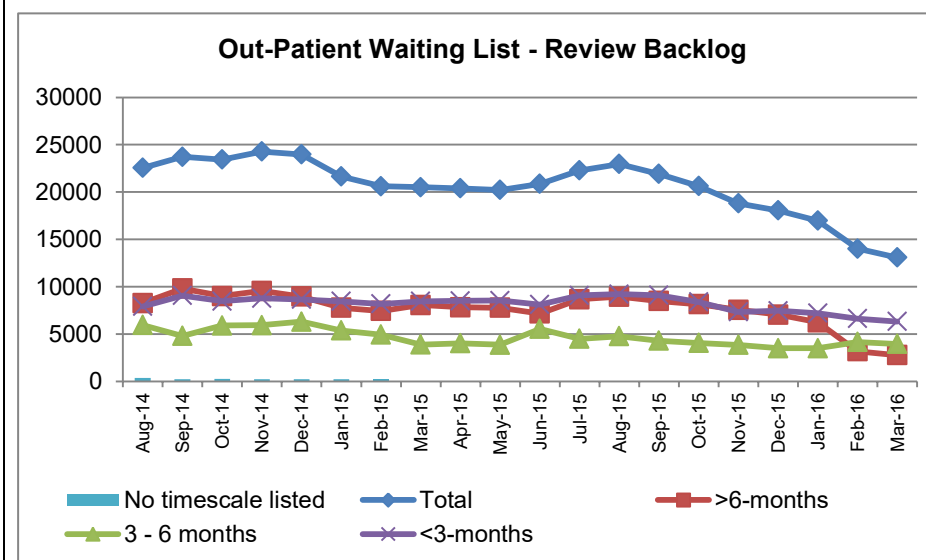
- 21% of those waiting are in excess of 6-months;
- 30% are waiting between 3 – 6 months; and
- 48% are waiting less than 3-months for a review.

The longest Trust waits are in Urology, with 6 patients waiting from 2012/2013 (financial year). All of these patients have been validated with 4 patient seen / offered appointments which were unsuitable for the patient and 2 patients to be discharged. Capacity has been in place to ensure these longest waits have access to an appointment over the next few months.

Internally re-directed resources has provided capacity to target over 5000 of our longest waits across a range of specialty areas before the end of March, which will minimise the volume of patients waiting beyond their clinically indicated timescale for review. It is anticipated that number of patients waiting on Review appointments will increase in the coming months as there is no longer any internally re-directed resources.

Actions to Address:

- Arrangements in place to minimise risk and ensure reviews with high clinical priority take place in accordance with the clinically indicated timescale;
- Trust has sought, via SLCG, engagement with Primary Care to consider potential solutions in the absence of additional funding options to address backlog - not progressed;
- Trust undertook a data and patient validation programme to review patients waiting beyond their clinically indicated date. This was resourced internally by the Trust until March 2015;
- The Trust has highlighted the on-going emergent risk in the clinical



pathway from review patients waiting beyond their clinically indicated timescale to HSCB. HSCB acknowledging the issue but have currently no additional resources available to support this. HSCB have indicated that should additional monies become available they would be happy to consider this, and														
• The Trust in the interim continues to re-direct internal resources to this area as it becomes available or where clinical risk is identified.														
	Monthly Position:												Cum Assess	Trend
	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016		
Total	20391	20223	20874	22294	22968	21915	20627	18803	18065	16987	14018	13090	R	↑
>6 months	7839	7786	7189	8680	8957	8501	8163	7574	7067	6256	3199	2786		
3 – 6 months	4035	3886	5562	4514	4786	4303	4065	3876	3522	3510	4174	3967		
<3 months	8517	8551	8123	9096	9220	9107	8398	7353	7476	7209	6643	6330		
No 'Date Required' listed	58	53	6	4	5	4	1	0	0	12	2	7		

Note: Totals include hospital based reviews including Paediatrics, Orthopaedic ICATS but excludes Mental Health which is reported separately.

Note: Visiting Services have been excluded from February. The number of Visiting Service patients in review backlog at March are: Ophthalmology (1983), Oral Surgery (36), Paediatric Cardiology (330), Paediatric Neurology (9), and Paediatric Dentistry (14) – Total of 2372 patients at 1 April 2016. The Trust provides regular updates on this position to the Provider Trust and to the SLCG.

CP 16: ELECTIVE CARE – DIAGNOSTICS: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, no patient waits longer than 9-weeks for a diagnostic test and all urgent diagnostic tests are reported on within two-days of the test being undertaken. (No change in target)

Baseline: Imaging Diagnostics – 1566 >9-weeks
 Non-Imaging Diagnostics – 1123 >9-weeks
 Endoscopy – 302 >9-weeks patients
 Imaging DRTT – Urgent tests 85.2%
 Non-Imaging DRTT – Urgent tests 96.9%

TDP Assessment: Unlikely to be achieved/affordable

Standard: Diagnostic Testing 9-weeks
 Endoscopy 9-weeks
 DRTT 2 days

Comments: March 2016 not yet available.

Imaging

Volumes over 9 weeks have decreased, by 1090, to 3103 in February with the largest decrease in NOUS (-692) and MRI (-317). This is due to additional capacity in place in the Independent Sector.

HSCB provided additional non-recurrent funding for additional capacity for CT, Non-Obstetric Ultrasound and Plain Film reporting in Quarters 3/4 2015/2016. Capacity secured both in-house and in the Independent Sector has maintained the longest wait for imaging at 22-weeks at March 2016.

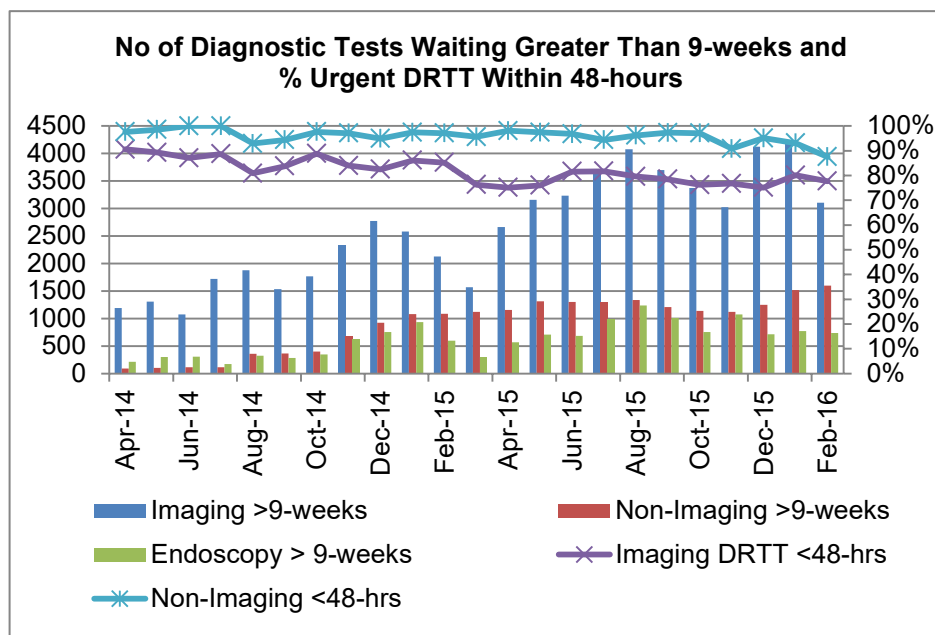
Regionally, in January, 25,636 patients were waiting longer than 9-weeks for a diagnostic test, with the Trust accounting for 22.44% (5,754) of this.

HSCB has indicated that a formal allocation of non-recurrent funding to address elective waits in imaging will be made in Q1/2 2016/17.

Whilst diagnostic imaging continues to perform well against the agreed SBA, capacity is not sufficient to provide for all routine examinations and focus is therefore on in-patients, red flag and urgent patients.

A replacement scanner for the original CT scanner has been commissioned and the Trust has secured a mobile scanner to provide seamless capacity during the replacement period. The SLCG have provided a letter of revenue support for a second CT scanner and the Trust is developing a capital case for the investment.

Current access times are provided in table 16a.



Actions to Address:

- The Trust is preparing an IPT proposal for consideration in 2016/2017 to address capacity gaps, in part, in non-obstetric ultrasound.

Non-Imaging

At the end of February 1596 patients were waiting in excess of 9-weeks, the majority (94%) were waiting for Cardiac Investigations which have an identified capacity gap and which has demonstrated an increase of 87 patients in the last month. Cardiac Investigations, more specifically Echocardiography, has been affected by on-going increase in demand and capacity gaps associated with sickness in the accredited workforce for this area.

Whilst HSCB made an allocation for additional capacity for Echocardiogram and Ambulatory Cardiac Monitoring early in 2015/2016 the Trust was unable to secure the total additional capacity required.

The Trust has sought to recruit a number of Cardiac Investigations posts to address current vacancies and prepared for future additional investment, however, this has been unsuccessful and options now include pursuing internal training routes.

Actions to Address:

- An IPT has been submitted for cardiac investigations (Echocardiogram) and an a recurrent investment has been made;
- The SLCG are in the process of analysing the increase in demand and the key drivers for same.

Endoscopy

Demand continues to present challenges in maintaining waits for urgent patients and those waiting for repeat procedures. The HSCB has made a recurrent commitment of funding to support training of two new Nurse Endoscopists and establishment of 4 additional Medical-led sessions. Due to the time lag for training the new Nurse Endoscopist posts a residual capacity gap exists.

HSCB made an allocation of additional non-recurrent capacity in 2015/2016 and whilst in-house additional capacity has been put in place the Trust has been unable to secure the full capacity required in the Independent Sector,

Table 16(a)

Modality	Current Access (end March)	Volume over 9 weeks & change in position +/- from Feb (Not available)	SBA position as at 29/02/16
Endoscopy - Symptomatic	45 weeks		Under performing by 9%
Non-Imaging			
Audiology	9 weeks		Over-performing by 4%
Cardiac Investigations (total)	29 weeks		No SBA
Neurophysiology	9 weeks		Regional service
Sleep Studies	9 weeks		No SBA
Urodynamics (Urology)	67 weeks		Included in OP SBA
Urodynamics (Gynae)	<9 weeks		Under performing by 27%
Imaging			
Plain Film	9 weeks		Over performing by 16%
CT	16 weeks		Over performing by 6%
CTC	19 weeks		
Non-Obstetric Ultrasound	15 weeks		Under performing by 2%
Dexa	19 weeks		Over performing by 4%
MRI	15 weeks		Under performing by 4%
Fluoroscopy	22 weeks		No SBA
Barium Enema	13 weeks		No SBA
Gut Transit Studies	13 weeks		No SBA
Radio Nuclide	13 weeks		No SBA

Note: 1. Urodynamics (Urology) – following a review of reporting, access times need to be validated.

with no providers responding to the Trust's most recent mini-competitive tender. Within the limited capacity secured there were high volumes of 'fall out' as some patients choose not to avail of the offer and others were unsuitable. In lieu of this the Trust has been able to secure further additional sessions internally in March. In total the Trust has created capacity for an additional 1800+ patient in-house and 550+ in the independent sector.

The Trust is projecting an access time of 46-weeks for routine endoscopy at the end of March 2016. Patients waiting for new urgent and urgent planned repeat procedures are waiting in accordance with Trust internal target of 12 weeks. However patients waiting for routine planned repeat procedures are waiting almost one-year beyond their clinically indicated timescales.

HSCB has indicated that a non- recurrent allocation of funding to address waits in endoscopy will be provided in Q1/2 2016/17. Pending this allocation the Trust has proceeded to put additional capacity in place.

Actions to Address:

- Trusts continue to focus capacity to red flag, urgent and urgent planned repeat scopes in the first instance;
- Endoscopy User Group in place who regularly review the access times for red flag, urgent, urgent planned repeat endoscopy and routine scopes and operational issues,
- The Trust is implementing the agreed investment for endoscopy and has two additional nurse Endoscopists in training; and
- An action plan to look at the range of issues affecting endoscopy and seek solutions if being prepared in conjunction with Endoscopy Users Group.

Reporting Times

- Diagnostic reporting turnaround times for urgents within 48-hours remains at the lower end of Regional performance. Work is ongoing to refresh reporting and an updated position will be reflected in the HSCB February Performance Report.
- Monitoring is in place to monitor the reporting time for plain films including chest x-rays. HSCB has provided funding for additional plain film reporting in Quarters 1/2 and Quarters 3/4 2015/2016 and an

Independent Sector contract is in place.

- HSCB has provided indication that additional allocation of non-recurrent funding will be provided in Q1/2 to address reporting pressures.

Actions

- A supplementary contract has been put in place with the Independent Sector to provide further capacity to address reporting pressures;
- The Trust has submitted an IPT proposal for consideration in 2016/2017 to address capacity gaps, in part, in plain film reporting; and
- The Trust has advertised for additional consultant capacity within the EU.

A summary of actual access times for January is attached in Appendix 2.

	Monthly Position:												Cum Assess	Trend
	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016		
Imaging >9-weeks	2660	3155	3233	3628	4075	3700	3372	3024	4125	4193	3103		R	↓
Non-Imaging >9-weeks	1156	1311	1302	1287	1335	1207	1137	1122	1250	1517	1596		R	↓
Endoscopy >9-weeks	567	709	686	991	1238	1012	756	1073	713	770	738		R	↓
Imaging DRTT Urgents <48-hrs	74.8% (2491 out of 3330)	74.9% (2514 out of 3357)	80.6% (2732 out of 3390)	81% (2538 out of 3134)	79.2% (2420 out of 3054)	77.6% (2670 out of 3439)	75.9% (2823 out of 3718)	76.2% (2519 out of 3306)	73.5% (2702 out of 3674)	77.8% (2831 out of 3638)	77.7% (2670 out of 3435)		R	↑
Non-Imaging DRTT - Urgent <48-hrs	98.1% (158 out of 161)	97.4% (187 out of 192)	96.8% (183 out of 189)	94.4% (169 out of 179)	96.2% (179 out of 186)	97.3% (179 out of 184)	97.1% (203 out of 209)	90.8% (158 out of 174)	95.1% (155 out of 163)	93.1% (148 out of 159)	87.5% (203 out of 232)		R	↓

Note: Non-Imaging data refreshed by Information team and available as above.

CP 17: ELECTIVE CARE – IN-PATIENTS AND DAY CASES: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, at least 65% of in-patients and day-cases are treated with 13-weeks and no patient waits longer than 26-weeks. (Target change from 80% to 65% <13-weeks)

Baseline: 68.5% <13-weeks and 1162 >26-weeks

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 65% <13-weeks
0 >26-weeks

Comments: March 2016 data not yet available.

There are a total of 1,522 patients waiting greater than 26-weeks at the end of February.

Regionally there were 20,313 patients waiting greater than 26-weeks in January of which the Trust accounted for 8.64% (1755). Those specialities waiting over 26-weeks are identified in Table 17a.

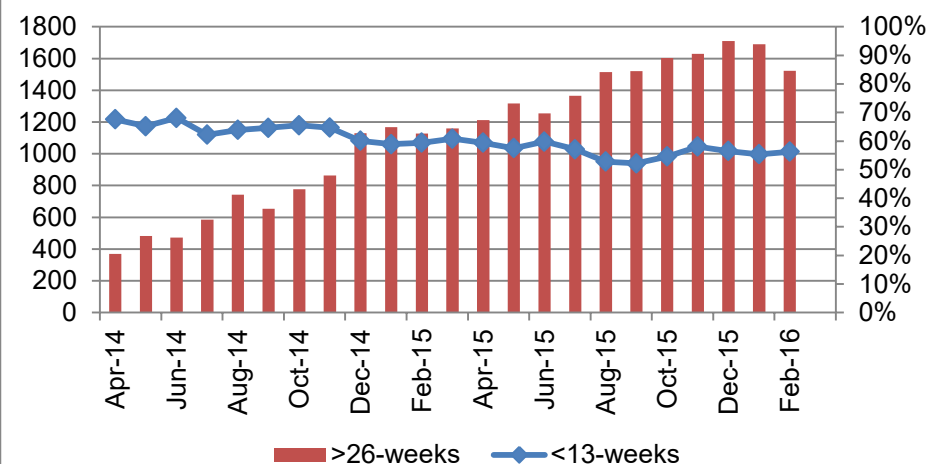
The percentage of those waiting less than 13-weeks has increased slightly, to 56.3%, which is below the target of 65%.; however, performance is above the Regional average of 48% in January. Issues affecting access times prevail and include:

- Impact of decreased level of non-recurrent funding available in 2014/2015 for in-house additionality and independent sector which has resulted in accrued backlogs;
- No non-recurrent funding allocation for areas with capacity gaps in 2015/2016, which has resulted in inability to reduce accrued backlogs and seen access times increase where capacity gaps exist. (Exceptions are Pain Management, General Surgery and small volume of Orthopaedics funded via November Monitoring Round); and
- The Trust continues to monitor performance against SBA to ensure that this is optimised and that SBA underperformance does not account for growth in access times. Whilst a number of specialty areas are currently underperforming against SBA, plans are in place to recover the majority of areas in-year. Key exceptions include General Surgery, Orthopaedics and Urology. Endoscopy day cases, monitored under diagnostic targets will also not achieve the SBA in year.

Actions to Address:

- Internal focus continues on the need to balance the access time for urgent and routine waits within the agreed acceptable levels in each

% of Patients Waiting Less Than 13-weeks and No Waiting Greater Than 26-weeks



specialty area;

- Review of performance for routine and urgent waits and core SBA activity undertaken with bi-weekly & monthly performance meetings. These meetings review and challenge the SBA performance and access delivery and are utilised to agree remedial action required to improve the areas of underperformance;
- Internal recovery plans in development for any areas identified as underperforming against SBA by more than -5%; and
- Information on access times is shared monthly with General Practice to ensure referrers and patients are aware of current access times; and
- Procurement concluded and capacity for additional General Surgery and Pain Management has been secured in the independent sector.

Table 17(a)

Speciality	Access Times (End March)	Volume >26-weeks and +/- from February position (Not available)	SBA position as at 29/02/16
General Surgery	73 weeks		Under-performing by 11%
ENT	29 weeks		Under-performing by 11%
Breast Surgery	66 weeks		Over-performing by 2%
Gynaecology	20 weeks DC 35 weeks IP		Under-performing by 2%
Pain Management	83 weeks		Over performing by 12%
Urology	120 weeks		Under-performing by 5%
Orthopaedics	87 weeks		Under-performing by 2%
Cardiology	42 weeks		SBA to be agreed
Gastroenterology	13 weeks		SBA to be agreed

A summary of actual access times for February is attached in Appendix 2.

	Monthly Position:												Cum Assess	Trend
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16		
<13-weeks	59.4% (3839)	57.5% (3835)	59.8% (4061)	57.1% (3920)	52.8% (3559)	52.2% (3511)	54.6% (3707)	58.1% (3945)	56.5% (3892)	55.4% (3876)	56.3% (3875)		R	↑
>26-weeks	18.8% (1213)	19.7% (1316)	18.5% (1255)	20.1% (1366)	22.5% (1515)	22.6% (1520)	23.6% (1604)	23.99% (1629)	24.8% (1709)	24.15% (1690)	22.11% (1522)		R	↑

CP 19: STROKE PATIENTS: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, ensure that at least 13% of patients with confirmed Ischaemic Stroke receive Thrombolysis. (Change in target from 12% to 13%)

Baseline: 15% (April – December 2014 – Year-end baseline to be available July 2015)

TDP Assessment: Achievable and Affordable

Target: 13%

Comments: Reporting three months in arrears.

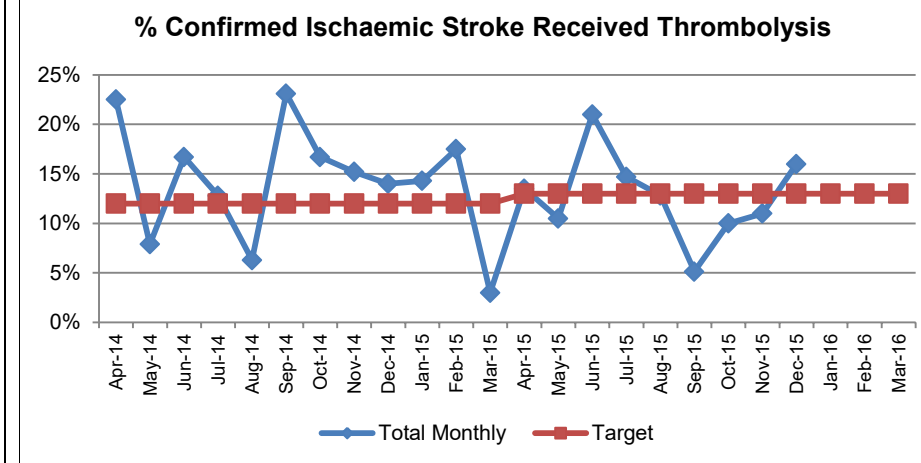
Thrombolysis is a key intervention in the treatment of ischaemic stroke and increasing the number of patients receiving this treatment will allow for significant or complete recovery thereby preventing the need for long-term healthcare and enhancing the potential for improved quality of life post stroke.

Performance at 31 March 2015 demonstrated a cumulative performance of 14%, which is above the target of 13%. This year to date (April – December 2015) is showing a cumulative performance of 13%, which is on target.

Monthly performance against this target is impacted by the variable presentation of strokes, which is affected both seasonally and geographically. It should be noted strokes vary in type and they will vary in time presentation and clinical decisions will determine whether the drug is to be delivered considering the risks and benefits.

Actions to Address:

- A multi-disciplinary group has been established across hospital sites which reviews each case, focusing on performance and identifying any areas for improvement;
- Review of time from scanning to reporting with a view to reducing this ongoing;
- Close monitoring of door to needle time out of hours; and
- Seeking improvement in communication with and feedback to NIAS.



Notes:

- April May 2014 to March 2015 data is based on 12% in line with 2014/2015 Commissioning Plan.
- April 2015 onwards is based on 13% in line with 2015/2016 Commissioning Plan – reporting as per technical guidance Deaths and Discharges are used as an approximation of Admissions and figures are presented by month on discharge not month on admission.

	Monthly Position:												Cum Assess	Trend
	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015		
Trust	14.3%	17.5%	3%	14%	11%	21%	15%	13%	5%	10%	11%	16%		
Trust Admissions* see below	A 42 T 6	A 40 T 7	A 33 T 1	A 37 T 5	A 38 T 4	A 39 T 8	A 34 T 5	A 39 T 5	A 39 T 2	A 30 T 3	A 28 T 3	A 45 T 7		
Trust Cumulative	-	-	14.1%	-	-	-	-	-	-	-	-	13%	G	↑
CAH	20.7%	15.4%	3.7%	9%	15%	18%	11%	16%	4%	11.1%	12%	15%		
CAH Admissions* see below	A 29 T 6	A 26 T 4	A 27 T 1	A 23 T 2	A 26 T 4	A 28 T 5	A 28 T 3	A 25 T 4	A 23 T 1	A 18 T 2	A 17 T 2	A 27 T 4		
CAH Cumulative	-	-	10.6%	-	-	-	-	-	-	-	-	13%		
DHH	0.0%	21.4%	0%	21%	0%	27%	33%	7%	6%	8%	9%	17%		
DHH Admissions* see below	A 13 T 0	A 14 T 3	A 6 T 0	A 14 T 3	A 12 T 0	A 11 T 3	A 6 T 2	A 14 T 1	A 16 T 1	A 12 T 1	A 11 T 1	A 18 T 3		
DHH Cumulative	-	-	22.1%	-	-	-	-	-	-	-	-	13%		

Key: Stroke: A = Stroke Admissions (14-15) / Deaths or Discharges (15-16) / T = Patients Who Had Thrombolysis Administration

Notes:

- April May 2014 to March 2015 data is based on 12% in line with 2014/2015 Commissioning Plan
- April 2015 onwards is based on 13% in line with 2015/2016 Commissioning Plan – reporting as per technical guidance Deaths and Discharges are used as an approximation of Admissions and figures are presented by month on discharge not month on admission

CP 20: HEALTHCARE ACQUIRED INFECTIONS: Lead Director – Dr Richard Wright, Medical Director**By March 2016, secure a reduction of 20% in MRSA and Clostridium Difficile infections compared to 2014/2015.****Baseline:** MRSA – 9
C Diff – 39**TDP Assessment:** Requires further clarification from
HSCB/DHSSPS**Target:** MRSA – 5
C Diff – 32**Comments:****MRSA**

April - January cumulative performance varied across the Region from 2 (SHSCT) to 28 reported cases (BHSCT). SHSCT has had no new reported cases in March.

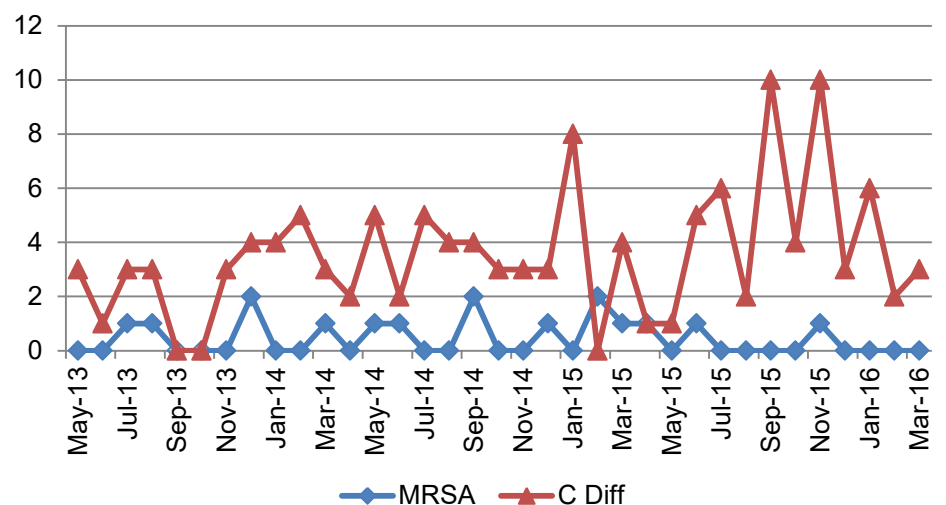
C Difficile

April - January cumulative performance varied across the Region from 49 (SHSCT) to 113 reported cases (BHSCT). There have been an additional 2 C-diff cases in February bringing the total for SHSCT to 54.

In August the SHSCT noted a significant increase in the number of cases, and performance has been variable over the subsequent months.

Actions to Address:

- Focus on range of actions to increase accountability and promote shared learning, including root cause analysis, review of trends;
- A re-focus on antibiotic stewardship is in place and Trust has secured clinical leads to re-enforce this;
- Daily operational review meetings in place between Infection Prevention Control staff and acute bed management staff to review appropriate use of isolation facilities for potentially infectious cases within the Trust;
- A continued focus on monitoring and auditing of adherence to good infection prevention and control standards is in place including regular hand hygiene and environmental self-audit and independent audit;
- On-going training and education programmes for all staff involved in patient care including introduction of Aseptic Non-Touch Technique (ANTT) training program into all augmented care areas; and
- The Trust has appointed 3 Public and Patient representatives as members of the HCAI Strategic Forum; and Trust has identified infection prevention and control as one of its key quality priorities under the new Quality Improvement Framework.

No of MRSA and C Diff

	Monthly Position:												Cum Assess	Trend
	April 2015	May 2015	Jun 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016		
MRSA Actual	0	1	0	0	0	0	1	0	0	0	0	0		
MRSA Cum	0	1	1	1	1	1	2	2	2	2	2	2	G	↔
C Diff Actual	1	5	6	2	10	4	10	3	6	2	3	2		
C Diff Cum	1	6	12	14	24	28	38	41	47	49	52	54	R	↓

CP 21: PATIENT DISCHARGE: Lead Director – Mr Francis Rice, Director of Mental Health & Disability

From April 2015, ensure that 99% of all Learning Disability and Mental Health discharges take place within 7-days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28-days. (No change in target)

Baseline: LD – 7-days 74%; 28-days 83%
MH – 7-days 95%; 28days 98%

TDP Assessment: Mental Health – Achievable and affordable
Learning Disability – Partially achievable/
achievable with additional resources

Standard: 99% 7-days
0 > 28-days

Comments:**Learning Disability**

The relatively low level of patients in this cohort presents a challenge in maintaining a 99% target. Cumulatively year to date the Trust has achieved 20 out of 25 discharges within 7-days equating to 80%, which is below the Regional performance of 84% year to date. Performance in March was 0% as there was 1 patient who should have been discharged within 7-days which was not achieved.

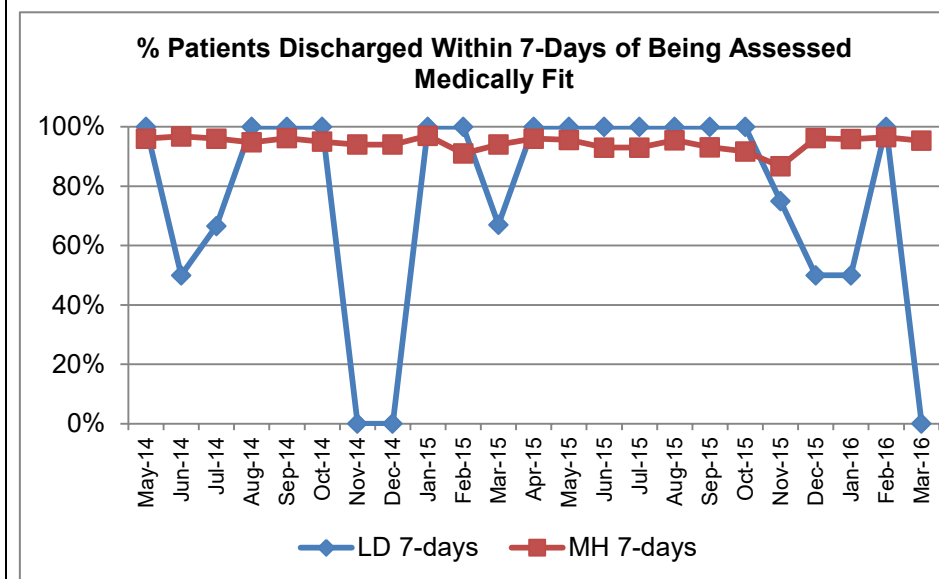
The number of patients waiting longer than 28-days for discharge in March was 1.

Mental Health

Discharge performance has been fairly static, however, the 99% target remains challenging. Cumulatively year to date the Trust has achieved 94%, which is below the Regional average of 97%.

Regional average performance for January was 97%, with performance ranging from 96% (SET, BHSCT, SHSCT, WHSCT) to 100% (NHSCT).

The number of patients waiting longer than 28-days for discharge in March was 2.



	Monthly Position:												Cum Assess	Trend
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16		
LD 7-days	100% (2 out of 2)	100% (2 out of 2)	100% (5 out of 5)	100% (1 out of 1)	100% (1 out of 1)	100% (0 out of 0)	100% (2 out of 2)	75% (3 out of 4)	50% (2 out of 4)	50% (1 out of 2)	100% (1 out of 1)	0% (0 out of 1) Cum: 80% (20 out of 25)	A	↓
LD >28-days	0	0	0	0	0	0	0	0	0	0	0	1 Cum: 1	Y	↓
MH 7-days	96% (98 out of 102)	95.6% (88 out of 92)	93% (115 out of 123)	93% (80 out of 86)	95.5% (84 out of 88)	93.1% (94 out of 101)	91.7% (100 out of 109)	89.69% (87 out of 97)	96.2% (76 out of 79)	95.8% (93 out of 97)	96.5% (83 out of 86)	95.3% Cum: 94% (102 out of 107)	A	↓
MH >28-days	0	2	3	3	2	3	1	1	2	1	1	2 Cum: 21	R	↓

CP 21: PATIENT DISCHARGE: Lead Directors – Mrs Esther Gishkori, Director of Acute Services and Mrs Angela McVeigh, Director of Older People & Primary Care

From April 2015, ensure that 90% of complex discharges from an Acute Hospital take place within 48-hours, with no complex discharge taking more than 7-days; and all non-complex discharges from an Acute Hospital take place within 6-hours. (No change in target)

Baseline: Non-Complex 6-hours – 93%
Complex 48-hours – 98%
All Discharges 7-days – 99.7%

Standard: Non-Complex 6-hours 100%
Complex 48-hours 90%
All discharges 7-days 100%

TDP Assessment: Achievable and affordable

Comments:

Delayed Discharge ‘Coding’/Data Completeness

Performance against the delayed discharge standard is based on the discharges that have had their data completely recorded and not the totality of the discharges. Performance in this area has significantly improved in the last 6 months. Focus on sustainability now required.

Non-Complex Discharges

Performance against the 6-hour standard remains challenging and is affected by a number of challenges including operational delays in discharge communication, pharmacy scripts, transportation and availability of community support arrangements such as re-starting packages of care and delivery of equipment.

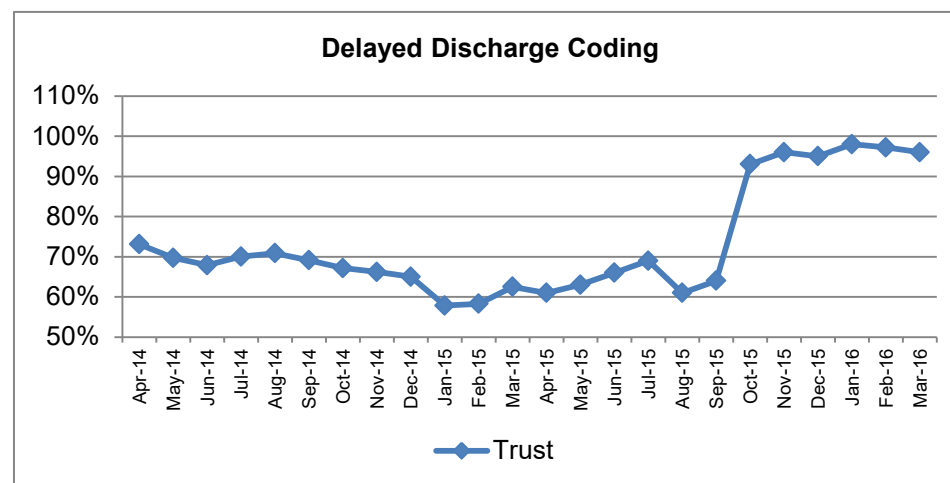
Whilst there are on-going actions the performance has been relatively static. March is showing a small improvement on the February position at 92.8%. Regional average performance in January was 94%.

Actions to Address:

- Analysis of key issues and actions to address will be included in the Unscheduled Care Operational Improvement Group work plan.
- Additional medical staff have been engaged to focus on the follow of information to pharmacy at discharge as part of Winter Pressures planning and the impact of this on the timeliness of simple discharges will be assessed.

Complex Discharges

Performance remains variable but continues to perform well against the target and was at 100% in March. Trust performance is significantly above

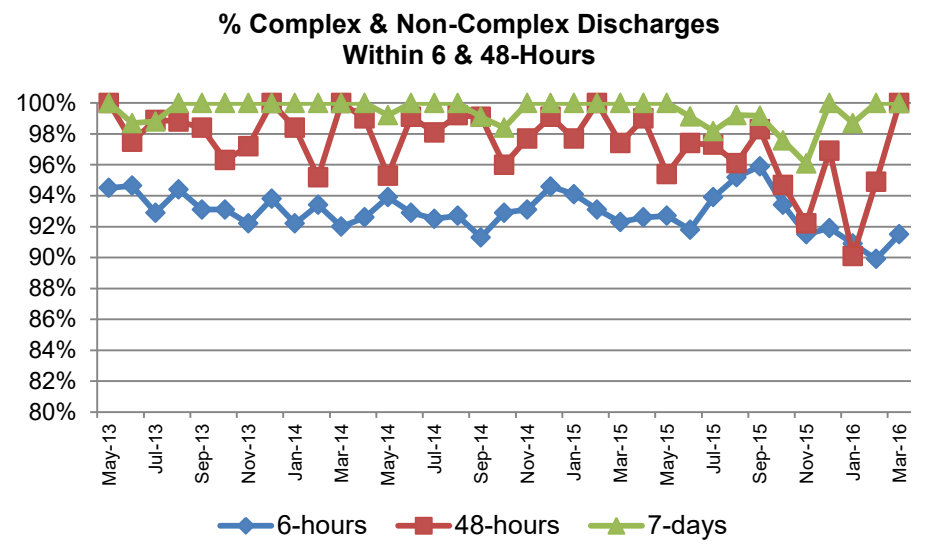


the January Regional average of 75%.

The Trust will continue working closely with multi-disciplinary teams including mental health services and services in the community as part of a proactive discharge planning process to meet the access standards for complex and non-complex discharges.

Actions to Address:

- Review of all actions to promote timely discharge will be undertaken as part of the Unscheduled Care Operational Improvement Group work plan.



Monthly Position:														Cum Assess	Trend
	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016		
% of Coded Delayed Discharges – Trust*	62%	60.7%	63.4%	66.2%	69.2%	60.6%	63.9%	93.2%	96.2%	95.3%	98%	97.2%	96.08%	G	↔
6-hours**	92.6% (1837 out of 1983)	92.7% (1632 out of 1770)	91.8% (1816 out of 1979)	93.9% (1967 out of 2095)	95.2% (1972 out of 2072)	95.9% (1621 out of 1690)	93.4% (1742 out of 1866)	91.5% (2587 out of 2826)	91.9% (2691 out of 2928)	90.9% (2787 out of 3065)	89.9% (2688 out of 2989)	91.5% (2715 out of 2967)	92.9% (2870 out of 3088)	A	↑
48-hours**	99% (100 out of 101)	95.4% (103 out of 108)	97.4% (111 out of 114)	97.3% (107 out of 110)	96.1% (122 out of 127)	98.4% (119 out of 121)	94.7% (196 out of 207)	92.2% (141 out of 153)	96.9% (93 out of 96)	90.1% (73 out of 81)	94.9% (74 out of 78)	100% (68 out of 68)	100% (71 out of 71)	G	↔
7-days**	100% (101 out of 101)	100% (108 out of 108)	99.1% (113 out of 114)	98.2% (108 out of 110)	99.2% (126 out of 127)	99.2% (120 out of 121)	97.6% (202 out of 207)	96.1% (147 out of 153)	100% (96 out of 96)	98.8% (80 out of 81)	100% (78 out of 78)	100% (68 out of 68)	100% (71 out of 71)	G	↔

*Note - % of coded discharges revised further to HSCB clarification on definitions April 2015 – January 2016

**Note – data updated April 2015 – February 2016 (April 2016)

CP 22: MENTAL HEALTH SERVICES: Lead Director – Mr Francis Rice, Director of Mental Health & Disability

By April 2015, no patient waits longer than 9-weeks to access Child and Adolescent Mental Health Services; 9-weeks to access Adult Mental Health Services; 9-weeks to access Dementia Services; and 13-weeks to access Psychological Therapies (No change in target, however potential change in definition for CAMHS services to be confirmed).

Baseline: Adult Mental Health – 65 >9-weeks
 CAMHS – 0 >9-weeks
 Dementia Services – 41 >9-weeks
 Psychological Therapies – 54 >13-weeks

TDP Assessment: Adult Mental Health – Partially achievable/achievable with additional resources
 CAMHS – Achievable and affordable
 Dementia Services – Achievable and affordable
 Psychological Therapies – Partially achievable / achievable with additional resources

Standard: Adult Mental Health 9-weeks
 CAMHS 9-weeks
 Dementia Services 9-weeks
 Psychological Therapies 13-weeks

Comments:**Adult Mental Health Care**

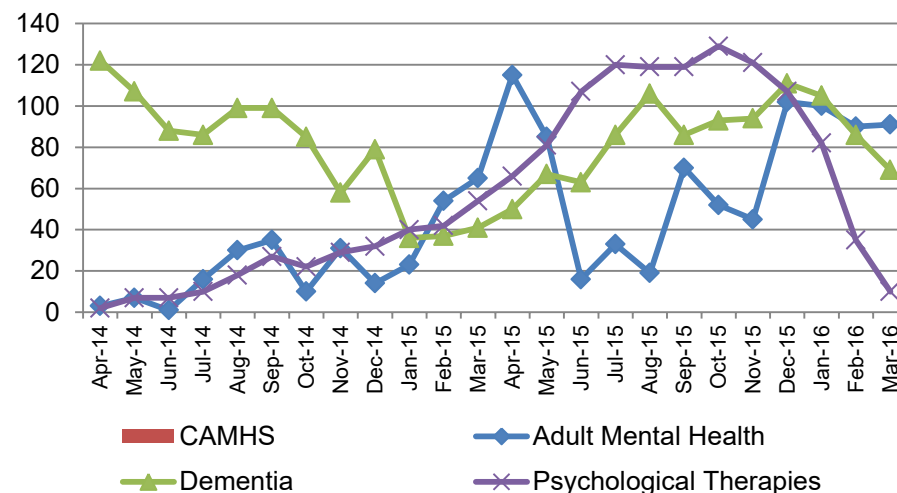
The number of patients waiting in excess of 9-weeks shows a slight decrease in March, however, the Trust has retracted some patients from the IS provider as waiting times were beginning to be inequitable for the patients in the IS versus the patients in-house. There is potential for further patients to be moved from the IS to the Trust. Demand for Cognitive Behavioural Therapy (CBT) practitioners and vacancy associated capacity gaps still continues to be monitored closely.

Regional performance in January demonstrates a total of 349 patients waiting in excess of 9-weeks ranging from 0 (NHSCT) to 217 (BHSCT). The Trust accounted for 29% (100) of this.

Actions to Address:

- Additional capacity in place via independent sector providers. On-going focus on performance management issues to embed this service component
- The Performance Team are commencing a process to establish a robust Service and Budget Agreement baseline and anticipate completion of this in Quarter 2. This baseline will facilitate the Trust in identifying any recurrent capacity gap in order to engage with the

No Patients Waiting in Excess of 9 and 13-weeks Access Standards



Commissioner to seek additional recurrent funding.

Child and Adolescent Mental Health Service

Whilst there are currently no breaches of the 9-week standard within CAMHS the ability to maintain this position is potentially unsustainable. The current longest waiting patient is 8-weeks.

Within CAMHS the 9-week standard currently only applies to Step 3 referrals. Within the Step 2 service there is a significant pressure on the waiting lists.

Actions to Address:

- A bid for non-recurrent resources in Quarters 1/2 has been submitted as part of the HSCB Q1/2 £700,000 allocation to address patient safety issues and long waiters.

Memory/Dementia Services

Identified capacity gap in this service as part of regional demand and capacity work. No indication on how this will be addressed until work related to a consistent regional model of service provision is completed.

The Trust is seeking to develop a short-term recovery plan to improved capacity in 2016/17 and address increasing waits. Additional consultant capacity for mental health services, which is anticipated to be in place July/August 2016, will provide additional consultant capacity to this area.

Regionally the Trust is the only one breaching this target.

Actions to Address:

- Ongoing work to finalise capacity and demand issues in association with HSCB; and
- Short term recovery plan in development

Psychological Therapies

New ways of working had been implemented with Psychological Therapies, however, there remains a shortfall in capacity associated with vacancies, for which recruitment is underway. In the interim additional temporary capacity has been established and this has resulted in a

Table 22 (a)

Specialty	Access Time (end March)	Waiters >9 />13 weeks	SBA performance
Adult Mental Health	32 weeks (IS)	81 (-9)	To be agreed
CAMHS	9-weeks	0	To be agreed
Dementia Services	34 weeks	69 (-17)	To be agreed
Psychological Therapies (waiters >13 weeks)	21 weeks (CBT IS)	10 (-24)	To be agreed

decrease in the number of patients waiting greater than 13-weeks in-month. The Trust is utilising an Independent Sector provider to provide additional capacity for suitable cases. This and ongoing validation has seen waits reduce by 24 patients from February and there are now only 10 patients waiting greater than 13 weeks.

Regional performance in January demonstrates a total of 1224 patients waiting in excess of 13-weeks ranging from 586 (SEHSCT) to 82 (SHSCT).

Actions to Address:

- Internal review on-going to consider manpower issues; and
- Head of Service level performance meetings are held with Mental Health Directorate monthly to review performance against the access standards.

	Monthly Position:												Cum Assess	Trend
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16		
Adult Mental Health	115	85	16	33	19	70	52	45	102	100	90	81	R	↑
CAMHS	0	0	0	0	0	0	0	0	0	0	0	0	G	↔
Dementia	50	67	63	86	106	86	93	94	111	105	86	69	R	↓
Psychological Therapy	66	81	107	120	119	119	129	121	107	82	35	10	Y	↑

OUT-PATIENT REVIEWS – Patients waiting beyond their clinically indicated timescales: Lead Director – Mr Francis Rice, Director of Mental Health & Disability (Not a commissioning plan target)

Comments:

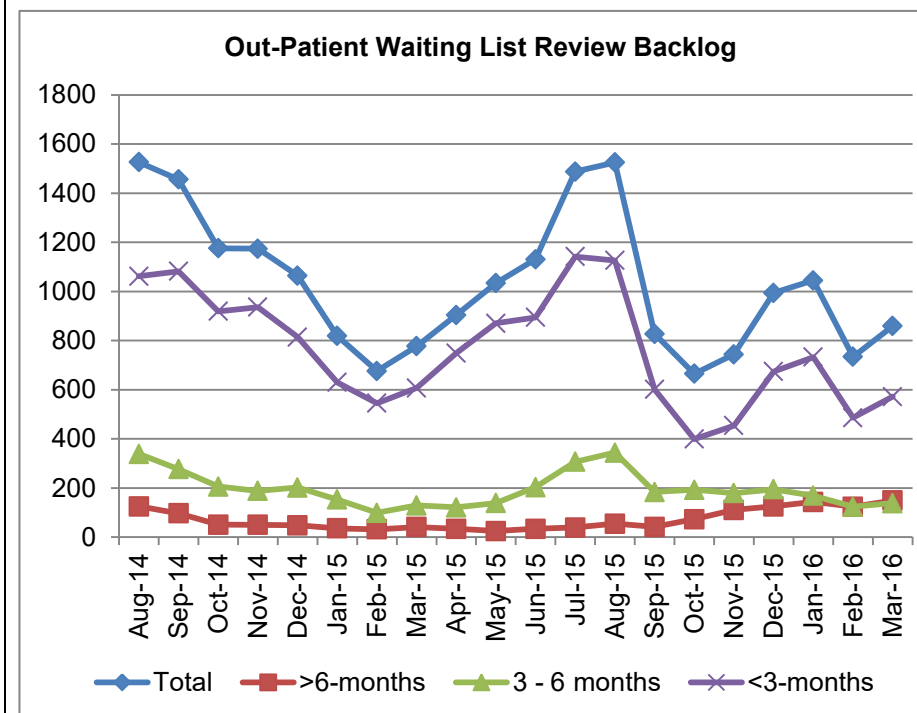
Of the 859 review patients waiting beyond their clinically indicated timescales:

- 17% (149) of these are waiting in excess of 6-months;
- 16% (138) of these are waiting between 3 – 6 months; and
- 67% (572) are waiting less than 3-months.

Focus on the longest waiters, with validation and additional capacity created via internal re-direction of resources, saw the cohort of patients waiting initially decrease before incurring a backlog in the 'short' end of the waiting list which indicated an increase in recent additions to the review waiting list beyond capacity.

Actions to Address:

- Discussion paper submitted to HSCB and SLCG to highlight ongoing issues (July);
- The Trust has highlighted the on-going emergent risk in the clinical pathway from review patients waiting beyond their clinically indicated timescale to HSCB. HSCB has acknowledged this issue but have currently no additional resources available to support this. HSCB have indicated that should additional monies become available they would be happy to consider this; and
- Trust to continue to re-direct resources into this area, as this becomes available and an assessment of the level of additional capacity that can be provided is currently on-going.



	Monthly Position:												Cum Assess	Trend
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16		
Total	904	1034	1131	1488	1525	827	665	744	994	1045	734	859	R	↑
>6-months	34	25	34	39	55	42	73	111	125	143	124	149		
3 – 6 months	121	139	203	307	344	184	193	179	195	169	124	138		
<3-months	749	870	894	1142	1126	601	399	454	674	733	486	572		

CP 23: CHILDREN IN CARE: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services

From April 2015, increase the number of children in care for 12 -months or longer with no placement change to 85% (No change in target)

Baseline: To be confirmed

TDP Assessment: Partially achievable/achievable with additional resources

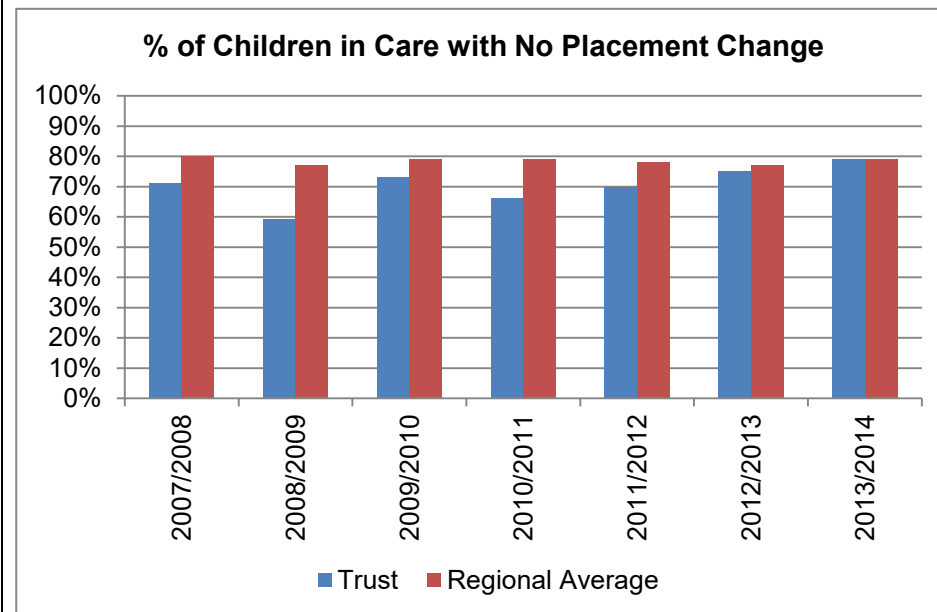
Target: Increase to 85%

Comment/Actions: 2014/2015 performance information is collated during August – September 2015 for the year and will not be available until July 2016 due to the annual reporting cycle associated with this target area.

This area remains an on-going priority in relation to care planning for all children, however, this is influenced by a number of factors including availability of carers, Court process including the planned change of placement for some children ie. return home, or change from fostering to an adoptive placement.

Detailed below is Trust and Regional performance (sourced from HSCB Trust Board Performance Report), against this standard, from 2007/2008 to 2013/2014. Trust performance in 2013/2014 was at its highest, for this 7-year period, at 79%. Trust performance was below the Regional average from 2007/2008 through to 2012/2013; however, in 2013/2014 Trust performance equalled the Regional average.

Cumulative performance in 2013/2014 across the Region varied from 84% (BHSCT) to 76% (NHSCT).



	Monthly Position:							Cum Assess	Trend
	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014		
Trust	71%	59%	73%	66%	70%	75%	79%	W	↔
Regional Average	80%	77%	79%	79%	78%	77%	79%		↔

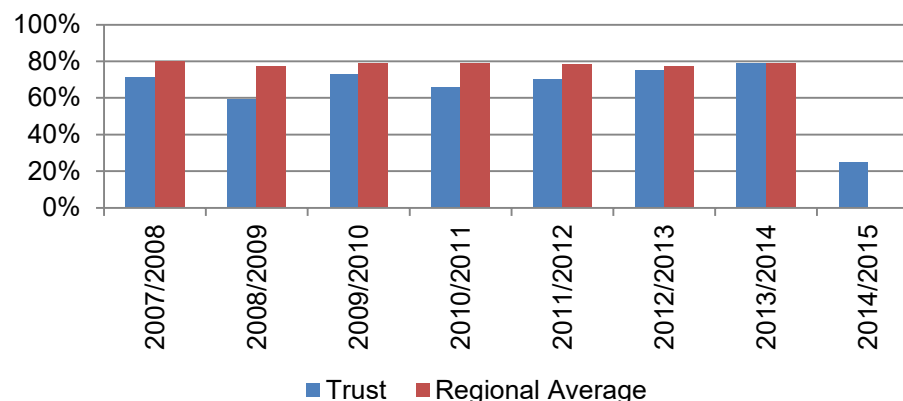
CP 24: CHILDREN IN CARE: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services**By March 2016, ensure a 3-year time frame for 90% of children who are to be adopted from care. (No change in target)****Baseline:** HSCB to source from AD1 return**Standard:** 3-Year timeframe for 90%**TDP Assessment:** Achievable and affordable**Comment/Actions: Regional data not yet available**

In 2014/2015 25% of children were adopted within 3 years, 65% were adopted between 3 and 5 years and 10% over 5 years.

Performance against the 3-year target is impacted on by the higher than normal number of older children being adopted, with over half of those adopted in the 5 – 9 years age bracket. The majority of these older children were adopted by their foster carers, which is typically a longer process.

The Trust has the highest percentage (28%) of children adopted regionally (20 in total for the year 2014/15).

Cumulative performance in 2013/2014 across the Region varied from 64% (SEHSCT) to 19% (WHSCT).

% of Children in Care with No Placement Change

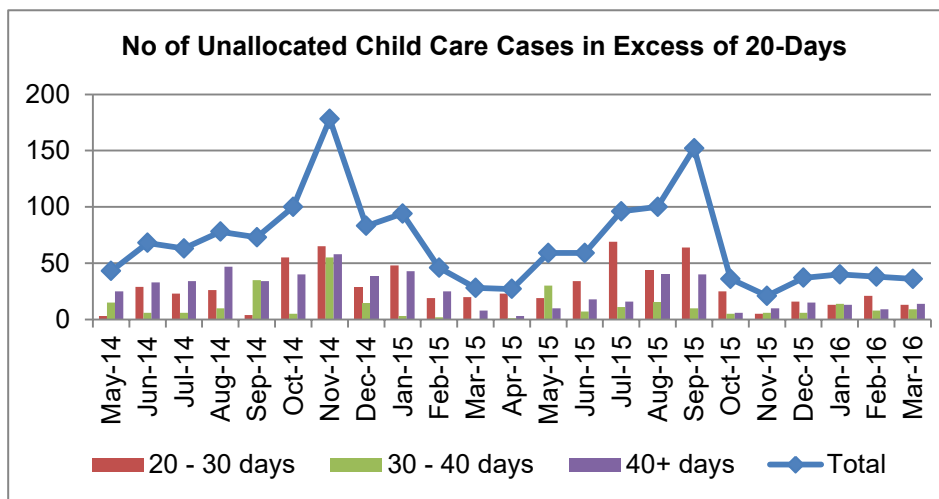
	Monthly Position:								Cum Assess	Trend
	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/15		
Trust	63%	No data	42%	No data	50%	50%	56%	25%	W	↓
Regional Average	47%	No data	40%	No data	47%	42%	61%	N/A		

**UNALLOCATED CHILD CARE CASES: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services
(Not a formal CP target)**
Comment/Actions:

At the end of March there were a total of 44 unallocated child care cases in excess of 20 days.

30% (13) of these are waiting between 20 and 30 days; and the volume over 40-days is 17.

Further information on the Unallocated Child Care Cases is provided within the Director of CYPS Trust Board Report.



	Monthly Position:												Cum Assess	Trend
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16		
Total	59	59	96	100	152	36	21	37	40	38	36	44	R	↓
>20 and <30-days	19	34	69	44	64	25	5	16	13	21	13	13		
>30 and <40-days	30	7	11	16	10	5	6	6	14	8	9	14		
>40-days	10	18	16	40	78	6	10	15	13	9	14	17		

CP 25: PATIENT SAFETY: Lead Director(s) – Mrs Esther Gishkori, Director of Acute Services & Dr Richard Wright

From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points. (New target)

Baseline: Clarification waited from HSCB on technical definitions

TDP Assessment: Partially achievable/achievable with additional resources

Standard: Death rate for unplanned weekend admissions does not exceed death rate of unplanned weekday admissions by more than 0.1%

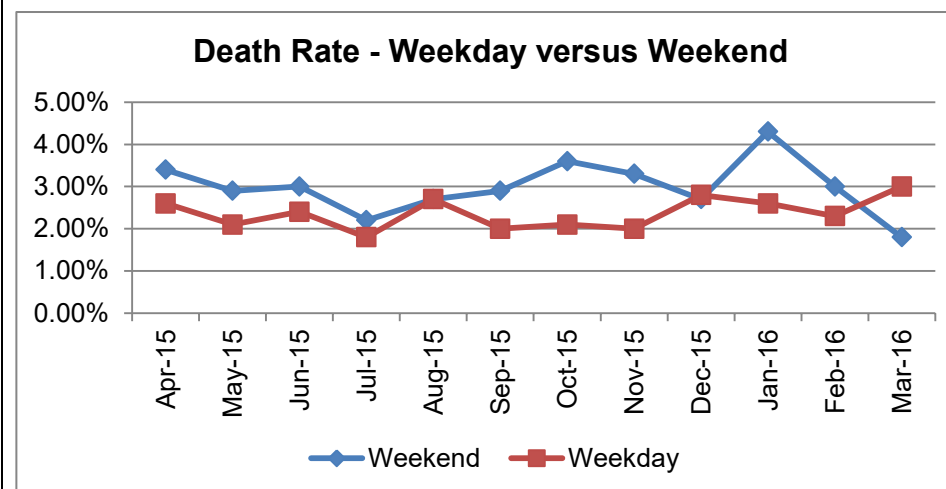
Comments:

Across Northern Ireland in 2013/14, the percentage of unplanned admissions resulting in patient death was 3% for those admitted on a weekday and 3.2% on a weekend. As such, the target for 2015/2016 is to ensure that there is no more than 0.1 percentage point difference between weekday and weekend rates.

Technical guidance has been received from HSCB for reporting against this target. As per this technical guidance, Deaths and Discharges are used as an approximation of Admissions and figures are presented by Month on Discharge not Month on Admission. Cumulatively for 2015/2016 there is a 0.6% difference between the death rate of unplanned admissions on a weekday compared to the weekend (2.4% weekday and 3% weekend).

The drivers for this target include:

- Implementation of recommendations from RQIA reviews of:
 - Acute Hospitals at Nights and Weekends (July 2013);
 - Care of Patients Following Stroke (11/12/2014); and
 - Care of Older People in Acute Hospital Wards (when Published).
- Implementation of safety initiatives around Early Warning Systems, Sepsis, Reducing Falls and VTE Risk Assessments.



	Monthly Position:												Cum Assess	Trend
	April 2015	May 2015	June 2015	July 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016		
Weekend	3.4%	2.9%	3.0%	2.2%	2.7%	2.9%	3.6%	3.3%	2.7%	4.3%	3.0%	1.8%		
Weekday	2.6%	2.1%	2.4%	1.8%	2.7%	2.0%	2.1%	2.0%	2.8%	2.6%	2.3%	3.0%		
Variance	0.7%	0.8%	0.6%	0.3%	0.1%	0.9%	1.5%	1.3%	-0.1%	1.7%	0.7%	-1.2%	R	↓

CP 26: NORMATIVE STAFFING: Lead Director – Mr Francis Rice, Director of Mental Health and Disability / Executive Director for Nursing and Allied Health Professionals

By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical in-patient units. (New target)

Baseline:	To be confirmed	Standard: 95%
TDP Assessment:	Partially achievable/achievable with additional resources	

Comments:

The Trust received confirmation of £2 million recurrent funding towards the implementation of normative staffing across medical and surgical wards from HSCB in March 2015, plus an additional non-recurrent £250k towards covering maternity leave. This funding has been allocated across the FSLs of all specified wards in Phase 1.

A report detailing the end of year compliance for 2015/2016 is currently being collated for submission to the HSCB by 18 May 2016. This data will be submitted to Trust Board via the Executive Director of Nursing Report.

Monthly Position:												Cum Assess	Trend
Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16		
N/A												W	

MINISTERIAL PRIORITY: TO ENSURE THAT SERVICES ARE RESILIENT AND PROVIDE VALUE FOR MONEY IN TERMS OF OUTCOMES ACHIEVED AND COSTS INCURRED

CP 27: EXCESS BED DAYS: Lead Director – Mrs Esther Gishkori, Director of Acute Services

By March 2016, reduce the number of excess beddays for the Acute Programme of Care by 10%. (No change in target)

Baseline: Clarification waited from HSCB on technical definitions – HSCB (April – November 2014) position indicates SHSCT 44% above the target profile for 2014/2015

TDP Assessment: Unlikely to be achieved/affordable

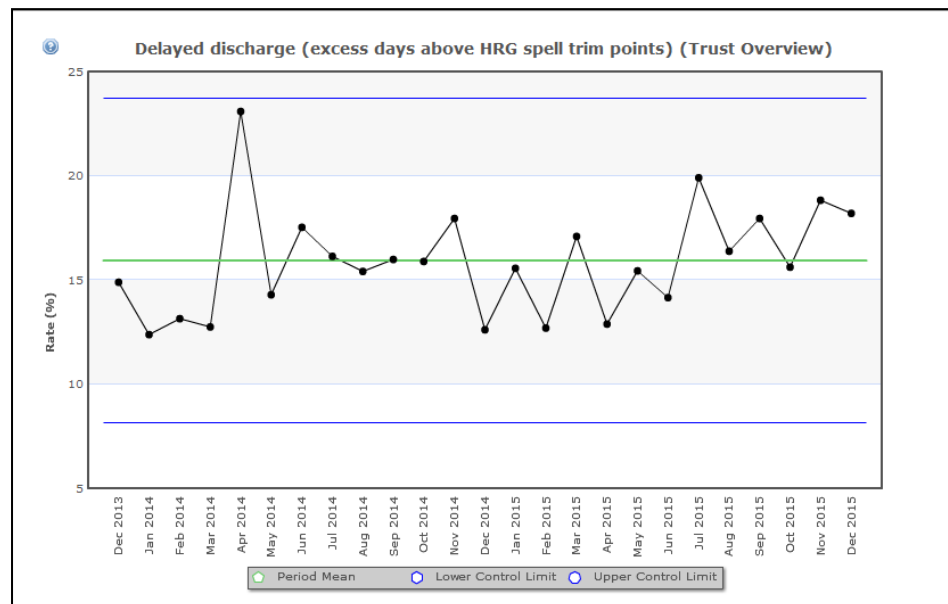
Comments: Internal reporting in development

CHKS, the comparative benchmarking system, measures excess bed days (delayed discharges) against the Top Hospital peers. Whilst this definition and the comparators are different from that used by HSCB as it is based on expected length of stay at condition level calculated for the payment by results (PbR) methodology adopted in England, it is a useful guide to peer performance. CHKS utilises information on 'spells' which will include the aggregated length of stay (beddays) in a patients total journey in the hospital system, including acute and non-acute hospital episodes and transfers across hospital sites.

Information available using CHKS data, December 2013 to December 2015 demonstrates the Trust with excess bed days of 16% against the HES Peer Average of 15.5%. The Trust has an average of 16% for excess bed days in the last 24 months which is in line with the peer.

The chart opposite demonstrates a timeline analysis of excess beddays at Trust level over the last two years which is largely within normal levels of variation.

Target: Reduce by 10%



CP 28: CANCELLED APPOINTMENTS: Lead Director – Mrs Esther Gishkori, Director of Acute Services

By March 2016, reduce by 20% the number of hospital cancelled consultant-led out-patient appointments in the Acute Programme of Care which resulted in the patient waiting longer for their appointment. (Change in target from 17% to 20% and area of focus)

Baseline: 5,419 patient cancellations 'put back' (2.7%)

TDP Assessment: Target is partially achievable/achievable with additional resources

Target: Reduce by 20%; Target 4335

Comments: March data not available.

The Trust is awaiting technical guidance from HSCB on how this target will be assessed. However as an interim the Trust will report on work undertaken by a Short Life Working Group at the request of the Health Committee, which analysed the level of cancellations within the Hospital system that had a direct impact on patients.

Cancellations primarily fall into 3 categories:

- Where the appointment is cancelled and 'put back' so the patient waits longer for their appointment;
- Where the appointment is cancelled and 'brought forward' so the patient actually is seen sooner than originally scheduled; and
- Where the appointment time or location is changed which while impacting on the patient does not lead to a longer wait.

Reporting for 2014/2015 year identified 2272 new and 6783 review patients had been cancelled out of 199,850 patients scheduled in the hospital system. As such 4.5% of patients scheduled were cancelled; 3% of new patients and 5.3% of review patients were cancelled.

Of those patients cancelled 2.7% had their appointments put back and waited longer. This equated to 1.8% of new patients and 3.2% of review patients. This relatively low rate of hospital cancelled consultant-led outpatient appointments, where the patient is 'put back' and effectively waits longer for their appointment, makes achievement of the target challenging in that the Trust had the lowest number of cancellations in the Region as a baseline.

Based on an apportioned target of 3974, for 11-months activity, performance in relation to actual cancellations which have been 'put back' is not on track, to meet the new target.

Actions to Address:

- Analysis to be undertaken related to the reasons for cancellations to inform action planning; and
- Key actions to be agreed to enable reduction of cancellations and install best practice in clinic management.

	Monthly Position:										
	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Cum Assess	Trend
Attendances	14530	14220	19366	18329	19678	17689	18455	18773	N/A		
Cancellations 'Put back' *	332 (2.3%) 1563 Cum	380 (2.7%) 1943 Cum	508 (2.6%) 2451 Cum	544 (3.0%) 2995 Cum	582 (3.0%) 3577 Cum	412 (2.3%) 3989 cum	486 (2.6%) 4475 Cum	540 (2.9%) 5015 Cum	N/A	R	↓
Cancellations 'Brought Forward'	132 (0.91%)	140 (0.98%)	184 (0.95%)	205 (1.11%)	151 (0.76%)	120 (0.68%)	103 (0.55%)	126 (0.77%)	N/A		
Cancellation of Time/ Location	89 (0.61%)	122 (0.86%)	111 (0.57%)	118 (0.64%)	295 (1.49%)	228 (1.28%)	97 (0.52%)	155 (0.82%)	N/A		
Total Cancellations	553 (3.8%)	642 (4.5%)	803 (4.14%)	867 (4.73%)	1028 (5.22%)	760 (4.3%)	686 (3.72%)	821 (4.37%)	N/A		

*Note apportioned target for Feb 2016 is 3974 cancellations

CP 29: DELIVERING TRANSFORMATION: Lead Director – (All)

By March 2016, complete the safe transfer of £83m from hospital/institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model. (New target)

Baseline: To be confirmed

TDP Assessment: To be confirmed

Trust Share: To be confirmed

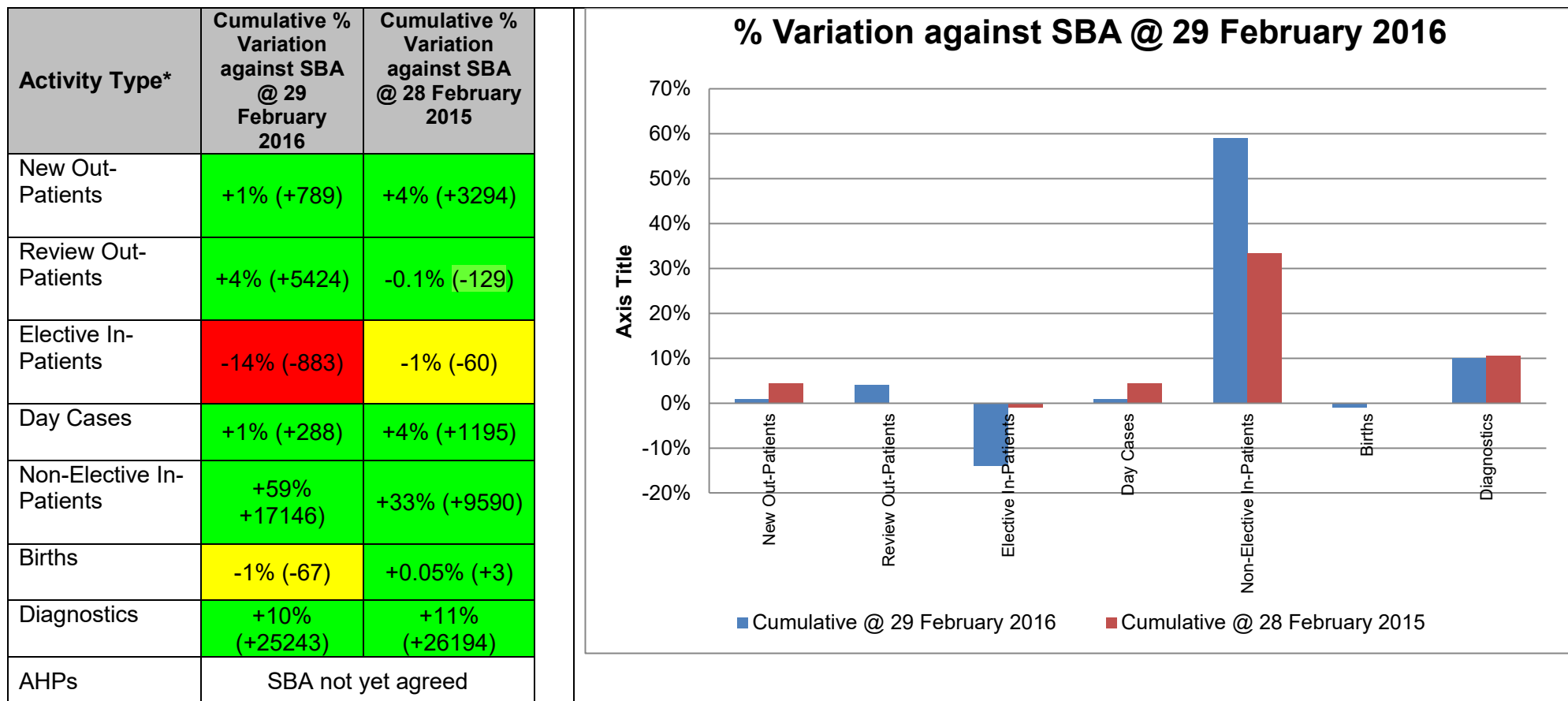
Comments:

This target represents the 'shift-left' aims of the Transforming Your Care strategy in totality. A Regional methodology has been agreed to facilitate identification and measurement of the shift left funding transfer into primary, community and social care services.

The Trust has reported, to HSCB, a cumulative total of 'shift-left' transformation investment of £7,351,700 as at March 2015.

The 2015/2016 year-end position is currently not available.

Total SBA Performance per Activity Type (inclusive of newly agreed in-year uplifts): Table 1 below provides a summary of the total performance against elective and non-elective apportioned SBA baselines; this excludes visiting services where the Trust is not responsible for the SBA, a number of areas in Mental Health Directorate where SBAs require to be updated/agreed and activity related to daycentres and bedday contracts. Allied Health Professionals are currently excluded from SBA analysis pending input from HSCB/PHA on new baselines. SBA levels in a small number of areas may differ from regional reporting due to timeline for agreeing volumes. The table below reflects the variation against apportioned SBA volumes as at 29 February 2016. The graph reflects the variation in performance against the apportioned SBA compared to the same period last year.



* **Note:** SBA performance includes ASD; CYPS; and OPPC specialties, where robust SBAs are in place. MHD is excluded as robust SBAs are not yet developed.

RAG Status:	On SBA or Over performing on SBA	Underperformance of up to -4.9%	Underperformance of -5.0 to -9.9%	Underperformance of -10% and above

APPENDIX 2 - ACCESS TIMES (Routine waits) – Month ended March 2016 and projected month end position for April 2016

OUTPATIENTS - From April 2015, at least 60% of patients wait no longer than 9-weeks for their first out-patient appointment and no patient waits longer than 18-weeks. 18 weeks is the defined backstop for outpatient waits

Specialty	SBA Performance: Over / Under (at 29/02/16)	Known Capacity Gap	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of March 2016							Projected position at End of April 2016
				End of March 2016 position	Actual Volume of patients waiting in excess of 18-week 'backstop'	Time Bands (in weeks)					
						Timeband Information Not Yet Available					
						18 - 21	21 - 26	26-31	31-36	36 +	
Anti-Coagulant	Under -11%	Minor capacity gap	9 weeks	5 weeks							5 weeks
Breast Family History	Under -8%		9 weeks	20 weeks							13 weeks
Cardiology (including ICATS)	Over +9%	Capacity gap	9 weeks	40 weeks							44 weeks
Cardiology – Rapid Access Chest Pain	Over +22%		2 weeks	7 weeks							8 weeks
Chemical Pathology	Over +19%	Capacity Gap	9 weeks	14 weeks							18 weeks
Colposcopy	Under -16%		9 weeks	5 weeks							5 weeks
Community Paediatrics	No SBA	N/A	9 weeks	9 weeks ¹							9 weeks
Dermatology (includes ICATS)	Under -7%		18 weeks	19 weeks							19 weeks
Endocrinology	Under -28%	Capacity gap	9 weeks	72 weeks							74 weeks
Diabetology	Under -10%			55 weeks							57 weeks
ENT (Cons Led includes ENT ICATS)	Over +11%	Residual Capacity gap	9 weeks	36 weeks							39 weeks

¹ Community Paediatrics figure excluding Education referrals which do not follow the 9-week access standard.

Specialty	SBA Performance: Over / Under (at 29/02/16)	Known Capacity Gap	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of March 2016							Projected position at End of April 2016
				End of March 2016 position	Actual Volume of patients waiting in excess of 18-week 'backstop'	Time Bands (in weeks)					
						Timeband Information Not Yet Available					
						18 - 21	21 - 26	26-31	31-36	36 +	
Gastroenterology	Over +18%	Capacity gap	9 weeks	51 weeks							53 weeks
General Medicine	Over +6%		9 weeks	18 weeks							18 weeks
Geriatric Medicine	Over +62%	Capacity gap	9 weeks	9 weeks (Acute)							9 weeks (Acute)
Ortho-Geriatric	Over +26%	Capacity gap	9 weeks	55 weeks							57 weeks
General Surgery (1)	Under -5.5%	Residual capacity gap	9 weeks	36 weeks							38 weeks
Gynaecology	Under -2%	Previous capacity gap/ accrued backlog	9 weeks	28 weeks							25 weeks
Haematology	Over +39%	Capacity gap	9 weeks	14 weeks							18 weeks
Nephrology	Over +9%	Minor capacity gap	9 weeks	9 weeks							9 weeks
Neurology	Over +7%	Capacity gap	9 weeks	55 weeks							57 weeks
Orthopaedics	Under -9%	Previous capacity gap/ accrued backlog	13 weeks	58 weeks							58 weeks
Orthopaedic ICATS	Under -14%	Previous Capacity gap/ accrued backlog	9 weeks	29 weeks	580						28 weeks

Specialty	SBA Performance: Over / Under (at 29/02/16)	Known Capacity Gap	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of March 2016							Projected position at End of April 2016
				End of March 2016 position	Actual Volume of patients waiting in excess of 18-week 'backstop'	Time Bands (in weeks)					
						Timeband Information Not Yet Available					
						18 - 21	21 - 26	26-31	31-36	36 +	
Paediatrics	Over +10%	Capacity gap	9 weeks	26 weeks							TBC
Pain Management (3)	Under -3%	Capacity gap	9 weeks	44 weeks							46 weeks
Rheumatology	Over +4%	Capacity gap	18 weeks	67 weeks							69 weeks
Symptomatic Breast Clinic	Over +6%		9 weeks	2 weeks (Red Flags) & 20 weeks (Routine)							2 weeks (Red Flags) & 24 weeks (Routine)
Thoracic Medicine	Over +3%	Capacity gap	9 weeks	40 weeks							43 weeks
Urology (2) (includes ICATS)	Under -9%	Minor Capacity gap	9 weeks	71 weeks							74 weeks

(1) Urology – Proposal has been submitted to SLGT to revise SBA to reflect the new agree pilot one stop model which has been agreed Regionally. Subject to agreement this will see a more accurate and improved position on performance against SBA for this area.

IN-PATIENTS / DAY CASES - From April 2015, at least 65% of in-patients and day-cases are treated with 13-weeks and no patient waits longer than 26-weeks. 26 weeks is the defined 'backstop'

Specialty	SBA Performance: Over / Under (as at 29/02/16)	Known Capacity Gap	Access Standard or Backstop	Actual Access Time and Volume of Waits (By Time Band) at end of March 2016					End of April 2016 position
				End of March 2016 position	Actual Volume of patients waiting in excess of 26-week 'backstop'	Timebands (in weeks)			
						Timeband Information Not Yet Available			
						26-31	31-36	36+	
Breast Surgery	Over +2%	Emergent minor capacity gap	26 weeks	66 weeks					66 weeks
Cardiology	TBC	Capacity gap	13 weeks	42 weeks					44 weeks
Community Dentistry	Under -16%		13 weeks	12 weeks					11 weeks
Dermatology	Over +38%	Capacity Gap	13 weeks	27 weeks					29 weeks
ENT	Under -11%	Emergent minor capacity gap	13 weeks	29 weeks					34 weeks
Gastroenterology (Non Scopes)	TBC		13 weeks	5 weeks					5 weeks
General Surgery	Under -11%	Previous Capacity gap / accrued backlog	26 weeks	73 weeks					78 weeks

Specialty	SBA Performance: Over / Under (as at 29/02/16)	Known Capacity Gap	Access Standard or Backstop	Actual Access Time and Volume of Waits (By Time Band) at end of March 2016					End of April 2016 position
				End of March 2016 position	Actual Volume of patients waiting in excess of 26-week 'backstop'	Timebands (in weeks)			
						Timeband Information Not Yet Available			
						26-31	31-36	36+	
Gynaecology	Under -3%	Previous Capacity gap/ accrued backlog	13 weeks	35 weeks IP 20 weeks DC					35 weeks IP & 17 weeks DC
Haematology	Over +33%		13 weeks	13 weeks					13 weeks
Orthopaedics	Under -1%	Residual Capacity gap	26 weeks	87 weeks					84 weeks
Pain Management (1)	Over +12%	Capacity gap	26 weeks	83 weeks					83 weeks
Rheumatology	Over +7%		26 weeks	17 weeks					18 weeks
Urology	Under -5%	No Capacity gap	26 weeks	120 weeks					117 weeks

(1) Pain – Access position could improve to 74 weeks dependent on IS

DIAGNOSTICS - From April 2015, no patient waits longer than 9-weeks for a diagnostic test (Routine)

Specialty	SBA Performance – over / under (as at 29/02/16)	Known capacity gap	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of March 2016						End of April 2016 position
					End of March 2016 position	Actual Volume of patients waiting in excess of target	Timebands (in weeks)				
							Timeband Information Not Yet Available				
							9 - 13	13 - 21	22 - 26	26 +	
Endoscopy Symptomatic	Under -9%	Capacity gap	-	9 weeks	45 weeks						49 weeks
Cardiac Investigations (Non-Echo)	No SBA		Pacing, ECG, BP, CM, Tapes (28/48 /72 hr), Tilts, Treadmill, DSE,TOE	9 weeks	24 weeks						24 weeks
Cardiac Investigations (Echo)	Under -5%	Capacity gap	Echo	9 weeks	29 weeks						29 weeks
Neurophysiology EEG only	Under -28%			9 weeks	9 weeks						9 weeks
Audiology	Over +4%			9 weeks	9 weeks						9 weeks
Sleep Studies	No SBA			9 weeks	9 weeks						11 weeks
Urodynamics (Urology)	Included in OP SBA			9 weeks	67 weeks						71 weeks
Urodynamics (Gynae)	Under -27%			9 weeks	3 weeks						3 weeks
Imaging	Over +6%	Capacity gap	CT (1)	9 weeks	16 weeks						18 weeks
			CTC	9 weeks	19 weeks						23 weeks
	Under -2%	Capacity gap	NOUS (1)	9 weeks	15 weeks						17 weeks
	Over +4%	Capacity gap	DEXA	9 weeks	19 weeks						21 weeks

Specialty	SBA Performance – over / under (as at 29/02/16)	Known capacity gap	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of March 2016						End of April 2016 position
					End of March 2016 position	Actual Volume of patients waiting in excess of target	Timebands (in weeks) <i>Timeband Information Not Yet Available</i>				
							9 - 13	13 - 21	22 - 26	26 +	
	Over +4%	Capacity gap	MRI (1)	9 weeks	15 weeks						17 weeks
	-		Fluoroscopy	9 weeks	22 weeks						22 weeks
	-		Barium Enema	9 weeks	13 weeks						13 weeks
	-		Gut Transit Studies	9 weeks	13 weeks						13 weeks
	-		Obstetrics Ultrasound	9 weeks	9 weeks						9 weeks
	-		Radio Nuclide	9 weeks	13 weeks						13 weeks

(1) CT / NOUS / MRI – patients waiting longer in the IS

MENTAL HEALTH AND DISABILITY - By April 2015, no patient waits longer than 9-weeks to access Child and Adolescent Mental Health Services; 9-weeks to access Adult Mental Health Services; 9-weeks to access Dementia Services; and 13-weeks to access Psychological Therapies

Specialty	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of March 2016							End of April 2016 position
			End of March 2016 position	Actual Volume of patients waiting in excess target	Timebands (in weeks)					
					9 - 13	13 - 18	18 - 26	26 - 39	39 +	
Adult Mental Health Services	Primary Mental Health Care	9-weeks	32 weeks (IS)	81	46	10	21	4	0	20 weeks (IS) 14 weeks (IH)
	Memory / Dementia Services		27 weeks	69	44	17	6	2	0	14 weeks
CAMHS	-	9-weeks	9 weeks	-	-	-	-	-	-	9 weeks
Learning Disability	-	9-weeks	9 weeks	-	-	-	-	-	-	9 weeks
Psychiatry of Old Age	-	9-weeks	21 weeks	13	6	4	3	-	-	21 weeks
Autism	-	13-weeks	13 weeks	-	-	-	-	-	-	13 weeks
Psychological Therapies	-	13-weeks	21 weeks (Cognitive Behaviour Therapy) 18 weeks (Support & Recovery)	10	8	2	0	0	0	23 weeks

ALLIED HEALTH PROFESSIONALS - From April 2015, no patient waits longer than 13-weeks for referral to commencement of AHP treatment.

Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of March 2016				End of April 2016 position
		End of March 2016 position	Actual Volume of patients waiting in excess of 13 weeks.	Timebands (in weeks)		
				13 - 26	26 +	
Dietetics – Acute	13-weeks	13 weeks	-	-	-	13 weeks
Dietetics – Elderly and Primary Health Care	13-weeks	19 weeks	5	5	0	15 weeks
Dietetics – Paediatrics	13-weeks	29 weeks	93	92	1	25 weeks
Occupational Therapy – Acute	13-weeks	13 weeks	0	0	0	13 weeks
Occupational Therapy – Elderly and Primary Health Care	13-weeks	48 weeks	97	97		52 weeks
Occupational Therapy – Paediatric	13-weeks	44 weeks	197	107	90	42 weeks
Occupational Therapy – Physical Disability	13-weeks	28 weeks	81	73	8	26 weeks
Occupational Therapy – Learning Disability	13-weeks	16 weeks	1	1	0	13 weeks
Orthoptics	13-weeks	13 weeks	0	0	0	15 weeks
Physiotherapy – Adult	13-weeks	26 weeks	1036	1036	0	28 weeks
Physiotherapy – Paediatrics	13-weeks	19 weeks	14	14	0	26 weeks
Physiotherapy -Physical Disability	13-weeks	20 weeks	10	10	0	16 weeks
Physiotherapy - Learning Disability	13-weeks	13 weeks	0	0	0	16 weeks
Physiotherapy – Mental Health	13-weeks	16 weeks	2	2	0	16 weeks
Podiatry – Adult	13-weeks	35 weeks	1440	1064	376	33 weeks
Podiatry – Paediatrics						
Speech & Language Therapy Elderly & Primary Health	13-weeks	28 weeks	62	59	3	24 weeks
Speech & Language Therapy Paediatrics	13-weeks	33 weeks	427	411	16	28 weeks

**From the Permanent Secretary
and HSC Chief Executive**



Paula Clarke
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

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Fax:
Email:

Personal Information redacted by the
USI
Personal Information redacted by the
USI

Personal Information redacted by the USI

Our Ref: RP292

Date: 26 March 2015

Dear Paula

1. Your appointment as Acting Chief Executive of the Southern Health and Social Care Trust carries with it the responsibility of accounting officer of that body. I am therefore writing to formally designate you as accounting officer, for the funds (including grant-in-aid) of that body, with effect from 1 April 2015 and to define the relationship between your responsibilities in that capacity and mine as principal accounting officer for the Department.
2. Chapter 3 of Managing Public Money Northern Ireland (MPMNI) sets out the responsibilities of accounting officers and can be accessed using the link: [Accounting Officer Memorandum](#) but I have attached this document for ease of reference. This sets out your duties as accounting officer in which capacity you will be responsible for safeguarding public funds in your charge and ensuring that they are applied only to the purposes for which they were voted and, more generally, for efficient and economical administration.
3. In order to carry out your responsibilities as accounting officer, you need a thorough understanding of propriety and accountability issues – these are set out in the HM Treasury Handbook: Regularity and Propriety which can be obtained by accessing the link: [HM Treasury Handbook: Regularity and Propriety](#). Comprehensive training is available through a course run by the Chief Executives' Forum which is specifically tailored for your needs in a Northern Ireland context. I am copying your appointment letter to the Head of the Chief Executives' Forum so that they can notify you of when the next relevant course is planned.
4. I should also explain that your designation as accounting officer may be withdrawn if I conclude that you are no longer a fit person to carry out the responsibilities of an accounting officer or that it is otherwise in the public interest that your designation be withdrawn. I would not take such a decision without full and careful examination of the facts which you would have a suitable opportunity to contribute to and to add your viewpoint. Nor would I take such a decision without giving your Board a full account of my reasons as well as a chance to make representations. Withdrawal of accounting

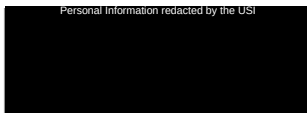
officer status would obviously bring into question your fitness for the position of Chief Executive generally.

5. As principal accounting officer of the Department I have a duty to satisfy myself that the body has adequate financial systems and procedures in place to promote the efficient and economical conduct of its business and to safeguard financial propriety and regularity. In addition, I am responsible among other things for advising the Minister on the allocation of departmental resources, and, after consultation with you, the setting of appropriate financial and non-financial performance targets for the Southern Health and Social Care Trust.
6. As accounting officer for the Southern Health and Social Care Trust you are responsible to the Board and accountable to the Assembly for the body's use of resources in carrying out its functions as set out in the Financial Memorandum. Subject to my responsibilities as described in paragraph 5 above, you are responsible for all the matters in the Memorandum in respect of the body.
7. In relation to your role, there are several areas, in particular, where the Assembly expects accounting officers to take personal responsibility:
 - *regularity and propriety*, including seeking DFP approval for any expenditure outside the normal delegations or outside the subheads of Estimates, and carried through with appropriate disclosures in the resource accounts;
 - selection and *appraisal* of programmes and projects: using the *Green Book* (supported by additional DFP guidance) to evaluate alternatives, and good quality project and programme management techniques, such as Office of Government Commerce (OGC) Gateways™, to track and where necessary adjust progress;
 - *value for money*: ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed to provide confidence about suitability, effectiveness, prudence, quality, good value and avoidance of error and other waste, judged for the public sector as a whole, not just for the Accounting Officer's organisation;
 - management of *opportunity and risk* to achieve the right balance commensurate with the institution's business and risk appetite;
 - *learning from experience*, both using internal feedback, and from right across the public sector; and
 - accounting accurately for the organisation's *financial position and transactions*: to ensure that the government published financial information is transparent and up to date, and that the organisation's efficiency in the use of resources is tracked and recorded.
8. Your judgement as accounting officer on matters for which you are responsible may only be overridden by the Board, in which case I should be informed as soon as possible. Advice to the Board is covered in the Accounting Officer Memorandum but in general terms you are responsible, inter alia, for advising the Board on matters of

financial propriety, regularity or of prudent and economical administration, efficiency and effectiveness. You are also responsible for taking formal action if the Board is contemplating a course that would infringe these requirements.

9. You are liable to be summoned to appear before the Public Accounts Committee (PAC) to give evidence on the discharge of your responsibilities as accounting officer for Southern Health and Social Care Trust. In such circumstances the PAC would probably wish to take evidence from both the Principal accounting officer and yourself. It will be for me to answer on those matters affecting the Southern Health and Social Care Trust, which fall within my responsibility as Principal accounting officer. In giving evidence to the Committee you should be guided as appropriate by the Accounting Officer Memorandum.
10. I am sending copies of this letter to the Head of the Northern Ireland Civil Service, the Comptroller and Auditor General, the Clerk to the Northern Ireland Public Accounts Committee, the Treasury Officer of Accounts, the Chief Executives' Forum and to Ian Fleming in DFP Supply.
11. I would be grateful if you would acknowledge receipt of this letter and its enclosures.

Yours sincerely

Personal Information redacted by the USI


ACCOUNTING OFFICER

Copies have been sent to (w/o enclosures):

Head of the Northern Ireland Civil Service
 Comptroller and Auditor General
 Clerk to the Northern Ireland Public Accounts Committee
 Treasury Officer of Accounts
 Chief Executives' Forum
 Ian Fleming DFP Supply
 Craig Morrow (NIAO)



3. ACCOUNTING OFFICERS

This chapter sets out the personal responsibilities of all Accounting Officers, both in government departments and in other parts of central government. Essentially Accounting Officers must be able to assure the Assembly and the public of high standards of probity in the management of public funds. This chapter is drawn to the attention of all Accounting Officers when they are appointed.

3.1 Role of the Accounting Officer

3.1.1 Each organisation in central government - department, agency, trading fund, HSC body, NDPB or significant arm's length body - must have an Accounting Officer. This person is usually the senior official in the organisation. In line with the *Code of Good Practice on Corporate Governance in Central Government Departments*, it is now usual for the Accounting Officer to be supported by a board whose structure should be agreed with the responsible minister(s) where it is not set in statute. Arrangements for leadership and accountability may be slightly different in other parts of the public sector.

3.1.2 Formally the Accounting Officer is someone who may be called to account in the Assembly for the stewardship of the resources within the organisation's control. The standards the Accounting Officer is expected to deliver in the organisation are summarised in box 3.1. The senior business managers of other public sector organisations are expected to deliver similar standards.

3.2 Appointment of Accounting Officers

3.2.1 DFP appoints the permanent head of each central government department to be its Accounting Officer. Where there are several Accounting Officers in a department, the permanent head is the Principal Accounting Officer.

3.2.2 Within departments, DFP also appoints the chief executive of each trading fund as its Accounting Officer; and may also appoint Additional Accounting Officers with responsibility for certain Requests for Resources.

3.2.3 In turn the Accounting Officer of each department normally appoints the permanent heads:

- of its executive agencies, as Agency Accounting Officers for their agencies; and
- of all its NDPBs¹, and of most other significant arm's length bodies, as Accounting Officers for these bodies.

¹ In certain NDPBs with small budgets, an Accounting Officer in the sponsor department may assume the role of the Accounting Officer for the NDPB, with the costs of the NDPB charged directly to the sponsor department's Estimate. This is the usual arrangement for advisory bodies and Royal Commissions.

box 3.1: standards expected of the Accounting Officer's organisation

Acting within the authority of the minister(s) to whom he or she is responsible, the Accounting Officer should ensure that the organisation, and any subsidiary to it or organisation sponsored by it, operates effectively and to a high standard of probity. The organisation should:

governance

- have a governance structure which transmits, delegates, implements and enforces decisions
- have trustworthy internal controls to safeguard, channel and record resources as intended
- operate with propriety and regularity in all its transactions
- treat its customers and business counterparties fairly and honestly
- offer redress for failure to meet agreed customer standards where appropriate
- give timely, transparent and realistic accounts of its business, underpinning public confidence;

decision-making

- support its ministers with clear, well reasoned, timely and impartial advice
- make all its decisions in line with the strategy, aims and objectives of the organisation set by ministers and/or in legislation
- meet DFP's requirements about limits on use of public resources
- manage its staff fairly, with inclusive policies designed to promote and integrate diversity having regard to Section 75 of the Northern Ireland Act
- communicate its decisions openly and transparently;

financial management

- use its resources efficiently, economically and effectively, avoiding waste and extravagance
- carry out procurement and project appraisal objectively and fairly, seeking good value for the public sector as a whole
- use management information systems to secure assurance about value for money and the quality of delivery and so make timely adjustments
- avoid overdefining detail and imposing undue compliance costs, either on its own staff or on its customers and stakeholders
- have practical documented arrangements for working in partnership with other organisations
- use internal and external audit to improve its internal controls and performance.

3.3 Special responsibilities of Accounting Officers

3.3.1 It is important that each Accounting Officer takes personal responsibility for ensuring that the organisation he or she manages delivers the standards in box 1.1. In particular, the Accounting Officer must personally sign:

- the organisation's accounts;
- the annual report;
- the statement on internal control (SIC);

and, having been satisfied that they have been properly prepared to reflect the business of the organisation, must personally approve any Request(s) for Resources.

3.3.2 In the case of Accounting Officers of corporate arm's length bodies, the Accounting Officer should also arrange for a board member to sign the accounts as well, if (unusually) he or she is not a member of the board.

3.3.3 There are several other areas where the Assembly expects Accounting Officers to take personal responsibility:

- *regularity and propriety* (see box 2.4), including seeking DFP approval for any expenditure outside the normal delegations or outside the subheads of Estimates, and carried through with appropriate disclosures in the resource accounts;
- selection and *appraisal* of programmes and projects: using the *Green Book* (supported by the *Northern Ireland Practical Guide to the Green Book*) to evaluate alternatives, and good quality project and programme management techniques, such as Office of Government Commerce (OGC) Gateways™, to track and where necessary adjust progress;
- *value for money*: ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed to provide confidence about suitability, effectiveness, prudence, quality, good value and avoidance of error and other waste, judged for the public sector as a whole, not just for the Accounting Officer's organisation;
- management of *opportunity and risk* to achieve the right balance commensurate with the institution's business and risk appetite;
- *learning from experience*, both using internal feedback, and from right across the public sector; and
- accounting accurately for the organisation's *financial position and transactions*: to ensure that the government published financial information is transparent and up to date; and that the organisation's efficiency in the use of resources is tracked and recorded.

3.4 Advice to Ministers

3.4.1 Each departmental Accounting Officer should take care to bring to the attention of the Minister to whom he or she is responsible any conflict between the Minister's instructions and his or her duties as set out in this chapter. Examples of concerns where this procedure is appropriate are in box 3.2 but the ultimate judgement must lie with the Accounting Officer personally.

3.4.2 There is no set form for doing this, though the Accounting Officer should be specific about the nature of his or her objections and where possible set these out in writing. Before doing so it is good practice for an Accounting Officer to discuss the matter with DFP if time permits. It may also be necessary to discuss the issue with officials from the Office of First Minister and Deputy First Minister to determine if the matter needs to be brought to the Executive Committee under the terms of the Ministerial Code.

3.4.3 If, despite the Accounting Officer's advice, the Minister decides to continue with a course the Accounting Officer has advised against, the Accounting Officer should ask for a formal Ministerial Direction to proceed. This can be oral but, if so, should be confirmed in writing as soon as possible. Directions of this kind are rare but the acid test is whether the Accounting Officer could justify the proposed activity if asked to defend it.

3.4.4 Such a direction is likely to mean that the associated expenditure is novel or contentious and therefore outside of the departmental delegated expenditure. Having received a Direction from the Departmental Minister, in these circumstances, the Accounting Officer should seek DFP approval.

3.4.5 A Minister may decide, in these circumstances, that the issue should be discussed by the Executive. If this happens and a decision reached at the Executive is to agree to the course of action proposed by the Departmental Minister it will be recorded in the minutes which can be treated as formal approval. The DFP Minister, as part of the Executive, is bound by this decision and in these circumstances it is not envisaged that it will be necessary for the Accounting Officer to seek a formal written approval from DFP. If the Executive decides not to proceed the Accounting Officer should abide by the Executive's decision and not undertake any course of action which could be seen as contrary to the decision.

3.4.6 When a Ministerial Direction is confirmed by the DFP Minister or Executive Committee as appropriate, the Accounting Officer should:

- write to the C&AG with the relevant details of the issue. This correspondence should be copied to DFP. The C&AG will normally draw the matter to the attention of the PAC, who will attach no blame to the Accounting Officer;
- follow the direction without further ado; and
- if asked, explain the Ministers/Executive's course of action. This respects Ministers' rights to frank advice, while protecting the quality of internal debate.

box 3.2: examples when Accounting Officers should seek a direction reflecting previous cases

- **Irregularity:** if a proposal is outside the legal powers, Assembly consents, or DFP delegations.
- **Impropriety:** if a proposal would breach Assembly control procedures.
- **Poor value for money:** if an alternative proposal, or doing nothing, would deliver better value, e.g. a cheaper or higher quality outcome.

3.5 Public Accounts Committee

3.5.1 The PAC may hold public hearings on the accounts of central government organisations laid in the Assembly (see section 1.6). In practice most PAC hearings focus on NIAO value for money studies. The PAC expects that NIAO will agree the texts of these reports with the Accounting Officer(s) of the organisation(s) concerned so there is a clear evidence base for their scrutiny to proceed.

3.5.2 When a hearing is scheduled, the PAC normally invites the Accounting Officer(s) of the relevant institution(s) to attend as witness(es). An Accounting Officer may be accompanied by appropriate officials. Where it is appropriate, and the PAC agrees, the Accounting Officer may send a substitute. In answering questions, the Accounting Officer should take responsibility for the organisation's business, even if it was delegated or if the events in question happened before he or she was appointed Accounting Officer.

3.5.3 The PAC expects witnesses to give clear, accurate and complete evidence. If evidence is sensitive, witnesses may ask to give it in private. It is also acceptable to offer supplementary notes if a witness does not have the detail to hand at the hearing. Where such notes are offered, they should be provided within two weeks and with attention to the PAC's concerns in asking for the information. If the evidence might take longer to prepare, witnesses may seek an extension. They should do so without delay.

3.5.4 The Treasury Officer of Accounts (TOA) (a DFP official who answers questions on behalf of DFP as the central department concerned with financial matters) or his/her nominee attends all PAC hearings. This allows scope for the PAC to explore any issues of more general application arising out of the subject of the hearing. Other responsibilities of the TOA are listed in Box 3.3.

3.6 When the Accounting Officer is not available

3.6.1 Each organisation must have an Accounting Officer available for advice or decision as necessary at short notice.

3.6.2 When the Accounting Officer is absent and cannot readily be contacted, another senior official should deputise. If a significant absence of more than 4 weeks is planned, the Accounting Officer, should invite DFP (or the sponsor department, as the case may be) to appoint a temporary acting Accounting Officer.

box 3.3: Specific responsibilities of the TOA

To supply advice on:

- the principles underlying the resource accounting system;
- the responsibilities and appointment of Accounting Officers;
- the responsibilities of Finance Directors;
- policy on internal audit and the prevention of fraud;
- parliamentary propriety, in terms consistent with the Assembly's requirements for the conduct of financial business and whether, and in what form, specific parliamentary authority for expenditure is required;
- financial provisions in Assembly Bills affecting public funds, accounting and audit arrangements, and acceptance of contingent liabilities;
- contingent liabilities generally and on the use of commercial insurance;
- fees and charges issues; and
- the departmental use of banks

In addition the TOA is also Head of Finance Profession for the Northern Ireland Civil Service.

3.7 Conflicts of interest

3.7.1 If an Accounting Officer faces an actual or potential conflict of interest, it is essential to find a way of eliminating it. There must be no doubt that the Accounting Officer meets the standards described in box 3.1 without divided loyalties. Possible ways of managing this issue include:

- for a significant but temporary conflict, inviting DFP (or sponsor department, as the case may be) to appoint an interim Accounting Officer for the period of the conflict of interest;
- for a minor conflict, arranging for someone other than the Accounting Officer to make the key decisions on the issue(s) in question; or
- for serious and lasting conflicts, resignation.

3.8 Arm's length bodies

3.8.1 The responsibilities of Accounting Officers in departments and in arm's length bodies (ALBs) are essentially very similar. But Accounting Officers in ALBs must also take account of their special responsibilities and powers. In particular, they must respect the legislation (or equivalent) establishing the organisation and the terms of the Management Statement/Financial Memorandum (MS/FM) agreed with the sponsor department. The relationship between sponsor departments and their ALBs is discussed further in chapter 7.

3.8.2 The Accounting Officer of a department which sponsors an ALB should, in addition, make arrangements to satisfy himself or herself that the Accounting Officer of the ALB is carrying out his or her responsibilities. Similarly, the Accounting Officer of an ALB with a subsidiary should have some meaningful oversight of the subsidiary. This means taking steps to gain assurance that public resources in the ALB, or its subsidiary, are being managed to appropriate standards (see box 3.1). It is not acceptable to establish ALBs, or subsidiaries to ALBs, in order to avoid or weaken Assembly scrutiny.

3.8.3 The MS/FM agreed between an ALB and its sponsor always envisages the sponsor department exercising meaningful oversight of the ALB's strategy and performance, pay arrangements and/or major financial transactions, eg by monthly returns, standard delegations, exception reporting or other techniques. ALBs should refer to their sponsor departments any activities which appear novel, contentious or repercussive; in turn the sponsor department may need to seek DFP consent.

3.8.4 There are some sensitivities about the role of the Accounting Officer in an ALB which is governed by an independent board, eg a charity or a company. The Accounting Officer, who will normally be a member of the board, must take care that his or her personal responsibilities do not conflict with his or her duties as board member. In particular, the Accounting Officer should vote against any proposal which appears to cause such a conflict; it is not sufficient to abstain.

3.8.5 Moreover, if the chair or board of such an ALB is minded to instruct the Accounting Officer to carry out some course which appears inconsistent with the standards in box 3.1, then the Accounting Officer should make his or her reservations clear, preferably in writing. If the board is minded nevertheless to proceed, the Accounting Officer should then:

- inform the Accounting Officer of the sponsor department without undue delay who will need to consider intervening to resolve the difference of view, preferably in writing;
- if the board's decision stands, seek its written direction to carry it out, asking the sponsor department to inform DFP;
- proceed to implement without delay; and
- inform the C&AG of what has happened.

3.8.6 This process is similar to what happens in departments (section 3.4), allowing for the special position of the organisation's board, which will often have been appointed under statute.

3.9 In the round

3.9.1 It is not realistic to set firm rules for every aspect of the business with which an Accounting Officer may deal. Sometimes the Accounting Officer may need to take a principled decision on the facts in circumstances where precedents are of limited value. Should that happen, the Accounting Officer should be guided by the standards in box 3.1, adapted if need be to suit the issue. Where time permits, DFP stands ready to help Accounting Officers think through and decide upon an appropriate course of action.

Southern Health and Social Care Trust

Assistant Director of Performance Improvement

Band 8c

Job Description

JOB SUMMARY

The job holder will be responsible to the Director of Performance and Reform for the performance management, service modernisation and reform, efficiency planning and contract support functions in the Trust. He/She will provide clear leadership for the delivery of these functions and will oversee the management of all staff and the efficient use of resources assigned to same. In addition, the job holder will manage the provision of high quality performance management and service reform expertise to directorate operational and planning teams. He/she will act as the key liaison on all performance, reform and contracting issues and manage the Trust's engagement processes with the HSCB, PHA, Local Commissioning Groups and Primary Care Partnerships.

As an Assistant Director, the job holder will be a member of the Directorate's senior management team and will therefore contribute to policy development in the Directorate and the achievement of its overall objectives.

KEY RESULT AREAS

Service Improvement

- lead the development of the Trust's reform and modernisation strategy and support continuous improvement, modernisation and efficiency savings within the Trust, ensuring appropriate expertise, systems and processes are in place to support this activity in all aspects of the Trust's business.
- work closely with directors, professional and managerial colleagues and commissioners to develop and deliver high quality health and social care services.
- support the delivery of organisation targets with an emphasis on continuous improvement.
- ensure appropriate engagement with operational staff, service users and their carers in the development of performance indicators and reporting of service performance.
- support access to best practice information and the benchmarking of services to identify and drive service improvement priorities.

Strategic Planning and Development

- lead the development and implementation of the Trust's reform and modernisation plans to deliver regional and Trust-specific reform priorities, delivering specialist skills and support for same.
- support corporate planning processes within the Trust including strategic and operational planning and the development of the Trust's Delivery Plan to ensure the delivery of high quality, safe and effective health and social care services which reflect service reform and modernisation priorities.
- lead the development of service improvement planning within the Trust and oversee implementation to ensure regional targets and local reform priorities are delivered.
- ensure appropriate engagement with users and their carers, professionals and service managers in the development of service reform and modernisation initiatives and the development of effective outcome measures.

Performance Management and Reform

- develop and maintain a performance management framework which reflects regional targets, Ministerial and HSCB priorities, local reform and modernisation priorities and optimises value for money.
- lead the development, monitoring, measurement and reporting of key Trust performance management indicators and ensure that robust performance management arrangements are developed and implemented within the Trust to monitor the achievements of targets and objectives.
- develop performance management reporting to Trust Board, commissioners and the general public.
- lead performance management of the implementation of the Trust's reform and modernisation plan.
- manage the provision of performance management and service modernisation skills and expertise to directorate planning teams to ensure they are adequately resourced to lead, develop and implement service modernisation and reform in all aspects of the Trust's business.
- lead engagement with the HSCB and local commissioning groups on all performance management issues.
- ensure that the performance management framework supports tariff based commissioning and payment by results.
- build performance management capability at every level within the Trust and. develop staff across the Trust in service improvement tools and techniques.

Information Management

- influence and direct the development of information flows and information management to provide timely and accurate information to underpin the performance management framework.
- ensure the effective implementation of all Trust information management policies and procedures in the department.
- ensure the department's systems and procedures for the management and storage of information meet internal and external reporting requirements.

Contracting

- lead the negotiation of the service and budget agreement with commissioners to ensure that sufficient funding is secured to deliver an appropriate range of services to the population of the Trust.
- Ensure expertise is available to support operational directorates in the negotiation and monitoring of service agreements with the independent and voluntary sector and lead the development and implementation of effective performance management and monitoring processes of same.
- ensure effective engagement with the HSCB and local commissioning groups on all contracting issues, and lead the performance management and monitoring for same.
- work closely with other statutory, voluntary and independent agencies in order to maximize the opportunities for mixed economies of care and promoting the independence of patients and clients in community settings

Quality and Governance

- ensure that the needs of patients, clients and their carers are at the core of the Trust's service improvement and reform processes.
- ensure high standards of governance including meeting controls assurance standards and the assessment and management of risk.

Financial and Resource Management

- work collaboratively with finance staff in the development and monitoring of financial plans and budgets to support the Trust to meet agreed performance targets.
- manage the performance improvement budget and resources and ensure the meeting of all financial targets.

People Management

- provide clear leadership to staff within the performance improvement department and ensure it has a highly skilled, flexible and motivated workforce.
- work closely with senior human resources staff to take forward the development and implementation of workforce planning and modernisation initiatives.
- ensure that management structures and practices in the department support a culture of effective team working, continuous improvement and innovation.
- ensure the effective implementation of all Trust people management policies in the department and the achievement of all relevant targets such as relating to the management of sickness and absenteeism, turnover etc.
- ensure the effective management of staff health and safety and support in the department.

Corporate Management

- develop and maintain working relationships with other directorate colleagues to ensure achievement of Trust objectives.
- attend meetings of the Trust Board and its committees as required to provide appropriate high quality information.
- establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
- contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.
- lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.
- lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

General Management Responsibilities

- participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.
- ensure that the review of performance identified above is performed for all levels of staff within the Trust in accordance with the Trust Board's policy.

- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

This job description is 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 Assistant Director of Performance Improvement works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Director.

GENERAL RESPONSIBILITIES

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- comply with the Trust's No Smoking Policy.
- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- adhere to equal opportunities policy throughout the course of their employment.
- ensure the ongoing confidence of the public in service provision.

- comply with the HPSS code of conduct.

RECORDS MANAGEMENT

The jobholder will be responsible to the Director 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.

October 2007 (amended December 2010)

Personnel Specification

JOB TITLE Assistant Director of Performance and Improvement

DIRECTORATE Performance & Reform

HOURS Full Time

Ref No:

Notes to applicants:

- 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.
- 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 how 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

- Hold a university degree or recognised professional qualification or equivalent qualification in a relevant subject¹ AND have a minimum of 2 years experience in a senior management² role in a major complex organisation³

OR

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 Head of Service level or equivalent or above 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

Have a minimum of 5 years experience in a Senior Management² role in a major complex organisation³

AND

2. Have at least 1 year's experience of managing major change programmes addressing significant⁴ 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 significant⁴ improvements.
4. Have a minimum of 1 years experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant change initiative.
5. Have a minimum of 2 years experience in high level people management.
6. Hold a full current driving license valid for use in the UK and have access to a car on appointment⁵.

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 highly effective planning and organisational skills.
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.
11. Have an ability to effectively manage a budget to maximise utilisation of available resources.

⁴ 'significant' is defined as contributing directly to key Directorate level 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.

DESIRABLE CRITERIA – 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 should therefore make it clear on their application form how they meet these criteria.** Failure to do so may result in you not being shortlisted.

PLEASE NOTE:

It is 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;

- Self Belief
- Self Management
- Seizing the future
- Drive for results
- Leading change through people
- Holding to account
- Effective and strategic influencing

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out a Protection of Children and Vulnerable Adults check (POCVA) 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

Job Description

JOB TITLE	Director of Acute Services
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Chief Executive
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The Director of Acute Services will be responsible through the Chief Executive for the development and delivery of safe, high quality emergency and elective hospital care within the Southern Trust. He/She will lead the strategic planning of the Trust's Acute Services and ensure effective multidisciplinary working and the most efficient use of hospital beds and other resources. He/She will provide clear leadership and oversee the management of all staff involved in Acute Services. In addition, the postholder will have a corporate role as a member of the Trust's senior management team that will include helping to shape the Trust's overall objectives.

KEY RESULT AREAS

Service Delivery

1. Ensure the co-ordination of multidisciplinary teams to deliver safe, high quality and equitable emergency and elective hospital care to the Trust's population and lead the effective and efficient deployment of all resources to achieve all relevant targets. This will include achieving waiting times and accessibility timeframes.
2. Responsible and accountable to the Chief Executive for delivery of effective clinical and social care governance within acute hospital services, including the successful delivery of agreed Patient Safety Programmes, and the reporting of appropriate indicators to provide assurance to the Chief Executive and Trust Board.
3. Work closely with other Directors to secure an appropriate balance between hospital and community based services and achieve an integrated approach in reducing inappropriate hospital admissions and lengths of stay.

4. Actively promote the development of clinical and professional networks across the Trust.
5. Lead the strategic development and integration of specialty and sub-specialty services across the Trust's hospital network, ensuring implementation of an effective and efficient service configuration in line with Commissioner intent.
6. Work closely with other Directors to ensure efficient patient flows into, through and out of acute hospital care, including the effective management of discharge planning in liaison with community services.

Quality

7. Ensure that the needs of patients and their carers are at the core of the way the Trust delivers acute hospital care.
8. Ensure high standards of governance including the effective assessment and management of risk.
9. Ensure the Trust's acute care services comply with all professional regulatory and requisite standards and the discharge of statutory functions.
10. Ensure that robust performance management arrangements are developed and implemented within the directorate.
11. Lead innovation and change to underpin the modernisation of acute hospital care in the Trust.
12. Lead quality initiatives in the Directorate to improve the patient experience.

Strategic Planning and Development

13. Ensure the development of a strategic plan for the delivery of acute hospital care to the Trust's population in line with regional strategies, Ministerial and HSCB priorities.
14. 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

15. Responsible for the management of the Trust's acute services budget and ensure the meeting of all financial targets within the directorate.
16. Participate in contract and service level negotiations with commissioners.
17. Lead the development of capital investment strategies within acute services, ensuring these reflect and contribute to meeting targets set by the HSSA and the Trust's Corporate Plan.

People Management

18. 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.
19. Ensure that staff working in Acute Hospital Care are trained and developed in line with professional standards as defined by the relevant Executive Director for that professional workforce and as agreed by the Senior Management Team.
20. Lead the development and implementation of workforce modernisation initiatives.
21. Ensure that management structures and practices support a culture of effective team working, continuous improvement and innovation.
22. Ensure the full engagement of all professional staff working in acute services.

Corporate Management

23. 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.
24. 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.
25. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.

26. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.
27. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

28. 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.
29. Maintain staff relationships and morale amongst staff.
30. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.
31. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
32. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

33. 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.
34. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.
35. 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
36. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

37. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
38. 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.
39. 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.



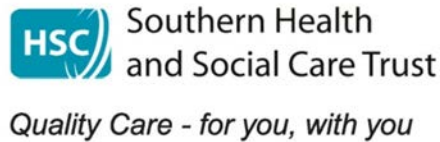
**THIS POST IS FOR EMPLOYEES OF THE
SOUTHERN TRUST ONLY**

**DIRECTOR OF
ACUTE SERVICES
SECONDMENT OPPORTUNITY ONLY**

Ref No: 73213002

APPLICANT INFORMATION PACK

**CLOSING DATE FOR RECEIPT OF
COMPLETED APPLICATIONS IS FRIDAY 18th
JANUARY 2013 AT 12.00 NOON**



SECONDMENT OPPORTUNITY
DIRECTOR OF ACUTE SERVICES
Reference Number 73213002
Salary Range: £71,279 - £95,039 per annum

Due to the retirement of the current post holder the Trust would wish to offer the opportunity of a secondment to the above post. The secondment will be for an initial period of 6 months commencing from 1st March 2013.

A full Job Description, Personnel Specification for this post 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 Luke's Hospital site, Loughgall Road, ARMAGH, BT61 7NQ.

The closing date for receipt of completed applications is Friday 18th January 2013 at 12.00 Noon.

Applicants should note that it is currently anticipated interviews for shortlisted applicants will take place week commencing 4th February 2013 however this may be subject to change.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER



Ref No: 73213002

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

Job Description

JOB TITLE

Director of Acute Services

(Secondment opportunity for an initial period of 6 months commencing from 1st March 2013)

INITIAL LOCATION

Craigavon Area Hospital

REPORTS TO

Chief Executive

ACCOUNTABLE TO

Chief Executive

JOB SUMMARY

The Director of Acute Services will be responsible through the Chief Executive for the development and delivery of safe, high quality emergency and elective hospital care within the Southern Trust. He/She will lead the strategic planning of the Trust's Acute Services and ensure effective multidisciplinary working and the most efficient use of hospital beds and other resources. He/She will provide clear leadership and oversee the management of all staff involved in Acute Services. In addition, the postholder will have a corporate role as a member of the Trust's senior management team that will include helping to shape the Trust's overall objectives.

KEY RESULT AREAS

SERVICE DELIVERY

1. Ensure the co-ordination of multidisciplinary teams to deliver safe, high quality and equitable emergency and elective hospital care to the Trust's population and lead the effective and efficient deployment of all resources to achieve all relevant targets. This will include achieving waiting times and accessibility timeframes.
2. Responsible and accountable to the Chief Executive for delivery of effective clinical and social care governance within acute hospital services, including the

successful delivery of agreed Patient Safety Programmes, and the reporting of appropriate indicators to provide assurance to the Chief Executive and Trust Board.

3. Work closely with other Directors to secure an appropriate balance between hospital and community based services and achieve an integrated approach in reducing inappropriate hospital admissions and lengths of stay.
4. Actively promote the development of clinical and professional networks across the Trust.
5. Lead the strategic development and integration of specialty and sub-specialty services across the Trust's hospital network, ensuring implementation of an effective and efficient service configuration in line with Commissioner intent.
6. Work closely with other Directors to ensure efficient patient flows into, through and out of acute hospital care, including the effective management of discharge planning in liaison with community services.

QUALITY

7. Ensure that the needs of patients and their carers are at the core of the way the Trust delivers acute hospital care.
8. Ensure high standards of governance including the effective assessment and management of risk.
9. Ensure the Trust's acute care services comply with all professional regulatory and requisite standards and the discharge of statutory functions.
10. Ensure that robust performance management arrangements are developed and implemented within the directorate.
11. Lead innovation and change to underpin the modernisation of acute hospital care in the Trust.
12. Lead quality initiatives in the Directorate to improve the patient experience.

STRATEGIC PLANNING AND DEVELOPMENT

13. Ensure the development of a strategic plan for the delivery of acute hospital care to the Trust's population in line with regional strategies, Ministerial and HSCB priorities.
14. 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

15. Responsible for the management of the Trust's acute services budget and ensure the meeting of all financial targets within the directorate.
16. Participate in contract and service level negotiations with commissioners.
17. Lead the development of capital investment strategies within acute services, ensuring these reflect and contribute to meeting targets set by the HSSA and the Trust's Corporate Plan.

PEOPLE MANAGEMENT

18. 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.
19. Ensure that staff working in Acute Hospital Care are trained and developed in line with professional standards as defined by the relevant Executive Director for that professional workforce and as agreed by the Senior Management Team.
20. Lead the development and implementation of workforce modernisation initiatives.
21. Ensure that management structures and practices support a culture of effective team working, continuous improvement and innovation.
22. Ensure the full engagement of all professional staff working in acute services.

CORPORATE MANAGEMENT

23. 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.
24. 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.
25. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
26. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.
27. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

28. 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.
29. Maintain staff relationships and morale amongst staff.
30. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.
31. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
32. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

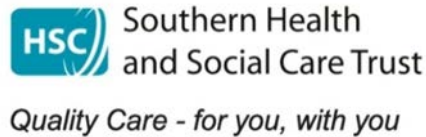
The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. 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
4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
6. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
7. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
8. 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.

9. 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.
10. 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.*

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 individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

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



PERSONNEL SPECIFICATION

JOB TITLE Director of Acute Services
(Secondment opportunity for an initial period of 6 months
commencing from 1st March 2013)

Ref No: 73213002

January 2013

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. Applicants are therefore strongly advised to clearly demonstrate on their application form how they meet each element of the stated criteria.***

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 may 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. You must be an employee of the Southern Health & Social Care Trust or an individual participating in the Trust's Employability Project or the Trust's Disability Project, to be eligible to apply for this post.

You must therefore clearly demonstrate your eligibility on your application form. **Please note that failure to do this will result in you not being shortlisted.**

2. Hold a university degree or recognised professional qualification or equivalent qualification in a relevant¹ subject AND have a minimum of 2 years' experience in a senior management² role in a major complex organisation³.
3. Have a minimum of 2 years' experience in delivering against challenging performance management programmes meeting a full range of key Corporate

goals demonstrated through personal involvement in the associated strategy development, implementation and sustainability of the objectives.

4. Have a minimum of 2 years' experience in Service planning aimed at ensuring the vision of the organisation is achieved, demonstrated through evidence of personal involvement in identifying innovative approaches to service delivery, influencing others on a multi-agency basis as to the direction of service developments and building of support to ensure the vision is owned by all key stakeholders.
5. Have a minimum of 2 years' experience in ensuring robust governance arrangements are in place which ensure high performance service outcomes in terms of quality, safety and standards demonstrated through rigorous performance management measures and holding others to account for achieving performance standards.
6. Have a minimum of 2 years' experience working with a diverse range of both internal and external stakeholders to deliver and improve services demonstrating effectiveness in developing and maintaining networks through lasting working relationships which contribute to service improvement and where the contribution of others is encouraged.
7. Have at least 3 years' experience of managing major change programmes addressing significant⁴ organisational change, demonstrated through personal involvement in risk management, planning and implementation of the change as well as evaluating the impact of the change in transforming services for the better
8. Have a minimum of 3 years' experience in managing services where successful outcomes can be evidenced and leadership demonstrated in the areas of strategic planning, inspiring and motivating individuals and teams to strengthen performance, and ensuring the best use of resources, in line with service values and goals.
9. Had personal accountability for a budget for a minimum of 3 years, in a major complex organisation³, securing value for money by effective prioritisation and driving efficiencies.
10. Hold a full current driving license valid for use in the UK and have access to a car on appointment⁵. 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

11. Have an ability to provide effective leadership to enable transformation of services.
12. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.
13. Demonstrate effective communication skills to meet the needs of the post in full.

PLEASE NOTE:

Candidates should note it is their responsibility to ensure that they have the permission of their line manager to take up this secondment opportunity IN ADVANCE of making application.

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 intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to all seven domains of the NHS Leadership Framework. Further details on the NHS Leadership Framework may be obtained from;

<http://www.leadershipacademy.nhs.uk/discover/leadership-framework/supporting-tools/documents-to-download/>

As part of the Recruitment & Selection process it may 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

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, Assistant Director level or equivalent or higher 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.

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.
- 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.

CLOSING DATE FOR RECEIPT OF COMPLETED APPLICATIONS

The closing date for receipt of completed applications is Friday 18th January 2013 at 12.00 Noon.

Applications can be submitted on line at www.HSCRecruit.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. Staff should not rely on the internal postal system.

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.

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. Only those applicants **who clearly demonstrate on their application form how they meet the essential criteria**, will be shortlisted for interview. 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 which will be assessed in line with the criteria for this post in the context of the NHS Leadership Framework.

At this stage it is anticipated that interviews for shortlisted applicants will be scheduled during week commencing 4th February 2013, 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;
- 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 and the successful applicant may 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.

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

You are strongly encouraged to complete this section of the form which is used purely for monitoring purposes. 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

APPLICANT INFORMATION PACK

DIRECTOR OF FINANCE & PROCUREMENT

**CLOSING DATE FOR RECEIPT OF COMPLETED
APPLICATIONS IS TUESDAY 14th DECEMBER 2010
AT 4.30PM**



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Dear Applicant

Thank you for your interest in the position of Director of Finance & Procurement, 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

or email to

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

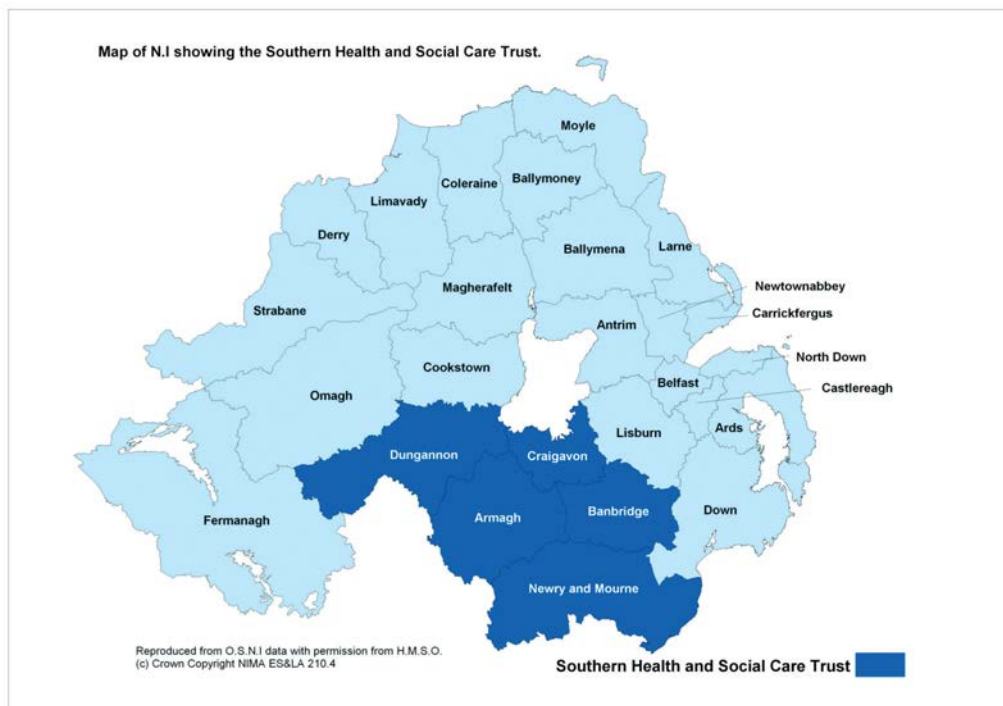
MRS MAIREAD MCALINDEN
Chief Executive



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.

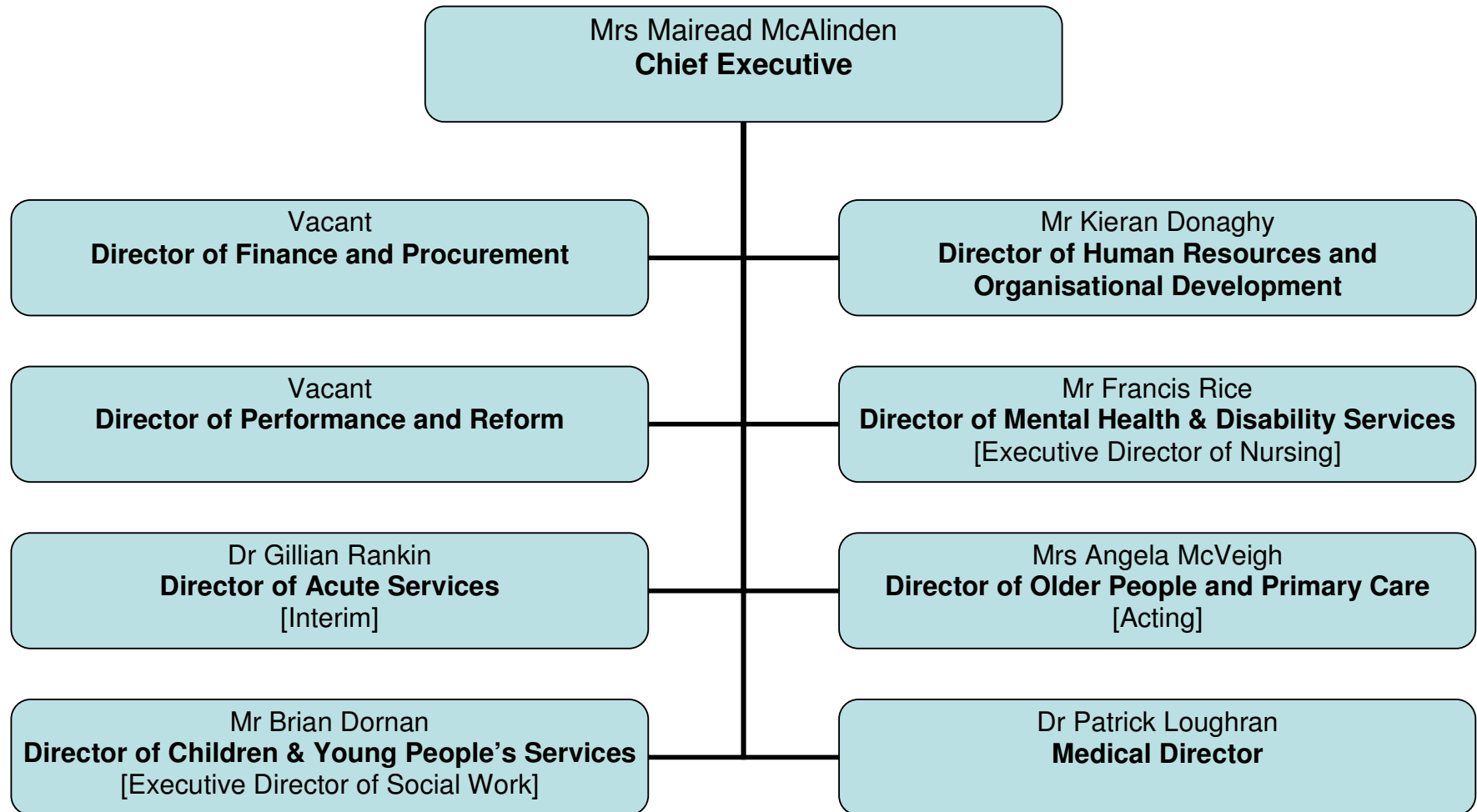
The Trust's vision is to deliver safe, high quality and responsive health and social care services, respecting the dignity and individuality of all who use them. This vision is underpinned by the Trust's values which shape what we do and how we do them. These values are:

- *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;





DIRECTOR OF FINANCE & PROCUREMENT

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

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

The successful applicant will be an Executive Director and will be responsible for provision of specialist advice to the Trust Board on all financial matters, ensuring the financial plan for the provision of services fully reflects the priorities of the Trust and its expectations in terms of service delivery.

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 14th December 2010 at 4.30pm

Applicants should note that it is currently anticipated interviews for shortlisted applicants will take place week commencing Monday 10th January 2011, however this may be subject to change.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

JOB DESCRIPTION

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

JOB SUMMARY

The Director of Finance is an Executive Director and a member of the Trust Board. The postholder will provide specialist advice to the Trust Board, Chief Executive and other Director colleagues on all financial matters. This will be in accordance with the Standing Orders and Standing Financial Instructions of the Trust and the requirements of the Health and Personal Social Services, the Health and Social Services Trust (Membership & Procedures & Regulation) (NI) 1991 Act.

He/She will be responsible for providing strong professional leadership and for ensuring the Trust's financial strategy and annual financial plan for the provision of services fully reflects the priorities of the Trust and its expectations in terms of delivery. 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.

KEY RESULT AREAS**Service Delivery**

1. Ensure that the statutory financial targets are met.
2. Lead the development of the Trust's financial strategy and annual financial plan for the provision of services in partnership with key stakeholders ensuring that the priorities and the expectations of the Trust's corporate plan and delivery plan are met.
3. Provide robust financial expertise to the development of the Trust's capital investment strategy including the acquisition and use of funds, the development of public / private partnerships and other funding arrangements.

4. Develop and maintain a financial performance management framework including the developing of costing systems in line with national, regional and local priorities, the production of benchmarking information and the development of targets and processes to improve performance and optimise value for money.
5. Lead the development, monitoring, measurement and reporting of key Trust financial performance management indicators. Deliver organisation financial targets with an emphasis on continuous improvement.
6. Lead the co-ordination of all procurement services across the Trust in the most cost-effective way and deliver targets through the management and leadership of the Heads of Department.

Quality

7. Ensure that the needs of patients, clients and their carers are at the core of the way that the Trust delivers services and that financial resources are effectively deployed to meet those needs.
8. Ensure that all statutory financial and integrated governance requirements are met, including the identification and management of financial risks.
9. Ensure compliance with standing financial instructions, professional standards, government accounting and treasury and departmental guidance in the use and deployment of public funds.
10. Ensure that robust financial and corporate performance management arrangements are developed and implemented.

Strategic Planning and Development

11. Lead the development of a strategic plan for the delivery of financial and procurement services in line with regional strategies, Ministerial and HSSA priorities.
12. Work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets.
13. Lead the development of the Trust's procurement strategies.

Financial and Resource Management

14. Discharge all professional duties imposed on the Director of Finance by statute or the determination of the Department of Health, Social Services and Public Safety and to ensure adherence to professional accounting standards.
15. Accountable for the quality of financial services provided to the Trust both by internal departments and external services.
16. Establish collaborative relationships with external partners in the public, private and voluntary sectors to develop initiatives which will support and enable recurring investments and inter-agency working to improve performance and effectiveness of service delivery.
17. Develop and monitor financial plans and budgets to ensure that income matches expenditure and provide timely and accurate financial advice and support to allow Directors and budget holders to manage budgets successfully.
18. Provide resolved advice to Trust Board on the Trust's financial position and risk management expertise in relation to same.
19. Co-operate with and contribute to the establishment of an effective shared service framework for the delivery of appropriate financial and procurement services.

People Management

20. Provide clear and strategic leadership to staff within the directorate to ensure the Trust has a highly skilled, flexible and motivated workforce to provide high quality financial management.
21. Develop management information on staff utilisation, development and return on investment, which improve management decision making and support a rigorous continuous improvement culture.
22. Ensure that management structures and practices within the directorate support a culture of effective team working, continuous improvement and innovation.

Corporate Management

23. Contribute to the corporate decision making of the Trust Board and ensure compliance with the Trust's Standing Orders and Standing Financial Instructions.
24. Advise the Trust Board and Chief Executive on the development of the Trust's corporate investment strategy including the acquisition and use of funds and the development of public/private partnerships and other appropriate funding arrangements.
25. 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.
26. 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.
27. Ensure the Trust's Annual Accounts are compiled, audited and reported in accordance with the Trust's Standing Orders and Standing Financial Instructions.
28. Implement and maintain effective income and treasury management arrangements for financial assessment and charging which take account of developing case law and trust obligations to clients and carers.
29. Participate in and comply with Departmental requirements in the production of whole of government accounts.
30. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.
31. Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.
32. Continuously strive to develop self and improve capability in the leadership of the Trust and its staff.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

33. 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.
34. Maintain staff relationships and morale amongst staff.
35. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.
36. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
37. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

38. 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.
39. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.
40. 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
41. 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.



42. 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.

PERSONNEL SPECIFICATION

JOB TITLE Director of Finance & Procurement

Ref No <>

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 as a minimum a CCAB recognised full professional accountancy qualification AND have a minimum of 5 years experience in a senior financial management¹ role in a major complex organisation²
2. Have a minimum of 3 years' experience of delivering against challenging financial performance management programmes meeting a full range of key targets and making significant³ improvements.
3. Have a minimum of 2 years experience working with a diverse range of both internal and external stakeholders to achieve successful outcomes.
4. Demonstrate a minimum of 2 years experience in successful Financial Control at a senior¹ level within a major complex organisation²

5. Hold a full current driving license valid for use in the UK and have access to a car on appointment⁴. 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

6. Have an ability to provide effective leadership to enable transformation of services.
7. Demonstrate evidence of high level skills in;
 - (a) Effective planning and organisation
 - (b) Governance and Risk Management
 - (c) People Management
8. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.
9. 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) 3 years experience in a senior financial management¹ role within a health and / or social care setting.

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

¹'senior financial management' is defined as financial experience gained at Director, Assistant Director or equivalent in a major complex organization

²'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

³'significant' is defined as contributing directly to Key Corporate Objectives of the organisation concerned.

⁴This 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;

- Drive for results
- Seizing the future
- Effective and strategic influencing
- 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.
- 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.



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 place 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 14th December 2010 at 4.30pm

Applications can be submitted on line at www.HSCRecruit.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.

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.

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. 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 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:

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

At this stage it is anticipated that interviews for shortlisted applicants will be scheduled during week commencing Monday 10th January 2011, 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 and 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.

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

You are strongly encouraged to complete this section of the form which is used purely for monitoring purposes. 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



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

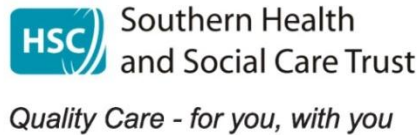
Further details on the NHS Leadership Qualities Framework may be obtained from;

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, telephone Personal Information redacted by the USI or 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



Ref No: 73213011

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

Job Description

JOB TITLE	Director of Mental Health and Disability Services
INITIAL LOCATION	Bannvale House, Gilford
REPORTS TO	Chief Executive
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The jobholder will also have specific responsibility through the Chief Executive for the development and delivery of high quality services for people with mental illness, learning disability and physical or sensory impairment within the Southern Trust. He/She will lead the strategic planning of these services and ensure effective multidisciplinary working and the most efficient use of resources. He/She will provide clear leadership and oversee the management of all staff involved in mental health and adult disability. As a member of the senior management team he/she will share corporate responsibility for the achievement of the Trust's corporate objectives.

KEY RESULT AREAS

SERVICE DELIVERY

1. Lead multidisciplinary teams to deliver high quality disability services¹ and achieve all relevant targets with a particular emphasis on those relating to the retraction of long stay hospital provision, the implementation of the Bamford Review and other regional reforms.

¹ *disability services includes mental health, learning disability, physical disability and sensory impairment services.*

2. Work closely with the Director of Children's Services to ensure service delivery is seamless from adolescence to adult services.
3. Work closely with other statutory and voluntary agencies in order to maximize the opportunities for mixed economies of care and promoting the independence of patients and clients in community settings.
4. Ensure a close interface between health and social care and actively promote the development of professional networks across the Trust.

QUALITY

5. Ensure that the needs of patients, clients and their carers are at the core of the way the Trust delivers its disability services.
6. Ensure that practice and service development is underpinned by the most up to date evidence and research.
7. Ensure high standards of governance for the Trust's nursing and midwifery services and disability services including the assessment and management of risk.
8. Ensure the Trust's disability services comply with all professional regulatory and requisite standards and the discharge of statutory functions.
9. Ensure that robust performance management arrangements are developed and implemented within the directorate.
10. Ensure the defining and monitoring of performance standards in contracts/service level agreements with independent service providers.
11. Lead innovation and change to underpin the modernisation of services.
12. Lead quality initiatives such as investors in people and charter standards in the directorate.

Professional Management

13. Advise and report to the Chief Executive and Trust Board on all policies, legislative requirements and standards.

14. Responsible for ensuring the maintenance of high quality standards in mental health and disability services in the Trust.
15. Provide advice and guidance on all workforce planning issues pertaining to the Trust's mental health and disability services.
16. Ensure performance management and development is delivered effectively across programmes of care.

STRATEGIC PLANNING AND DEVELOPMENT

1. Ensure the development of a strategic plan for the delivery of mental health and disability hospital and community care to the Trust's population in line with regional strategies, Ministerial and HSCB priorities.
2. 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

3. Responsible for the management of the Trust's mental health, disability, transport and psychology services budget and ensure the meeting of all financial targets within the directorate.
4. Participate in contract and service level negotiations with commissioners.
5. Lead the development of capital investment strategies within acute services, ensuring these reflect and contribute to meeting targets set by the HSCB and the Trust's Corporate Plan.

PEOPLE MANAGEMENT

6. 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.

7. Ensure that staff working in mental health and disability Hospital and Community Care are trained and developed in line with professional standards as defined by the relevant Executive Director for that professional workforce and as agreed by the Senior Management Team.
8. Lead the development and implementation of workforce modernisation initiatives.
9. Ensure that management structures and practices support a culture of effective team working, continuous improvement and innovation.
10. Ensure the full engagement of all professional staff working in mental health and disability services.

CORPORATE MANAGEMENT

11. 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.
12. 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.
13. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
14. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.
15. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

16. 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.

17. Maintain staff relationships and morale amongst staff.
18. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.
19. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
20. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. 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
4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
6. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible

to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
8. 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.
9. 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.
10. 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.*

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 individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

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

PERSONNEL SPECIFICATION

JOB TITLE Director of Mental Health & Disability Services

Ref No: 73213011

February 2013

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. Applicants are therefore strongly advised to clearly demonstrate on their application form how they meet each element of the stated criteria.*

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 may 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. You must clearly demonstrate your eligibility on your application form. Please note that failure to do this will result in you not being shortlisted.

QUALIFICATIONS / EXPERIENCE

1. You must be an employee of the Southern Health & Social Care Trust.
2. Hold a university degree or recognised professional qualification or equivalent qualification in a relevant¹ subject AND have a minimum of 2 years' experience in a senior management² role in a major complex organisation³.
3. Have a minimum of 2 years' experience in delivering against challenging performance management programmes meeting a full range of key Corporate goals demonstrated through personal involvement in the associated strategy development, implementation and sustainability of the objectives.
4. Have a minimum of 2 years' experience in Service planning aimed at ensuring the vision of the organisation is achieved, demonstrated through evidence of personal

involvement in identifying innovative approaches to service delivery, influencing others on a multi-agency basis as to the direction of service developments and building of support to ensure the vision is owned by all key stakeholders.

5. Have a minimum of 2 years' experience in ensuring robust governance arrangements are in place which ensure high performance service outcomes in terms of quality, safety and standards demonstrated through rigorous performance management measures and holding others to account for achieving performance standards.
6. Have a minimum of 2 years' experience working with a diverse range of both internal and external stakeholders to deliver and improve services demonstrating effectiveness in developing and maintaining networks through lasting working relationships which contribute to service improvement and where the contribution of others is encouraged.
7. Have at least 3 years' experience of managing major change programmes addressing significant⁴ organisational change, demonstrated through personal involvement in risk management, planning and implementation of the change as well as evaluating the impact of the change in transforming services for the better
8. Have a minimum of 3 years' experience in managing services where successful outcomes can be evidenced and leadership demonstrated in the areas of strategic planning, inspiring and motivating individuals and teams to strengthen performance, and ensuring the best use of resources, in line with service values and goals.
9. Had personal accountability for a budget for a minimum of 3 years, in a major complex organisation³, securing value for money by effective prioritisation and driving efficiencies.
10. Hold a full current driving license valid for use in the UK and have access to a car on appointment⁵. 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

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

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

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

PLEASE NOTE:

Candidates should note it is their responsibility to ensure that they have the permission of their line manager to take up this secondment opportunity IN ADVANCE of making application.

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 intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to all seven domains of the NHS Leadership Framework. Further details on the NHS Leadership Framework may be obtained from;

<http://www.leadershipacademy.nhs.uk/discover/leadership-framework/supporting-tools/documents-to-download/>

As part of the Recruitment & Selection process it may 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

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, Assistant Director level or equivalent or higher 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.

Job Description

JOB TITLE	Director of Older People & Primary Care
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Chief Executive
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The Director of Older People and Primary Care will be responsible through the Chief Executive for the development and delivery of safe, high quality primary care and non acute hospital services to older people within the Southern Trust, as well as lead Director for the Trust's Health and Wellbeing and Community Development services. He/She will lead the strategic planning of these services and ensure effective multidisciplinary working and the most efficient use of resources to promote health and well being and support people to live independent lives in the community. He/She will provide clear leadership and oversee the management of all staff 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 helping to shape the Trust's overall objectives and be a member of the Trust Board.

KEY RESULT AREAS

Service Delivery

1. Lead the co-ordination of multidisciplinary teams to deliver high quality health and social care to older people and ensure the effective and efficient use of all resources to achieve all relevant targets with a particular emphasis on those relating to care in the community and rehabilitation.
2. Work closely with the Director of Acute Services to secure appropriate integration of hospital and community based services aimed at reducing inappropriate hospital admissions and lengths of stay.
3. Work closely with the independent sector to expand the use of supported living, domiciliary and day care as alternatives to residential care.

4. Ensure the co-ordination of the primary care workforce to deliver high quality care and achieve all relevant targets emanating from *Caring for People Beyond Tomorrow* and other strategic frameworks.
5. Work closely with General Practitioners, community and voluntary sector partners, and public sector agencies to promote the health and well being of the Trust's population.
6. Develop and embed expert patient, specialist services, latest technology and other mechanisms to support people with a chronic illness to better manage their condition.

Quality

7. Ensure that the needs of patients, clients and their carers are at the core of the way the Trust delivers its preventative services, primary care and services to older people.
8. Ensure high standards of governance within the directorate including the effective assessment and management of risk.
9. Ensure the Trust's primary care and services to older people comply with all professional regulatory and requisite standards.
10. Ensure that robust performance management arrangements are developed and implemented within the Directorate
11. Lead innovation and change to underpin the modernisation of primary care and service delivery to older people.
12. Lead quality initiatives such as Investors in People and Charter Standards in the Directorate.

Strategic Planning and Development

13. Continually review, develop and deliver the Trust's strategic plan for the delivery of primary care and services to older people in the Trust in line with regional strategies, Ministerial and HSSA priorities.
14. Work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets.

15. Financial and Resource Management

16. Responsible for the management of the Trust's H&WB, primary care and older people services budgets and ensure the meeting of all financial targets within the Directorate.
17. Participate in contract and service level negotiations with commissioners.
18. Lead the development of capital investment strategies for older people and primary care services, ensuring these reflect and contribute to meeting targets set by the Health & Social Care Board (HSCB) and the Trust's Corporate Plan.

People Management

19. Provide clear and strategic leadership to all staff in the directorate and ensure the Trust has a highly skilled, flexible and motivated workforce to provide high quality care.
20. Lead the development and implementation of workforce modernisation initiatives in the Directorate.
21. Ensure that management structures and practices in the directorate support a culture of effective team working, continuous improvement and innovation

Corporate Management

22. 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.
23. 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.
24. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
25. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

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

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

27. 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.
28. Maintain staff relationships and morale amongst staff.
29. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.
30. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
31. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

32. 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.
33. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.
34. 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
35. All employees of the Trust are required to be conversant with the Trust's 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.

36. 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.

PERSONNEL SPECIFICATION

JOB TITLE Director of Older People & Primary Care

Ref No 73211007

Notes to applicants:

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

- Hold a university degree or recognised professional qualification or equivalent qualification in a relevant¹ subject AND have a minimum of 5 years experience in a senior management² role in a major complex organisation³.
- Have at least 3 years experience of managing major change programmes addressing significant⁴ organisational, managerial or service change.
- Have a minimum of 2 years experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant⁴ improvements.
- 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 significant⁴ change initiative.

5. Had personal accountability for a budget for a minimum of 3 years, in a major complex organisation³, 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 appointment⁵. 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 managing 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.

⁵This 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



Information Pack

Director of Mental Health and Disability Services and Executive Director of Nursing

Performance Management Arrangements

Performance in the HPSS is managed under four main areas:

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

Under the new arrangements, performance management and improvement in the HPSS will include:

- measurable objectives, standards and targets which define what the HPSS 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.

Within these arrangements you will be expected to support the Chief Executive to deliver against the challenging agenda set by the Minister, the HSSA and local commissioners.



Information Pack

Director of Mental Health and Disability Services and Executive Director of Nursing

Director of Mental Health and Disability Services and Executive Director of Nursing

Band 4 - £64,481 - £85,976

(under review)

Southern HSS Trust

Job Description

The Director of Mental Health & Disability Services and Executive Director of Nursing is an Executive Director and a member of the Trust Board. The jobholder will advise the Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory requirements, professional practice and workforce requirements. He/She will be responsible for providing strong professional leadership and for ensuring high standards of nursing practice in all programmes of care. As a member of the Trust Board and the senior management team he/she will share corporate responsibility for the achievement of the Trust's corporate objectives.

The jobholder will also have specific responsibility through the Chief Executive for the development and delivery of high quality services for people with mental illness, learning disability and physical or sensory impairment within the Southern Trust. He/She will lead the strategic planning of these services and ensure effective multidisciplinary working and the most efficient use of resources. He/She will provide clear leadership and oversee the management of all staff involved in mental health and adult disability.

KEY RESULT AREAS

Service Delivery

- lead multidisciplinary teams to deliver high quality disability services³ and achieve all relevant targets with a particular emphasis on those relating to the retraction of long stay hospital provision, the implementation of the Bamford Review and other regional reforms.
- work closely with the Director of Children's Services to ensure service delivery is seamless from adolescence to adult services.

³ disability services includes mental health, learning disability, physical disability and sensory impairment services.

- work closely with other statutory and voluntary agencies in order to maximize the opportunities for mixed economies of care and promoting the independence of patients and clients in community settings.
- ensure a close interface between health and social care and actively promote the development of professional networks across the Trust.

Quality

- ensure that the needs of patients, clients and their carers are at the core of the way the Trust delivers its disability services.
- ensure that practice and service development is underpinned by the most up to date evidence and research.
- ensure high standards of governance for the Trust's nursing and midwifery services and disability services including the assessment and management of risk.
- ensure the Trust's disability services comply with all professional regulatory and requisite standards and the discharge of statutory functions.
- ensure that robust performance management arrangements are developed and implemented within the directorate.
- ensure the defining and monitoring of performance standards in contracts/service level agreements with independent service providers.
- lead innovation and change to underpin the modernisation of services.
- lead quality initiatives such as Investors in People and Charter Standards in the directorate.

Professional Management

- advise and report to the Chief Executive and Trust Board on all professional nursing issues, policies, legislative requirements and standards.
- responsible for ensuring the maintenance of high quality nursing standards in the Trust.
- provide advice and guidance on all workforce planning issues pertaining to the Trust's nursing and midwifery workforce.
- ensure the effective facilitation and quality assurance of pre and post registration education and training, and work with the HSSA on the commissioning of education programmes.

- ensure nurse prescribing, performance management and development is delivered effectively across programmes of care.
- actively contribute to and influence work of the Chief Nursing Officer (DHSSPS) and the Director of Nursing (HSSA) taking the delegated lead on key themes as requested.

Strategic Planning and Development

- ensure the development of a strategic plan for the delivery of disability services to the Trust's population in line with regional strategies, Ministerial and HSSA priorities.
- 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

- responsible for the management of the Trust's disability services budgets and ensure the meeting of all financial targets within the directorate.
- participate in contract and service level negotiations with commissioners.
- lead the development of capital investment strategies within the directorate, ensuring these reflect and contribute to meeting targets set by the HSSA and the Trust's Corporate Plan.

People Management

- 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 care.
- lead the development and implementation of workforce modernisation initiatives within the directorate.
- ensure that management structures and practices within the directorate support a culture of effective team working, continuous improvement and innovation.

Corporate Management

- contribute to the corporate decision making of the Trust Board and ensure compliance with the Trust's Standing Orders and Standing Financial Instructions.
- advise the Trust Board and Chief Executive on all issues relating to nursing policy, statutory requirements, professional practice and workforce issues.

- ensure the maintenance of professional standards and statutory requirements as laid down in the current rules of nurses, midwives and health visitors and the NMC Code of Professional Conduct.
- work closely with education and training bodies to ensure the Trust has a highly skilled nursing and midwifery workforce.
- 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.
- 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.
- establish collaborative relationships with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
- contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.
- lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

GENERAL MANAGEMENT RESPONSIBILITIES

- participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.
- ensure that the review of performance identified above is performed for all levels of staff within the Trust in accordance with the Trust Board's policy.
- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

This job description is 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 Director of Mental Health & Disability Services and Executive Director of Nursing works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Chief Executive.

OTHER GENERAL RESPONSIBILITIES

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- comply with the Trust's No Smoking Policy.
- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- adhere to equal opportunities policy throughout the course of their employment.
- ensure the ongoing confidence of the public in service provision.
- comply with the HPSS code of conduct.

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.

October 2006



Information Pack

Director of Mental Health and Disability Services and Executive Director of Nursing

Terms and Conditions

Salary will be £64,481 - £85,976 per annum. (Salary scales are currently under review).

In addition to the 10 public holidays the annual leave allowance will be 33 days. He/she may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere. The successful candidate should therefore have access to a form of transport that will permit them to meet the requirements of the post in full and be prepared to travel as required.

An applicant wishing to speak to someone about the process for appointment to the above position should contact Vivienne Walker (Mrs) at the DHSSPS – RPA Unit – Beeches Management Centre (telephone Personal Information redacted by the USI or by email to Personal Information redacted by the USI

Personal Information redacted by the USI



Information Pack

Director of Mental Health and Disability Services and Executive Director of Nursing

Director of Mental Health and Disability Services and Executive Director of Nursing

Southern HSS Trust

Personnel Specification:

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are working in a substantive post in the HPSS or an organisation affected by RPA⁴ and :

- be on the NMC live register and have worked for at least 5 years in a senior management role in a major complex organisation.
- delivered against challenging performance management programmes for a minimum of 3 years in the last 6 years meeting a full range of key targets and making significant improvements.
- worked with a diverse range of stakeholders, internal and external to the organisation, to achieve successful outcomes for a minimum of 3 years in the last 6 years.
- successfully demonstrated high level people management, governance and organisational skills for a minimum of 2 years in the last 6 years.

SHORTLISTING

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 following additional desirable criterion may be introduced dependant upon the number of applications received:-

- experience of financial flows in a major complex organisation.

⁴ Details of RPA affected groups are listed on pages 26-35

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. The competencies concerned are given in the HPSS Leadership Qualities Framework. Particular attention will be given to the following:

- Self Belief
- Self Management
- Seizing the future
- Drive for results
- Leading change through people
- Holding to account
- Effective and strategic influencing

“senior management” is defined as experience gained at Chief Executive, Director, Assistant Director or equivalent in a major complex organisation;

“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;

“significant” is defined as contributing directly to key corporate objectives of the organisation concerned.



Information Pack

Director of Mental Health and Disability Services and Executive Director of Nursing

Selection Process

The Merit Principle

In accordance with recruitment good practice all appointments will be made under the ‘merit principle’ where the best person for any given post is selected in fair and open competition.

Making 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 hpssjobs.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 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;
- Write down clearly your personal involvement in any experience you quote; Write “I” statements eg 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.

Job Description

JOB TITLE	Medical Director
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Chief Executive
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The Medical Director is an Executive Director and member of Trust Board. The postholder will advise the Trust Board and Chief Executive on all issues relating to professional Medical workforce, clinical practice and quality and safety outcomes.

The postholder is the Trust's nominated Responsible Officer and will also carry lead Director responsibility in a number of organisationally critical areas including Health Care Acquired Infection (HCAI), Litigation and Emergency Planning.

As a member of the Trust Board and the senior management team he/she will inform and shape Trust strategies, support the communication and consultation on such strategies, share corporate responsibility for the achievement of the Trust's corporate objectives and for driving forward a culture of change, innovation, development and modernisation.

KEY RESULT AREAS

GOVERNANCE

1. Provide professional leadership and guidance to support Associate Medical Directors (AMD's), Clinical Directors (CD's) and Lead Clinicians throughout the Trust in relation to governance of the medical workforce including clinical practice and service change.
2. Work with other Directors to inform, support and provide assurance on the effective identification and management of clinical and organisational governance concerns, ensuring that any learning is incorporated into professional practice and systems.

3. As a member of the Senior Management Team and Trust Board, the Medical Director has corporate responsibility for ensuring an effective system of integrated governance within the Trust which delivers safe, high quality care, a safe working environment for staff and appropriate and efficient use of public funds.
4. As the designated Responsible Officer for the Trust, the postholder will have responsibility and accountability for the following key areas;
 - The effectiveness of medical appraisal of the medical workforce, for quality and standard of CPD to meet development needs arising from appraisal, and for revalidation.
 - The provision of expert advice and assurance to the organisation in relation to the Trust's processes for addressing concerns about a medical practitioner's fitness to practice (as set out in the Trust's Guidelines for Handling Concerns about Doctors' and Dentists' Performance).
 - The designated Trust officer for referring concerns about a medical practitioner to the General Medical Council.
 - Providing professional advice to SMT as to the appropriate indicators of safety, quality and performance, to inform and commission the measurement of such indicators as part of SMT Governance, to regularly review this information, and to provide assurance or expert input into necessary steps to address any issues arising from same.
 - Providing regular 'Responsible Officer' reports on the medical workforce to SMT, Governance Committee and Trust Board
5. Designated lead Director for strategic management of Patient Safety initiatives, and the link Director with the Patient Safety Forum and other regional Fora.
6. While the operational responsibility and accountability for patient safety rests with operational Directors, the postholder will be responsible for;
 - Participation in regional co-ordination of patient safety initiatives, bringing intelligence and direction on these approaches into the organisation and providing strategic and professional advice on implementation.



- Co-ordinating the implementation of agreed Patient Safety priority projects and monitoring systems, as endorsed by SMT, within the wider Clinical and Social Care Governance arrangements of the Trust.
 - Reviewing and monitoring the impact of Patient Safety Initiatives and providing regular Patient Safety reports to SMT, Governance Committee and Trust Board.
7. Professional lead in relation to Information Governance, specifically the Trust's nominated Caldicott Guardian, and chair of Trust Information Governance Committee.

SERVICE DELIVERY

8. Strategic management and co-ordination of effective Emergency planning within the Trust, including Pandemic Planning.
9. Responsible for ensuring a Major incident policy is in place for the Trust, and suitable support is in place for the testing, recording and subsequent modification of the policy and attached plans are reviewed constantly and reported on at agreed intervals.
10. Responsibility for Controls Assurance Standards (CAS) for Emergency Planning and Research Governance with provision of Annual Reports to Trust Board.
11. Management of ECRs and Drug Requests for Southern Trust patients, and responsible for medical evaluation, decision-making and liaison with Commissioner in relation to same.
12. Responsible for the strategic management of the clinical aspects of HCAI and Infection Control within the Trust, including the line management of the Infection Control Team and responsibility for CAS for infection control and provision of Infection Prevention and Control Annual Report to Trust Board. The postholder will liaise as appropriate with the Director of Acute Services who is responsible for environmental hygiene.
13. Develop and implement health surveillance methodologies for the Trust.
14. Responsible to Trust Board for the discharge of medical statutory functions.

LITIGATION

15. The effective governance and management of the Litigation function within the Trust, including effective integration with wider clinical and social care governance systems and engagement and involvement of other Directorates.
16. Lead Director for the Trust's Medical Negligence and other related committees to:
 - provide an investigation and management service on behalf of the Trust in relation to claims of litigation in respect of clinical negligence and associated matters
 - assist HM Coroner with enquiries and the preparation of statements prior to inquests
 - liaise with the HSCB and/or the Department of Health as necessary for follow up action subsequent to sudden death or significant adverse incidents.
17. Lead decision-maker for management of medical negligence. Provision of regular reports to SMT, Governance Committee and Trust Board to provide assurance of effectiveness of Litigation function, systems and processes.

MEDICAL EDUCATION, & TRAINING

18. The postholder will be responsible for the quality of medical education and training within the Trust working closely with education and training bodies and ensure the Trust has a highly skilled career grade medical workforce. This will include accountability for the quality of undergraduate training including delivery of QUB Accountability Framework and utilisation of SUMDE budget, and the provision of Annual Report to Trust Board.
19. Lead on the post graduate training of junior doctors in training within SHSCT, including managing the relationship between NIMDTA and the Trust, and ensuring the Trust and NIMDTA work in partnership to maintain a high standard of education and related patient safety.
20. Lead on the work related to the newly established "Sub Deanery" for Queens University [QUB] Medical School within SHSCT, including managing the relationship between QUB and the Trust, and ensuring the Trust and QUB work in partnership to maintain a high standard of education and supervision of the Medical students placed with SHSCT. This work includes an Annual report and

financial report on the funding provided to SHSCT by QUB in respect of the work of the sub-deanery.

21. Management of the Associate Medical Director (AMD) for postgraduate Medical Education, induction and training for Junior Doctors, QA / evaluation of training and supporting operational Directors to address issues arising from Deanery and PMETB evaluation and inspections.
22. Responsible for the development and maintenance of professional standards and education liaising with professional and education bodies as necessary.
23. Provide advice on medical workforce policy including staffing levels, changes in working patterns and skill mix which will ensure the delivery of effective and efficient clinical services to patients and clients.
24. Ensure that all doctors and dentists in the Trust work within agreed procedures, and, as appropriate the GMC's guidance 'Duties of a Doctor', 'Good Medical Practice' and related documents, and succeeding and replacement documents or the GDC's lifelong learning requirements.
25. Ensure the implementation of an effective process of professional self-regulation for doctors employed by the Trust.

RESEARCH & DEVELOPMENT

26. The postholder will be responsible for the strategic and operational management of Research and Development within the Trust, including the line management of the AMD for Research and Development and associated support staff. This role includes responsibility for CAS for Research and provision of Research and Development Annual Report to Trust Board.
27. Responsible for the Trust's Research Committee to agree a programme of research and development and ensure the extant legal and regularity permissions are obtained.

QUALITY

28. Promote the highest possible standard of medical practice, advice and support to ensure the development of a quality culture with an emphasis on the need for continuous improvement.

29. Promote quality initiatives such as Investors in People and Charter Standards in the Trust.
30. Ensure that medical standards are clear and defined in contracts/service level agreements for the provision of services to other Trusts or with independent service providers.
31. Continue to develop and maintain appropriate Quality Indicators, including a comprehensive Mortality Report and provide information and assurance on the intelligence from such indicators to operational Directors, Chief Executive and Trust Board.
32. Keep up to date with policies and guidelines on good practice from the Royal Colleges, GMC, universities etc. and identify opportunities to enhance the quality of services provided by the Trust.

FINANCIAL AND RESOURCE MANAGEMENT

33. Assist the Trust Board and Chief Executive in determining its expenditure on clinical services.
34. Participate in contract and service level negotiations with commissioners.
35. Advise and assist in the development of capital investment strategies across the trust, ensuring these reflect and contribute to meeting targets set by the HSCB and the Trust's Corporate Plan.

CORPORATE MANAGEMENT

36. Contribute to the corporate decision making of the Trust Board and ensure compliance with the Trust's Standing Orders and Standing Financial Instructions.
37. 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.
38. 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.

- 39. Establish collaborative relationships with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
- 40. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.
- 41. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.
- 42. Ensure appropriate risk management arrangements are in place to deliver safe medical services to patients and minimise the potential for actions against the Trust.
- 43. Participate in the assurance that an effective system of clinical risk management and adverse event reporting is in place.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

- 44. Ensure the development of strong medical leadership in the Trust.
- 45. Oversee, and participate in the arrangements for consultant and associate grade appraisals.
- 46. Participate in arrangements for recognition of clinical excellence including providing advice on nominations and citations for Distinction and Meritorious Service awards.
- 47. Ensure the aims and targets of the New Deal for junior doctors are implemented and compliance with EWTD for junior doctors and career grade doctors is achieved and maintained.
- 48. Support managers both in establishing and reviewing performance targets with individual consultants, recognising workloads and other pressures on medical staff, and ensuring that adequate mechanisms are in place for the welfare of medical staff.
- 49. Provide advice and guidance on medical workforce policy driving forward a culture of change, innovation and development and modernisation of services.

50. Responsible, in association with HROD for the management of disciplinary matters and complaints relating to medical staff.
51. Review individually, at least annually, the performance of immediately managed staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.
52. Maintain staff relationships and morale amongst staff.
53. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.
54. Participate, as required, in the selection and appointment of Trust staff in accordance with procedures laid down by the Trust.
55. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
56. Where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.

GENERAL REQUIREMENTS

57. 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.
58. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.
59. 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
60. 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.

61. 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.

PERSONNEL SPECIFICATION

JOB TITLE Medical Director

Ref No 73811041

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 will 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 full registration with the GMC⁵.
2. Have minimum of 2 years experience in a senior medical management¹ role in a major complex organisation².
3. Have at least 2 years experience of managing major change programmes addressing significant³ organisational, managerial or service change.
4. Have a minimum of 2 years experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant³ improvements.
5. 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 significant³ change initiative.

6. Hold a full current driving license valid for use in the UK and have access to a car on appointment⁴. 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;
 - » effective planning and organisation
 - » Governance and Risk Management
 - » 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.

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

¹ 'senior medical management' is defined as experience gained at Medical Director, Associate Medical Director, Deputy / Assistant Medical Director, Co Director (Medical) or Clinical Director or equivalent level in a major complex organisation.

² '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

³ 'significant' is defined as contributing directly to Key Corporate Objectives of the organisation concerned.

⁴ 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.

The Trust reserves the right to review and consider, as appropriate, the information available about you on the GMC register as part of this selection process. This information will be treated in confidence and will not debar you from appointment unless the selection panel considers that it renders you unsuitable for appointment.

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
- Leading Change through people
- Holding to Account
- Drive for Improvement
- Self Management

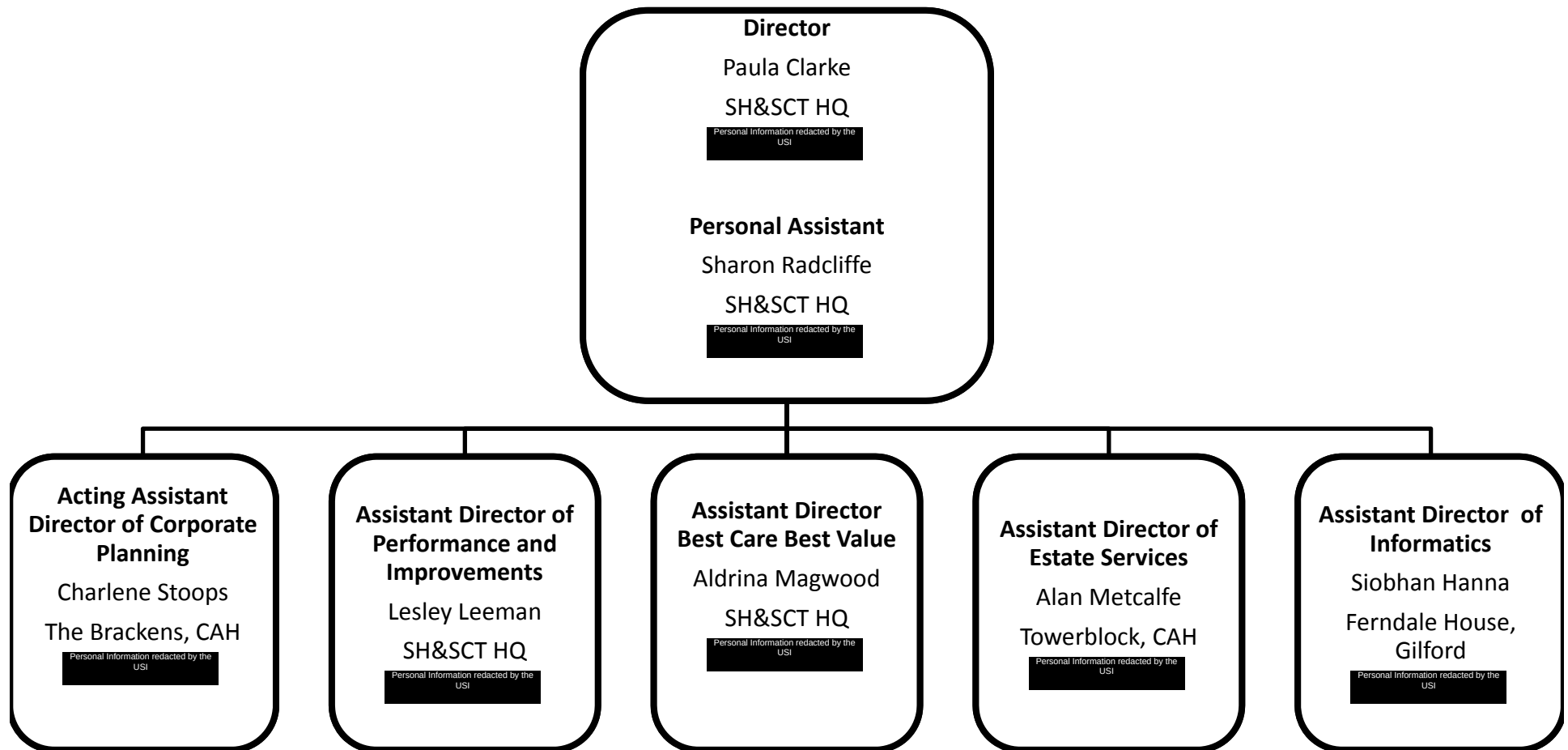
As part of the Recruitment & Selection process it will be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

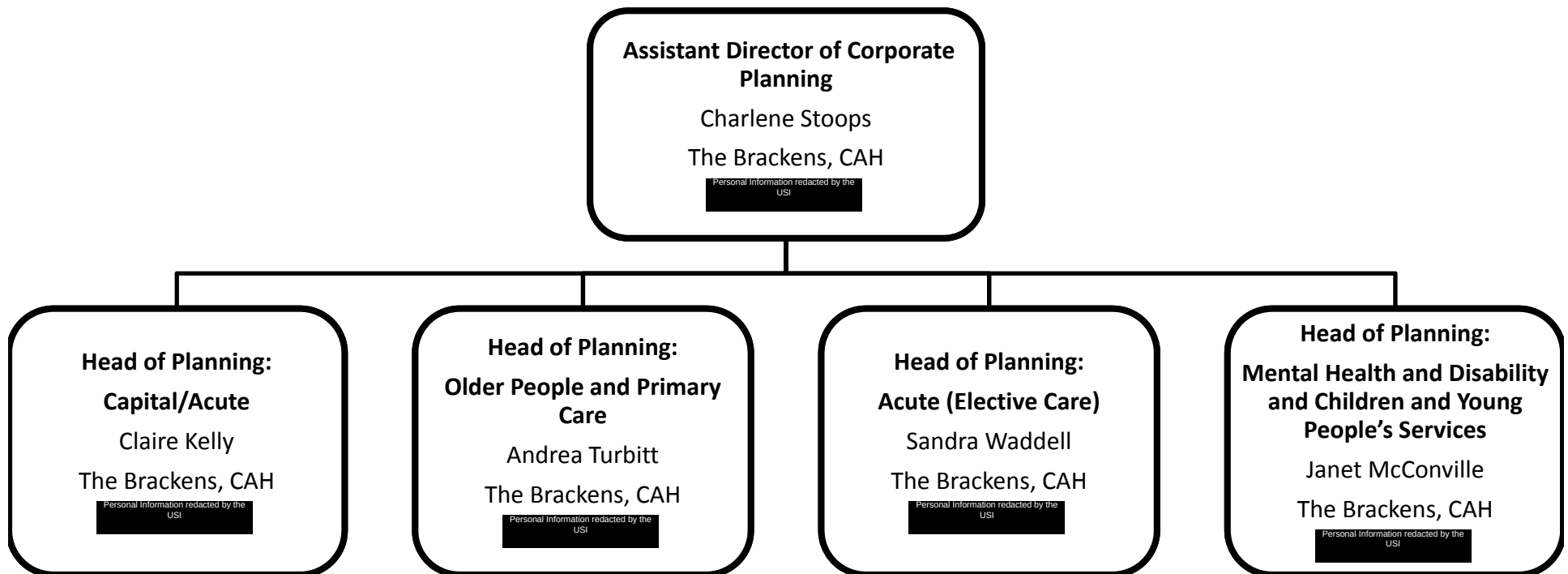
WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

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

DIRECTORATE OF PERFORMANCE AND REFORM





Assistant Director of Performance and Improvements

Lesley Leeman

SH&SCT HQ

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USI

Head of Contracts

Dawn Livingstone

The Rowans, CAH

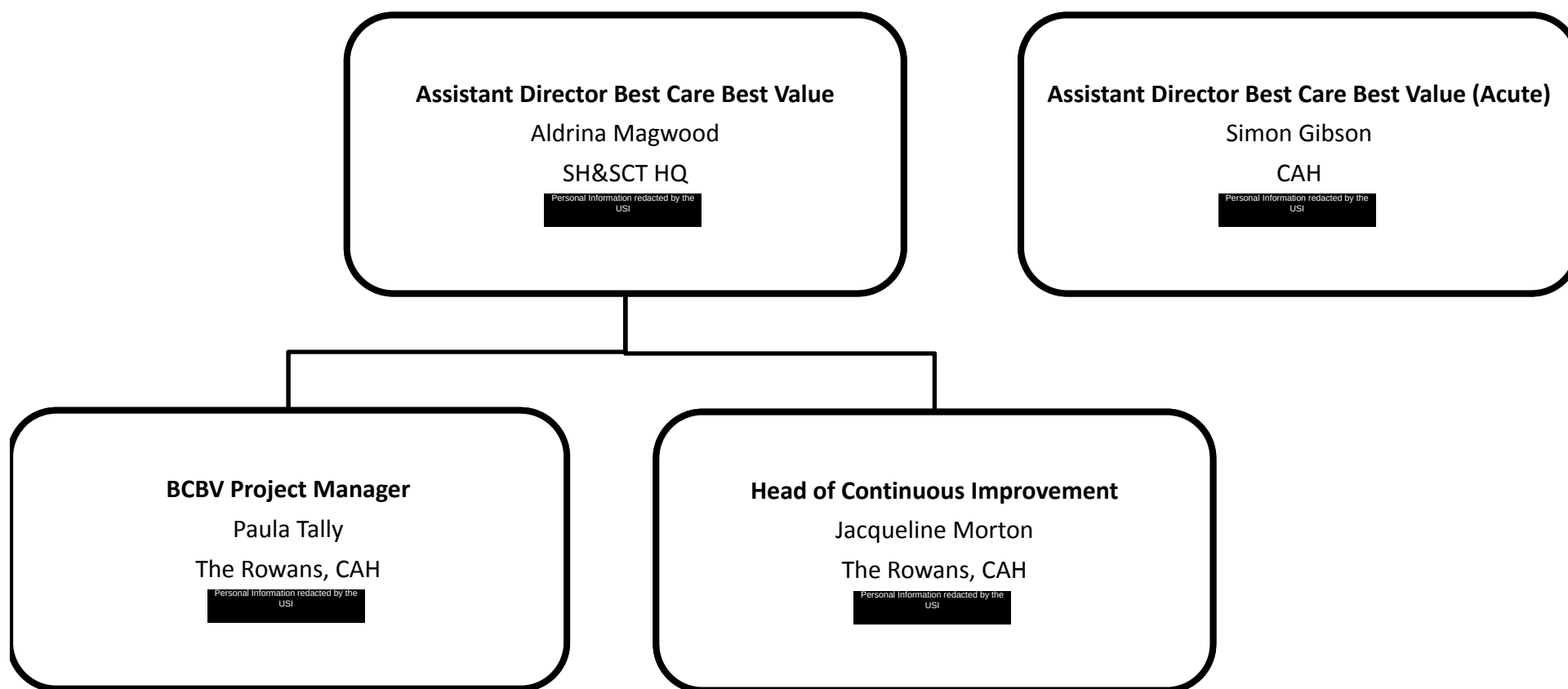
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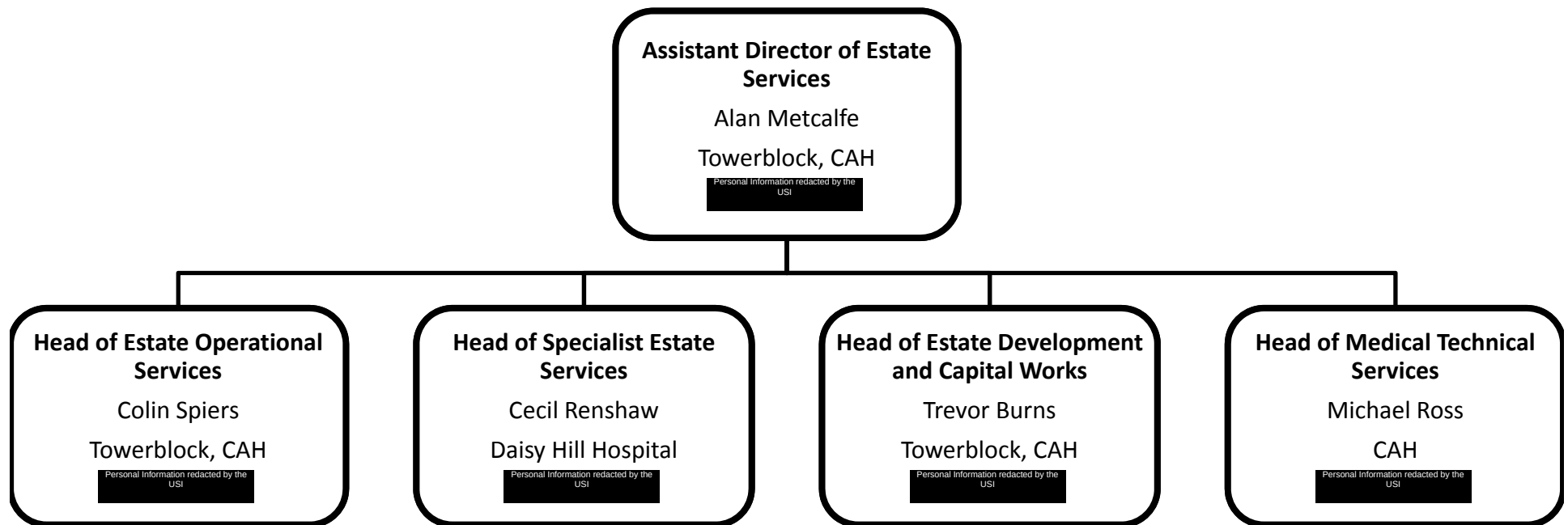
Head of Performance

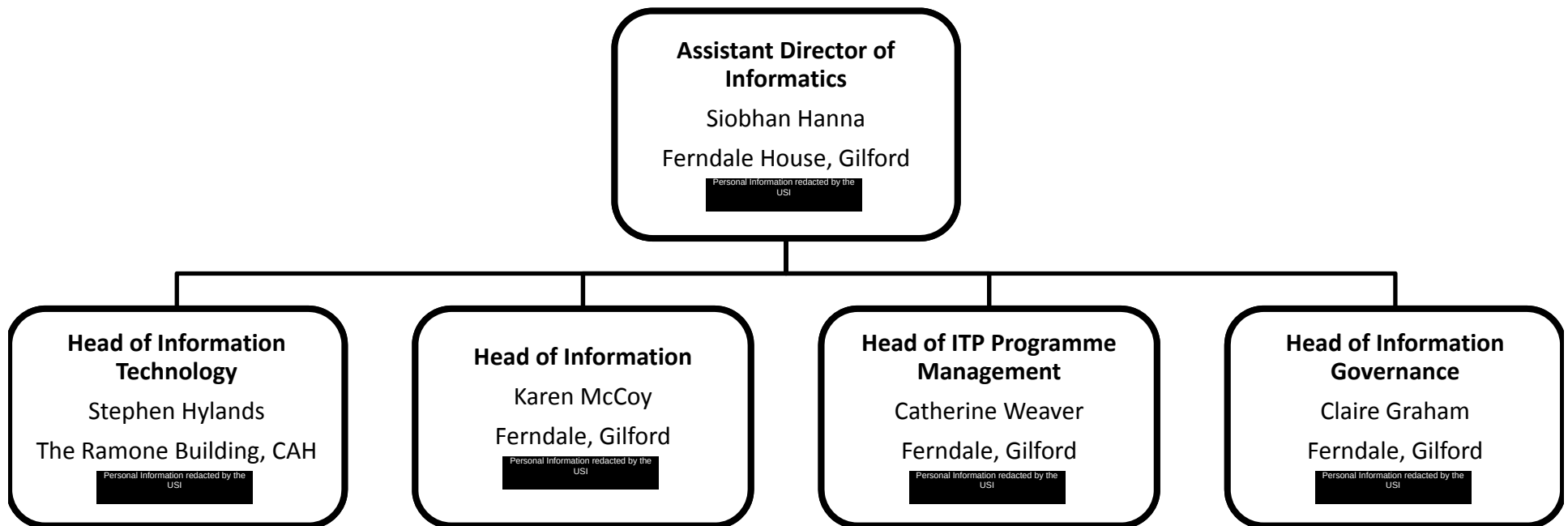
Lynn Lappin

The Rowans, CAH

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ORGANISATIONAL CHART

December 2016



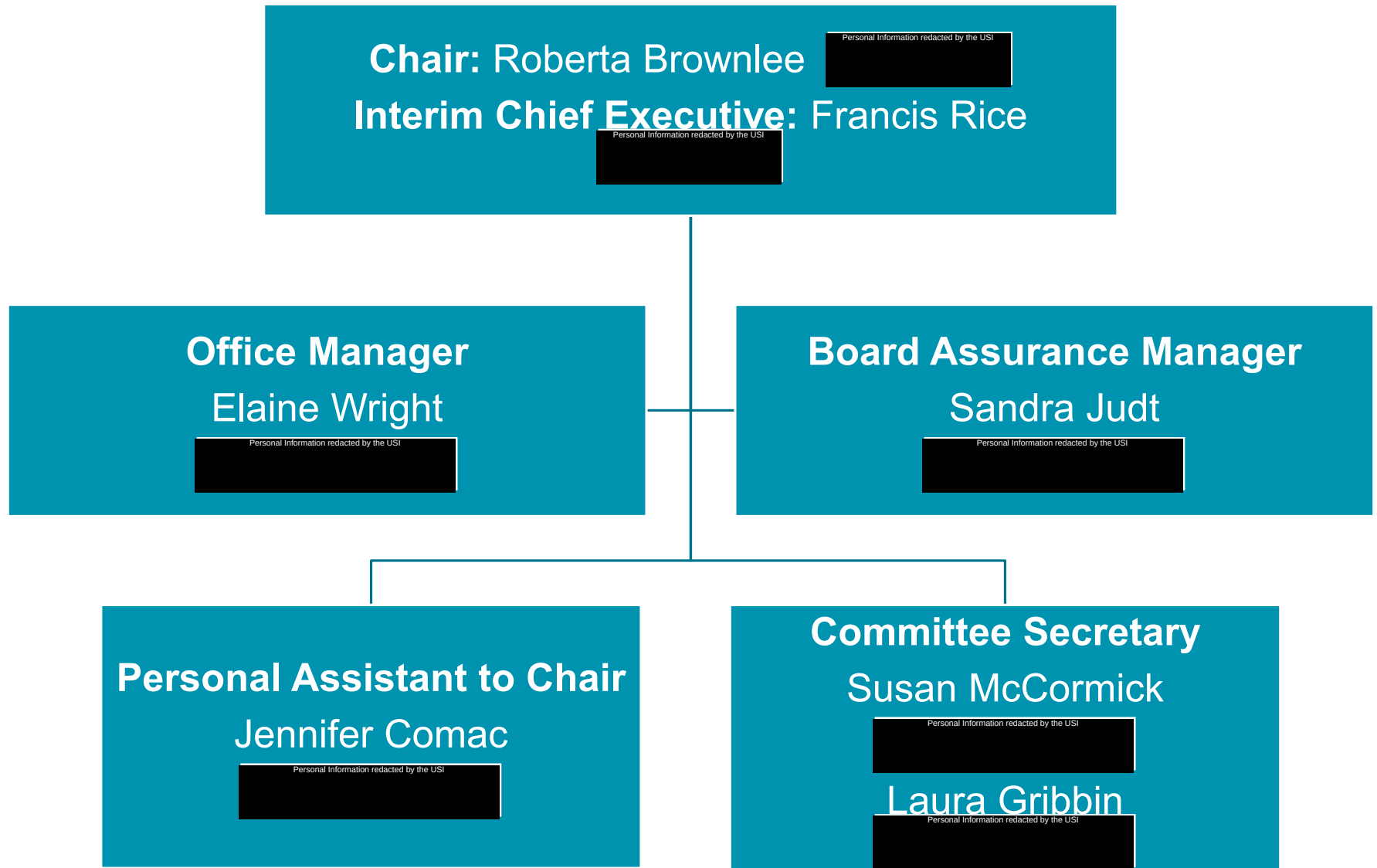
Southern Health
and Social Care Trust

Quality Care - for you, with you

Issued by Urology Services Inquiry on 28 April 2022. Annotated by the Urology Services Inquiry.

Office of the Chair and Chief Executive

Chair and Chief Executive's Office SH&SCT Headquarters 7883



Communications Team

WIT-37884

Head of Communications (Job-Share)

Jane McKimm	Ruth Rogers
Monday-Wednesday	Wednesday-Friday
SH&SCT HQ	SH&SCT HQ

Personal Information redacted by the USI

Personal Information redacted by the USI

Communication Manager

Paula McKeown
The Rowans

Personal Information redacted by the USI

Communications Manager

Peter Toal
The Rowans

Personal Information redacted by the USI

Communications Officer

Anna Donnelly
The Rowans

Personal Information redacted by the USI

Communication Support

Jessie Weir
SH&SCT

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Directorate of Acute Services

Director, Mrs Esther Gishkori
SHSCT, Craigavon Area Hospital

Personal Information redacted by the USI

Personal Assistant
Emma Stinson

Personal Information redacted by the USI

**Assistant
Director of
Acute
Services;
Surgery &
Elective
Care &
ATICs**

Ronan
Carroll

Personal
Information
redacted by
the USI

**Assistant
Director of
Acute
Services;
Medicine and
Unscheduled
care**

Anne McVey

Personal Information redacted by the USI

**Assistant
Director of
Acute
Services;
Integrated
Maternity and
Women's
Health and
Cancer and
Clinical
Services**

Heather
Trouton

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**Assistant
Director of
Acute
Services;
Functional
Support
Services**

Anita Carroll

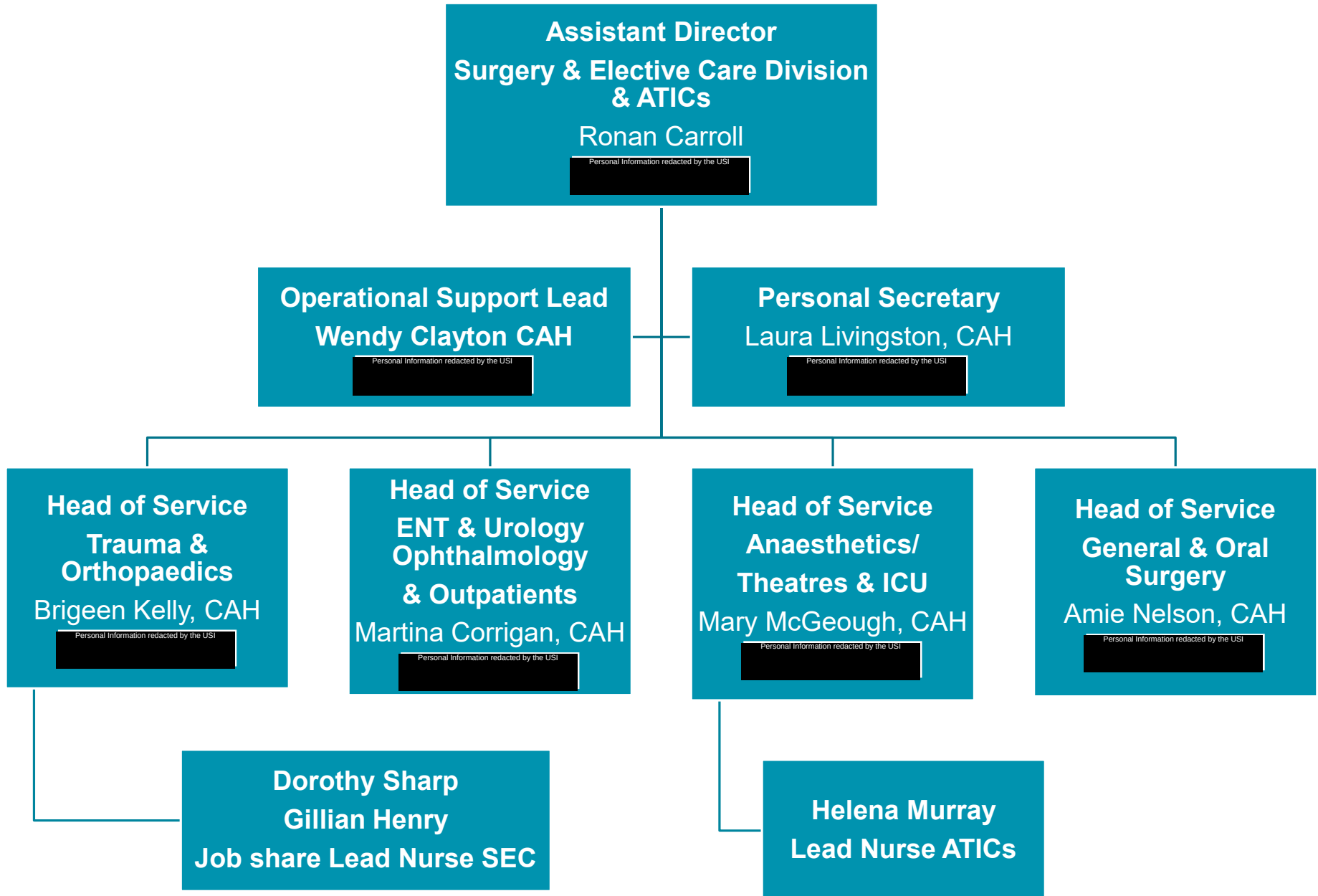
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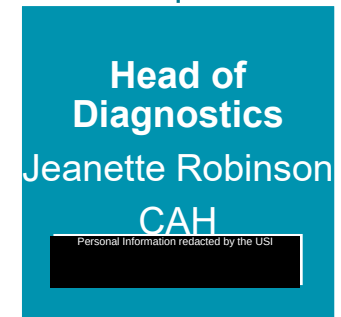
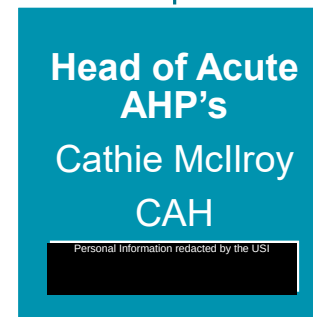
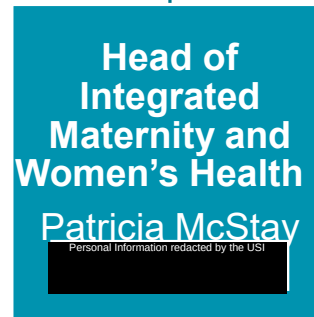
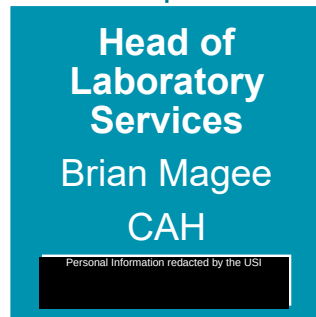
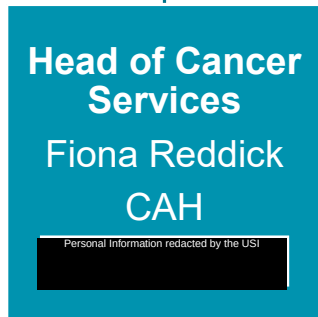
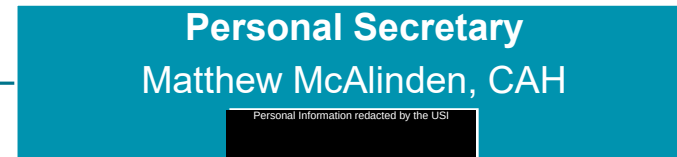
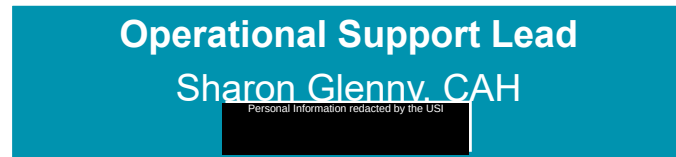
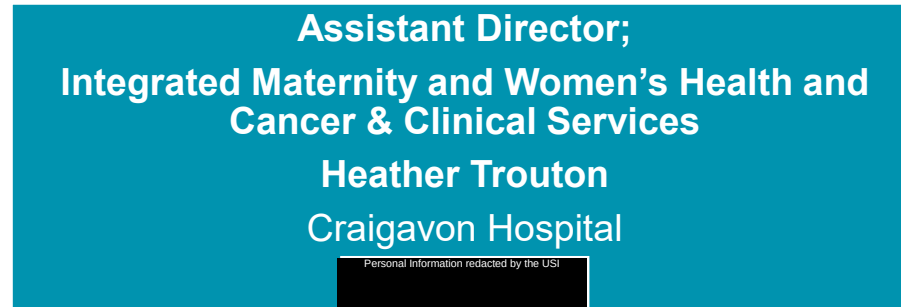
**Director of
Pharmacy;**
Dr Tracey
Boyce

Redaction Code 4

**Assistant
Director of
Acute
Services;
Strategy,
Reform and
Service
Improvement**
Barry Conway

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Wendy Clarke – Lead Midwife (CAH)
Joanne McGlade – Lead Midwife (DHH)
Patricia Kingsnorth – Lead Midwife (Community)

Assistant Director; Functional Support Services

Anita Carroll

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Personal Secretary

Aideen Lappin, DHH

Personal Information redacted by the USI

**Head of Domestic,
Catering, Portering &
Security Services**

Kate Corley

Craigavon Area
Hospital (CAH)

Personal Information redacted by the USI

**Booking & Contact
Centre
Manager**

Katherine Robinson,
CAH

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**Head of Health
Records**

Helen Forde, CAH

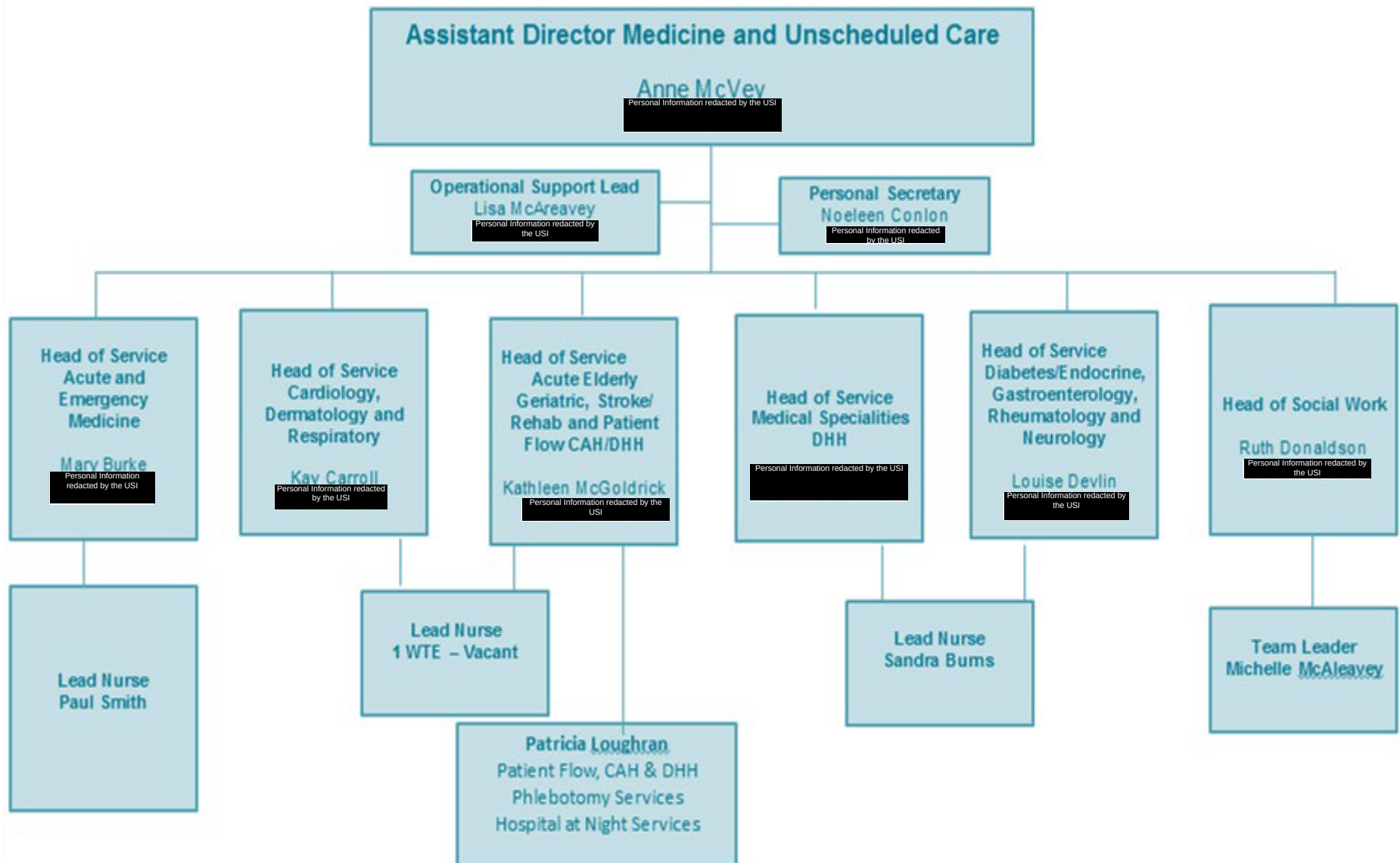
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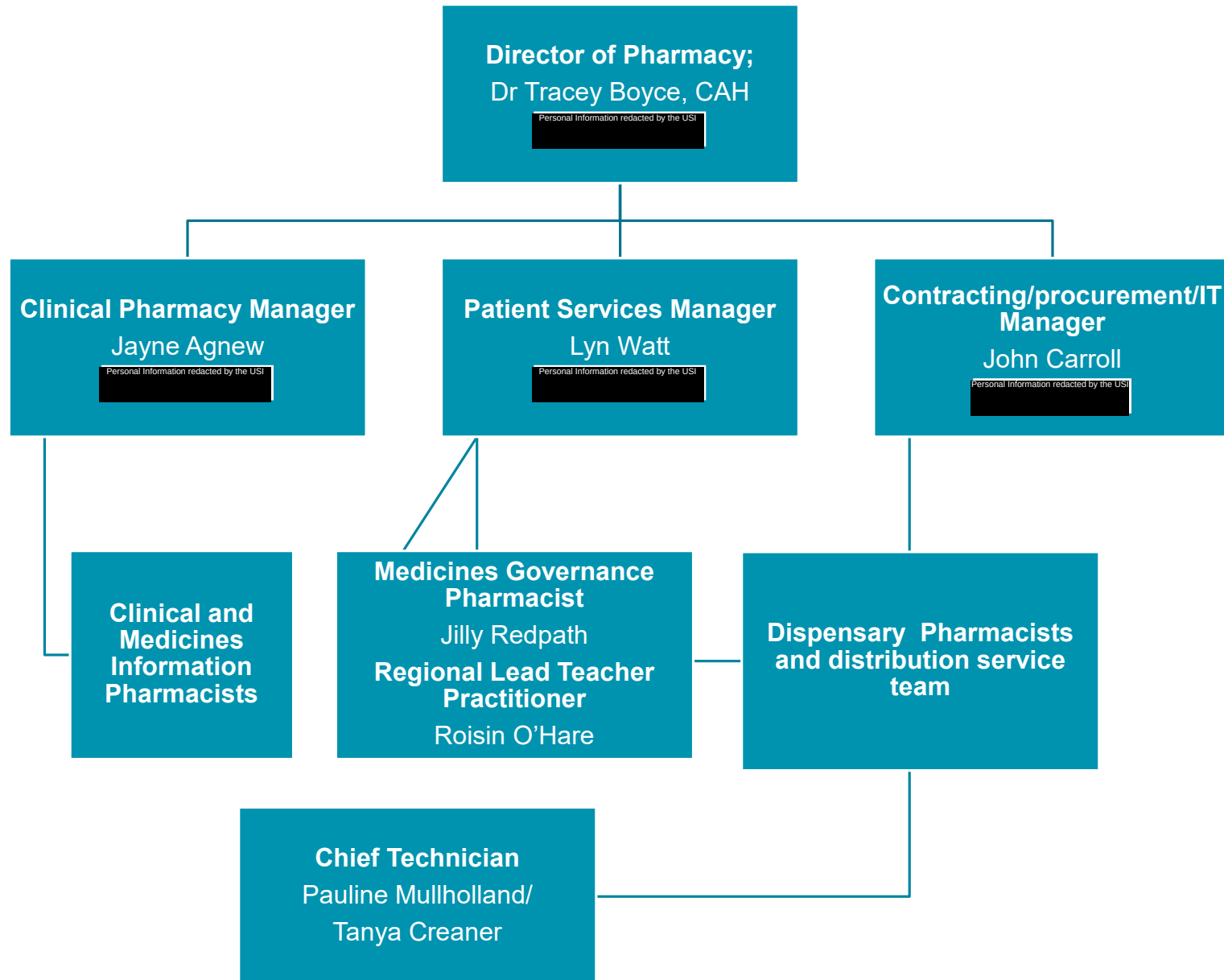
**Head of
Decontamination,
Switchboard &
Laundry Services**

Sandra McLoughlin,
CAH

Personal Information redacted by the USI

MUSC Organisational Structure





Assistant Director; Strategy, Reform and Service Improvement

Barry Conway

Personal Information redacted by the USI

Support to be
agreed

Directorate of Children and Young Peoples Services

Children & Young Peoples Services Directorate

Wt 067894

DIRECTOR Paul Morgan

Edenderry House, Portadown

Personal Information redacted by the USI

Personal Assistant Ruth Alexander

Personal Information redacted by the USI

Associate Medical Director

Dr A Khan

DHH, Personal Information redacted by the USI EXT Personal Information redacted by the USI

Assistant Director of Family Support & Safeguarding

David Douglas

Edenderry House Personal Information redacted by the USI

Assistant Director of Specialist Child Health & Disability

Geraldine Maguire

Edenderry House Personal Information redacted by the USI

Assistant Director of Corporate Parenting

Colm McCafferty

Lisanally House Personal Information redacted by the USI

Assistant Director Social Work

(Governance, Workforce Development & Training)

Francesca Leyden

Edenderry House Personal Information redacted by the USI

Head of Planning

Janet McConville, Rosedale, Gilford

Personal Information redacted by the USI

Finance

Michael Gillespie, Financial Management Accountant

Personal Information redacted by the USI

Assistant Director Human Resources

Lindsay McElrath

Edenderry House Personal Information redacted by the USI

Informatics

Karen McCoy, Bannvale House

Personal Information redacted by the USI

Performance & Reform

Paula Tally, BCBV Programme Manager
Trust HQ, CAH Personal Information redacted by the USI

Governance Manager

Daphne Johnston

Edenderry House Personal Information redacted by the USI

Assistant Director Specialist Child Health & Disability

Geraldine Maguire

Edenderry House, Portadown

Personal Information redacted by the USI

**8B Head of
Acute
Paediatric
Services**

**Bernie
McGibbon**

Personal
Information
redacted
by the USI

2 NNU Units
2 Paediatric
Wards
3 Ambulatory
Services
6 Outpatient
Service Sites
Acute Admin

**8B Head of
Acute
Paediatric
Services**

**Bernie
McGibbon**

Personal
Information
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by the USI

2 NNU
Units
2 Paediatric
Wards
3
Ambulatory
Services
6 Outpatient
Service
Sites
Acute
Admin

**Clinical
Director/
Head of
Dental
Services**

**Michelle
Oliver**

Personal Information redacted by the USI

10 Community
Dental
Services

**8B HOS N/M Locality
Wraparound Service &
Professional AHP
Lead**

Pauline Douglas

Personal Information redacted by the USI

Trustwide Non
Integrated AHP
Services
2 Locality Based
Integrated Care Teams
Trustwide AHP
Surestart Services
Paediatric Wheelchair
Services
Occupational Therapy
Grants Services
School Based AHP
Services
Trustwide CDC

**8B HOS A/D
Locality
Wraparound
Service &
Professional SW
Lead**

Lesley Waugh

Personal Information redacted by the USI

Trustwide Short
Breaks Services
2 Trustwide Short
Breaks Units
1 Medium Term
Residential Unit
1 Trustwide
Transition Team
2 Locality based
Integrated Care
Teams (ICTs)
Short Breaks
Contracts inc Vol
Short Breaks Unit

**8B HOS CAMHS
Peadar White**

Personal Information redacted by the USI

Single Point of Entry
Team
3 Locality based
CAMHS teams
1 ACT (Assessment
Crisis Team)
1 Community
Intensive Treatment
Service
3 Primary Mental
Health Teams
1 Intellectual Disability
CAMHS
1 Eating Disorder
1 Action for Children
in Education
3 Autism Teams
1 Infant CAMHS

Children & Young Peoples Services Directorate

W11-07896

Assistant Director Family Support & Safeguarding

David Douglas

Edenderry House, Portadown

Personal Information redacted by the USI

Head of Service Family Support & Safeguarding A&D

Gateway Service

(APSW Gateway)

Family Intervention Teams A&D

Public Protection Service (Principal Officer)

Independent Chair – Child Protection & LAC

Family Support Hubs

YYP/Youth Homeless Service

Service Level Agreements

Michael Hoy

Child & Family Care Office

2 Old Lurgan Road
Portadown

Personal Information redacted by the USI

Head of Service Family Support & Safeguarding C&B

Family Intervention Teams C&B

Early Years Service Trust Wide

Parenting Service Trust Wide

Court Welfare Service Trust Wide

Principal Practitioner Courtwork

Sure Starts

Independent Chair-Child Protection /LAC

Service Level Agreements

Ciaran Eastwood

Child & Family Care Office
2 Old Lurgan Road,
Portadown

Personal Information redacted by the USI

Head of Service Family Support & Safeguarding N&M

Family Intervention Teams N&M

Lead for Child Protection Practice

SSWP Child Sexual Abuse

Independent Chair- Child Protection /LAC

Independent Assessors Panel

Carers/Young Carers Lead

Change/Service Improvement

Domestic & Sexual Violence Partnership

Service Level Agreements

Donna Murphy

Dromalane House

Dromalane Road

Newry

BT35 8AP

Personal Information redacted by the USI

Head of Health Visiting & School Nursing Family Support & Safeguarding

Health Visiting Service

School Nursing Service

NINES

Deputy Head of HV & SN

Named Nurse

Safeguarding

/Safeguarding Children's Nurse Service

Family Nurse Partnership Service

Sure Starts

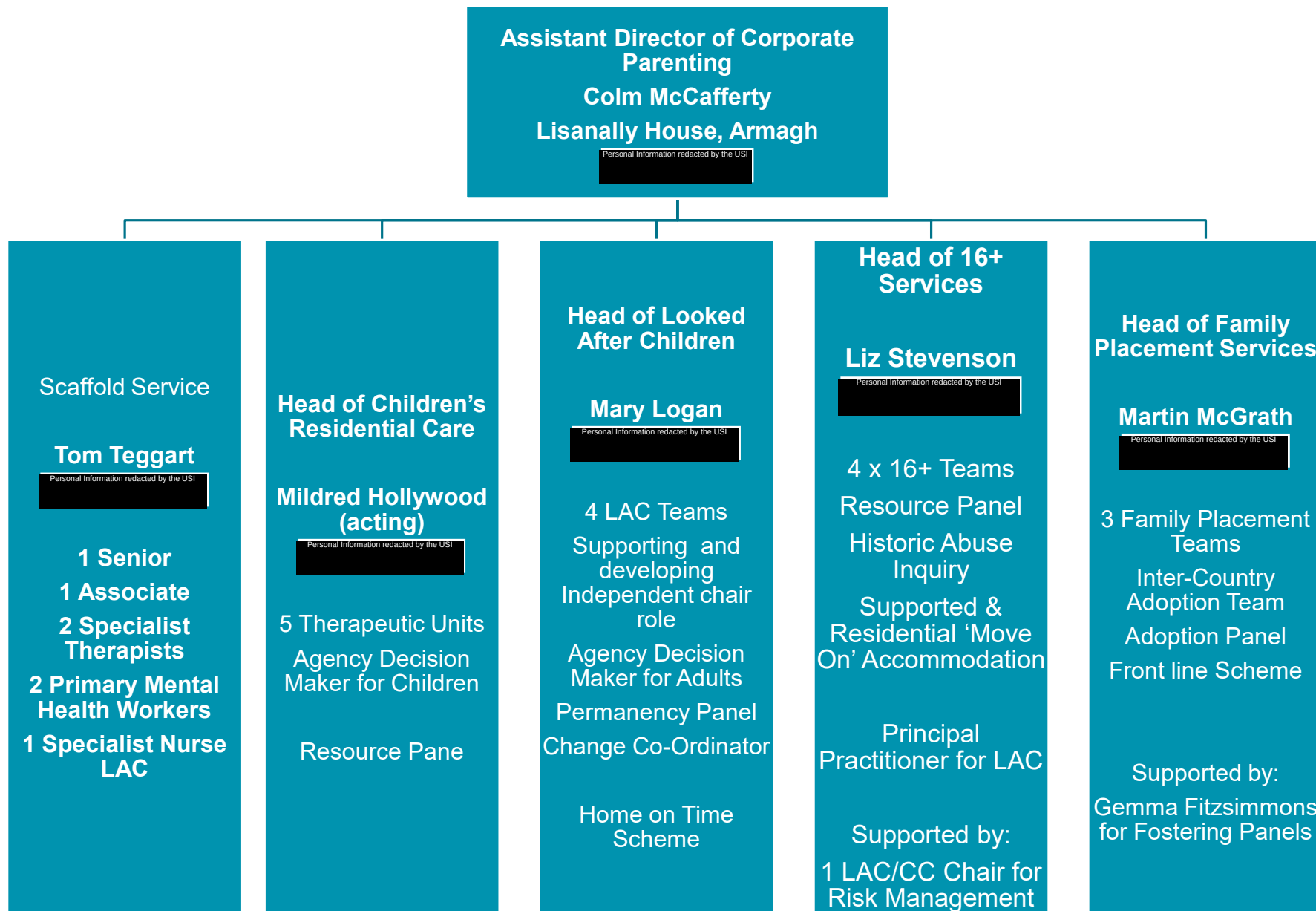
Service Improvement Lead

Julie McConville

Edenderry House,
Portadown

Personal Information redacted by the USI

Children & Young Peoples Services Directorate WIT-07897



**Assistant Director of Social Work
(Governance, Workforce Development &
Training)**

**Francesca Leyden
Edenderry House, Portadown**

Personal Information redacted by the
USI

**Head of Social Work
Workforce
Development
& Training**

**Daphne Johnston
Social Services Training
Unit,
St Luke's**

Personal Information redacted by the USI

**Head of Social Work
Governance**

**Marita Magennis
Oakdale House, Newry**

Personal Information redacted by the USI

**Clinical & Social Care
Governance Manager**

**Vacant Post
Edenderry House,
Portadown**

Personal Information redacted by the USI

**Safety In
Partnership
Programme**

**Niamh Donnelly,
Lisanally House
Armagh**

Personal Information redacted by the USI

Directorate of Mental Health and Disability

DIRECTORATE OF MENTAL HEALTH & DISABILITY WITH BY 900

DIRECTOR OF MENTAL HEALTH & DISABILITY SERVICES (ACTING)

Bryce McMurray, Bannvale House

Personal Assistant: Mrs Tracy Griffin

Personal Information redacted by the USI

Assistant Director Mental Health Services (Acting)

Adrian Corrigan

Personal Information redacted by the USI

Asst Dir Nursing, Workforce Development & Training

Lynn Fee

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Associate Medical Director Dr Neta Chada

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Assistant Dir Human Resources

Jenny Johnston

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Assistant Director Disability Services

Miceal Crilly

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Assistant Director Nursing Services Governance

Fiona Wright

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Clinical Director General Adult Psychiatry

Dr Pat McMahon

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Senior Financial Management Accountant.

Johnny McMahon, Lurgan
Hospital,

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Head of Psychology

Dr Ivor Crothers

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Assistant Dir Allied Health Professions, Governance & Workforce Development

Carmel Harney

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Clinical Director Learning Disability and Physical/Sensory Disability

Dr Joan McGuinness

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Head of Planning

Janet McConville

Rosedale,

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Bereavement Co-ordinator

Anne Coyle

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Performance & Reform

Paula Tally

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Mental Health & Disability ServicesWIT-37901

DIRECTOR OF MENTAL HEALTH & DISABILITY SERVICES (ACTING)

Bryce McMurray, Bannvale House

Personal Assistant Tracy Griffin

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Assistant Director Mental Health Services (Acting)

Adrian Corrigan

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Assistant Director Disability Services

Miceal Crilly

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Acute Mental Health Services Manager

Louise Hall

Primary Mental Health Care Services Manager

Joanne McConville

Mental Health Support & Recovery Services Manager

Post Vacant

Head of Head of Memory Service

Cathy Mawhinney

Supported Living

Dessie Cunningham,

Day Services

Bronagh McKeown

Community Services

Northern Area

Donna Curley

Community Services

Southern Area

John McEntee

Wheelchair Services

Carol Grills / Sally Wilson

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Specialist Services Manager

Noreen McComiskey

Specialist Services Manager

Pat McAteer

Head of Transport

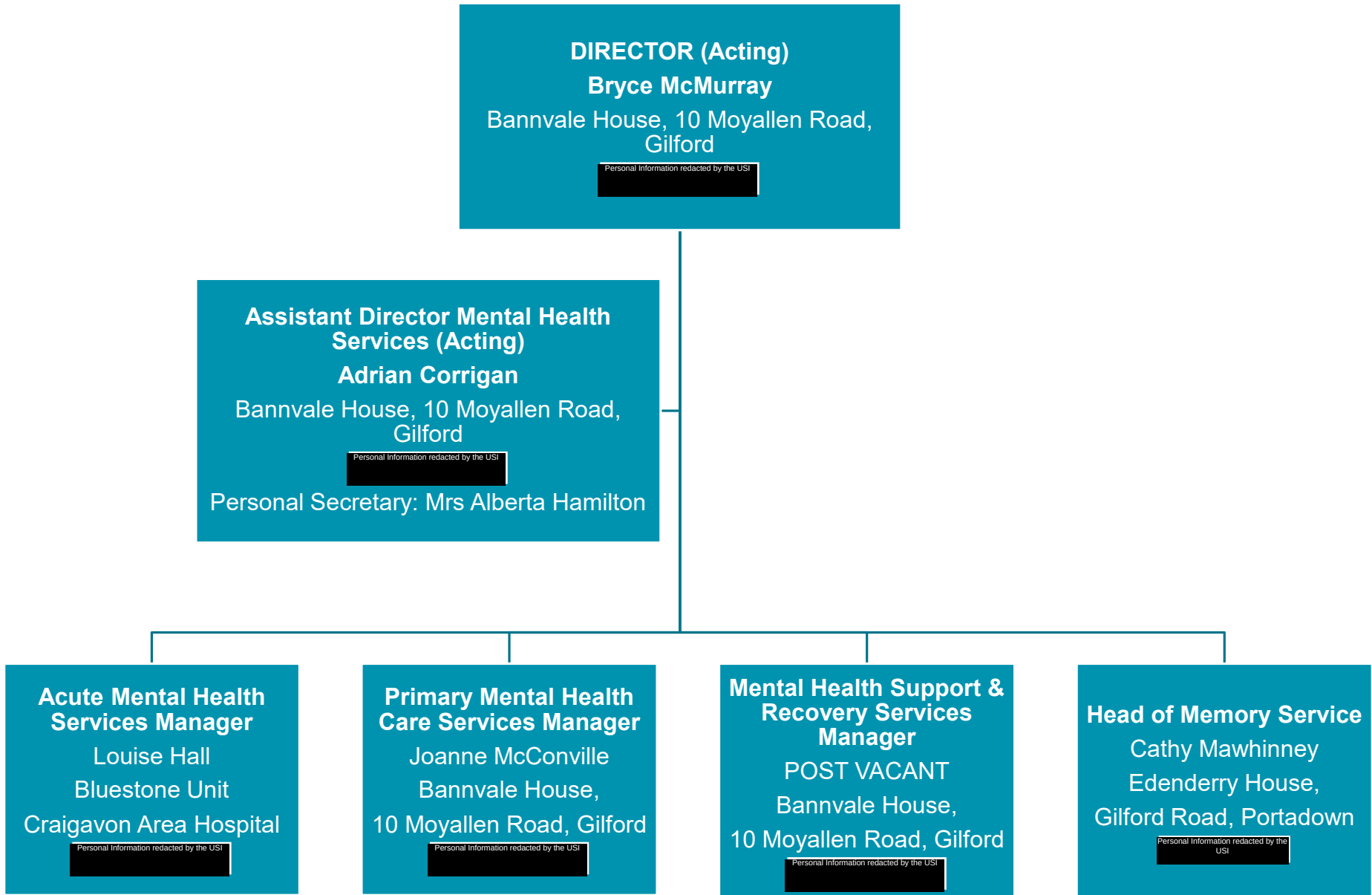
Barry Collins

Head of Adult Safeguarding

To be Appointed

Interim contact:

Personal Information redacted by the USI



DIRECTOR OF MENTAL HEALTH & DISABILITY SERVICES (ACTING)

Bryce McMurray, Bannvale House
Personal Assistant Tracy Griffin

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Assistant Director Disability Services

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Personal Information redacted by the USI

Personal Secretary: Mrs Jill Duffy

Supported Living

Dessie Cunningham

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Day Services

Bronagh McKeown

Personal Information redacted by the USI

Community Services

Northern Area

Donna Curley

Personal Information redacted by the USI

Community Services

Southern Area

John McEntee

Personal Information redacted by the USI

Wheelchair Services

Carol Grills / Sally Wilson

Personal Information redacted by the USI

Specialist Services Manager

Noreen McComiskey

Personal Information redacted by the USI

Specialist Services Manager

Pat McAteer

Personal Information redacted by the USI

Head of Transport

Barry Collins

Personal Information redacted by the USI

Head of Adult Safeguarding

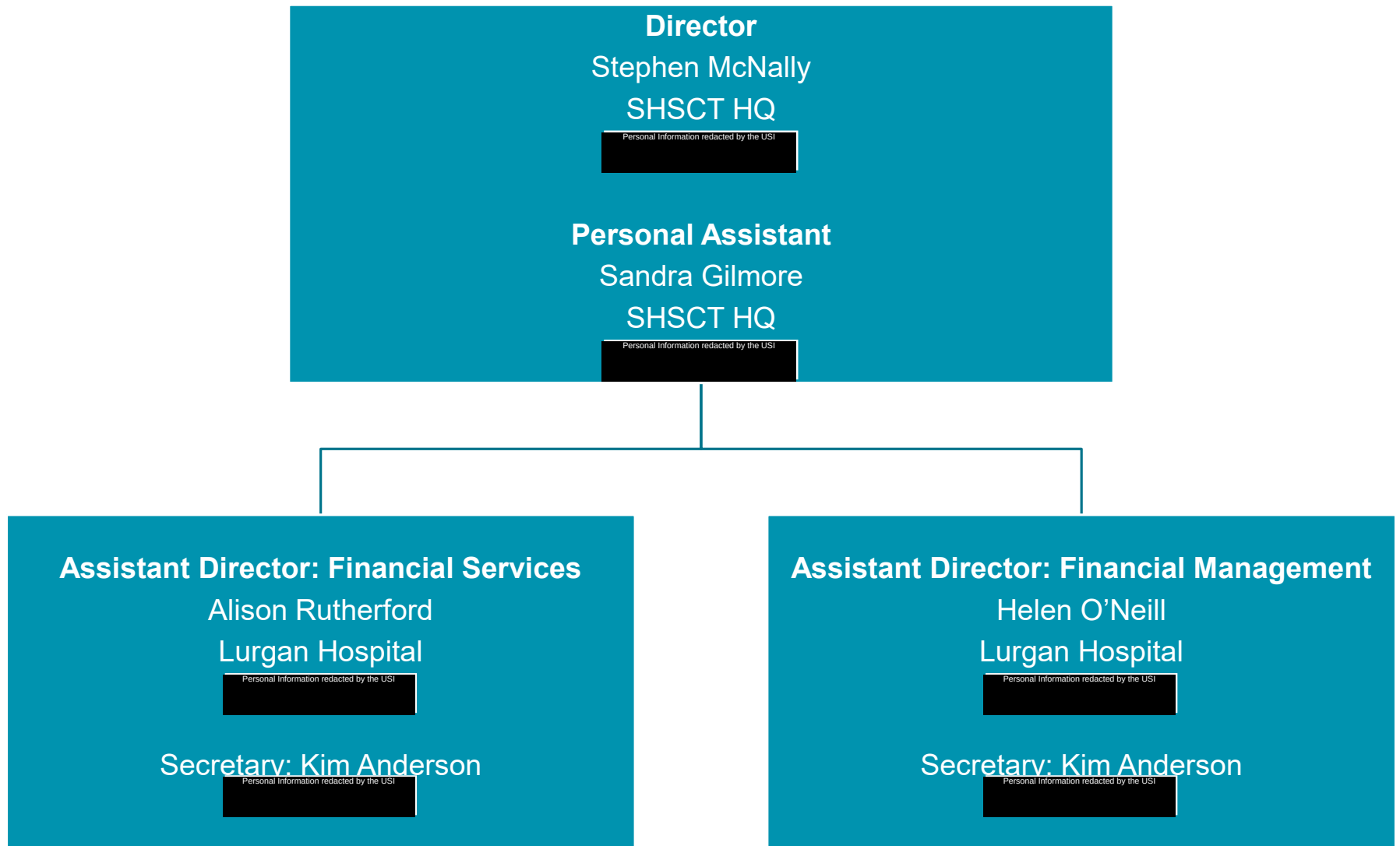
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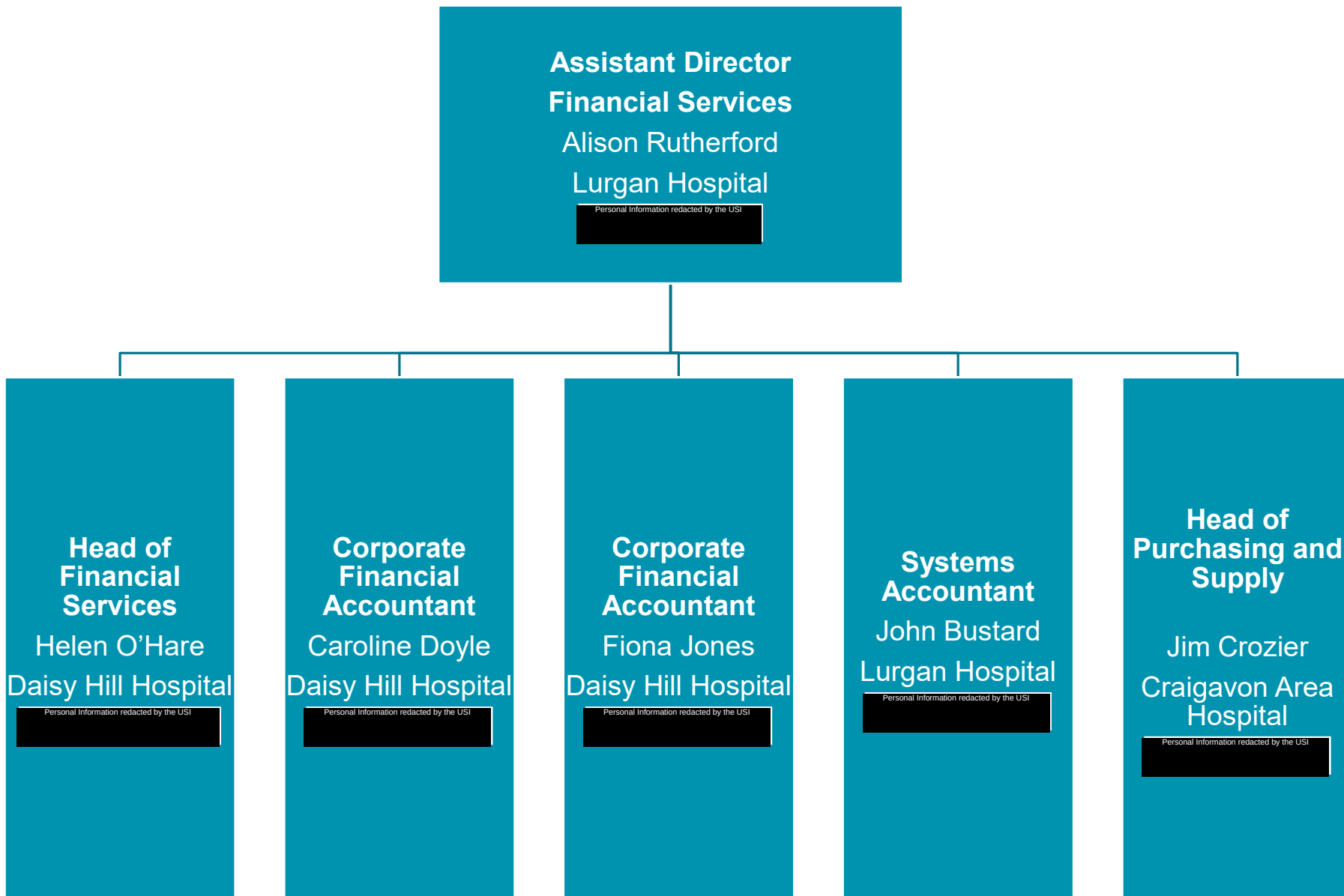
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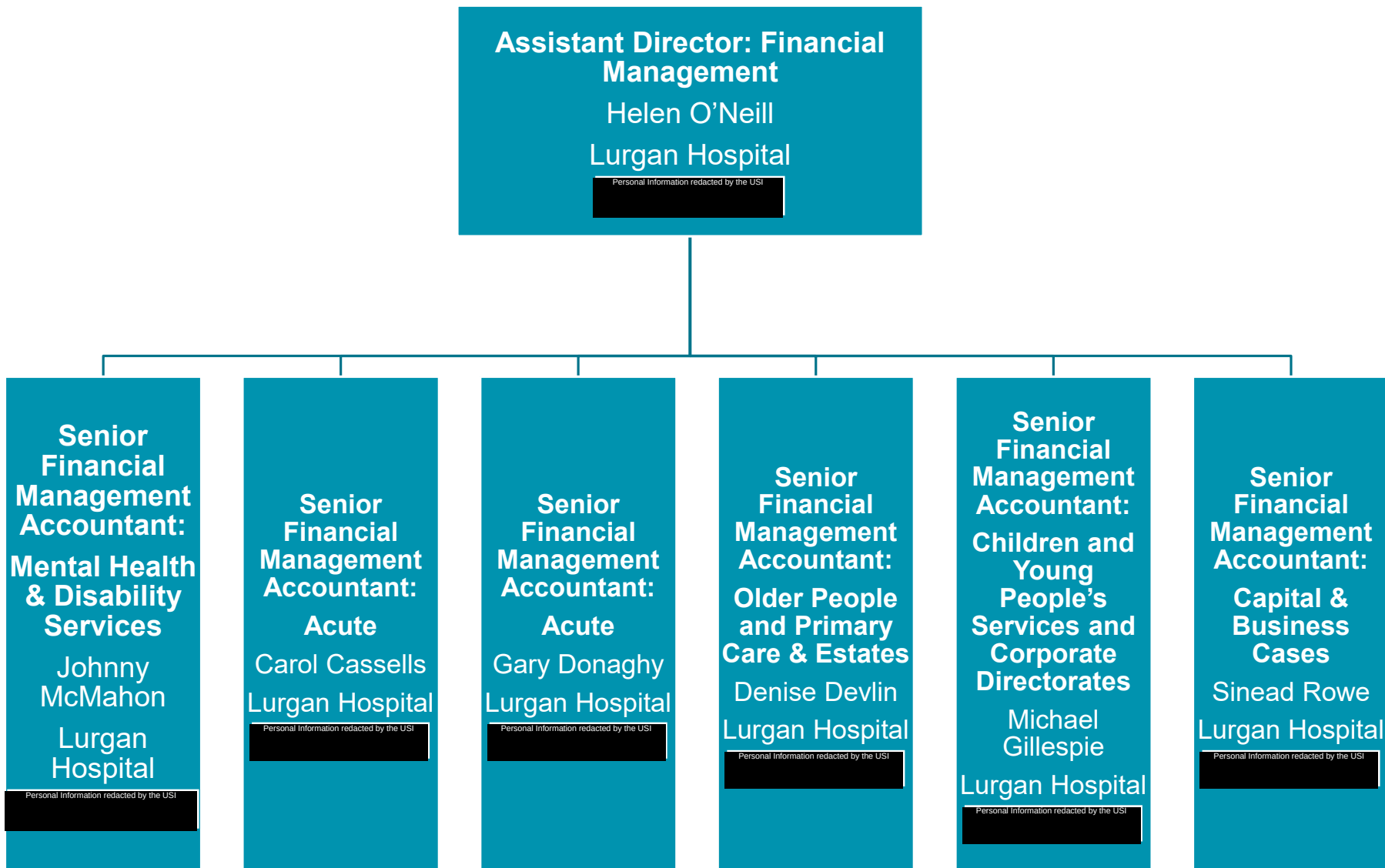
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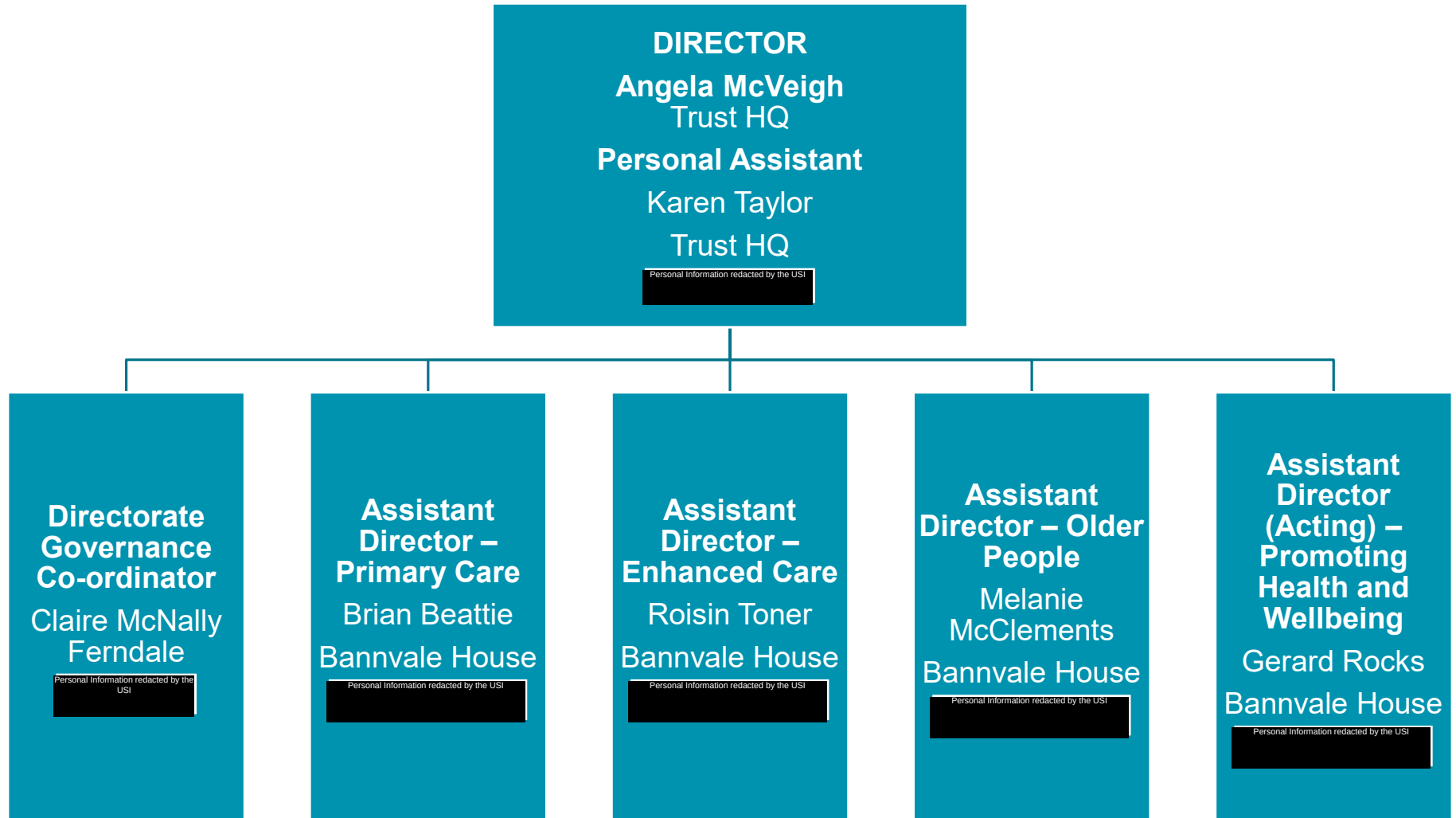
Directorate of Finance and Procurement

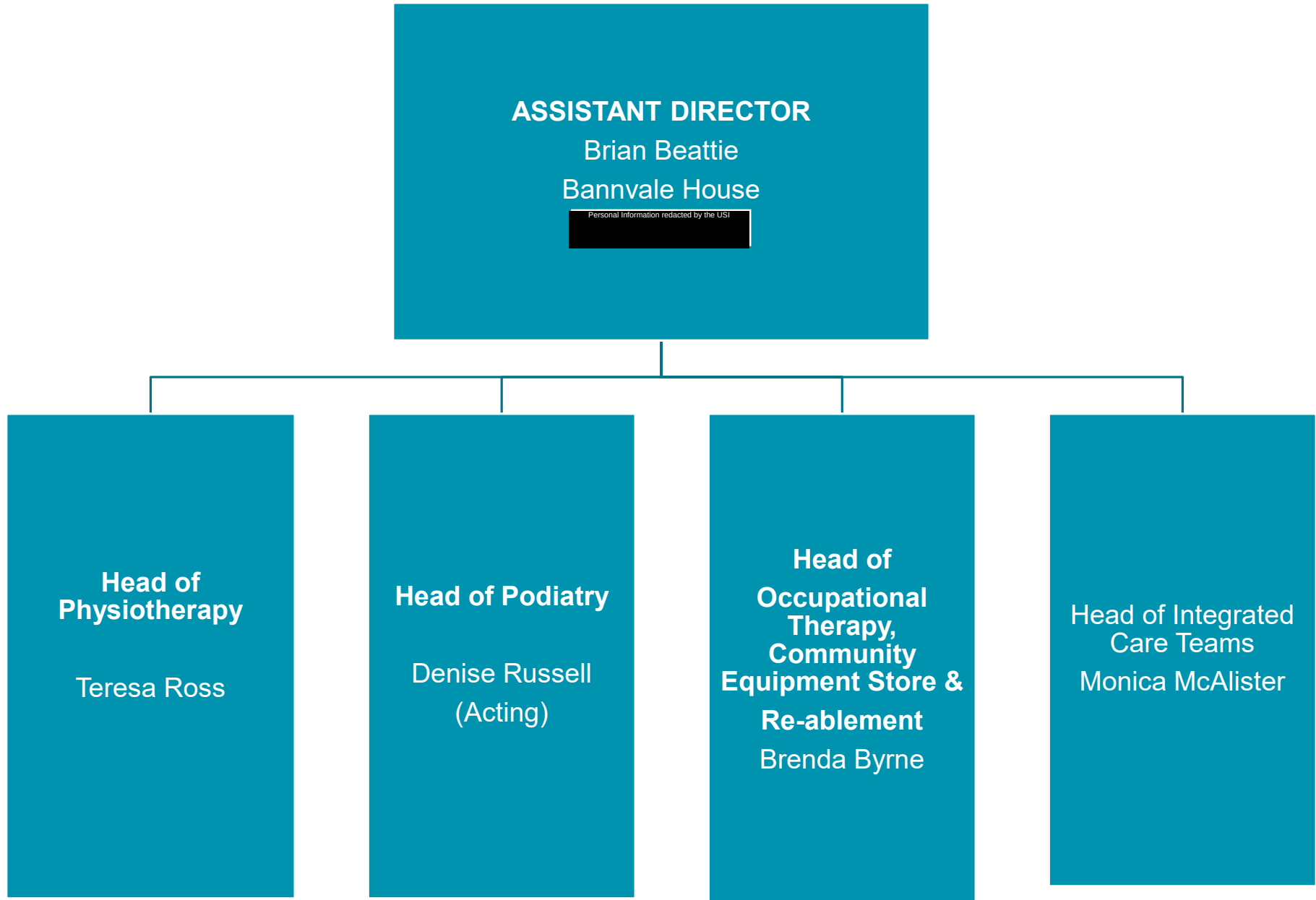


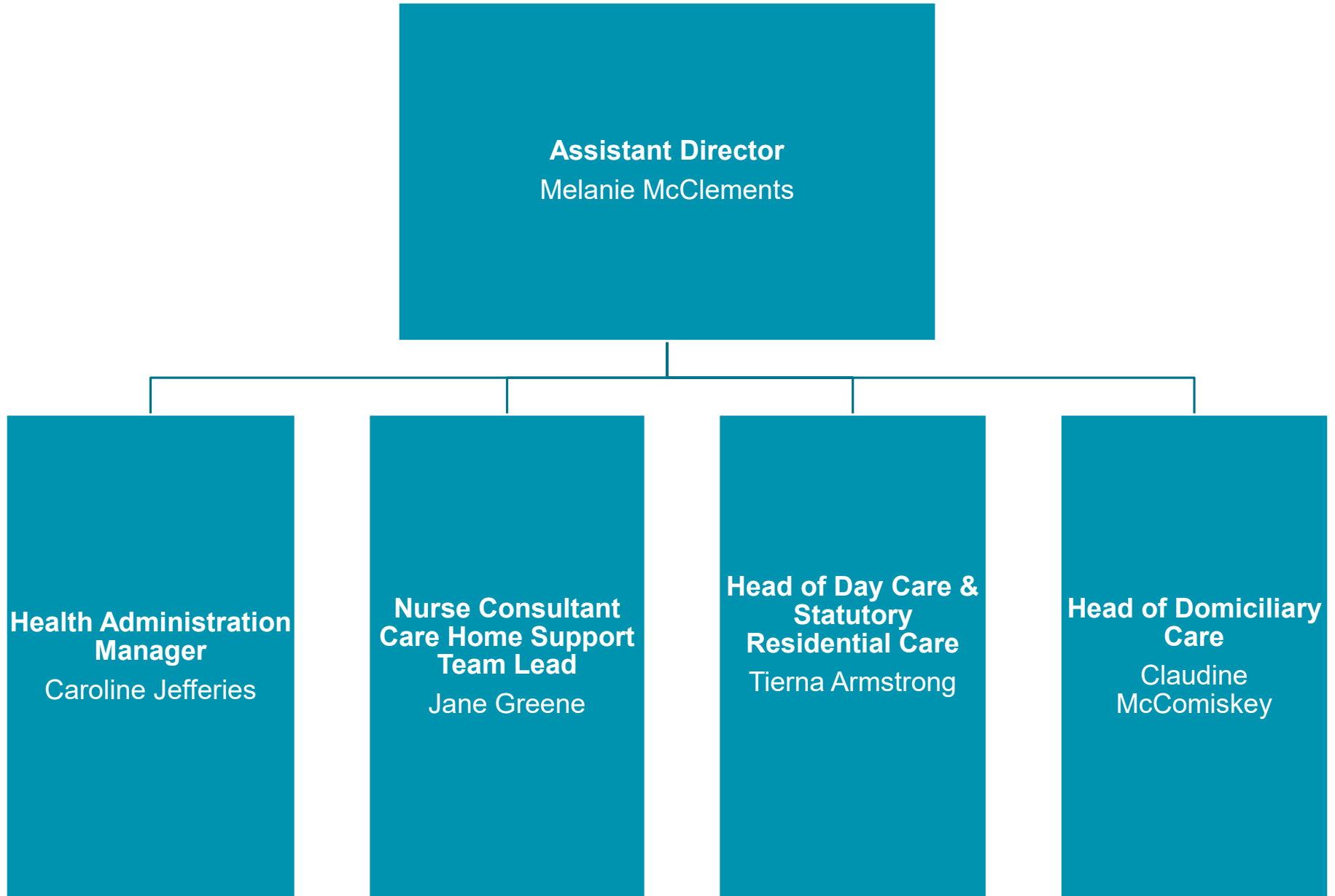


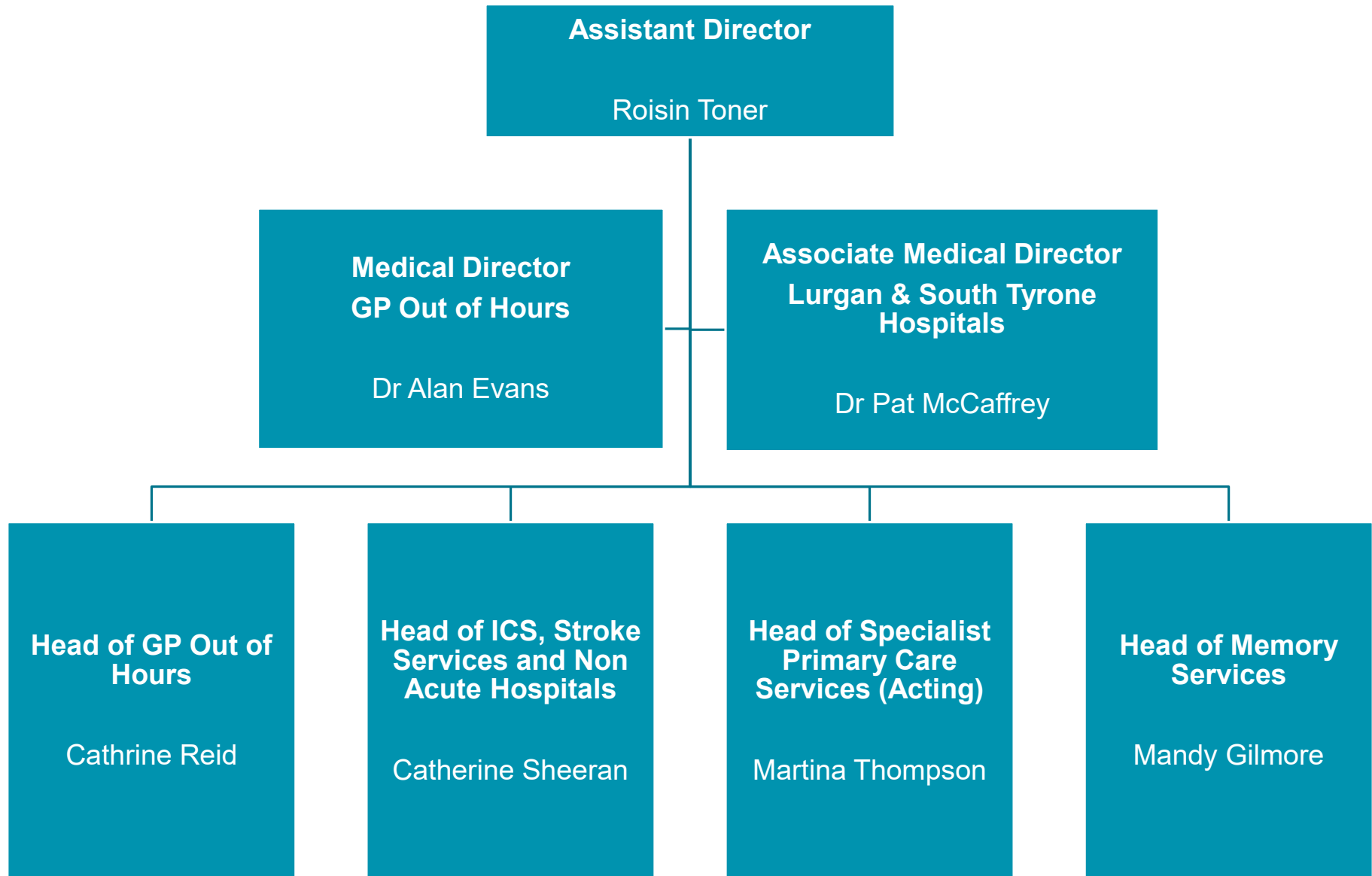


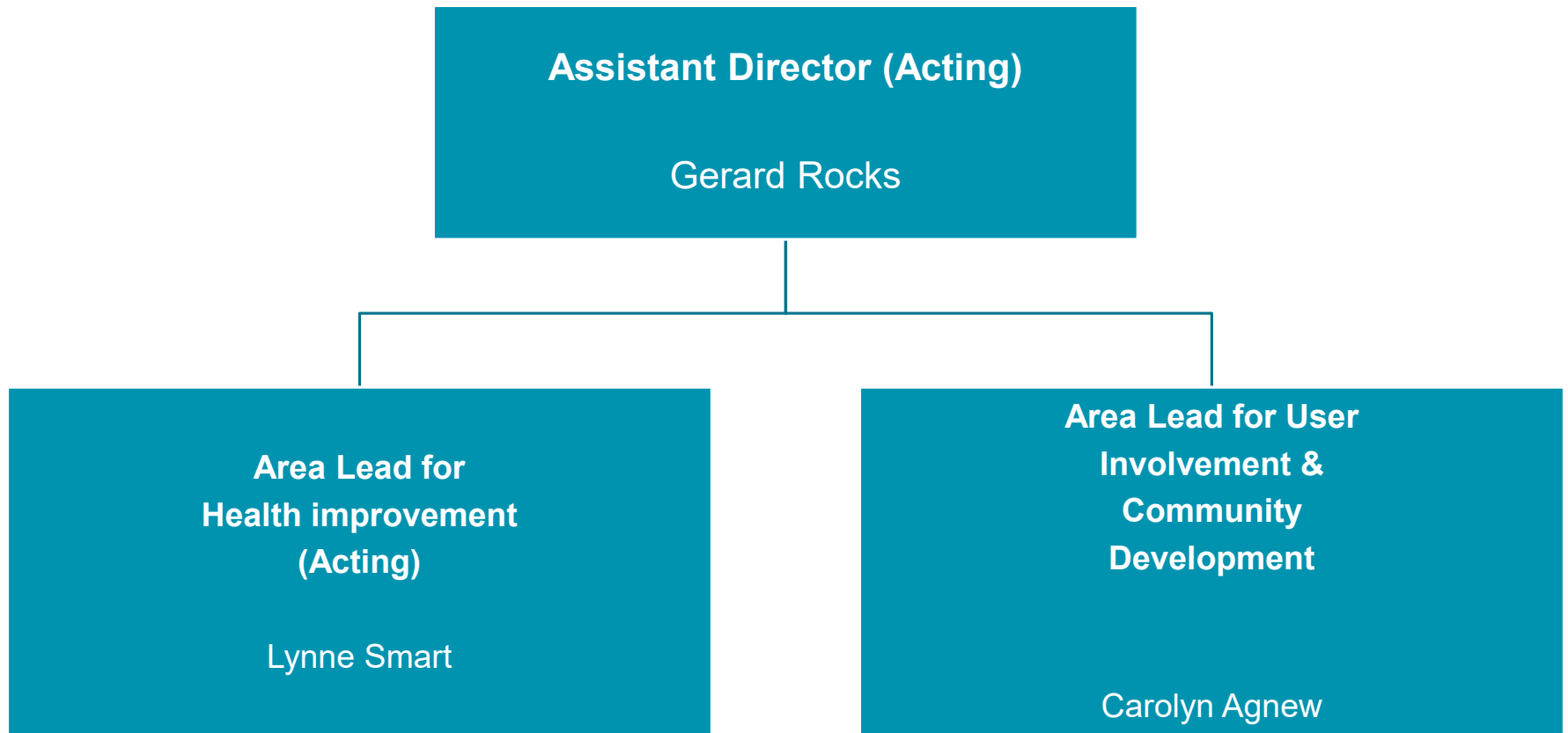
Directorate of Older People and Primary Care











Directorate of Performance and Reform

Director of Performance & Reform (Acting)

Aldrina Magwood

SH&SCT HQ

Personal Information redacted by the USI

Personal Assistant

Jane Murphy

SH&SCT HQ

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**Assistant Director of
Corporate Planning**

Charlene Stoops
The Brackens, CAH

Personal Information redacted by the USI

**Assistant Director of
Performance
Improvement**

Lesley Leeman
SH&SCT HQ

Personal Information redacted by the USI

**Assistant Director
Best Care Best Value
(Acting)**

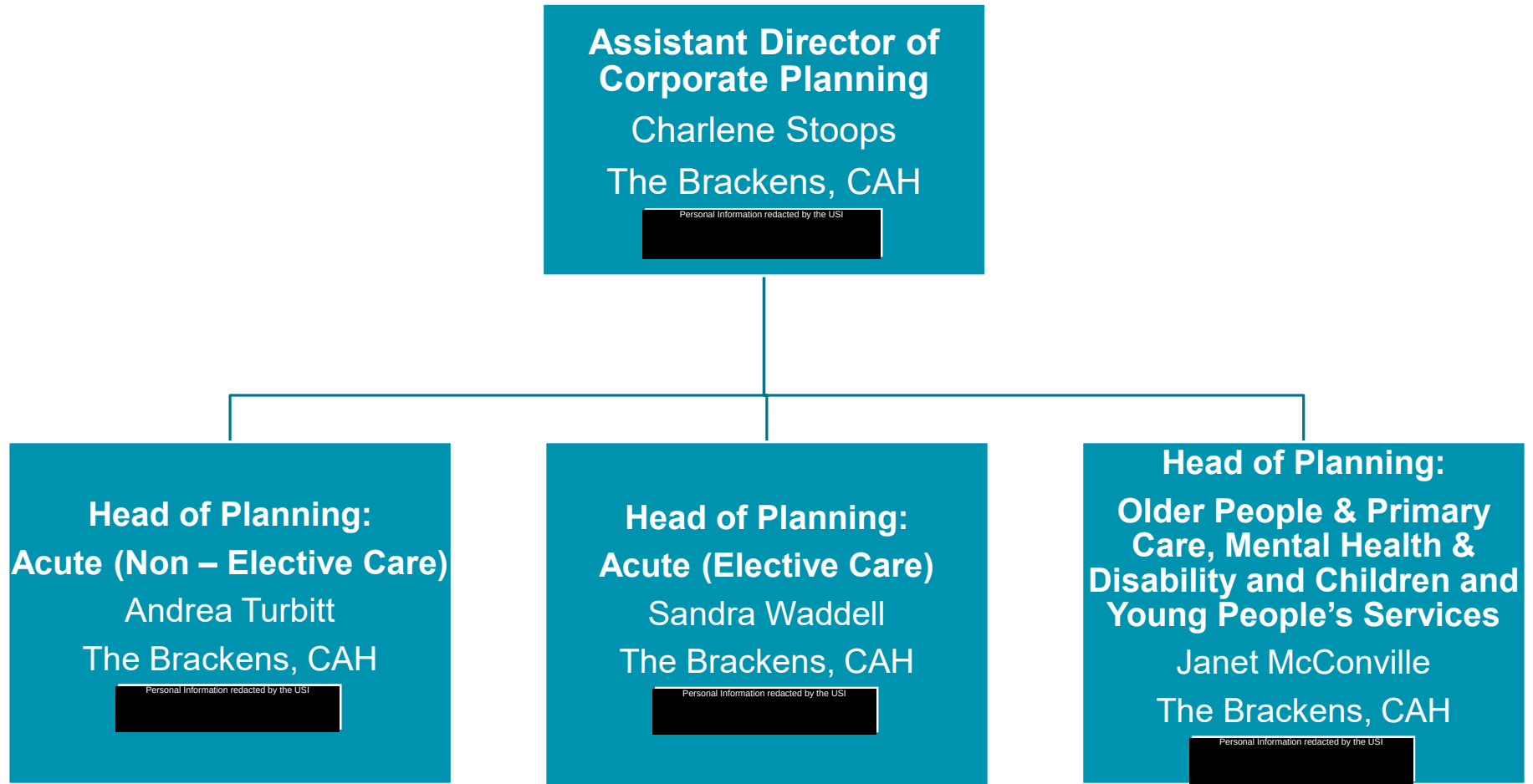
Paula Tally
SH&SCT HQ

Personal Information redacted by the USI

**Assistant Director
of Informatics**

Siobhan Hanna
Ferndale House,
Gilford

Personal Information redacted by the USI



**Assistant Director of
Performance Improvement**

Lesley Leeman
SH&SCT HQ

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**Head of Social Care
Contracts & Procurement**
Dawn Livingstone
The Rowans, CAH

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Head of Performance
Lynn Lappin
The Rowans, CAH

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**Assistant Director of Best Care
Best Value (Acting)**

Paula Tally
SHSCT HQ

Personal Information redacted by the USI

**Head of Continuous
Improvement**

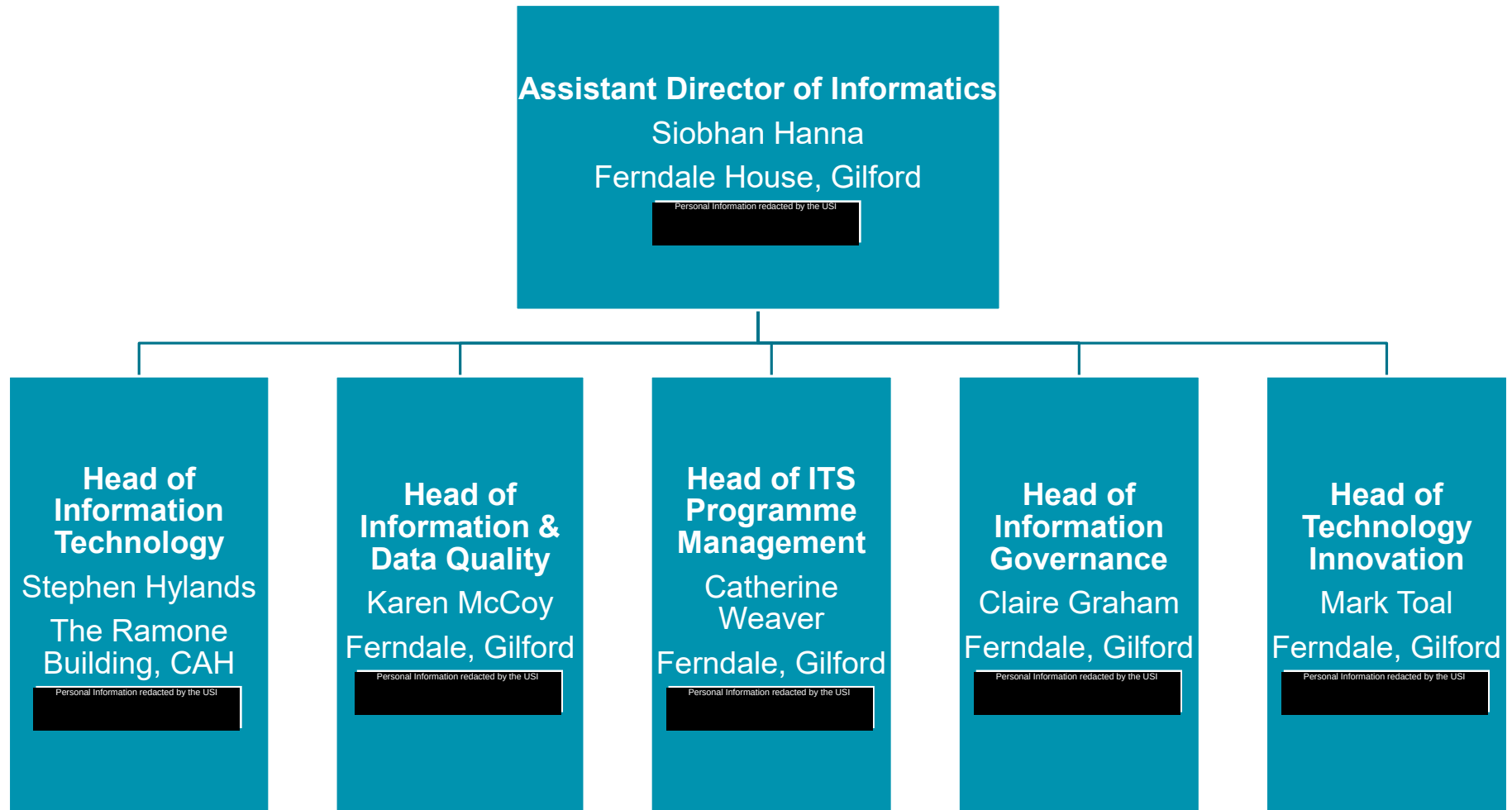
Jacqueline Morton
The Rowans, CAH

Personal Information redacted by the USI

**Best Care Best Value
Project Manager**

Claire Kelly
The Rowans, CAH

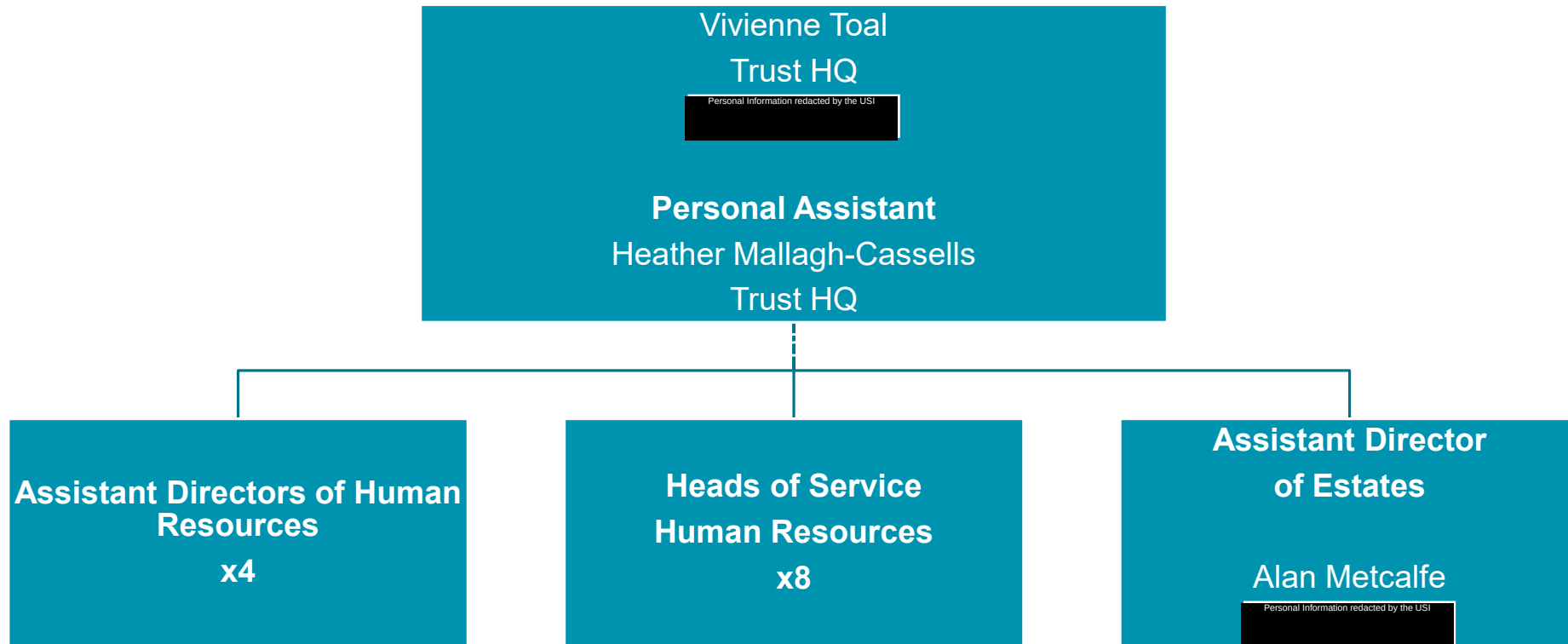
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Directorate of Human Resources and Organisational Development

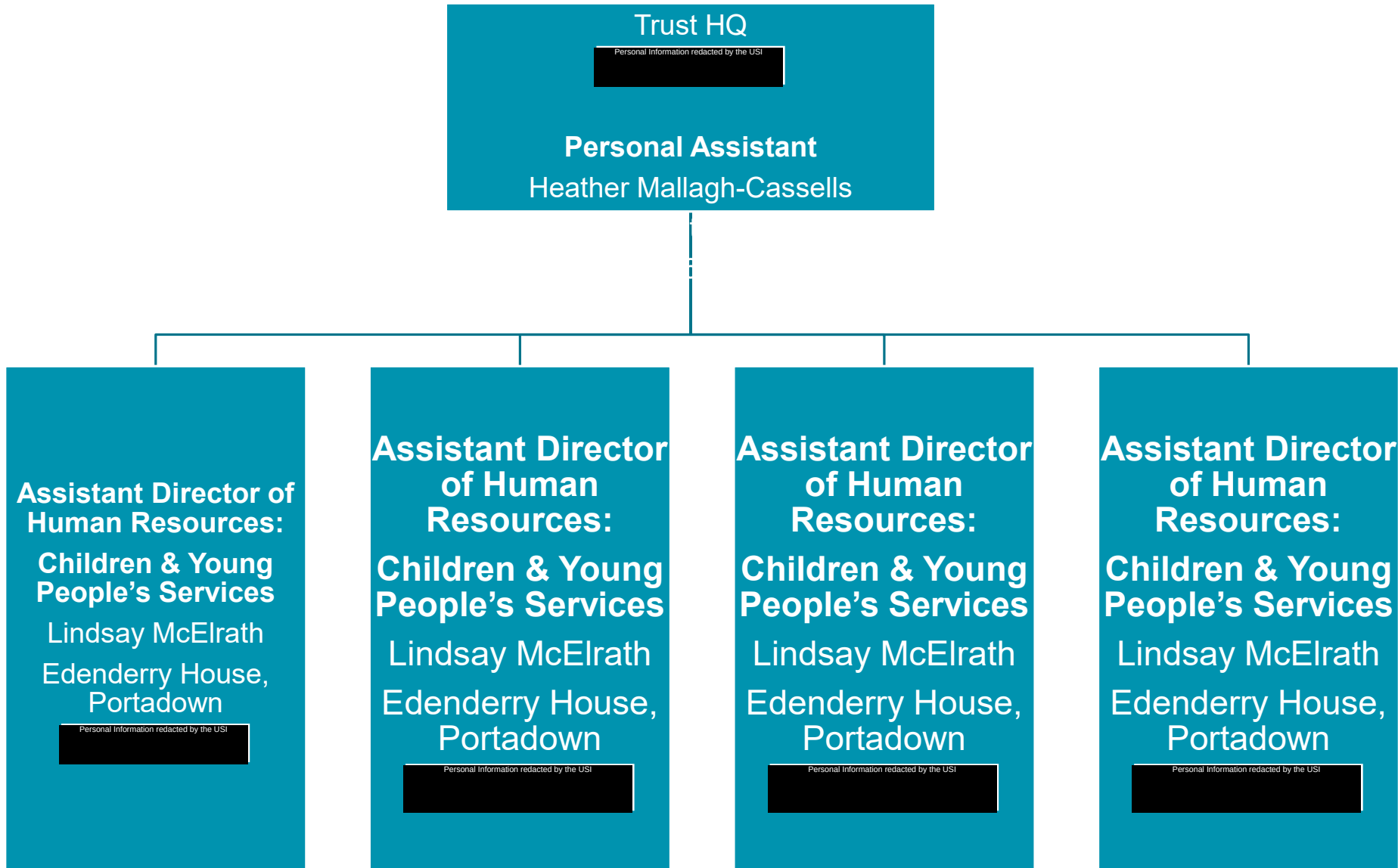
Directorate of Human Resources and Organisational Development

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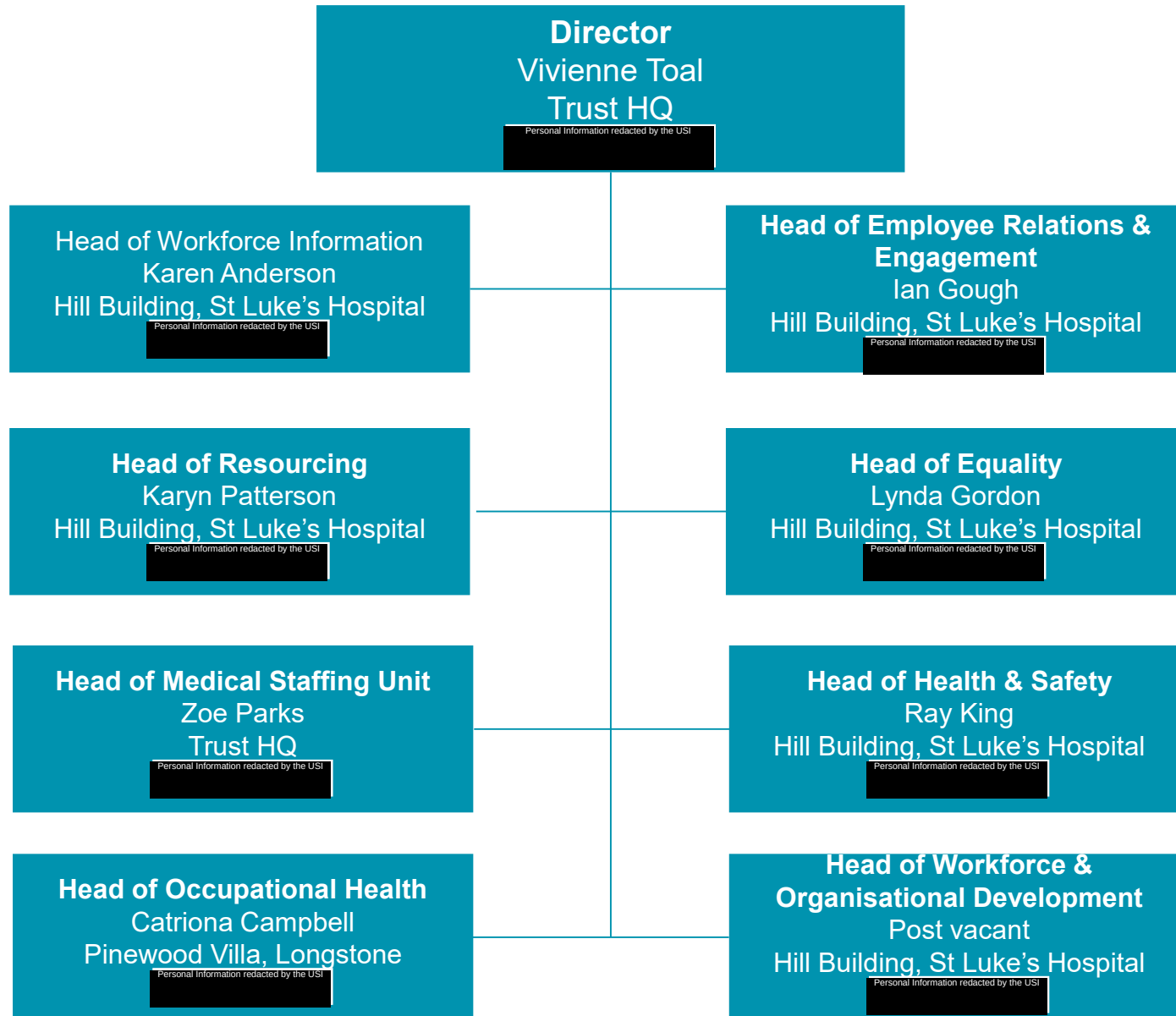
Directorate of Human Resources and Organisational Development

WIT-37923



Directorate of Human Resources and Organisational Development

WIT-37924



Medical Directorate

Medical Directorate

WIT-37926

MEDICAL DIRECTOR
Dr Richard Wright
Personal Assistant
Laura White

Personal Information redacted by the USI

ASSISTANT DIRECTOR
Simon Gibson
Ruth Montgomery
Administrator

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**Infection
Control**
Colin Clarke

**Project
Managers**
Stephen
Wallace

**Research &
Development**
Irene Knox

**Medical
Education**
Kelly Jones

**Revalidation
Manager**
Norma
Thompson

**Emergency
Planning**
Teresa
Cunningham

Dr Martin Brown
Margaret Markey
Josie Matthews
Kate Kelly
Annette O'Hara
Barbara Soye
Elizabeth Rennie
Douglas Barbieri
(in CAH)

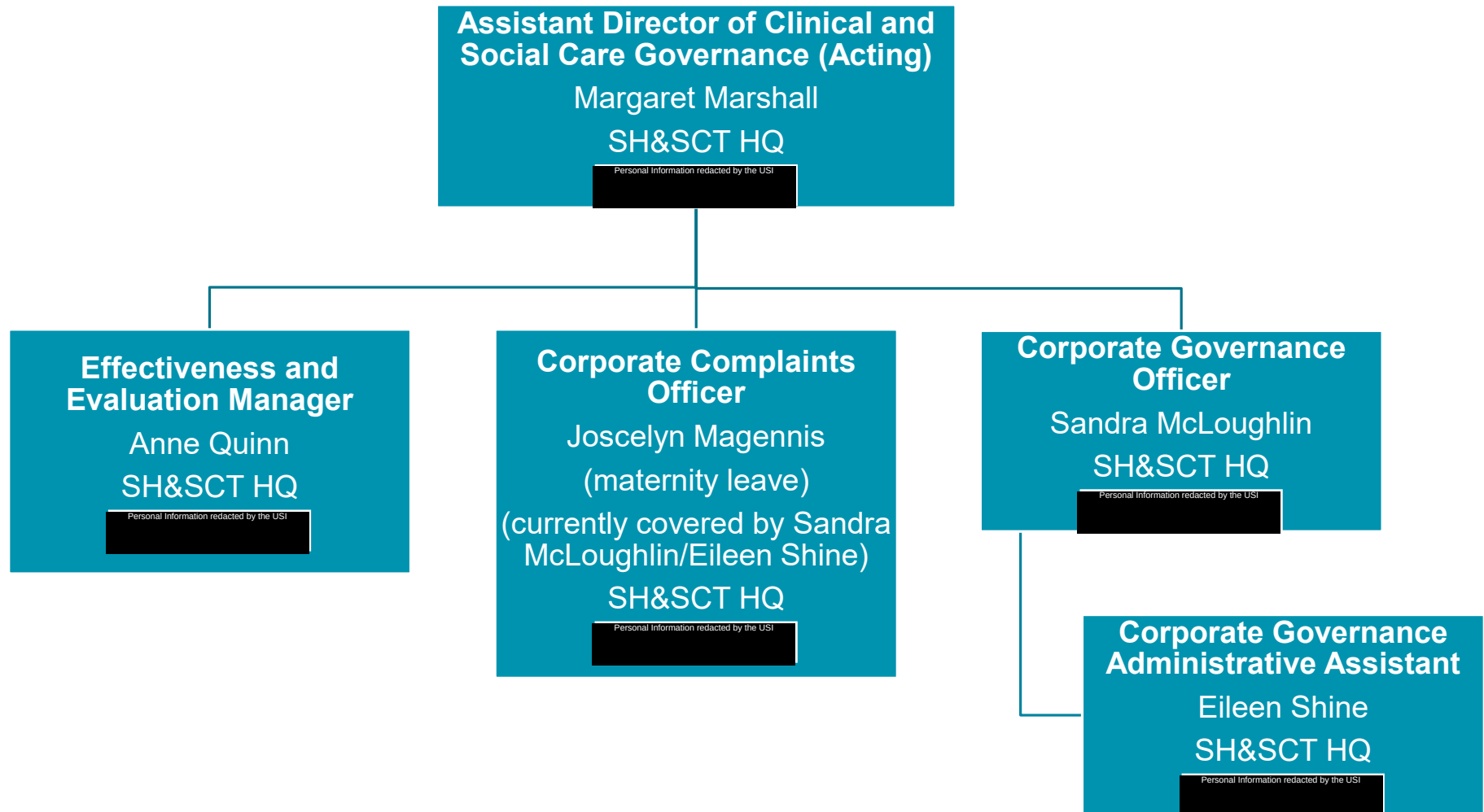
Roisin Feely
(DHH)
(maternity
leave)

Valerie
Hamilton
Mairead
McAreavey
(in CAH)

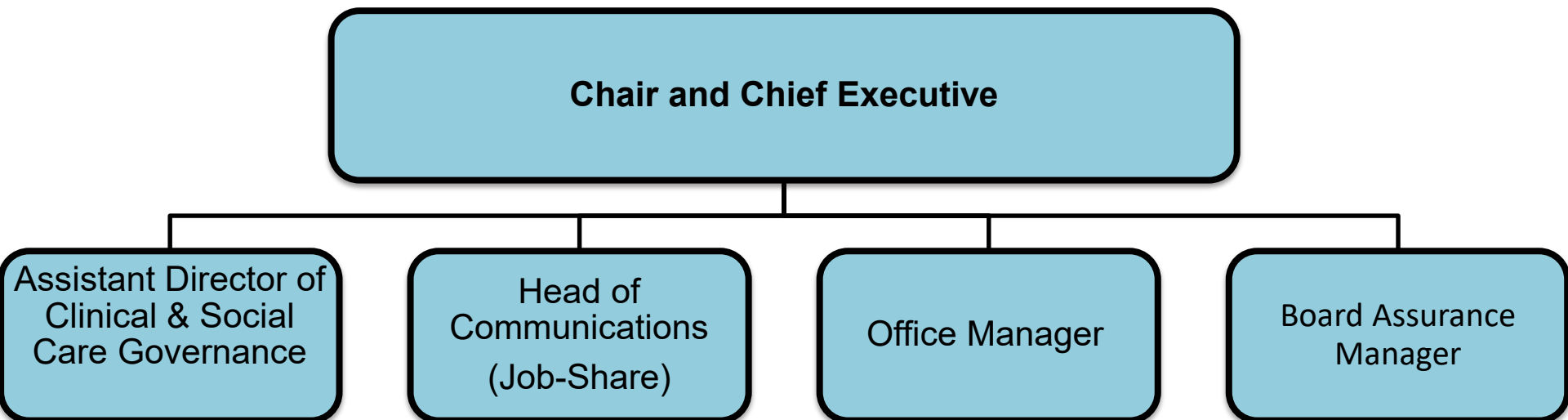
Lenore Peile
Eoin Daly
(in CAH)
Sonia Ferris
Siofra
McSherry (in
DHH)

Katie Shields
Patrick
Morrison
(in DHH)
Diane Davidson
Elizabeth
McCreary
(in CAH)

Ann Corvan
(in DHH)



OFFICE OF THE CHAIR AND CHIEF EXECUTIVE



Chair and Chief Executive's Office SH&SCT Headquarters

Chair: Roberta Brownlee
Chief Executive: Paula Clarke

Personal Information redacted by the USI

Personal Information redacted by the USI

Office Manager
Elaine Wright

Personal Information redacted by the USI

Board Assurance Manager
Sandra Judt

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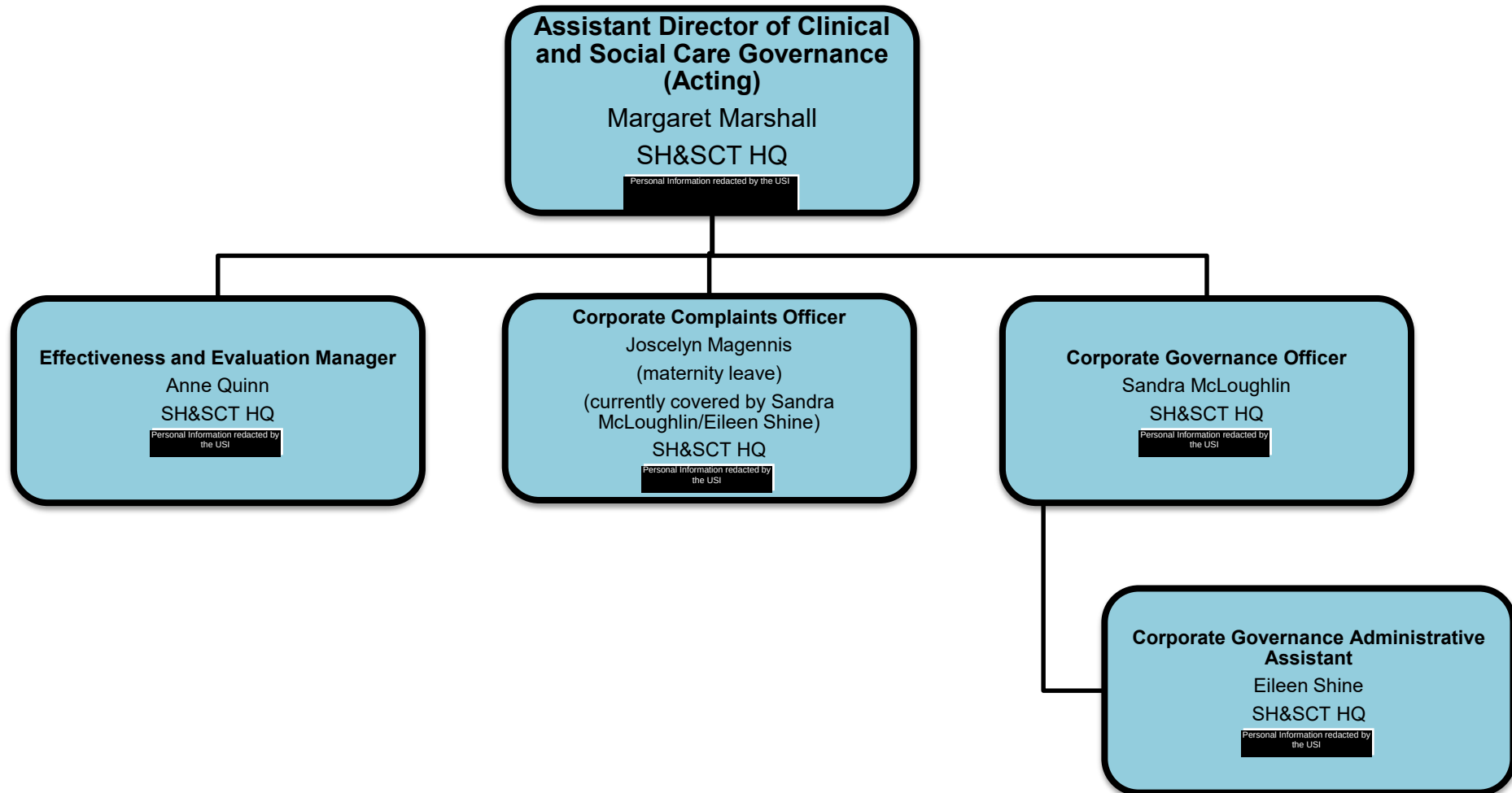
Personal Assistant to Chair
Jennifer Comac

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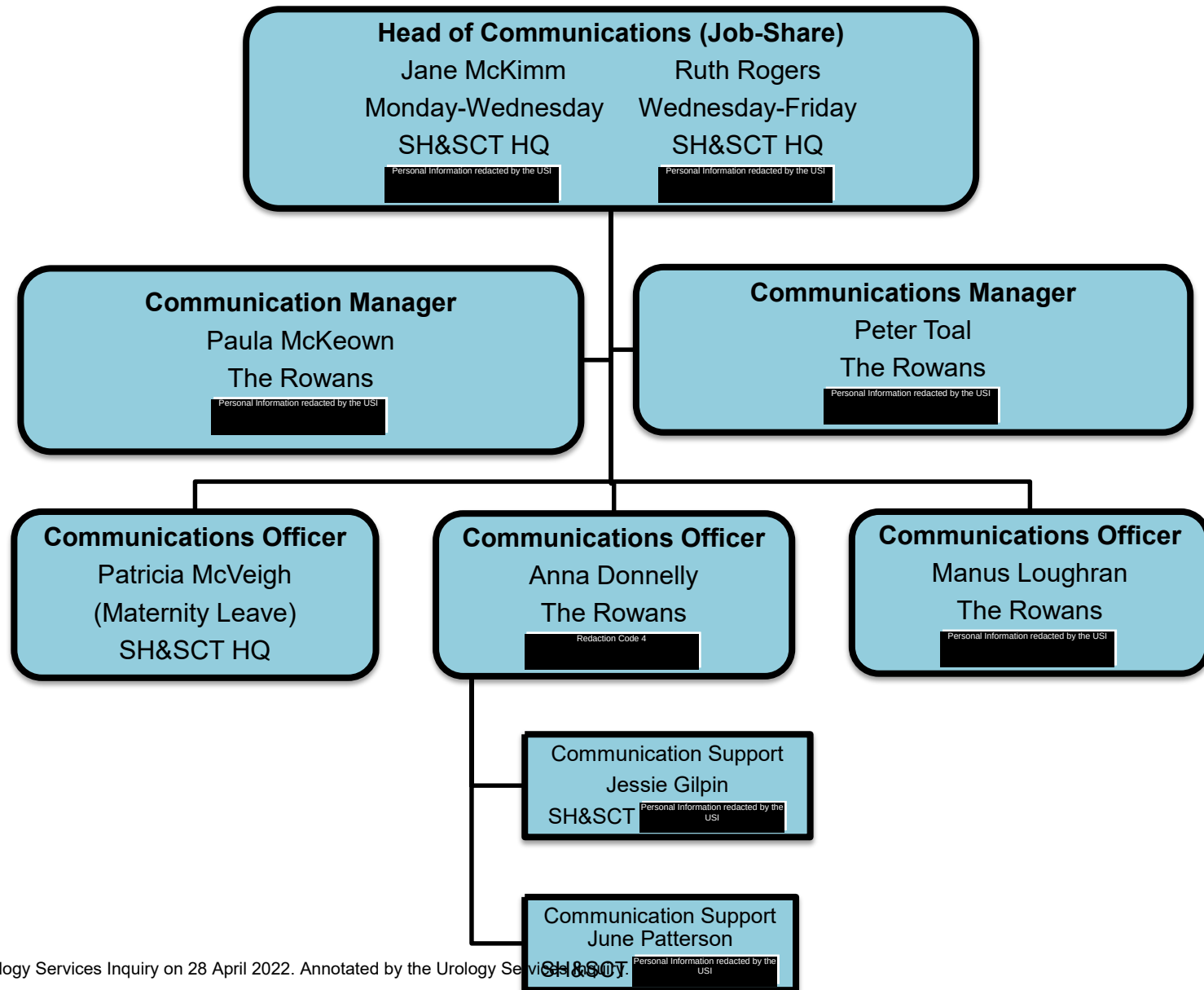
Committee Secretary
Susan McCormick

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Corporate Clinical & Social Care Governance Team

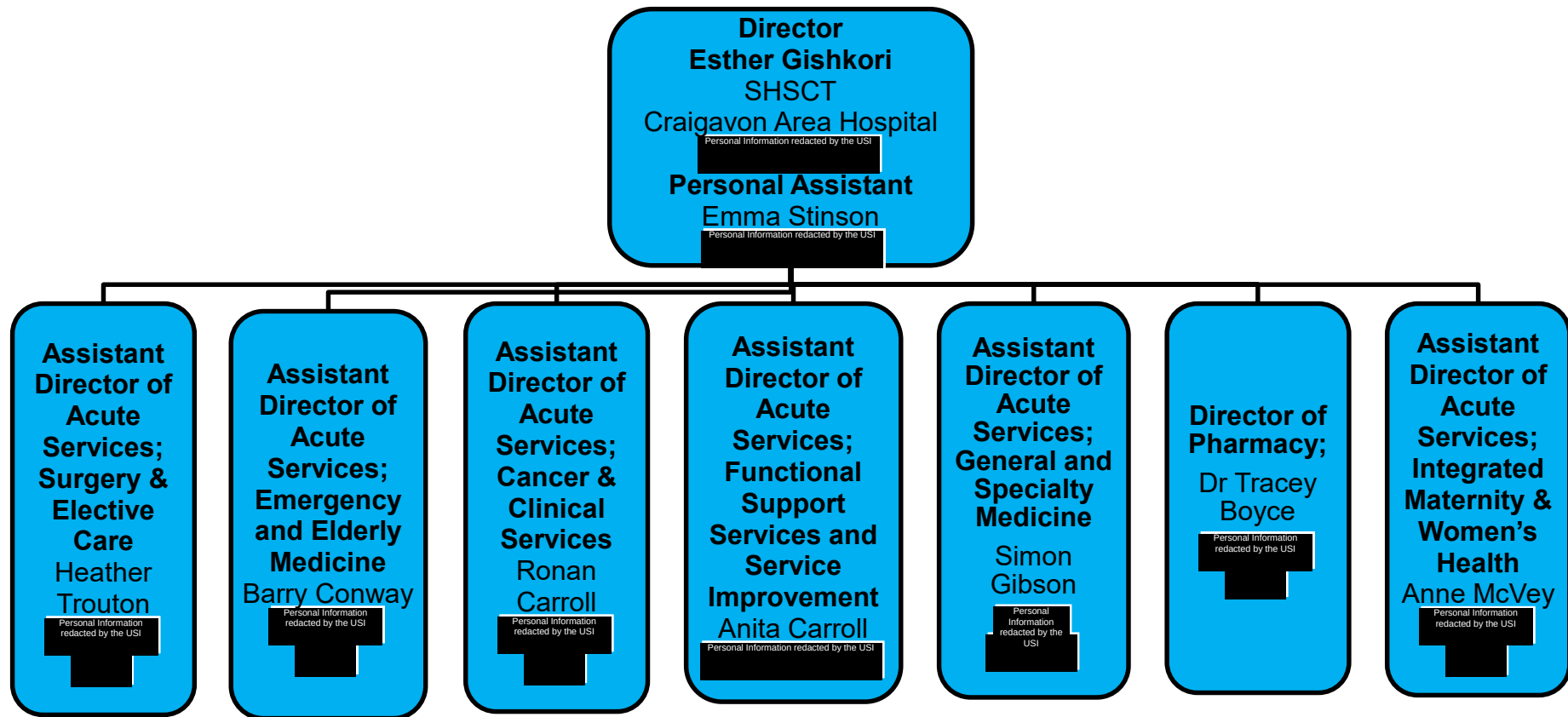


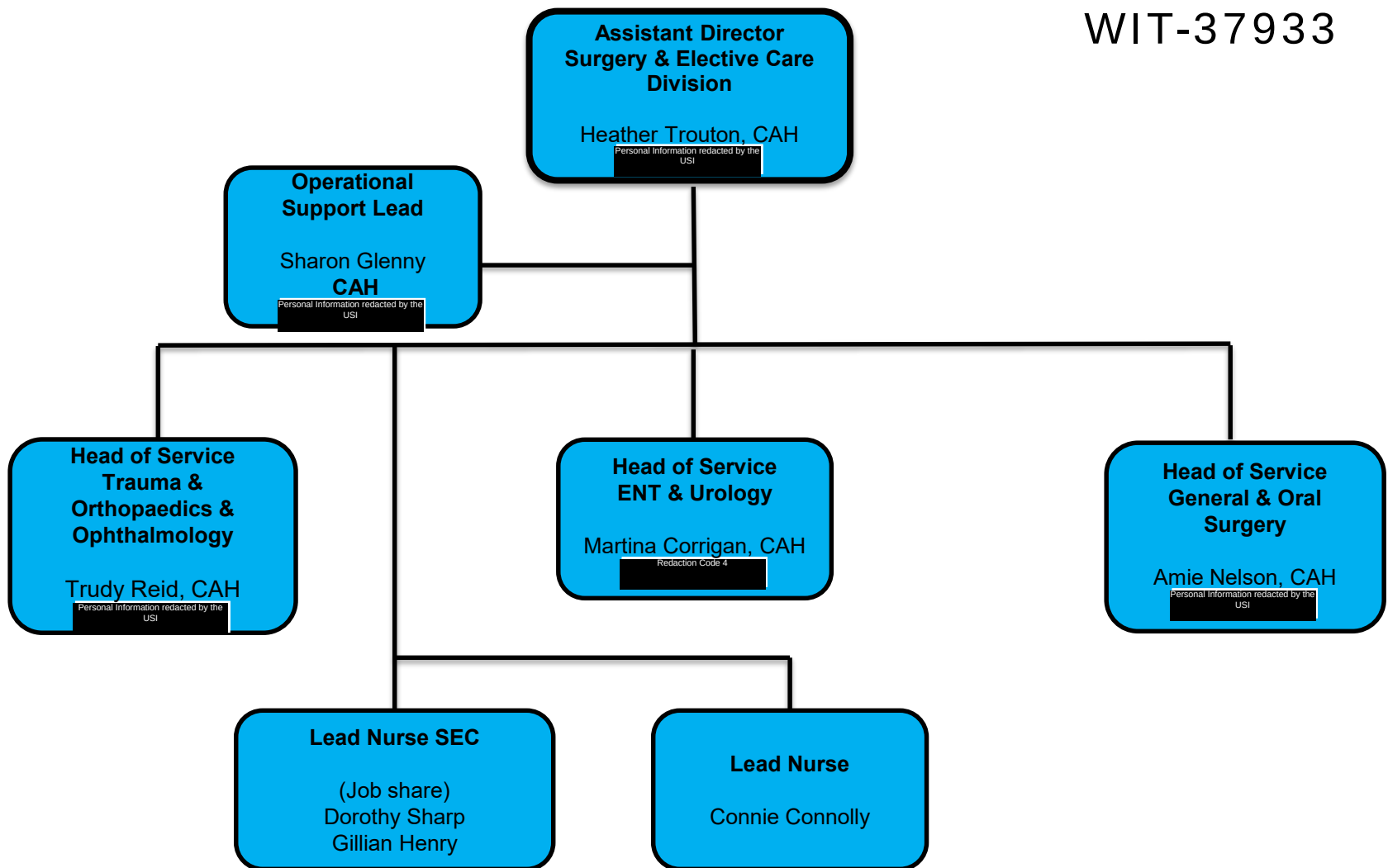
Communications Team

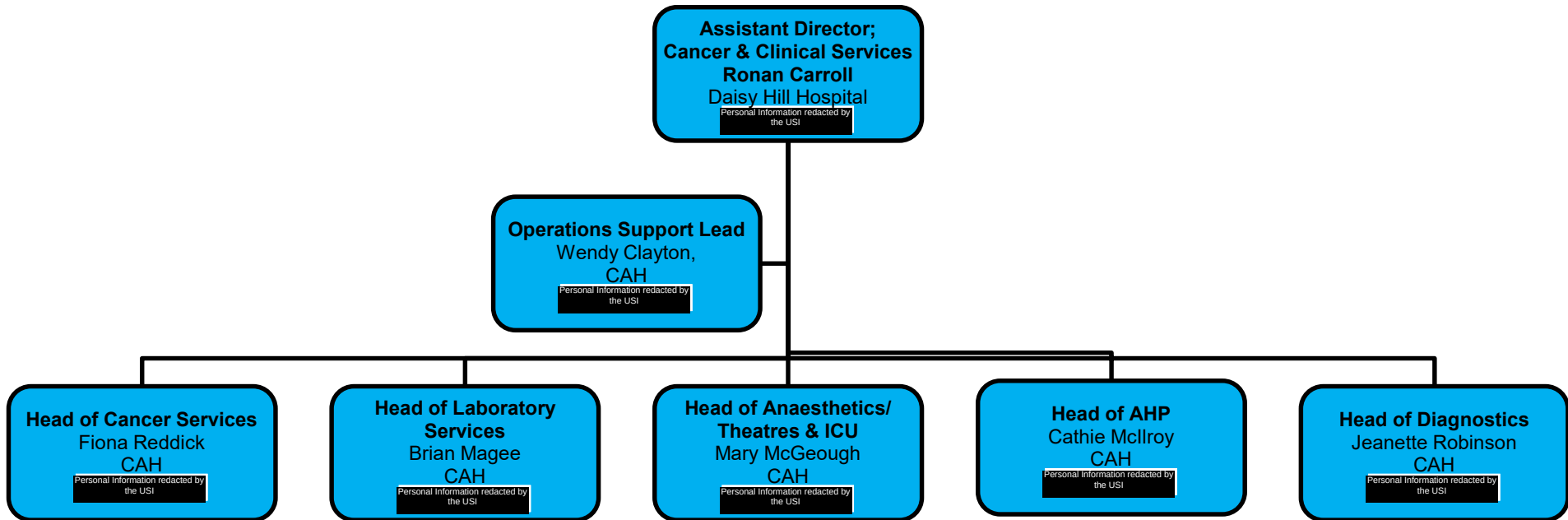


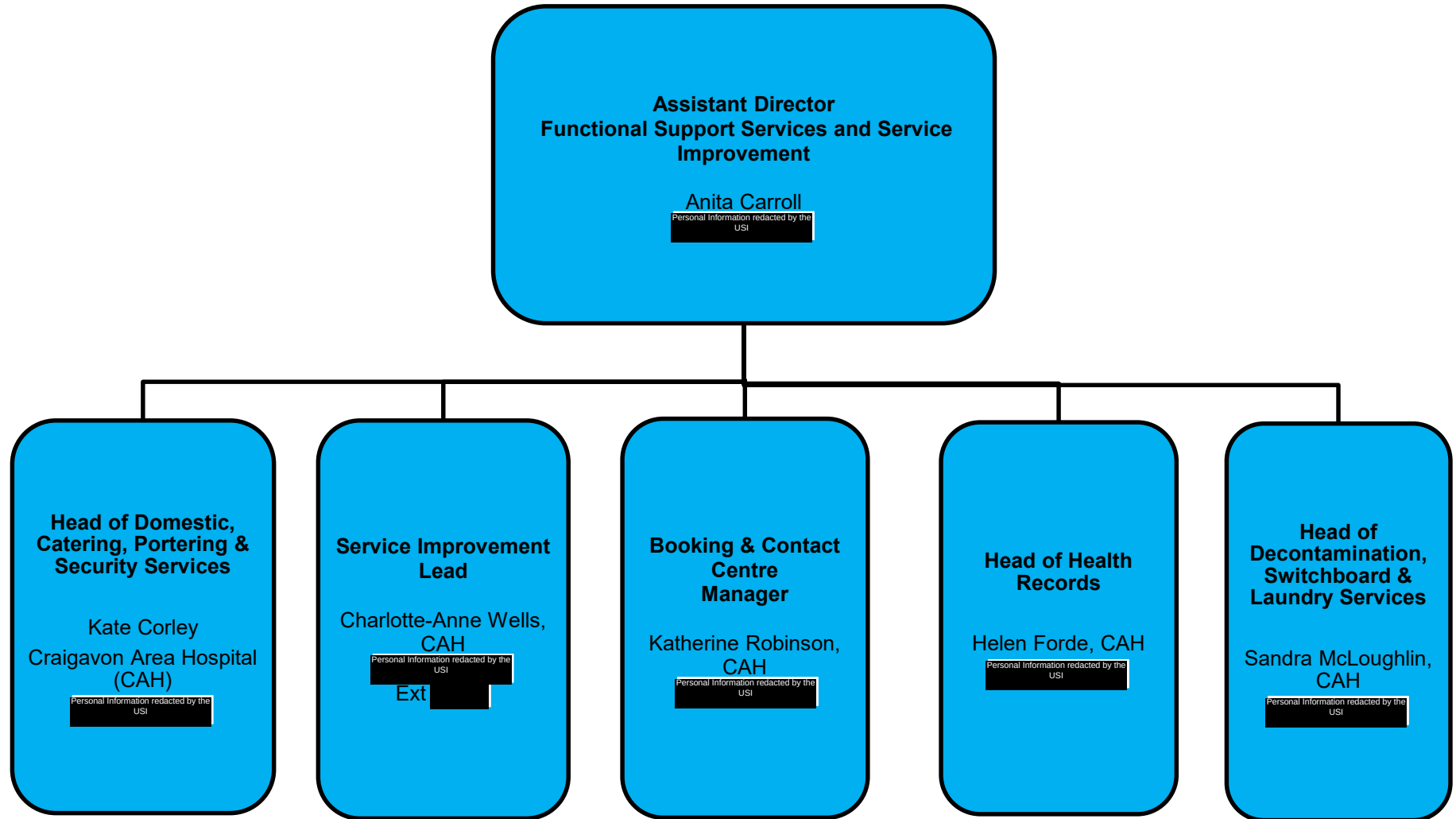
Directorate of Acute Services

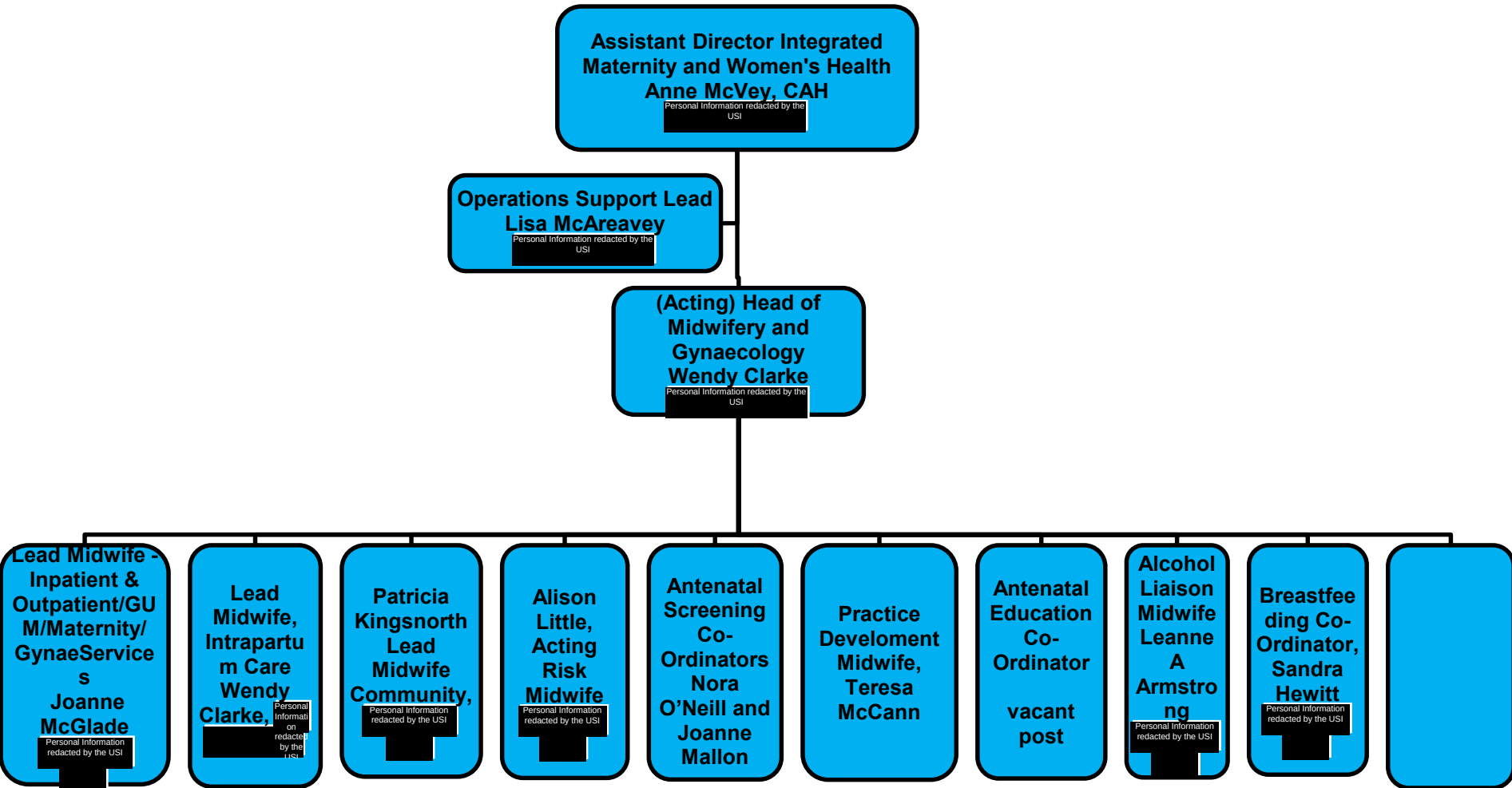
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**Assistant Director,
Medicine &
Unscheduled Care**
Barry Conway

Personal Information redacted by the USI

Mary Burke

Personal Information redacted by the USI

Specialties

Acute Medicine
Emergency Medicine

Ward/Departments

Emergency
Departments (2)
Emergency Dental
Service
MAU
Minor Injuries Unit
Winter Ward, CAH

Ruth Donaldson

Personal Information redacted by the USI

Ward/Departments

Social Work, CAH
Social Work, DHH
Social Work, Lurgan

**Caitriona
McGoldrick**

Personal Information redacted by the USI

Specialties

Acute Geriatric
Ortho-Geriatric
Rehabilitation
Stroke
Wards/Departments
Level 6, DHH
2 South Medicine,
CAH
2 South Stroke, CAH

Professional Lead

1 South, CAH
DCC, CAH

Edel Corr

Personal Information redacted by the USI

Wards/Departments

Patient Support,
CAH
Patient Support,
DHH
Chaplaincy Services

Patricia Loughan

Personal Information redacted by the USI

Wards/Departments

Patient Flow, CAH
& DHH
Phlebotomy
Services
Hospital at Night
Services

Simon Gibson

Personal Information redacted by the USI

**Assistant Director,
Medicine &
Unscheduled Care**

Kay Carroll

Personal Information redacted by the USI

Specialties

Cardiology
Dermatology
Neurology

Wards/Departments

Cath Lab
1 North, CAH
Neurology Centre
Dermatology Centre
2 North Haematology

Louise Devlin

Personal Information redacted by the USI

Specialties

Diabetes/Endo
Gastroenterology
Rheumatology

Wards/Departments

1 South, CAH
DCC, CAH

Service Lead

Medical Rotas

Catriona Kavanagh

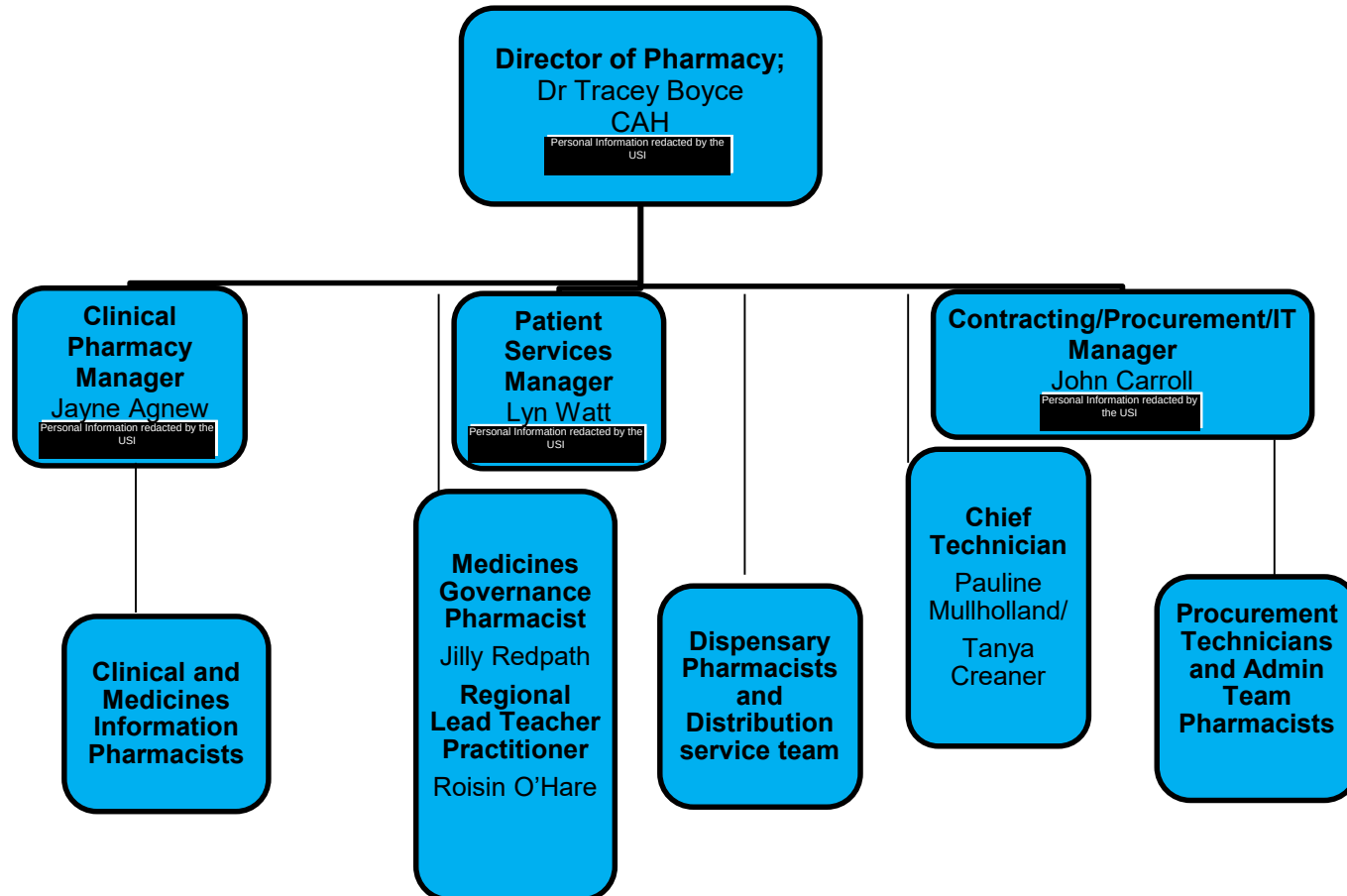
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Specialties

Respiratory
Nephrology

Wards/Departments

Renal Unit, DHH
Female Medical, DHH
Male Medical, DHH
2 North Respiratory,
CAH
DCC, DHH





Southern Health and Social Care Trust

Consultation on Proposed Structures for Clinical and Social Care Governance

Consultation Period (1st Dec to 14th Dec 2010)

“A SYSTEM OF TRUST”

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SECTION 1: Context

Introduction

In September 2010 the Trust Governance Committee approved the initial findings and recommendations of the Review of Clinical & Social Care Governance. The document, previously circulated, (see Appendix I) recommended a model for clinical and social care governance (CSCG) within the Southern Trust and the rationale for the proposed model. This consultation document is an addendum to the review, summarising it, but with the specific purpose of proposing how the review recommendations could be translated into new organisational structures which would deliver high quality CSCG and with the aim of consulting the wider workforce on these structural proposals.

Background

The Southern Health and Social Care Trust (the Trust) is committed to **providing safe, high quality care**. Key to the achievement of safe, quality care is effective structures, systems and processes to ensure that standards for services, care and our workforce are agreed, understood, implemented monitored and reported, and that where these standards are not met, this is known at all levels in the organisation and effective actions are taken to address any gap and manage any resultant risks.

In the current and future environment, with increasing standards for safety and quality of care, rising public and political expectations and reducing resources, it is even more important that Trust Board and staff at all levels are focused on the delivery of safe care; that there are systems in place to measure and assure our compliance with key standards, and systems and processes to quickly and effectively address any gap in compliance which could impact on the delivery of safe care. Where compliance is not possible within our resources, it is equally important that the Trust understands the constraints in

achieving compliance and the resulting risks, effectively communicating these both internally and to our commissioner and DHSSPS.

Service Reviews from England and elsewhere have highlighted organisational and practice issues which have resulted in poor quality, and in some cases unsafe care. The Mid Staffordshire NHS Foundation Trust Inquiry and the resultant reports provide an important framework against which to judge our capability to provide safe, high quality care.

It is in this context that the Senior Management Team of the Trust commissioned a review of CSCG arrangements within the Trust.

Purpose and Objectives of Review

The review was commissioned by the Acting Chief Executive and SMT in March 2010 with the remit to critically appraise the Trust's current operational and assurance systems in relation to CSCG, including processes, capacity, capability and outcomes from the current system (see Appendix 2 for Terms of Reference).

Methodology

The Review, while intending to satisfy its terms of reference and benchmark the organisation against the findings of Independent Inquiries in other Trusts, for example the Mid Staffordshire Inquiry, adopted a very basic and fundamental template on which to assess the current CSCG system and make recommendations for improvement. Four basic questions were considered in the examination of the current roles, responsibilities, accountability arrangements and systems, and the resolution of these questions shaped and informed the Senior Management Team (SMT) recommendations:

1. What does the Trust mean by clinical and social care governance – what are its components?
2. Who is responsible and accountable for delivering these components?
3. How does the Trust deliver these components?

4. What products does the Trust get from these components, and will these products address the findings and recommendations of other Inquiries?

The methodology adopted within the Review considered each of these questions against the current position and derived recommendations for improvement, based on best practice literature and interviews with all key staff groups including the Medical Directorate and the CSCG team within that, professional governance staff from Medicine, Nursing, Social work and Allied Health Professionals (AHP's) and operational staff from all Directorates and all disciplines. The emerging issues and associated professional views were presented to SMT on an ongoing basis and worked through in a series of SMT workshops. The recommendations emerging from these workshops were endorsed by the Trust Governance Committee in September 2010 and have formed the basis of this consultation document.

SECTION 2:

Rationale for Change

During the review, while within the Southern Trust it was evident that although there were no major operational shortcomings identified with respect to patient safety and quality of care, a number of significant system and organisational issues emerged. Through a series of workshops SMT produced recommendations and developed a pathway for change and improvement to the CSCG systems and processes within the Trust. The recommendations are summarised below:

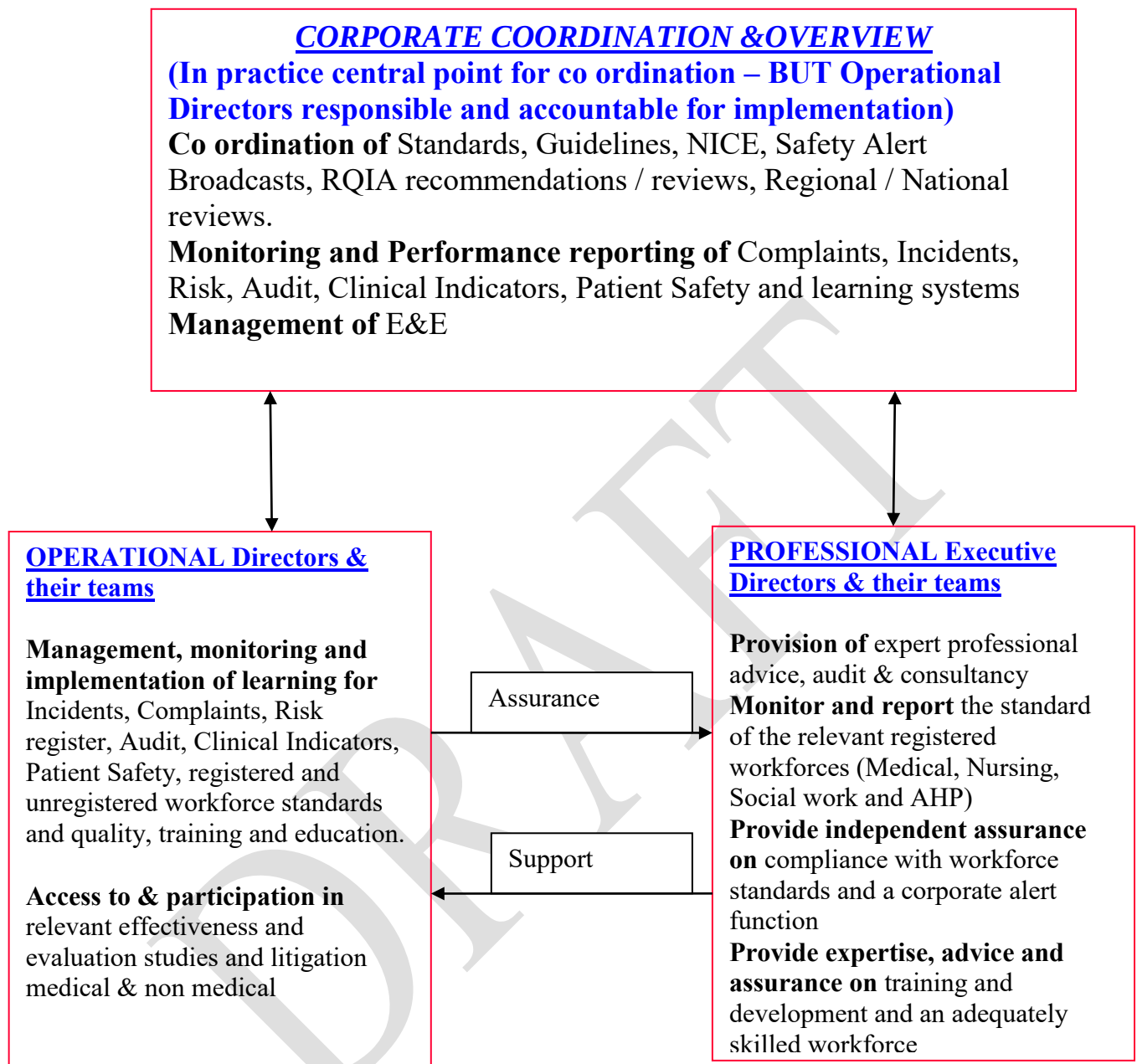
- Effective decision making on issues of safety and quality should be taken as close to the point of service delivery as possible.
- Clarity and singularity of responsibility and accountability are required with respect to CSCG within the organisation.
- An in-depth understanding and agreement of the 'professional' Executive Director role and responsibilities, to provide the organisation with resolved professional guidance, advice and expertise in relation to standards for quality and safety of care and of the professional workforce (medical, nursing, social work and AHP). They will also independently assess and provide assurance on the levels of compliance to SMT Governance and Governance Committee, while providing a corporate alert when compliance with standards is at an unacceptable level.
- The operational management of services carries the responsibility and accountability for the safety and quality of those services and of the workforce delivering the care, supported by the Executive Directors when appropriate in relation to professional workforce matters.
- Service teams have a clear understanding of the roles and responsibilities within the organisation for clinical and social care governance. They have both confidence and ownership of their role, combined with the support mechanisms to provide the capacity for them to respond to the current and increasing CSCG agenda.

- Clear arrangements are needed to ensure shared learning across the organisation.
- Effective organisational intelligence is critical to the identification and effective management of patient and client safety and service quality, and this must be available both corporately and at all levels in the organisation.
- These principles are underpinned by the organisation's continued commitment to a culture of openness, transparency and fairness.

In order to achieve these recommendations the SMT agreed a model of CSCG with three clear core components

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Three Core Components of CSCG



In order to meet the recommendations from the review and achieve the above model of CSCG where appropriate safety and quality actions happen in real time, at the frontline, by the people involved in service delivery who are given the means to make and effect change, the current central structures of CSCG need to be decentralised and supported by an improved information management system accessible by all frontline staff. The proposed changes to the current structure are outlined in Section 3.

SECTION 3:

Proposed Structures

Within this section the three core components of the Trust CSCG model have been populated with the proposed structure to deliver them. How the new structure will actually work in practice is then described. It is essential that the concepts described earlier – decision making as close to the point of service delivery as possible by those who can effect change and learn from it, clarity and singularity of accountability, communication and Trust wide patient safety learning and organisational intelligence are the foundations of how the CSCG system needs to function.

We need to understand the Trust systems for CSCG:

- Who takes decisions and who is accountable for the decisions and the following action or inaction?
- How will we communicate these decisions and provide organisational intelligence to improve patient safety learning?
- How will we achieve the actions which flow from these decisions and meet the increasing CSCG agenda?

The description of Trust systems will then be followed by a brief synopsis of the processes within the CSCG model, for example complaints, incidents, etc. The description will be at a high and generic level as the core business for each Directorate varies in nature and thus so will the detail. However it is expected that the Directorate detail, if not already in place, will be worked through by the Operational Director and their teams facilitated by the Directorate Governance Coordinator when appointed.

Finally within this section a brief description of each of the new job roles within the CSCG system will be presented. Detailed job descriptions for new roles are available on request; those whose role will be essentially similar with the same banding, but whose lines of reporting will change, will be invited to participate in formulating revised job descriptions for their modified roles.

What category each post falls into, new or modified will be detailed in section 4.

Job Descriptions for **new** roles are available on request via email only from Catherine Irwin (Wednesday – Friday) or Loretta Crawley (Monday to Wednesday), HR Administrators.

Email:

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Personal Information redacted by the USI

It should be noted that the banding for these posts are indicative bandings which are yet to be subject to desktop banding process.

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Three Core Components of CSCG - Structure

CORPORATE COORDINATION & OVERVIEW

Reporting to Chief Executive's Office:

1 wte Band 8C AD CSCG
 1 wte Band 6 Governance Manager
 1 wte Band 3 Governance admin Assistant
 1 wte Band 7 (Temporary for 1 year) Governance Training Officer
 Current central reporting team (Systems manager will report to Informatics Division)
 Current Effectiveness and Evaluation team

OPERATIONAL Directors & their teams

Will be supported by a Directorate Governance team using both existing arrangements and complemented by proposed new arrangements

Existing Structure:

AMD's,
 CD's,
 AD's,
 AD / HOS senior Directorate advisor for nursing, AHP and Social work
 In reach nurse workforce, dev & training
 In reach Social work governance, workforce dev & training

New Structure:

1 wte Band 8B governance coordinator reporting to Director
 1 wte Band 5 governance officer (*1.6 wte in Acute services)
 1 wte Band 3 governance admin assistant (*1.6 wte in Acute service)
 Pro rata wte Band 7 nurse governance facilitator (previously practice support & governance lead)
 1 wte AHP Directorate Lead (Operational and Governance lead)
****Acute services only**
 1 wte Band 7 Patient Safety & Quality Manager (Encompass standards & Guidelines)
 1 wte Band 6 Patient Safety & Quality Officer

PROFESSIONAL Executive Directors & their teams

Nursing:

2 wte Band 8C (current posts)
 Education, training & Development team (current team)

AHP:

1 wte Band 8C (current post)
 1 wte Band 7 workforce development and training (new post, temporary for one year in the first instance)

Social Care:

1 wte Band 8C (Current post)
 Governance, workforce development and training team (current team)

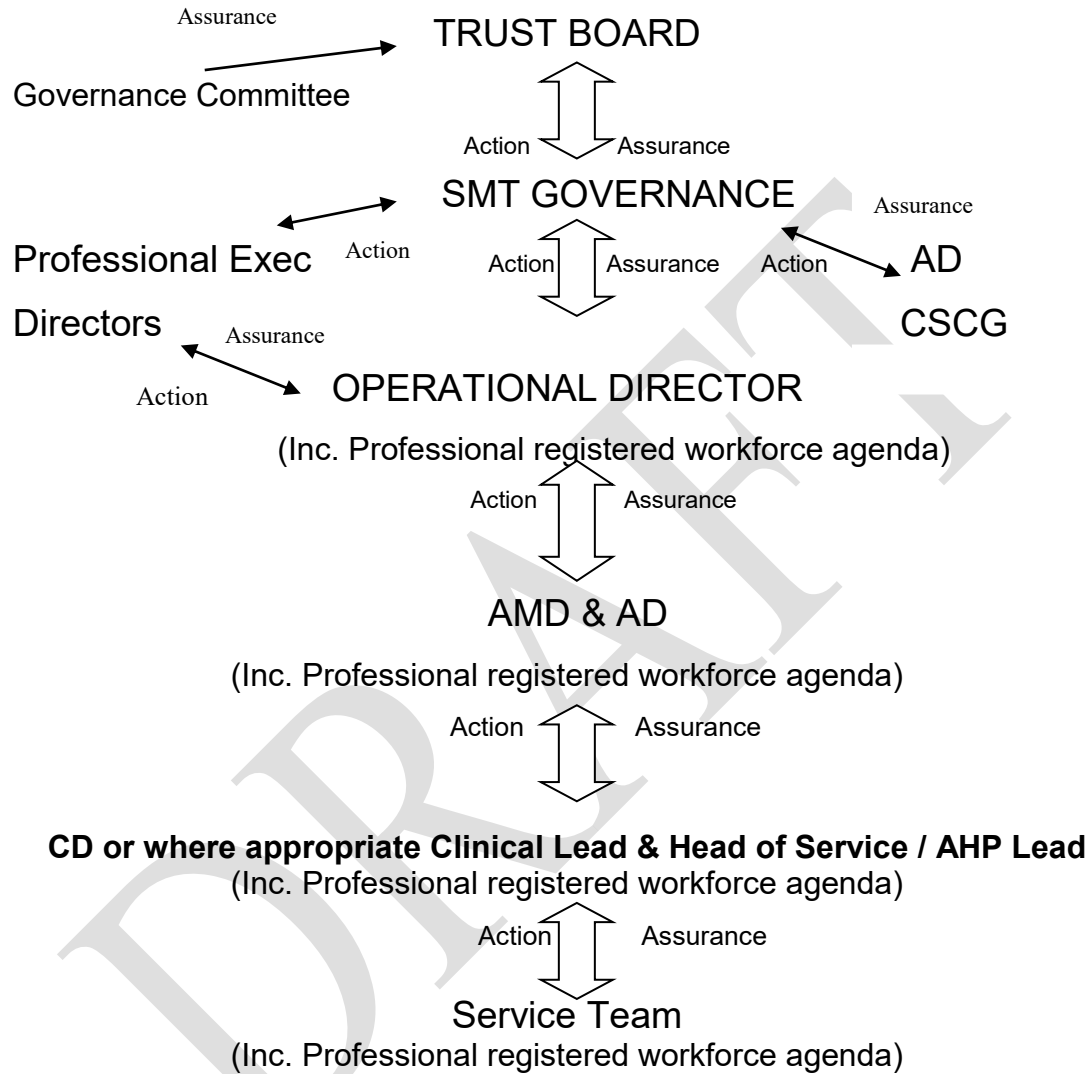
Medical:

8b Medical workforce (current post)
 Band 7 (Current post)
 Band 6 Patient Safety Initiatives Officer (current post)
 Litigation team (current posts)

Assurance

Support

SYSTEM FOR DECISION, ACTION & ACCOUNTABILITY

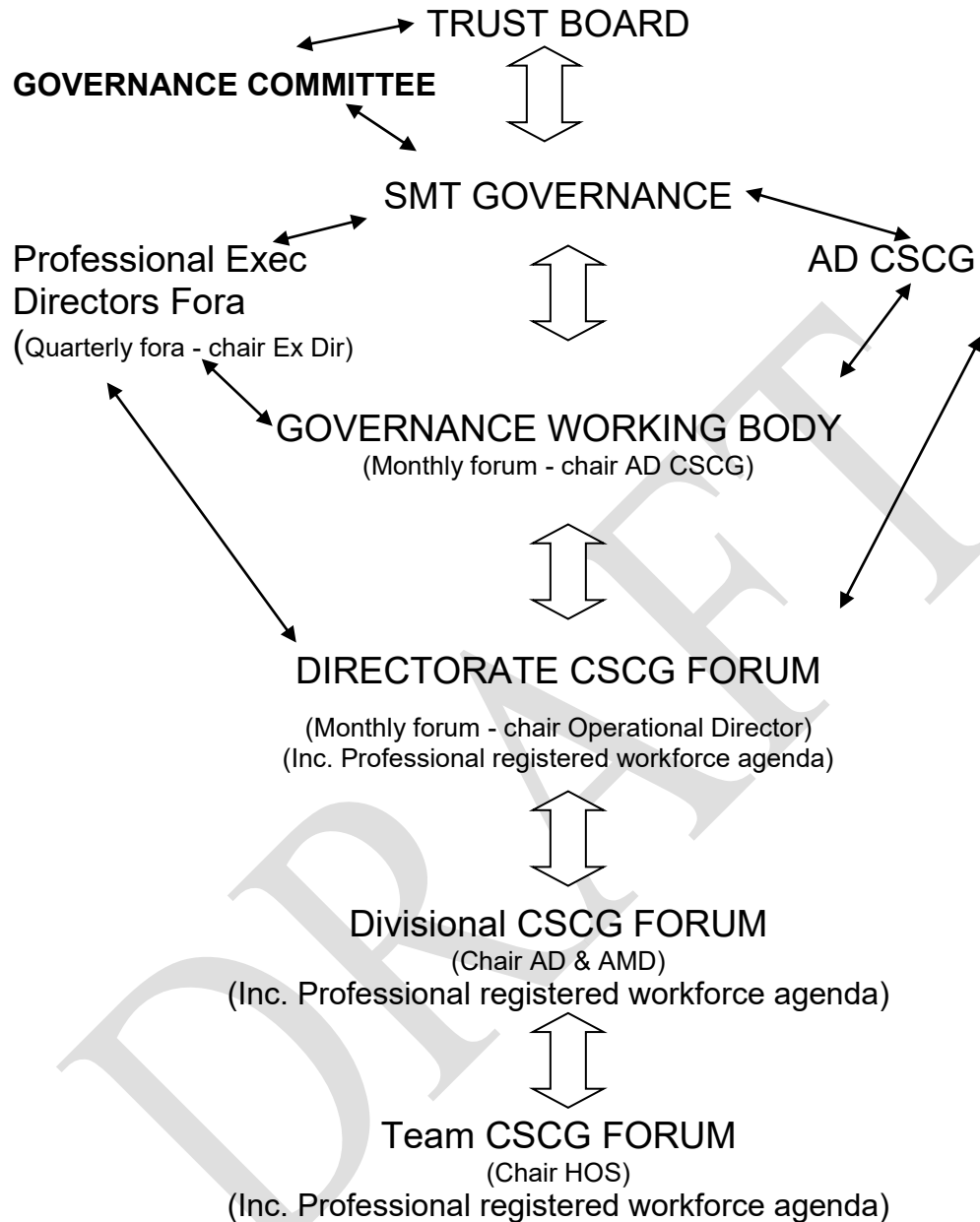


Explanatory Notes:

- Each level in the diagram is both a decision making point and a point of accountability following a decision and action.
- SMT Governance in the central point for decision making in relation to the **organisational CSCG agenda**. They are guided, advised and obtain organisational intelligence from the Executive Directors, Operational Directors and their teams and the AD CSCG. The forum for this to take place is described in the next flow diagram on page 12. This should result in a clear, single corporate agenda for all aspects of CSCG, and an awareness of the CSCG workload across the Trust, preventing too many initiatives being worked on at any one time.
- The central point for decision making in relation to CSCG decisions involving procedure, resources or a change in practice is the Operational Director who will be advised by and communicate with SMT Governance, AD's and AMD'S and where appropriate Executive Directors.
- SMT Governance are accountable to Trust Board
- The Governance Committee provide independent assurance to Trust Board that SMT Governance is undertaking it's responsibilities in a thorough and acceptable way. The Executive Directors assist Governance Committee by providing independent assurance to the latter and Trust Board.
- Executive Directors assure and advise SMT Governance on workforce standards, training, education & development and provide exception alerts to SMT Governance.
- This facilitates decisions on the Professional registered workforce agenda to be agreed at SMT Governance before dissemination to the wider organisation

- The Executive Director of Nursing will for the most part delegate to their Assistant Directors for governance and workforce standards, training, education & development. For the purposes of this document where Executive Director Nursing & Midwifery is used this is interchangeable with the AD positions in this office.
- The Executive Medical Director / Responsible Officer will have additional responsibilities which include litigation, medical appraisal, fitness to practice, research & development, emergency planning, infection control and lead for Healthcare Acquired Infection performance. They will also be the lead professional Director for information governance and the Trust representative on the Regional Patient Safety forum and for the performance monitoring and reporting of specific DHSSPS Patient Safety Initiatives. In discharging the latter role the Medical Director will agree monitoring arrangements for DHSSPS Patient Safety Initiatives with the appropriate Service Director.
- Responsibility and accountability for patient safety and quality lies with the Operational Directors.
- Operational Directors provide assurance to Executive Directors on workforce standards, training, education & development. The Executive Directors will agree and assess the assurance information which should be provided and give SMT Governance an independent and considered view on the professional workforce.
- Operational Directors are responsible & accountable for all aspects of CSCG to SMT Governance and its chair the Chief Executive, and via this body through to Trust Board.
- The AMD & AD are responsible & accountable for all aspects of CSCG within their area to the Operational Director

System for Communication & Organisational Connectivity (Intelligence Flows)



Explanatory Notes:

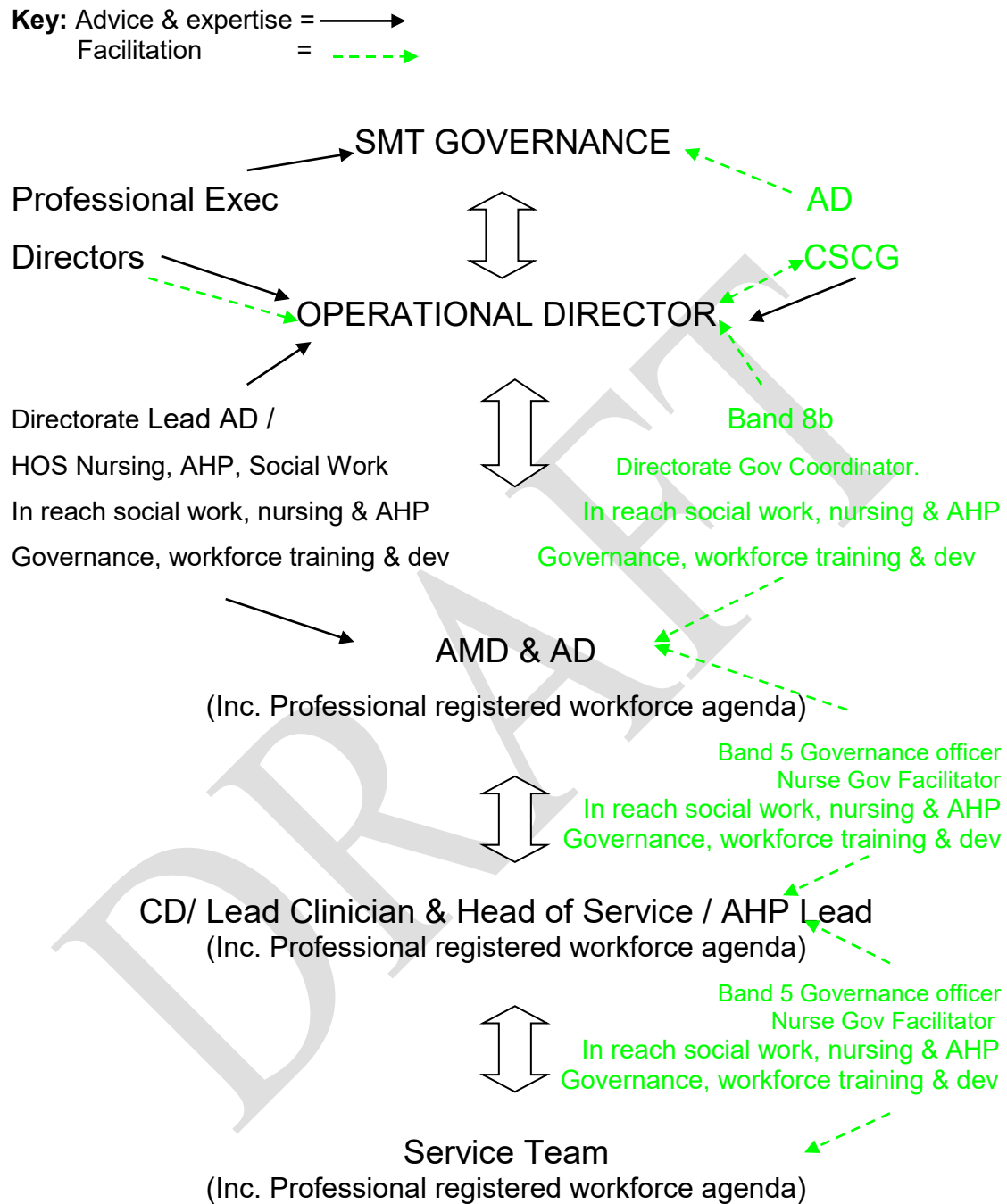
- As previously illustrated the decision hub of SMT Governance will be informed by the Governance Working Body. This group chaired by the AD CSCG will be instrumental in proposing, forward planning, implementing and reviewing a practical and robust CSCG agenda to be endorsed by SMT Governance. This will provide SMT Governance with the capacity to focus on the strategic and operational direction of CSCG based on good intelligence and sound information and allow them to focus on critical issues, organisational risks and decisions on prioritisation of CSCG issues.
- The Governance working body will therefore have a Trust wide membership including Executive Directors or their representatives (Medical, Nursing & midwifery, AHP, Social work), AD's and AMD's, Directorate CSCG Coordinators, Pharmacy, Estates, Health & Safety, Human Resources, Litigation, Effectiveness & Evaluation and other co-opted members as required. All other CSCG committees, such as Drugs and Therapeutics will be represented at the working body and feed in their reports for assimilation to SMT Governance. It will meet monthly and have corporate priorities, plans and proposals, progress and outcomes endorsed by SMT Governance.
- This working group is central to the coordination and success of the CSCG agenda within the Trust and in order to facilitate membership, attendance and participation there will be a streamlining in the frequency and agenda of uni-professional fora held during a financial year. There will be one Nursing & Midwifery forum across the Trust, one social work & care forum, one AHP forum and one Medical forum focussed on workforce standards, training and development, each chaired by the respective Executive Director. These will be held quarterly for resolved professional advice on workforce issues which will be fed into the Governance working body and SMT Governance, information sharing,

communication and debate. No other uni-professional fora will take place as the Governance Working Body and Directorate Governance Fora will now be responsible for, on a wider and more coordinated platform, implementing the agreed standards within the significant professional workforce agenda.

- Another essential decision hub is the Directorate Governance Forum chaired by the Operational Director. Again this monthly forum will be another key point for input from the Executive Director teams and will monitor progress and review outcomes of CSCG initiatives within the Directorate including implementation of the agreed workforce standards.
- The Executive Director's delegated representatives (usually the Band 8C for each profession) will attend the appropriate parts of this monthly forum. They will on behalf of the Executive Director provide expert advice and guidance as well as a performance management role in relation to seeking assurances on workforce standards and an acceptable level of compliance with quality and safety indicators.
- Within this forum the Executive representatives will discuss any aspects of poor or unacceptable levels of compliance with the Directorate and will by exception alert the corporate organisation if performance against indicators is unacceptable and irresolvable.
- It is essential that all decisions on issues of CSCG policy, procedure, resources and changes in practice are brought to the Governance Working Body for discussion and organisational learning and intelligence. They should also be escalated to SMT Governance for endorsement or a decision or as an alert and then be devolved to Directorate Governance fora for implementation and / or further action. Decisions taken outside these hubs or interaction at other levels of the organisation with teams or individuals should be avoided as this could lead to confusion of accountability, conflicting communication and non optimum accountability.

- In the exceptional circumstance where a registered or non registered member of staff at any level within the organisation believes that an issue of CSCG is not being addressed at team, division, directorate or a corporate level they should highlight this in the first instance through the accountability and communication lines set out above. However if the highlighted issue is not being addressed and the reasons for this are either not communicated or not acceptable, staff are encouraged once all line management communication lines are exhausted to raise the issue to either the Executive Directors office or that of the Chief Executive through the AD CSCG. This exception reporting is a further safety mechanism within the organisation to ensure that all CSCG decisions and actions are taken as intended by the accountable officers involved, namely SMT Governance.

SYSTEM FOR SUPPORTING THE CSCG AGENDA



Explanatory Notes:

- As with communication, decision making and accountability, facilitation and expert advice by the right people at the right level of the organisation is key to the success of the CSCG agenda.
- SMT governance will be facilitated by the AD CSCG, who will provide intelligence, information and real time data from across the Trust and via the Governance Working Body.
- SMT Governance will also be provided by expert advice and receive compliance monitoring on professional workforce standards, education, training & development from Professional Executive Directors.
- Operational Directors will provide further Directorate information and assurance on compliance with CSCG standards to SMT Governance.
- Operational Directors will be supported in their role by the AD CSCG, their Band 8b CSCG Coordinator and in reach support from the Professional Executive Directors' offices. The Operational Director will also receive expert advice and guidance on uni - professional issues from their most senior staff within each profession – the AD/HOS/Lead for Nursing, AHP, Social Work and AMD's for Medicine, this is an existing role within each Directorate.
- The above assistance to the Operational Director and their team are advisory and facilitatory providing expert guidance and “another pair of hands” to assist with this large agenda. However each individual AD and AMD for each division / Directorate are responsible and accountable to the Operational Director for the delivery of the CSCG agenda within their specific service area, as in turn is the Operational Director to SMT Governance.

PROCESSES TO SUPPORT THE CSCG AGENDA

These processes are essential components of the CSCG systems and should be viewed as individual parts of a larger patient and client safety and quality reporting process, which when combined, maps the journey through Trust services from the user perspective. This mapping should give the organisation a clear picture in relation to user experience and outcomes and identify when and where these outcomes are sub-optimal; some literature describes these measurable, sub-optimal outcomes as the 6 D's, death, disease, dysfunction, disability, dissatisfaction and dollars or the follow up to poor care. While these measure the less positive side of the service user's journey these are the outcomes we need to prevent whenever possible to protect staff and those who use our services. When fed into the CSCG systems the outcomes from the processes of complaints, incidents, effectiveness & evaluation, litigation etc should enable the organisation to predict where problems may arise, manage risk by making uncertainty visible and ensuring we have contingencies and controls to minimise these risks and ensure learning.

Participation by clinical teams in CSCG processes in which they have confidence is essential to build a safe organisation. It is clearly recognised that in an organisation of this size where we provide health and social care for those who need it most that there will inevitably be poor outcomes for a number of patients and clients. However where the poor outcome was not inevitable but preventable, this in itself only becomes a disaster when it is allowed to be repeated. That is why we need organisational processes that frontline staff will use to detect, analyse and respond to poor outcomes to prevent the likelihood of them being repeated. At all levels the organisation needs to identify the important problems and issues, analyse and respond to them in an appropriate and coordinated way.

The processes described below are dependent on the roll out of the web based management information system - DATIX, which will take place over the next year to eighteen months. Several of the processes will also require

review and potential revision following phased implementation of the recommendation within the governance review.

Process 1: Complaints

- Complaint received by central reporting in AD CSCG office. Logged on system. Sent electronically to Directorate Governance coordinator.
- Governance coordinator screens and prioritises for Assistant Director (AD), Associate Medical Director (AMD) and Director attention or Head of service (HOS) and service team attention. Electronically transferred to AD / AMD/ Director or HOS /team.
- Directorate governance officer monitors complaint progress and ensures timeframes adhered to as laid out in the Trust Complaints policy. Provides assistance as required to service team
- Response agreed with service team, AD, AMD and Director, as appropriate, by Directorate Governance Coordinator before being sent to complainant - eventually this process will be managed by the Directorate governance officer and rely less on input from the Governance coordinator
- It is envisaged that this system will be improved by the potential roll out of the web based datix module for complaints which will be on staff desktops. The roll out of the information management system will also significantly improve our ability to track trends of complaints and share learning at a team, division, directorate and corporate level – a role taken on by the Directorate governance coordinators and the AD CSCG. Shared learning will take place via the Governance Working Body and recommendations for change will be agreed and prioritised by SMT Governance

NB: Ombudsman issues will be dealt with in a similar format but will have input from the AD CSCG to ensure organisational learning. Chief Executive will sign off these responses.

Process 2: Incidents

This area of work will change significantly from the current process with the piloting and roll out of web based datix for incident management during the next 6- 9 months. Described below is a vision of what the process will be when the web based system is in place.

- Incident occurs within service team – reported by a member of the team via the web based system on their desktop.
- The reporting format will have been designed by the team and the incident will then be electronically alerted to the team line management
- Directorate Governance coordinator and service AD'S / AMD's /HOS will have an agreed process for service teams to action and deal with incidents in real time. An example of how this is achieved currently within one team can be found in Appendix 4. The detail of this may vary within each Division and Directorate – particularly the who and the how, however the principles of senior clinical involvement and a practical, workable mechanism to ensure learning is shared within the teams / division / directorate must be a key element of the process that is clearly visible.
- Incidents will then be reviewed on weekly real time reports by teams, Divisions, Directorates and at a corporate level, as will the recorded action and learning by the teams.
- Incidents that have not been actioned, closed and learning taken from them will be evident at team, Divisional, Directorate level and a corporate level by the AD CSCG
- Trends, learning and failure to effectively address incidents will also be identified and actioned by the Directorate Governance coordinator through the Directorate CSCG forum and the AD CSCG. These will be shared within the Governance working body and analysed as to whether escalation of learning is required to SMT Governance.

Process 3: Patient Safety & Quality (inc. Standards & Guidelines):

The Trust currently receives a significant volume of standards and guidelines and key performance indicators from various professional and patient safety bodies including NPSA, NICE, NCEPOD, RQIA, Chief Nursing Officer, the Chief Medical Officer and the Departmental Director of Safety, Quality and Standards. The following describes the process of how these publications will be dealt with.

- The office of the Chief Executive will be the central receptacle for these standards, guidelines and recommendations. Any such communication received at any other point within the Trust should be redirected to this central point.
- They will be logged on a database within the office of the AD CSCG and early distribution will take place to relevant Directors for information and consideration prior to a work plan being developed by the Governance working body.
- The AD CSCG will table the publications at the Governance working body meeting and a relevant implementation team will be identified within each Directorate including any assistance required from professional, operational and governance leads.
- A timetable and implementation plan will be agreed by this team and reports on progress and constraints and monitoring of progress will be via the Governance working body.
- Executive Directors requiring monitoring progress on any professional specific standards and guidance will also receive progress reports and updates on assurance from Directorates via their AD representatives on the Governance working body.
- The Medical Director will receive information on the specific Departmental Patient Safety Initiatives in the same way via his Band 6 representative.
- Each Directorate can then monitor the number of ongoing implementation plans and feasibility of implementing standards and

guidelines through their Directorate Governance coordinator who sits on the Governance working body

- Due to the highest percentage of standards, guidelines and recommendations requiring implementation being within the Acute Services Directorate, this service will have 1 wte Band 7 Patient Safety and Quality manager and 1 wte Band 6 Patient Safety and Quality officer
- These posts will assist with implementation of standards and guidelines within Acute services, including key performance indicators relating to specific patient safety initiatives and alerts in relation to medical devices and equipment.
- They will also maintain the ongoing programme of undertaking the quality standard of ISO 9000 for equipment management in order to support the maintenance and safe use of equipment.
- The Patient Safety and Quality Manager will also chair a small sub committee of the Governance Working Body which includes estate services, representation from the older people and primary care Directorate and Acute services together with Health & Safety representation. This will ensure the ability to address any issues arising from Medical Devices on a Trust wide basis and should include the procurement of new equipment from a user and continuity perspective.

Process 4: Risk Management

This process will be taken forward by the Directorate Governance Coordinators and service teams. Again it is envisaged that during the phased implementation of the web based Datix management information system this process will become less labour intensive. Further work is required within this area to ensure that there is an organisational understanding of the principles behind risk management and a clear process for the management of identified risk. Risk registers should not be a long list of concerns; it is a formal record of potential / possible / probable dangers which could result in loss, harm or failure and detail how this risk

is being managed. The organisation at every level must have a mechanism for detection, prevention and contingency for risks and have a resolved position at each level in the Trust as to acceptable levels of risk which can be borne and those which cannot.

The improvement of the organisational understanding of risk management at a team, division, directorate and corporate level will be a follow up project for the AD CSCG, Directors, service teams and Directorate Governance Coordinators when the new structures are in place. Training to support effective organisational understanding and operation of risk management systems will be led by the Governance Training Officer within the central coordinating function.

Process 5: Registered & Unregistered Workforce Standards, Quality, Training & Education

- CSCG and workforce training, education and development are inextricably linked, the latter flowing from the need to ensure patient and client safety and quality care and the systems and processes of the organisational model of CSCG indicating issues of safety and quality. Therefore to ensure these links are made and that a coordinated approach is taken both across Directorates and at a corporate level and that the profile of education, training and development is raised and is targeted at supporting patient and client safety and quality care, there is a need to describe how this function will be delivered and where the lines of communication and accountability lie. This has been done in diagrammatic form earlier within the paper but will be repeated for clarity.
- The offices of the current Executive Directors will continue to be responsible for setting, advising on and monitoring standards of safety, quality, training and education of the registered workforce including Medicine, Nursing, AHP and Social work. They will also

independently assess and provide assurance on the levels of compliance with these standards to SMT Governance, Governance Committee and Trust Board, while providing a corporate alert when compliance with standards is at an unacceptable level.

- However as the Executive function is neither a line management nor an operational role, it cannot be held accountable for delivering the actions required to implement agreed workforce standards and quality and safety of care.
- This accountability, for implementing agreed workforce standards, clearly lies with the Operational Director charged with delivering this service, who must provide assurance to the Executive function that action is taking place to ensure a workforce of an acceptable standard and safe and high quality care is delivered.
- The Operational Directors will achieve this through their Directorate Governance team. The Accountability chain for implementing the required standards and for highlighting training, education and development needs flows up from Heads of Service, AHP leads and Clinical Directors to Assistant Directors and Associate Medical Directors to the Operational Director who assures the appropriate Executive Director and is accountable to the Chief Executive. This Operational team will be supported and facilitated internally by the Directorate Governance Coordinator, the Nurse Governance Facilitators, the Lead AD Nursing Advisor, the AHP lead, lead for Social Work and AMD's. They will have in reach support from the Social Work governance, workforce development and training team, Nursing and Midwifery education, training and development team, the AHP governance and workforce development and training support and the medical workforce team all of whom are within the relevant Executive Director's office.

- The vehicle for this to take place should be the Directorate, divisional and service team governance meetings, with final sign off of any issues pertaining to workforce standards, training, education and development being achieved at the Directorate Governance meeting. This ensures that there is a coordinated approach to this issue by Directorate, due consideration given to Directorate workloads and pressures and that those who will be held accountable for implementation – the Operational Directorate - are engaged in the process. Those described above who facilitate, advise and monitor workforce issues should therefore attend the Directorate Governance meeting to provide expert advice and to seek assurances on compliance with agreed standards.
- In relation to the non registered workforce, to ensure that standards, quality and opportunities for workforce training and development are afforded to them, each staff group will have a lead Director appointed to implement this agenda. The list of staff groupings and responsible Director's can be found in Appendix 5.
- To ensure a corporate, value for money approach to workforce training, development and education the SMT has recommended that the Director of Human Resources chairs a Trust wide forum to enable a uniform approach to workforce development and training for both registered and unregistered staff. This forum will be fed by the collaborative working between Directorate and Executive functions described above and will have Directorate and Executive representation.

Process 6: Clinical indicators and Audit

- Executive Directors will provide expert advice and guidance on the organisational and service level quality indicators that will provide evidence of the safety and quality of care of care systems and the competence of the professional workforce within the Trust.

- The responsibility for progress and achievement of acceptable performance against these indicators rests with the Operational Directors and their teams. Again the Directorate Governance teams will support the service teams with this process.
- Directorate level audit, as agreed by SMT, will be undertaken and reviewed by service teams. The Executive Directors will also review these audits to ensure an acceptable level of compliance with quality and safety indicators and will alert the corporate organisation if performance against the indicators is unacceptable.

Process 7: Effectiveness and Evaluation

- Effectiveness and Evaluation team will in the main undertake audit of quality and safety indicators which are of a more corporate nature and provide a sound basis for a patient and client safety learning system.
- This programme of work will be decided by the SMT Governance, with advice and input from the Governance Working Body.
- Although having a corporate function and being centrally managed, the E&E team will continue to provide expert advice to Directorate teams in methodologies etc.

Process 8: Litigation

- Increased collaborative working between Operational Directors, their AMD's and AD's will be facilitated by the Medical Director and the litigation team.
- The Medical Director will bring forward a recommendation on how this will be achieved and through what forum.
- The Director of HR will act as an expert advisor on all non medical litigation, and will seek professional expert advice in relation to Social Work, AHP, and nursing when appropriate.
- The Directorate Governance coordinator will act as a conjugate within this system having a collaborative working relationship with the Litigation team.

Process 9: Morbidity and Mortality

- A review of current processes for the above has commenced with the purpose of ensuring integration and accountability structures within the wider CSCG systems in the Trust.
- This review will complete by the end of December and its recommendations will be integrated into the implementation plan of the CSCG Review.

Process 10: Managing Poor Professional Conduct and Performance

- The processes for the above have been the subject of revision as part of the Review of Governance. The Trust processes are attached in appendix 3
- It is evident from the processes that those involved are also those who can action change and effect patient and client safety. These processes should be reported on a regular basis at Directorate level and learning issues raised through the Governance Working Body

New and Modified Job Roles

Function: Corporate Coordination and Overview

WTE Band 8C AD CSCG: (Modified role)

- This new role will provide the SMT Governance with a Trust wide overview on all the CSCG systems and processes and their outputs. They will provide well analysed information to support decision making, prioritisation and awareness re exceptions and trends, thus enabling improved information to support both the SMT Governance and provide assurance to Governance Committee.
- The post holder will provide an early warning system from the process outcomes and highlight potential Directorate and Trust risks and will monitor trends.
- They will chair the Governance working body and ensure standards, guidance; alerts etc are planned, implemented and reviewed.

- They will ensure that corporate strategic intent is interpreted correctly at operational level and that it can be implemented. They will provide assistance to individual Directorates and their Directorate Governance team as required.
- They will continue to implement the Governance review findings in a phased approach and assist the Informatics Directorate with the information system roll out.
- They will manage the Serious Adverse Incident (SAI) process at a corporate level and the subsequent RCA reports required at a regional level
- Within the Trust this post holder will when appointed oversee a review of the internal use of RCA's and produce a policy and procedure detailing incident review and learning
- This post will report to the Chief Executive

WTE Band 6 Governance Manager (New Role)

- Manage staff and processes in relation to Central Reporting.
- Produce reports on a trust wide basis for all CSCG processes together with an early warning alert for exceptions to the AD CSCG.
- Manage the administration of the processes and systems relating to CSCG within this corporate function including the Governance working body, complaints, SAI reporting and subsequent regional RCA's together with the receipt and monitoring of standards and guidelines, RQIA reports etc
- This post reports to the AD CSCG

WTE Band 7 (Temporary for 1 year) Governance Training Officer (New Role)

- To embed the new systems and processes within the organisation by the provision of targeted training in incident and complaint management, resolution and learning.
- Specifically in the area of risk management to provide targeted training in respect of risk, recording, management and provision of contingencies.

- To work with all affected groups of staff to assist them in identifying issues or constraints within the processes and systems and to enable the successful adoption of the new model fro CSCG.
- This post reports to the AD CSCG

WTE Band 3 Governance Admin Assistant (Modified role)

- This post will also exist in Operational Directorates with the same role, it currently exists within the Medical Directorate and would be similar in nature within the new structure
- To provide general administration to both the Corporate and Directorate CSCG offices.
- This post reports to the Band 6 Governance Manager and within the Operational Directorates would report to the Band 5 Governance Officer

Function: Operational Directorate Governance Team

WTE Band 8B Directorate Governance Coordinator: (New role)

- On behalf of the Service Director, to take the lead within the Directorate in providing assurance to the organisation that both the operational and professional aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and are providing timely action, risk management, assurance and alerts to both the Service Director and the organisation.
- Be the lead within the Directorate in relation to sharing and learning from CSCG trends, exceptions, alerts and risk at an organisational wide level via the Trust CSCG working body. Disseminate this information throughout the Directorate and ensure learning has resulted in changes in practice.
- Lead on the interpretation and implementation planning of all standards and guidelines in relation to patient and client safety and service provision within the Directorate and facilitate service teams to ensure that these are implemented, monitored and reviewed in a timely

manner.

- This post reports to the Service Director

WTE Band 5 Governance Officer: (Modified role)

- This role will support the Band 8B and will line manage the Governance Admin Assistant.
- Specifically the tracking, compilation and administration of the complaints process will be undertaken for the Directorate by this post holder, under the supervision of the Band 8b.
- They will provide support to the Directorate teams with respect to identifying reports, trends and alerts and will monitor follow up action
- They will provide project assistance when required to the Directorate in relation to CSCG initiatives that are being undertaken
- They will liaise with the corporate CSCG office to ensure timely responses and information flows.
- This post will report to the Directorate Governance Coordinator.

WTE Band 8b AHP Directorate Lead (Modified role)

- This post will be responsible and accountable for both the operational and professional management of all AHP's within the Directorate, with the exception of those who are already operationally line managed as part of an integrated team. Where this is the case the AHP lead will be responsible for the professional standard of those AHP's within that Directorate who are part of an integrated team. This type of post currently exists within the Acute Directorate.
- The post holder will liaise closely with senior staff at Band 8a and below within each profession in their Directorate. They will recognise and continue to utilise the experience and expertise of team leaders in uni – professional services.
- The AHP lead will also liaise closely and receive expert advice and guidance from the AD AHP Governance and workforce Development, training and education within the office of the Executive Director and should also seek advice and guidance as required from the most senior

Trust employee in each individual profession.

- To assist with the provision of expertise and advice the most senior staff in each of the 7 AHP professions will meet with AHP leads via the AHP forum which will be chaired quarterly by the Executive Director.
- This post will report to a nominated AD within each Directorate.

WTE Band 7 Nurse Governance Facilitator (Modified role)

- This role, currently the practice support and governance team, will report to the Band 8b Directorate Governance Coordinator.
- They will support the service teams in the delivery of the significant nursing governance agenda which is inextricably linked to the service governance agenda.
- The resource will be provided to Directorates on a pro rata nursing wte basis
- This current group of staff will continue to receive supervision from the Band 8c AD for Nursing Governance.

Function: Operational Directorate Governance Team (Acute Services Only)

WTE Band 7 Patient Safety and Quality Manager and Band 6 Patient Safety and Quality Officer (Encompassing standards & guidelines)

- These posts will assist with implementation of standards and guidelines within Acute services, including key performance indicators relating to specific patient safety initiatives and alerts in relation to medical devices and equipment. They will project manage and monitor these functions within the Acute Directorate
- They will also maintain the ongoing programme of undertaking the quality standard of ISO 9000 for equipment management in order to support the maintenance and safe use of equipment.
- The Band 7 will be responsible for the Band 6 and will report to the Directorate Governance Coordinator.

Function: Executive Director Support (AHP & Medical are the Executive teams receiving new support)

WTE Band 7 Workforce Development, training and Education Officer AHP (new post temporary for 1 year)

- This post will assist the AD AHP Governance, workforce development, education and training. The post remit will be focused on education, training and development and will have a similar role to the equivalent team in within nurse education.
- This post will be available for 1 year in the first instance, after which the benefits of the role will be reassessed.
- This post will report to the AD AHP Governance and workforce development, education and training.

Section 4:**Achieving the New Organisational Structures**

The implementation of the new organisational structures will be undertaken in accordance with the principles and protocols of the Trust's agreed *Management of Change Framework*.

Staff directly affected will have opportunity for a personal meeting to discuss individual circumstances and requirements. Staff wherever possible will be offered a suitable alternative employment opportunity and where it is not possible to do so, immediately affected staff will be placed on the Redeployment Register so that any suitable posts throughout the Trust will be brought to their attention before it is advertised more widely. This meeting will be followed up in writing.

Under the terms of its agreed "Traceability Scheme" the Trust will consider applications for Voluntary Redundancy and Voluntary Early Retirement on a "without prejudice" basis.

Phasing:

The impact that the roll out of the new web based management information system (Datix) will have on the recommended CSCG systems, processes and proposed structures is in part an unknown. It is therefore proposed that while the structure as is proposed on page 10 of this document will be phase 1 of the implementation of the Review of CSCG, following the information system rollout over the next one to two years there will be a need to re-examine areas of the CSCG system administration in order to determine their future structure. However this can only be done following the completion of phase 1 and when the organisation has a clear understanding of the new embedded systems and processes and the impact of information technology.

Phase 1:

As described earlier a number of CSCG posts within the organisation will remain the same, another set of posts will have a similar job role with minor modifications to accommodate different reporting structures, while there will

be a third group of posts which are new and will therefore be available for open competition.

Obviously the exciting development of creating new posts available for open competition within the Trust is coupled with the fact that as a result some current posts no longer exist within the new structure. The Trust recognises the work that staff in these posts have undertaken since the inception of the new organisation in the field of CSCG during a difficult time of merger; in the intervening period much has been learnt with respect to what makes a successful CSCG system and so with the benefit of recent National reviews the Trust must move forward and implement a system designed for the current and future climate of patient and client safety and quality.

CURRENT POSTS WHICH REMAIN UNCHANGED:

Professional Executive Directors & their teams

Nursing:

2 wte Band 8C

Education, training & Development team

AHP:

1 wte Band 8C

Social Care:

1 wte Band 8C

Governance, workforce development and training team

Medical Workforce:

1 wte Band 8B

Band 7

Band 6

Litigation team

Explanatory Note:

- The current Practice Support & Governance Team for nursing (Band 7's) will be realigned to Service Directorates.
- The Band 8C AHP Governance will have an additional new post for 1 year in the first instance – AHP workforce development, education and training officer, Band 7.
- These changes will be summarised overleaf

CURRENT POSTS TO BE REALIGNED

To Service Directorates:

Band 7 Nurse Governance Facilitators (current Practice Support & Governance Team for nursing).

Band 5 Governance Officers (current governance support administrators within the Medical Directorate)

Band 3 Governance admin support (currently governance administrators within the Medical Directorate)

Band 8B AHP Leads (currently AHP HOS)

To Corporate Office of the Chief Executive:

Current Central Reporting Team

Please note the current systems manager will be realigned to the Informatics Division within the Planning and Performance Directorate

Current Effectiveness and Evaluation team

Explanatory Notes:

- It should be recognised that with any realignment there will be a modification of roles and responsibilities. It is intended that for those involved it should be minimal and modifications to job descriptors will be done in collaboration with the post holders.
- The Band 5 and band 3 realignment from the medical Directorate will not be sufficient to meet the whole time equivalency recommended in the review; therefore there would be open competition for the additional posts within the Trust.
- It is recognised that the role of AHP lead is a distinct modification of the current role of AHP HOS. It is intended that all the current HOS will be

widely consulted with and that the job description for the role and which Directorate individuals will be reporting to will be worked on collaboratively with the HOS as a staff group.

NEW POSTS FOR OPEN COMPETITION WITHIN THE TRUST

Corporate Office of the Chief Executive:

Band 8C AD CSCG

Band 6 Governance Officer

Band 3 Governance Admin Assistant (additionality)

Band 7 (1 year) Governance Training Officer

Service Directorates:

Band 8B Governance Coordinator (4 posts)

Additional Band 5 Governance Officer (balance of those that currently exist in the Medical Directorate)

Additional Band 3 Governance admin assistant (balance of those that currently exist in the Medical Directorate)

Acute Services only:

Band 7 Patient Safety and Quality Manager (Encompass standards & Guidelines)

Executive Director Teams:

AHP: Band 7 Workforce development, education and training officer (1 year)

SECTION 5: Equality Screening

The proposed organisational structures for Clinical & Social Care Governance (CSCG) emulating from the Review of CSCG within the SHSCT “A System of Trust” has been screened in line with the Trust’s Guidance on Equality and Human Rights Screening. The outcome of the screening exercise has indicated that the proposed structures are not likely to have significant/major implications for equality of opportunity and therefore will not be subject to a full Equality Impact Assessment. The structures were considered not to have an impact on human rights of staff. A copy of the Screening Template is available on request from the Equality Assurance Unit, Hill Building, St Luke’s Hospital Site, Armagh.

SECTION 6: The Consultation Process

SECTION 6: The Consultation Process

The purpose of the consultation paper is to seek your views on the proposed restructuring and in particular the following questions:

- Do you think that any aspects of an effective CSCG system and/or its processes are either missing or unclear within the model described?
- Are the new and modified roles as described within the CSCG model sufficiently clear?
- The role of the Directorate Governance Coordinator is key in achieving clinical and operational management engagement in the model and therefore critical to its success. Do you think post holders should have a clinical background?
- Are there any other barriers to achieving the necessary clinical engagement and ownership required to make the CSCG model work effectively?
- Do you have any other comments on the consultation document?

To this end, the Trust intends to consult as widely as possible with those directly affected and those with a vested interest. The consultation period will commence on < > and will conclude on < >, following which the final structures will be determined.

Staff who wish to discuss the proposed structures with the Chief Executive and Director of Human Resources & Organisational Development may do so by contacting < who > and arrangements will be made to meet with individuals or teams during the consultation period.

Staff are encouraged to participate in this consultation exercise and express their individual and/or collective views on the proposed structures. Staff can participate by sending their comments by writing/e-mailing to Catherine Irwin, Employee Engagement & Relations Department, Human Resources & Organisational Development Directorate, at the address below:-

Mrs Catherine Irwin
Employee Engagement & Relations Department
Hill Building
St Luke's Hospital Site
Armagh
Tel: Personal information redacted by the USI

Personal information redacted by the USI

Appendix 1 Review of CSCG

Please refer to separate attachment with this email

DRAFT

Appendix 2 Terms of Reference Review of CSCG



Southern Health
and Social Care Trust

Chair
Anne Balmer LLB BL

Chief Executive
Colm Donaghy

Our ref: MMcAl/ew

11 March 2010

To: Directors

REVIEW OF CLINICAL AND SOCIAL CARE GOVERNANCE

I refer to the recent review of assurance mechanisms for clinical and social care governance and the recommendations approved by Senior Management Team which included the establishment of the post of Head of Governance and a virtual Clinical and Social Care Governance Team.

An internal recruitment process for the Head of Governance post was recently undertaken however, while the post was offered, we have been unable to complete the recruitment process. The post will now be externally advertised.

Through engagement and consultation with staff, a number of issues have been raised regarding the robustness of our current governance operational and assurance systems, processes, capacity and capability. It is critical that these issues are explored and addressed, and should not be delayed pending appointment to the Head of Governance post.

I have therefore commissioned an urgent review of the effectiveness of current clinical and social care governance arrangements at operational level, and the information available to provide assurance on the safety and quality of our care.

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This review will focus on the effectiveness of current mechanisms to ensure that safety and quality indicators are being properly captured, identified and addressed, and will provide advice to SMT Governance on any actions required to improve the Trust's governance arrangements.

The Review will be carried out by Mrs Deborah Burns and will commence on 1 April for a three month period, reporting to myself as Chair of SMT Governance.

I would be grateful if you would share this letter with your Assistant Directors and Associate Medical Directors for circulation, as I am aware of the high degree of interest in this issue.

Yours sincerely

Personal information redacted by the USI

MAIREAD McALINDEN
ACTING CHIEF EXECUTIVE

TERMS OF REFERENCE

REVIEW OF CLINICAL AND SOCIAL CARE GOVERNANCE ARRANGEMENTS

Context

The Trust has moved to implement new arrangements designed to ensure an effective assurance framework for Clinical and Social Care Governance within the Southern Trust.

Under this model, direction will be provided by the Senior Management Team working through a new post of Head of Governance. The Head of Governance will lead a "virtual" integrated Clinical & Social Care Governance (C&SCG) Team with the aim of providing assurance that Trust services are delivered to the appropriate standards in relation to quality and safety of care, and that any risks in relation to quality and safety are effectively identified and managed.

This process is designed to ensure the identification and effective control of risks within the Trust's Board Assurance Framework, assurance on the effectiveness of the Trust's C&SCG arrangements, and the provision of expert advice and support to Directorate Governance arrangements.

The Trust was not successful in making an appointment when the post was advertised internally within the Trust in January 2010 and has decided to advertise externally for the post.

Due to the urgent nature of the work to be undertaken the Chief Executive has commissioned a review of the effectiveness of current clinical and social care governance arrangements at operational level, and the information and systems available to provide assurance on the safety and quality of our care.

Review Terms of Reference

The Trust has agreed to appoint a project manager on an interim basis for three months.

The aim of the review is to assess the effectiveness of the Trust's clinical and social care governance mechanisms in relation to:

- The appropriate and timely identification of risks in relation to the safety and quality of clinical and social care.
- The use of adverse incident reporting, 'near misses', risk assessments, complaints and other information sources to inform the identification of such risks.
- The effectiveness of current systems, processes, capabilities and capacity in providing effective management of such risks.
- Systems to ensure that lessons are learned from these internal processes and embedded throughout the Trust.
- Systems to draw and evaluate learning from elsewhere and use this information to assess and where necessary improve safety and quality of care.
- Clinical engagement and involvement in clinical and social care governance systems, processes and assurance mechanisms.
- Processes for ensuring the implementation of standards and guidelines.
- Support to and within Directorates to effectively implement the above.
- The selection, capture, measurement and reporting of safety and quality indicators and information to provide robust assurance to SMT Governance, Governance Committee and Trust Board on the safety and quality of Trust services.

- The definition, communication and understanding of responsibility, accountability and reporting mechanisms for clinical and social care governance.

The Project Manager will undertake a process of in-depth engagement with key stakeholders to ensure this assessment of effectiveness is robust, and to ensure ownership for any associated recommendations for improvement. Part of this engagement process will be the establishment of the 'Virtual Clinical and Social Care Governance Team' as to act in support of the Project Manager and as a key stakeholder group.

This assessment and engagement process will inform the Project Manager's recommendations to SMT Governance in relation to current and planned future clinical and social care governance arrangements, and will complement and integrate with the development of an action plan which ensures the findings and learning from the report into Mid-Staffordshire NHS Foundation Trust are implemented within the Southern Trust.

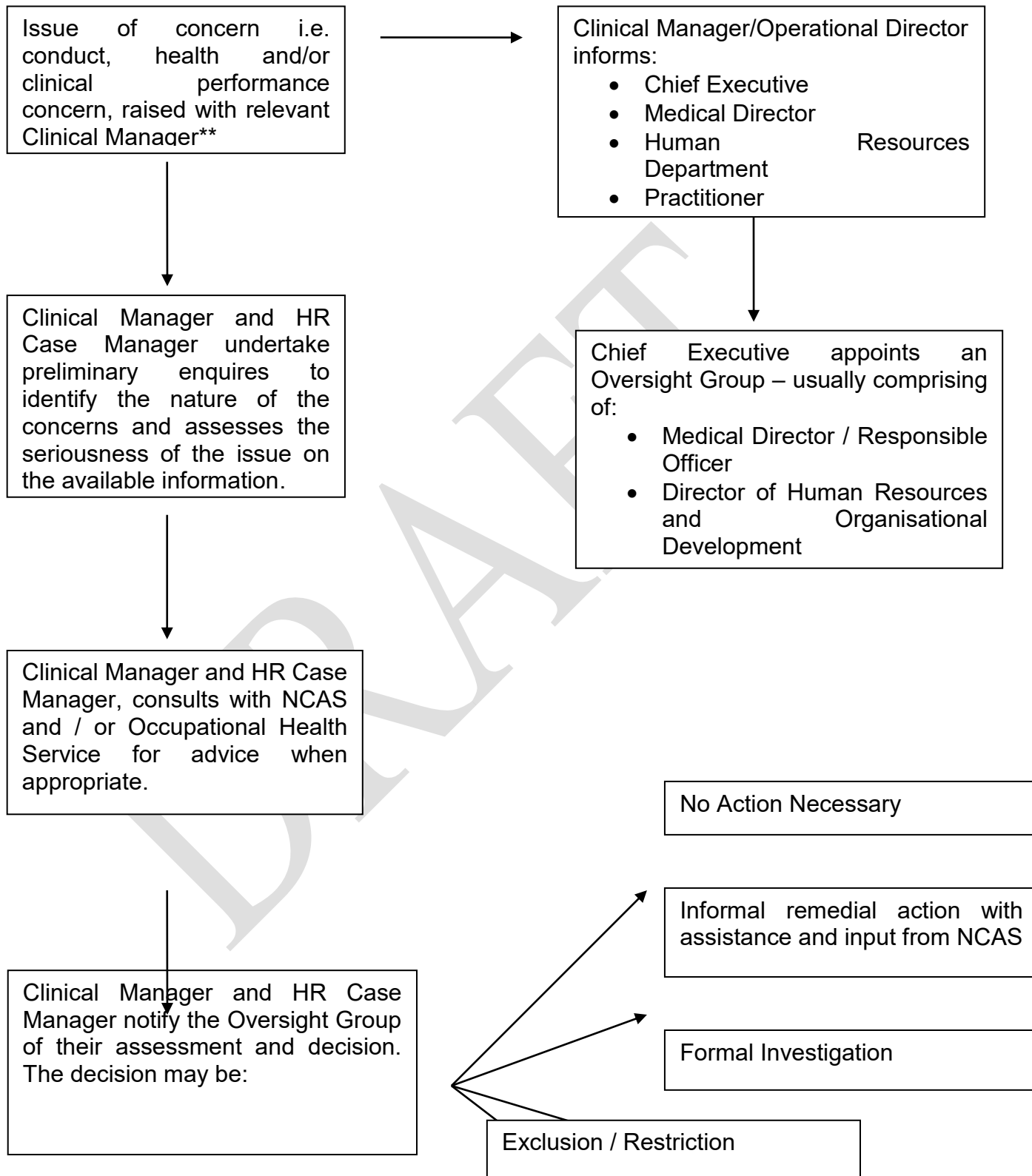
This assessment, recommendations and action plan will be presented to SMT Governance by the end of June, with updates on progress being provided on a monthly basis for the duration of the Review.

The project manager will report to the Chief Executive for the duration of the project.

March 2010

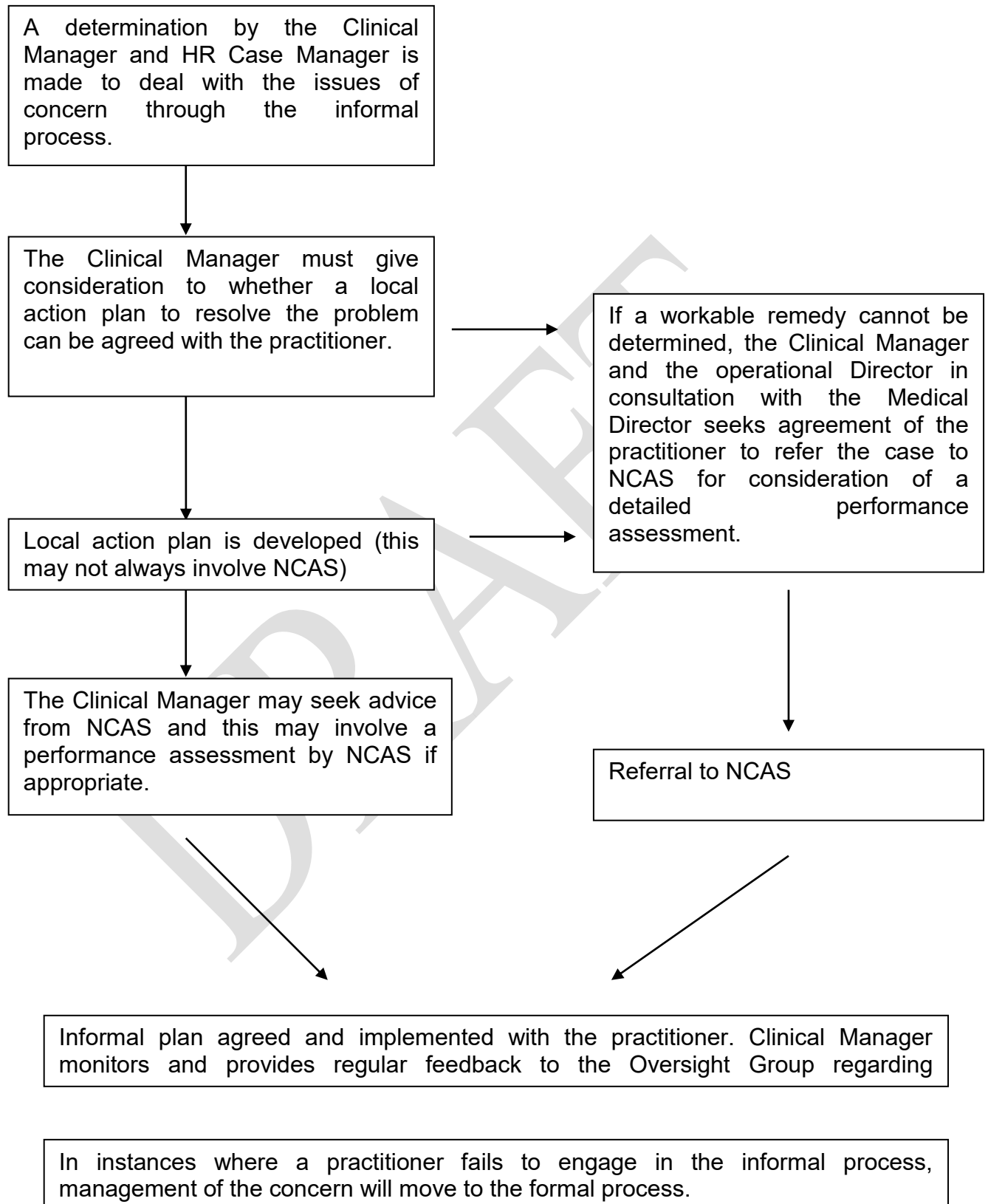
Appendix 3 - Processes for managing poor professional performance and conduct

Step 1 Screening Process

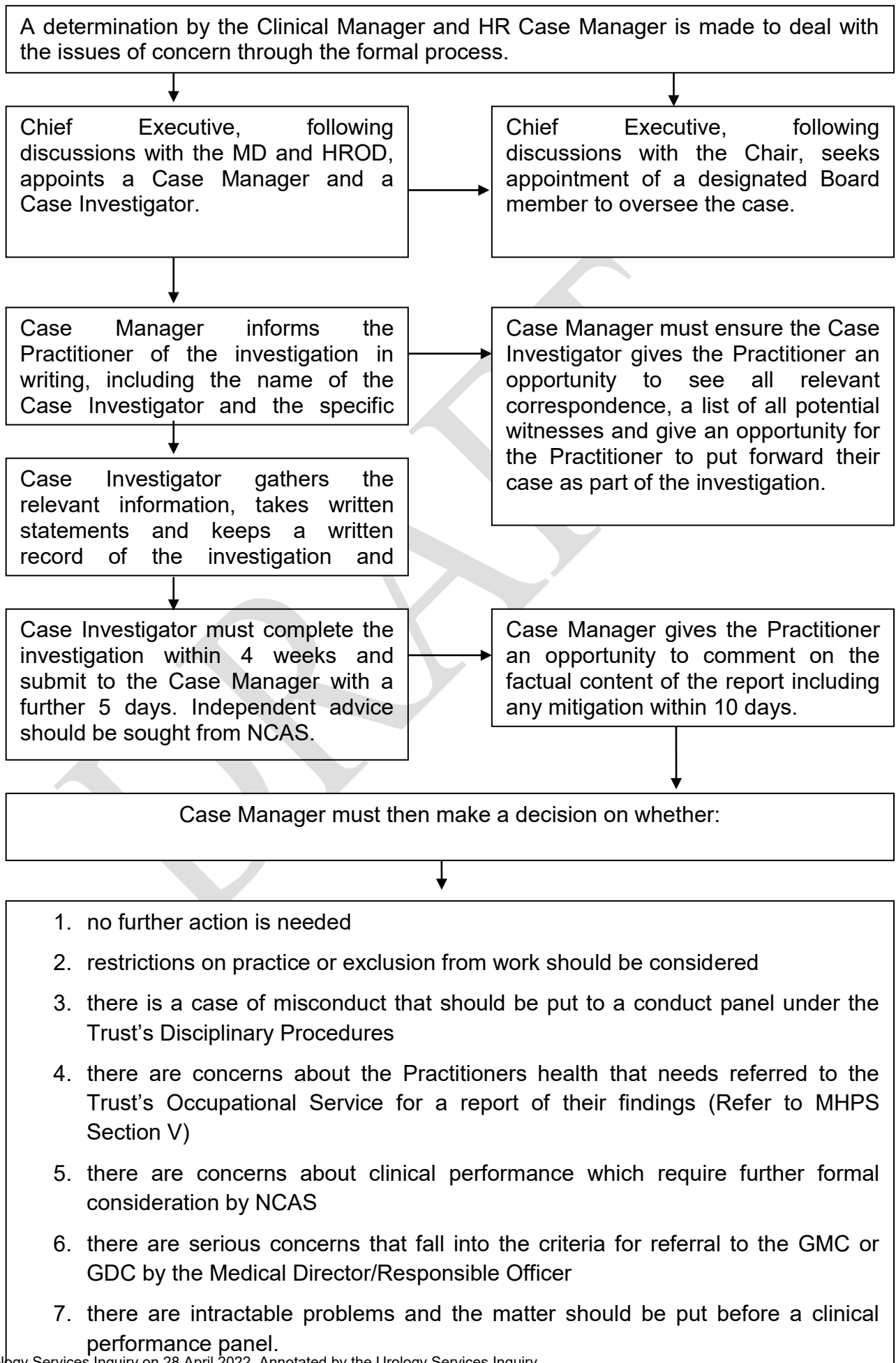


* If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

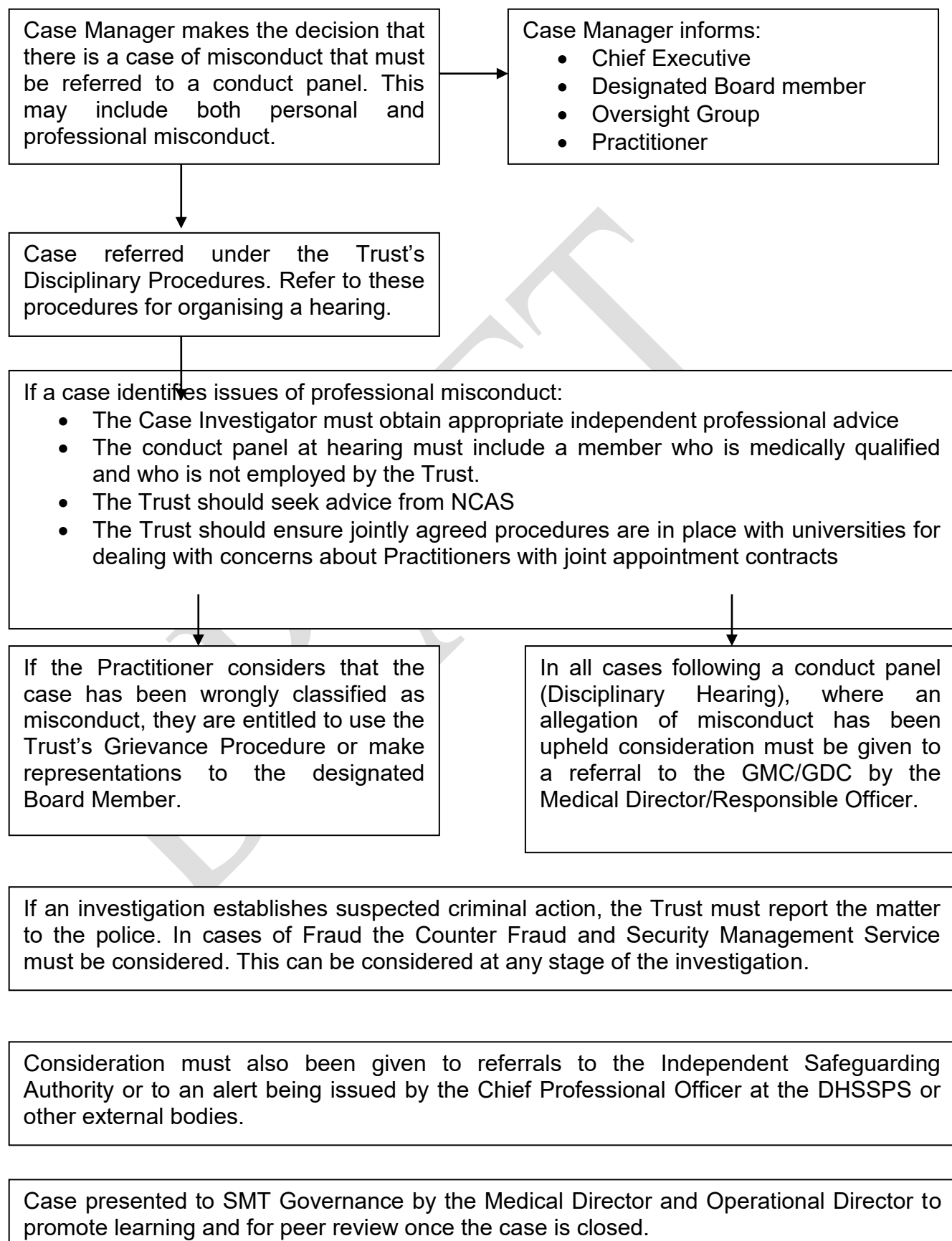
Step 2 Informal Process



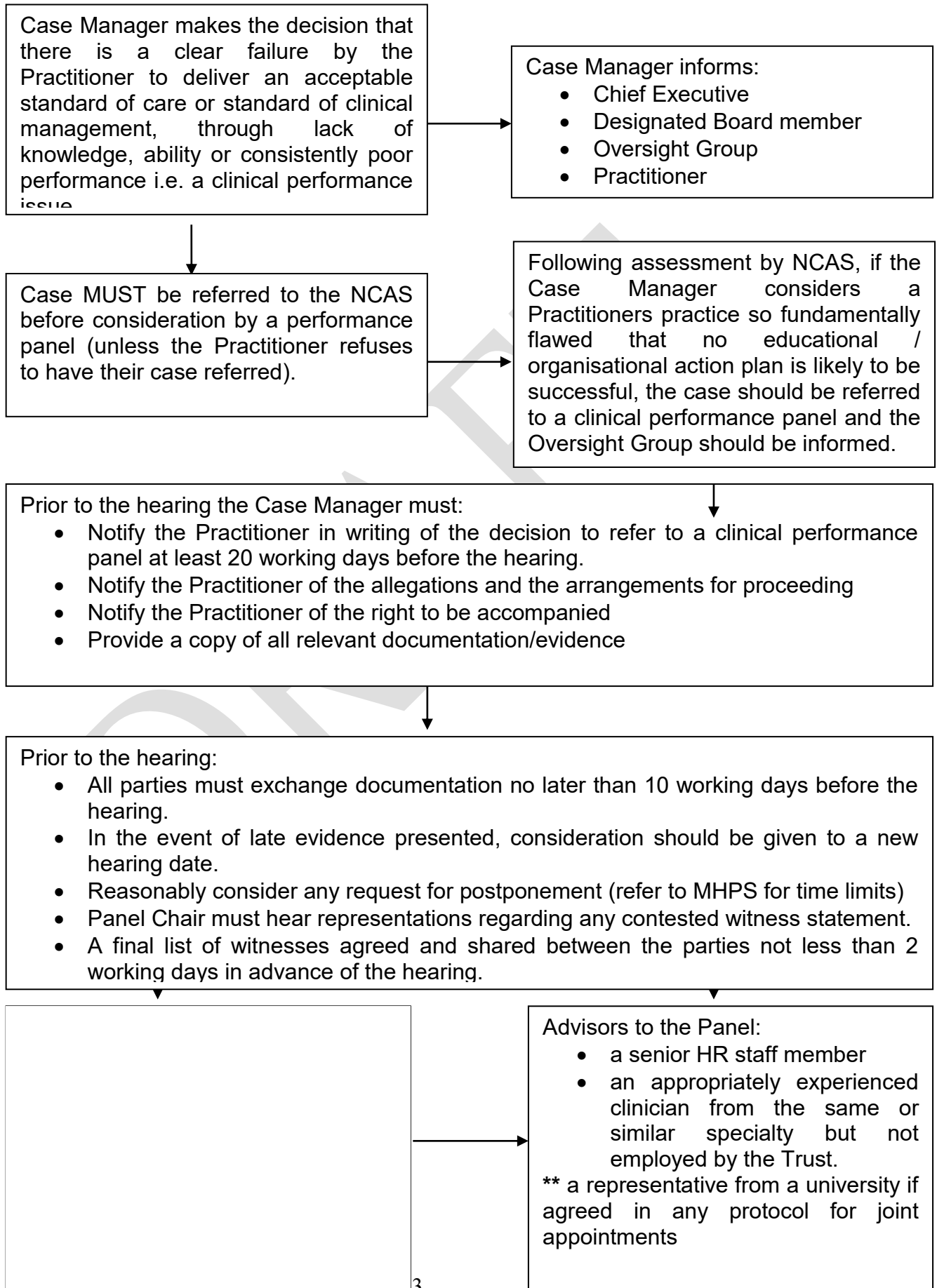
Formal Process



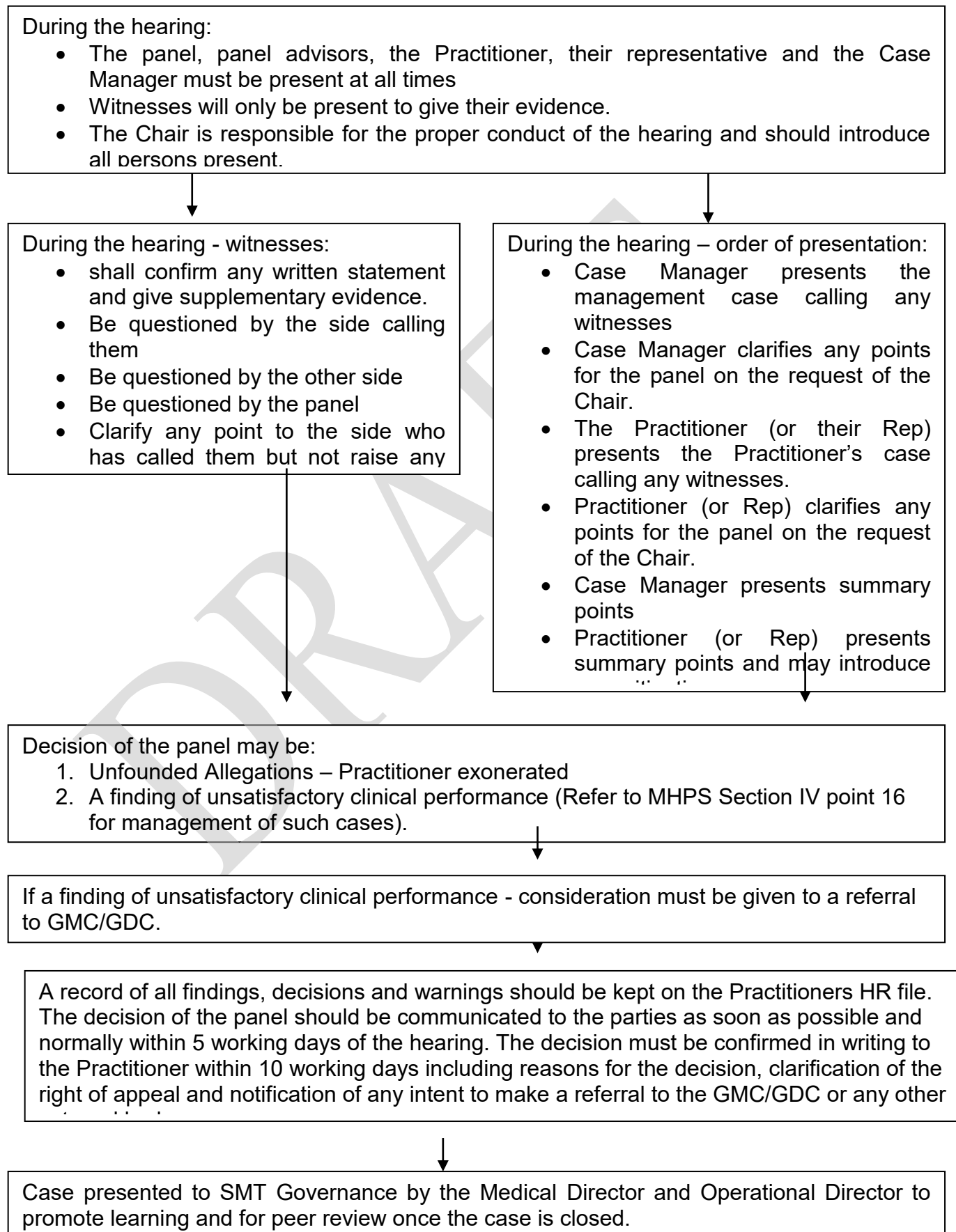
Conduct Hearings / Disciplinary Procedures



Clinical Performance Hearings



Clinical Performance Hearings



Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision.

The appeal panel should not re-hear the entire case but should direct that the case is

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

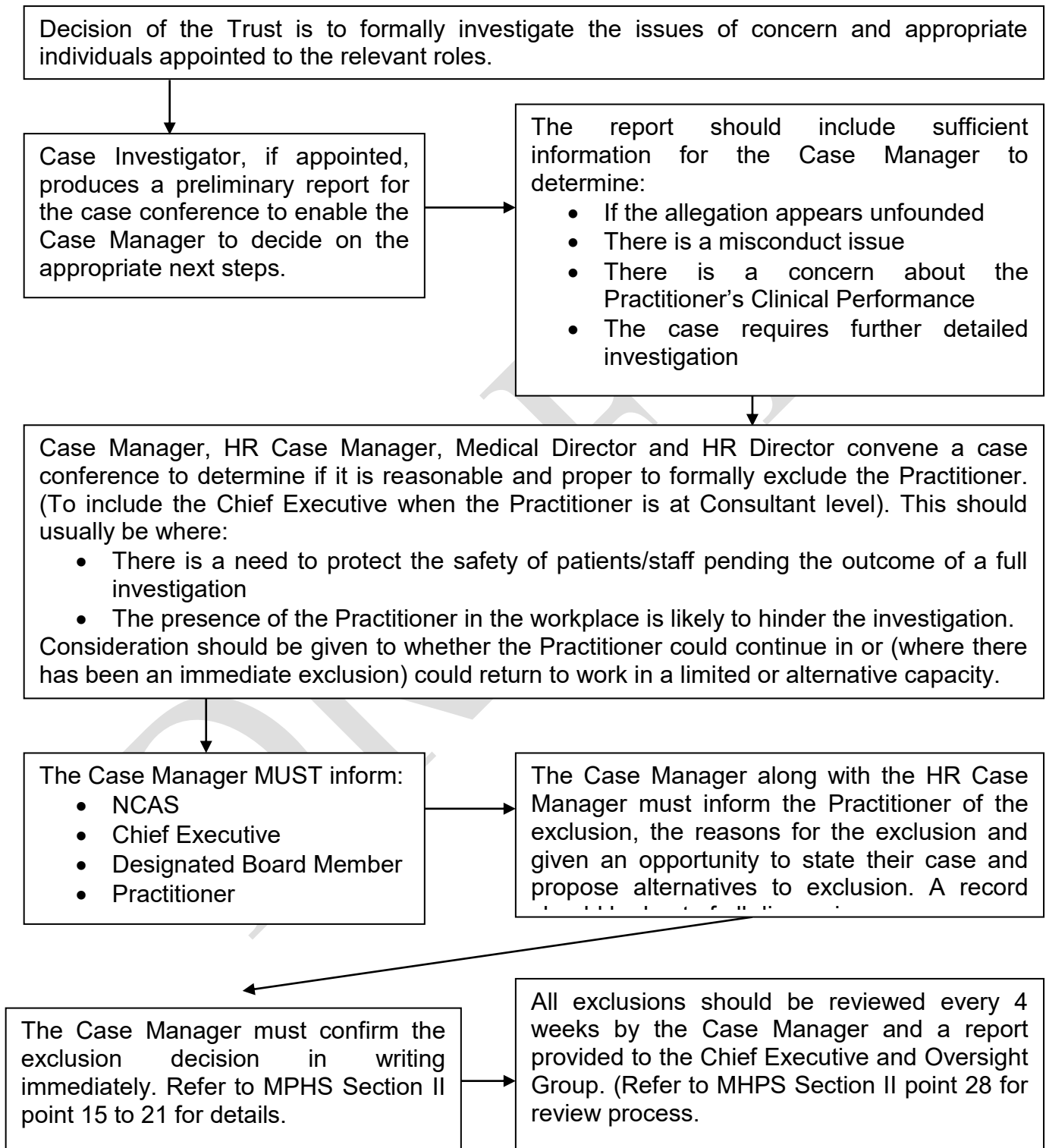
During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

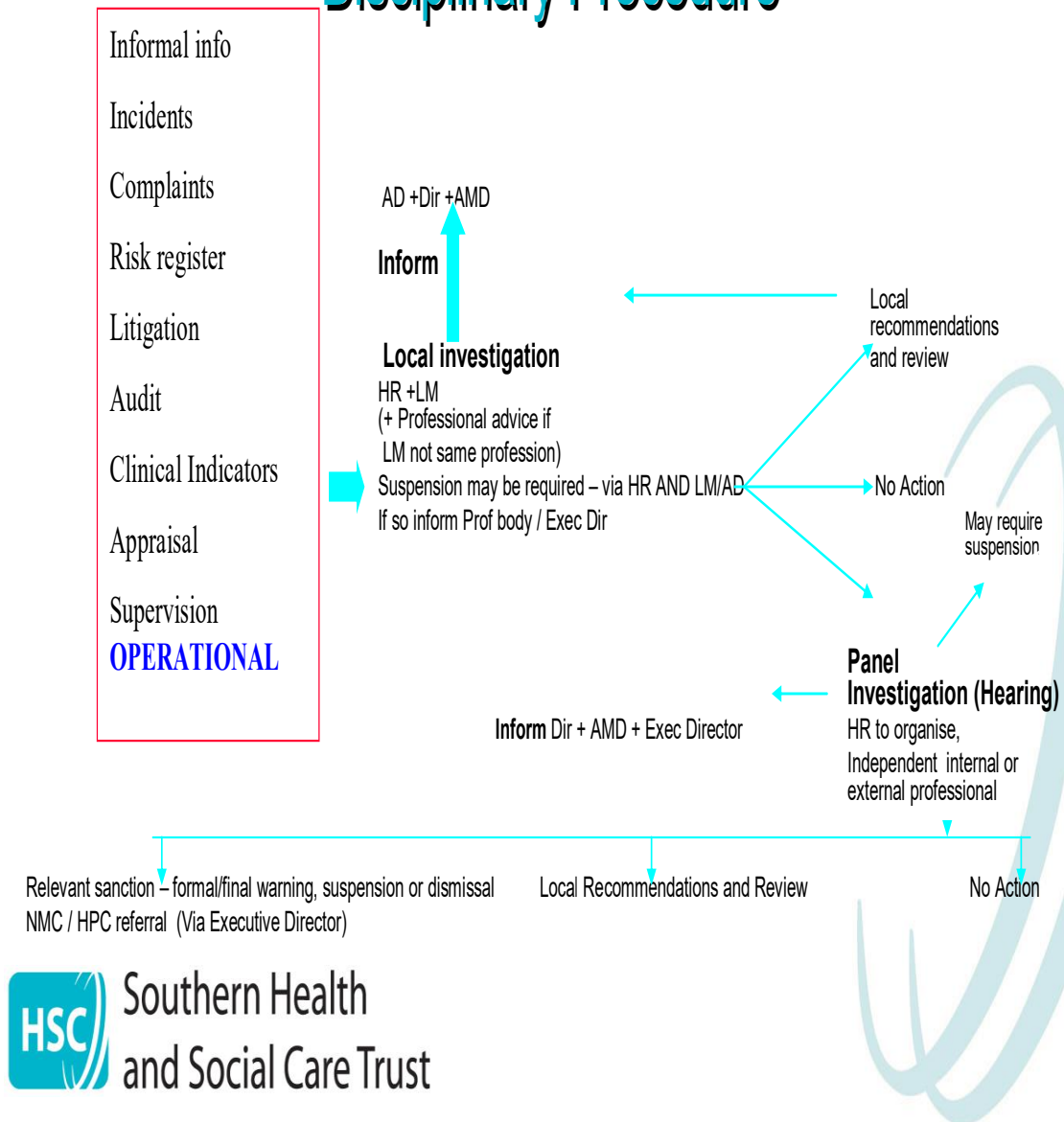
At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Restriction of Practice / Exclusion from Work

Formal Exclusion

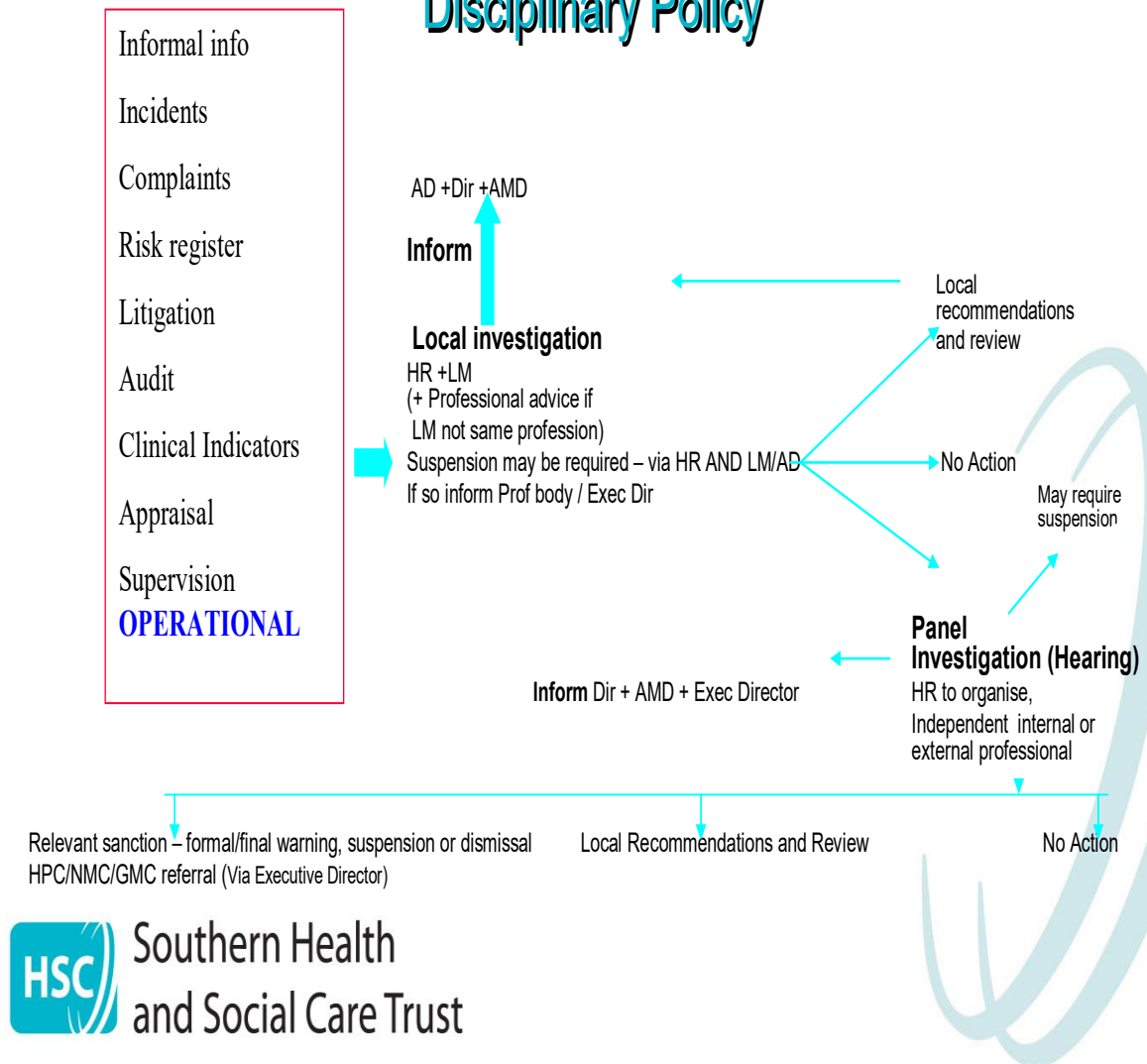


Agreement 6: – Managing poor professional performance - Nurse, AHP, SW. Ref – Trust Disciplinary Procedure



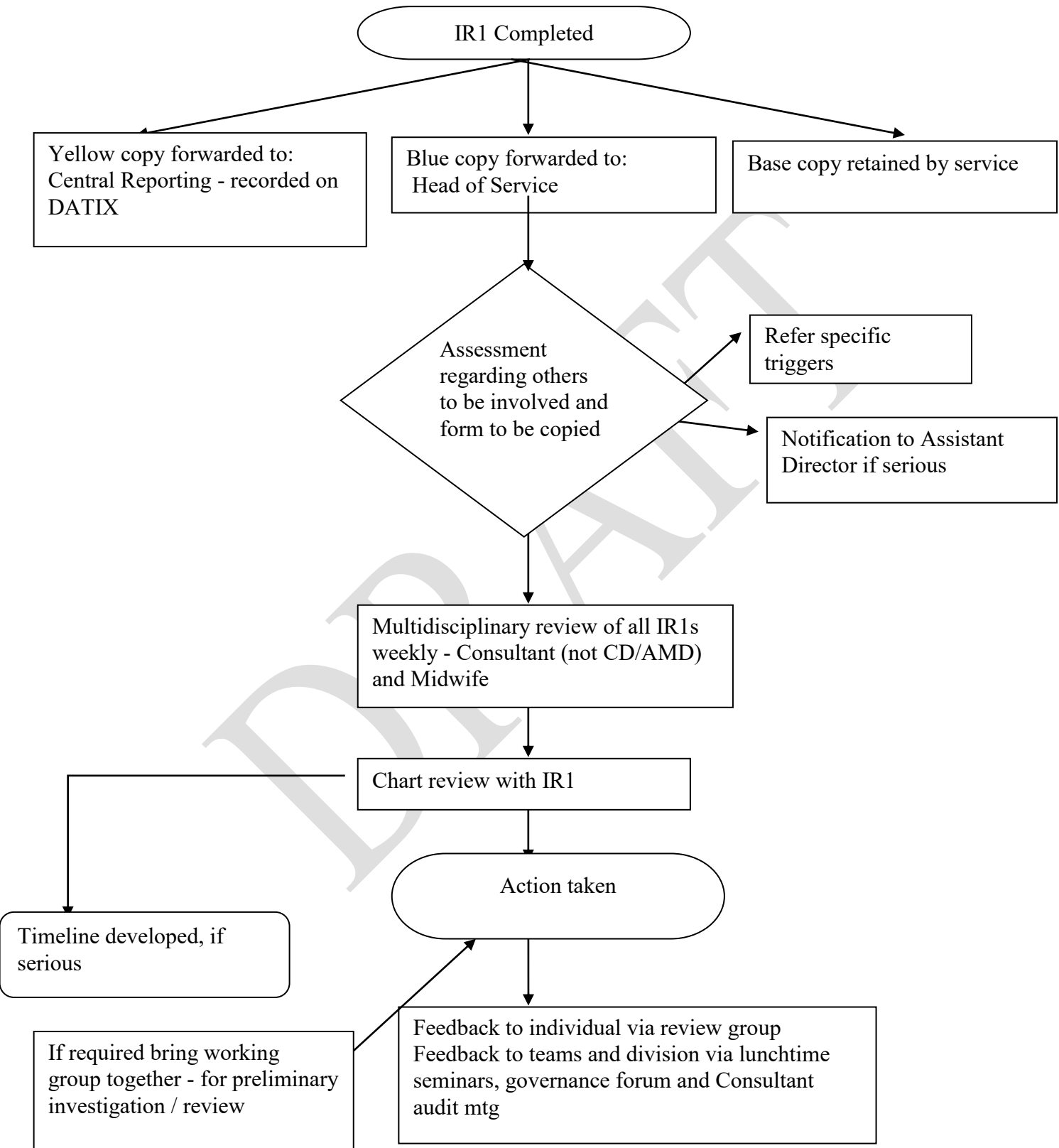
Agreement 8: Managing poor conduct – all employees.

Ref – Trust Working Well Together Policy and Trust Disciplinary Policy



Appendix 4 Example of - Acute Service Incident Management Process

Integrated Maternity and Women's Health - Model



**Appendix 5 Unregistered Workforces and Responsible Director for
Standards, Training and Development**