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AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

Confidence in Care

Guidance on the Role of Responsible Officers for Doctors and Employers

February 2011

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PURPOSE AND STRUCTURE OF THIS DOCUMENT

1. This is guidance to which responsible officers and designated bodies must have regard to under the Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010. It relates to the role of responsible officers to be nominated or appointed by those bodies designated under the Regulations. The guidance is also of relevance to doctors working outside designated bodies.
2. The guidance has been produced by the Department of Health, Social Services and Public Safety for Northern Ireland) (the Department) as part of the programme of reform (*Confidence in Care*) to professional regulation. In developing the guidance, the Department has drawn on the expertise of those practitioners involved in the programme's workstreams on revalidation and tackling concerns. Comments were also sought on the guidance during the legislative consultation process.
3. This document is designed to provide guidance to 3 key audiences:
 - all doctors licensed with the GMC to practise medicine;
 - all doctors taking on the role of responsible officer; and
 - all organisations designated as having to nominate or appoint a responsible officer in Northern Ireland.
4. Section 1 of the guidance sets out the background to the role of the responsible officer and describes it in the context of other measures aimed at improving the quality of care for patients and sustaining public confidence in doctors. It also defines the key areas of the responsible officer role.
5. Section 2 provides guidance for licensed doctors on how they relate to, and can identify, their responsible officer.
6. Section 3 is aimed at licensed doctors taking on the role of responsible officer. It provides guidance on a responsible officer's functions under the Medical Act 1983 (relating to the evaluation of fitness to practise) and their wider role under the Health and Social Care Act 2008.
7. Section 4 is aimed at designated organisations and defines their responsibilities in the legislation.

Coverage of this Guidance

8. This guidance relates to the Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010. As well as having duties in relation to regulation, responsible officers will be required to undertake a range of duties supporting clinical and social care governance.

Review of this Guidance

9. It is acknowledged that the role of the responsible officer will evolve as experience of the role is gained and shared. With this in mind the guidance will need to evolve to reflect developments and will be reviewed in light of operational experience.

SECTION 1 BACKGROUND AND KEY POINTS

Background

10. The role of managers, both medical and non-medical and systems in healthcare is to provide the best possible environment in which clinical professionals of all disciplines can deliver high quality, effective and safe care to patients.
11. It is acknowledged that the vast majority of doctors are competent and conscientious. However, after a series of high profile cases where the required professional standards were not met, proposals were made for a system of revalidation for every doctor.
12. The purpose of revalidation, when it is introduced, will be to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and are practising to the standards defined by *Good Medical Practice*¹.
13. The development of the responsible officer role is part of wide ranging regulatory reform set out in the White Paper *Trust, Assurance and Safety*.² In Northern Ireland, these reforms are being taken forward through the programme *Confidence in Care*. This programme values and celebrates the professionalism of the doctors who work in health and social care. In addition, it seeks to raise the already high standards of the overwhelming majority of doctors whilst ensuring that the small number of staff who are not meeting those standards are swiftly identified and any concerns are dealt with fairly and effectively.
14. In support of this the responsible officer role will:
 - ensure that those doctors who provide care continue to be safe;
 - ensure doctors are properly supported and managed in sustaining and continually raising their professional standards;
 - for the very small minority of doctors who fall short of the high professional standards expected, ensure that there are fair and effective local systems to identify them and ensure appropriate action to safeguard patients; and
 - increase public and professional confidence in the regulation of doctors.

¹ Good Medical Practice Framework for Assessment and Appraisal (GMP)

² Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century: TSO February 2007

Revalidation

15. The responsible officer will play a crucial role in the process of medical revalidation when it is introduced. This new process, and the role of the responsible officer, has major implications for every doctor and healthcare organisation. The Regulations mean that:
 - licensed doctors with a prescribed link to a designated body will relate to one and only one responsible officer;
 - the responsible officer, will make a recommendation to the GMC about the doctor's fitness to practice (as a positive statement of assurance, not simply an absence of concerns);
 - this recommendation for revalidation will be 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;
 - this supporting information must provide robust, accurate evidence about all aspects of the doctor's practice, including that resulting from any investigations already completed. It should be scrutinised through the clinical arm of corporate governance and be sufficient evidence that the doctor's performance meets the standards of *Good Medical Practice*
16. All designated healthcare organisations will be required to nominate or appoint, resource and support a responsible officer. This will be a senior licensed doctor, usually sitting on the Board of the organisation.
17. The public, the profession and the Health and Social Care sector (HSC) have a right to be assured that licensed doctors are fit to practise. The Regulations are designed to help doctors and the organisations in which they work further improve the quality of care provided to patients.
18. The roles and responsibilities of the responsible officer are described in this document as is the relationship between licensed doctors and a responsible officer and the duty of designated healthcare organisations to nominate or appoint to the role and resource it. The guidance has drawn on the outcomes of work undertaken across the UK, as part of the implementation of *Trust, Assurance and Safety*, together with local contributions from a wide range of clinicians, managers and patient groups who have been brought together to support the *Confidence in Care* programme .
19. The responsible officer arrangements will apply to the vast majority of practising doctors in the UK who will need to relate to a responsible officer nominated or appointed by a designated body.
20. The arrangements for revalidation for the small minority of doctors falling outside this framework are subject to further discussion with stakeholders,

and possibly piloting. The GMC, in partnership with all UK Health Departments and Medical Royal Colleges, are developing policy in relation to this group of doctors. When agreed, further guidance on the policy will be issued by the Department.

KEY POINTS

21. The following points provide the key messages in relation to responsible officers for all audiences.
22. A licensed doctor should normally relate to the responsible officer of the healthcare organisation most relevant to their principle area of practice.
23. The Regulations list designated bodies. All such organisations must nominate or appoint a responsible officer. The designated bodies are identified in the Regulations but they can broadly be summarised as:
 - Organisations that provide healthcare;
 - Organisations that set standards and policy for the delivery of healthcare;
 - Some specialist organisations.
24. These organisations should have only one responsible officer who carries overall accountability although individual tasks can be delegated.
25. A licensed doctor will have one, and only one, responsible officer at any point in time.
26. As a rule of thumb, a doctor will relate to the responsible officer in the organisation where they undertake the majority of their clinical work.
27. Doctors should ensure that they know who their responsible officer is.
28. Responsible officers must be doctors who are registered with the GMC and have a licence to practise medicine.
29. As licensed medical practitioners, responsible officers must relate to a responsible officer.

SECTION 2: GUIDANCE FOR ALL LICENSED DOCTORS

This section sets out the guidance that is applicable to all doctors in relation to the implementation of the responsible officer role and describes the relationship between a medical practitioner and 'his' or 'her' responsible officer.

A Doctors responsibility to a Responsible Officer

29. With the introduction of the new Regulations, a responsible officer will have a key role in supporting the doctors who are linked to the designated organisation to which they have been appointed. The role of the responsible officer across the UK is to evaluate doctors' fitness to practise. They will do so based on the evidence that is presented to them. To support doctors in compiling the necessary evidence, responsible officers will ensure that their organisation has the appropriate systems in place.

30. Every doctor who has a link with a designated body under the regulations will be required to undergo a strengthened process of appraisal in order to be able to demonstrate, by production of a portfolio of supporting information that their practice meets:

- Standards set by the GMC as laid out in Good Medical Practice⁽³⁾
- Expectations of their managed healthcare organisation in safely undertaking the clinical role for which they are employed or contracted.

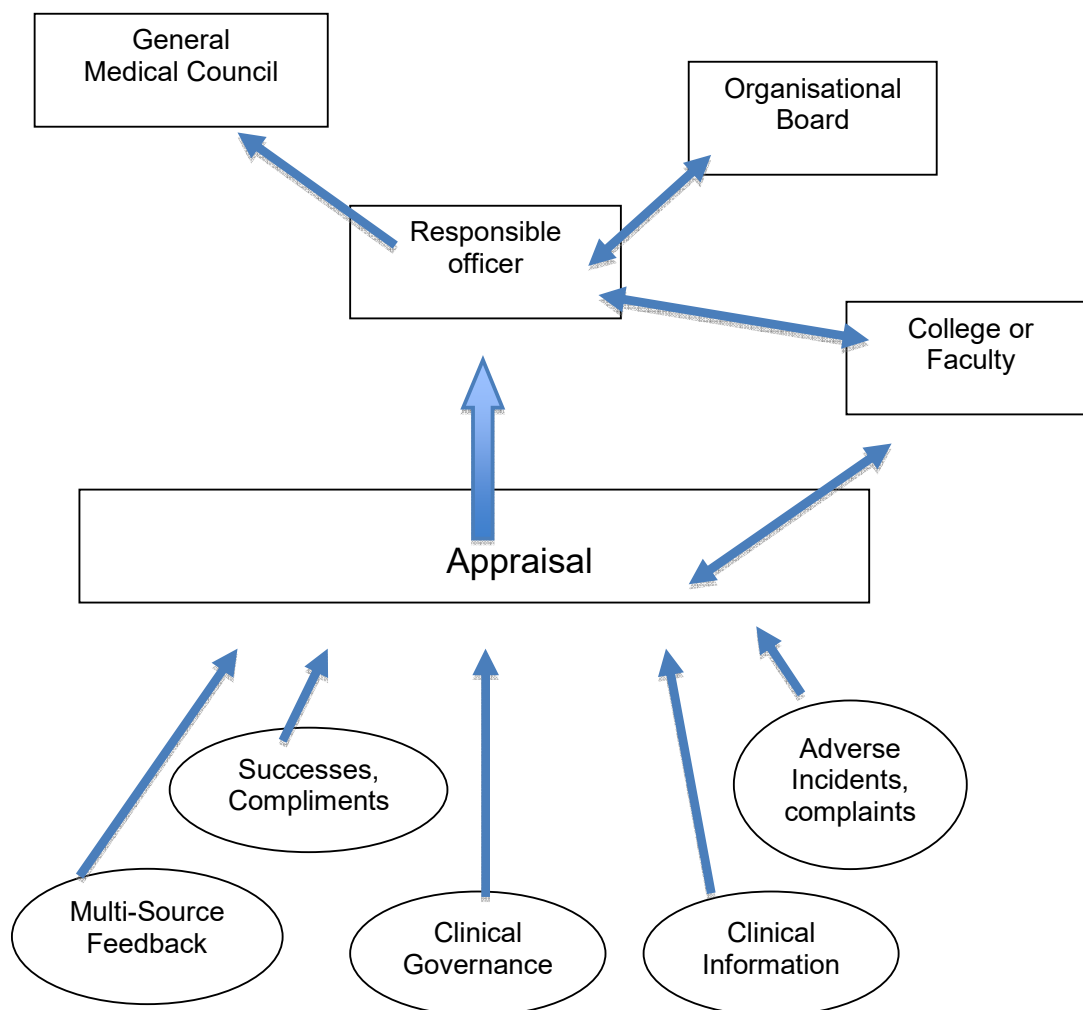
31. These systems must be fit for purpose and quality assured; the data generated by these systems will continue to be used to support doctors' portfolios, inform appraisal and will be the basis on which a recommendation on revalidation is made to the GMC. Therefore, this information must be properly assured, appropriately validated and reviewed where appropriate. It should also be accurate, timely, relevant to the full span of the individual's clinical practice and meet the standards set by the GMC.

³ Good Medical Practice, General Medical Council, November 2006
http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

Appraisal

32. The purpose of medical revalidation, when introduced, will be to assure patients, employers, commissioners and colleagues that licensed doctors are up to date and fit to practise.
33. The core mechanism underpinning revalidation will be a strengthened appraisal system, which is being designed to elicit the necessary information about a doctor's practice – see Figure 1.

Figure 1 – Appraisal System



34. Individual doctors will be expected to fully engage in the appraisal process and will be responsible for maintaining a portfolio of supporting information to demonstrate maintenance of their clinical and professional standards. .
35. The GMC have consulted on their proposals to require each doctor to inform, through the appraisal process, their responsible officer of all relevant practice they undertake. All relevant practice means all work undertaken by the individual in his or her role as a doctor, both clinical practice and non-clinical roles such as public health, administration, management and leadership.
36. Failure to do so may become a fitness to practise issue and may affect their future licensed status.
37. Supporting information for revalidation will be largely the same as the information doctors currently bring to their annual appraisal. 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. This range of supporting information should confirm the doctor is practising to the standards defined in the GMP framework and should include information required by the doctor's Medical Royal College where applicable and available.
38. The responsible officer will be accountable ultimately on behalf of the organisation for ensuring that the systems for appraisal, clinical governance and for gathering and retaining other local relevant information are in place and are effective. He/she will also be responsible for ensuring that systems are in place to record and collate all the necessary information, including a record of any practice undertaken by the doctor outside of the organisation.
39. Information from the outcomes of appraisal and the above organisational systems will be required by the responsible officer.
40. The responsible officer, having assessed all the information and, if necessary, consulted the relevant Medical Royal College or Faculty, will make a recommendation to the GMC regarding the doctor's fitness to practise. It is anticipated that the majority of doctors will be positively recommended in this way, with concerns related to the small number of doctors with performance or conduct issues having been identified and addressed as they arise through existing processes.
41. Appraisal is an annual process within a five year revalidation cycle, and, as such, it will provide useful points at which a doctor's progress towards revalidation can be reviewed, and identify any gaps identified in evidencing that a doctor is meeting the requirements of Good Medical Practice.

Concerns about a doctor's Performance

42. When a concern is raised about a doctor's performance, the responsible officer will decide whether local processes or remediation are appropriate or whether it is serious enough to warrant a referral to the GMC on the grounds of fitness to practise. However, this latter scenario should be a rare event.
43. It is the designated organisation's responsibility to ensure the proper governance of the process, challenging the responsible officer appropriately to ensure that any recommendation is based on evidence.
44. It is emphasised that where there is a justified cause for concern about a doctor's fitness to practise which cannot be concluded through local processes, the role of the responsible officer is limited to drawing the case to the attention of the GMC and to ensuring that the necessary supporting evidence is available. **Final decisions, which may affect the ability of a doctor to continue in practice, will remain, as at present, the sole responsibility of the GMC.**

Arrangements for Relating to a Responsible Officer

45. The arrangements are illustrated in Figure 2, Page 15. Doctors will relate to one responsible officer only. Each designated organisation will normally have only one responsible officer.
46. Doctors in postgraduate training will hold licenses to practise. Doctors in training are already subject to detailed assessment and performance review processes to meet the requirements of postgraduate medical training overseen by Northern Ireland Medical and Dental Training Agency (NIMDTA). NIMDTA will provide the responsible officer for doctors in training. Clearly both employers and NIMDTA have information that will be pertinent to confirming the fitness to practise of doctors in training. The effective flow of information between employer and the postgraduate dean will therefore be important to ensure a fair and robust process of revalidation, when introduced.
47. General Practitioners will relate to the Responsible Officer in the HSC Board. Where a doctor is also on a Performers List in another UK country, the doctor will relate to the Responsible Officer of the organisation where most of their work is carried out.
48. Doctors in HSC Trusts, the Blood Transfusion Service and the Regional Agency for Public Health and Social Well-Being will relate to the Responsible Officer of the employing organisation.

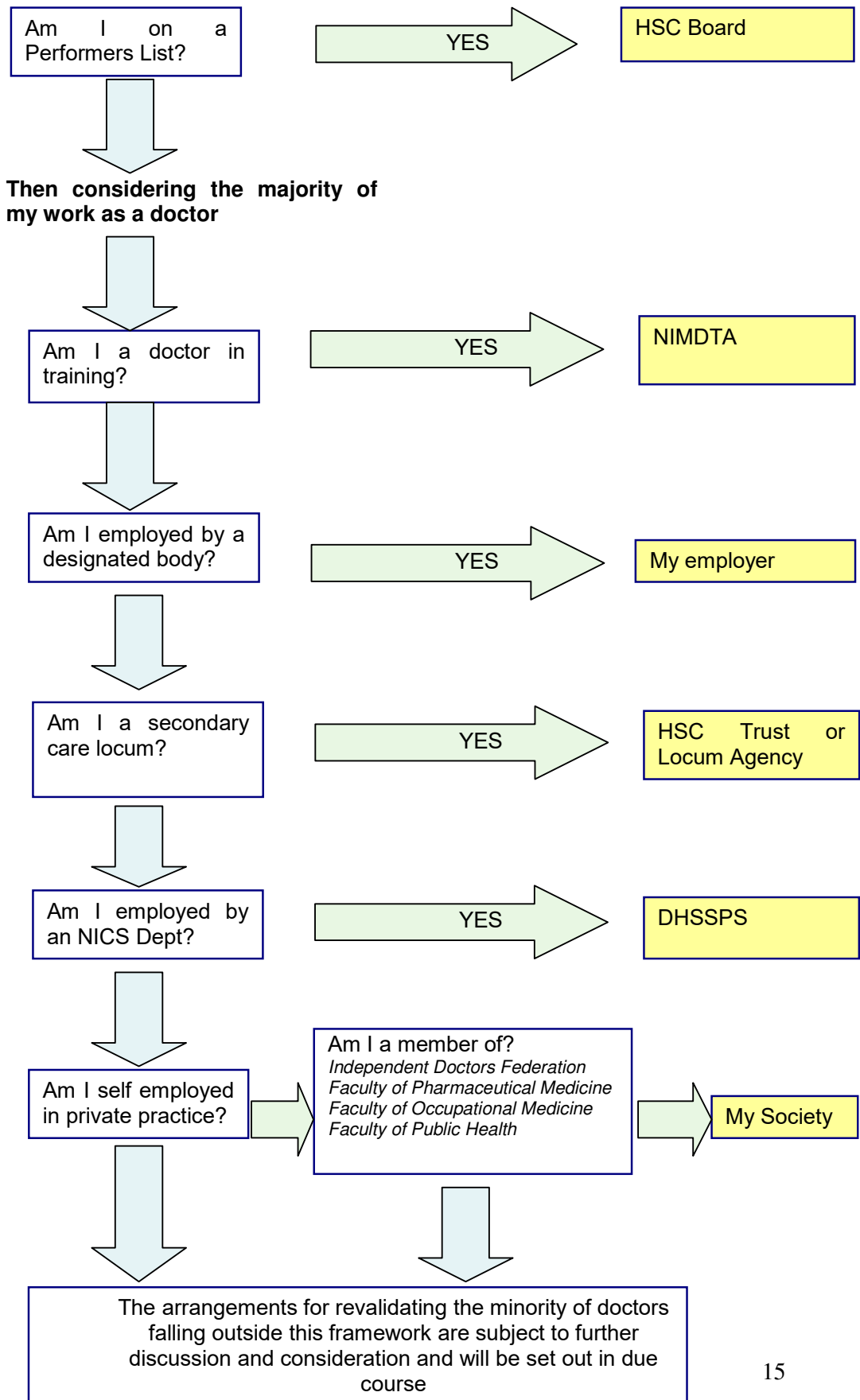
49. NIMDTA will also provide the Responsible Officer for all doctors employed by NIMDTA or employed for the majority of their time in NIMDTA. Similarly, RQIA (The Regulation & Quality Improvement Authority) will provide the Responsible Officer for all those doctors fully employed by RQIA or employed for the majority of their time by RQIA.
50. The Department of Health, Social Services and Public Safety (DHSSPS) will provide the Responsible Officer for all doctors employed for all or the majority of their time by Government Departments across the Northern Ireland Civil Service (NICS).
51. Where a doctor has more than one employer the principle will be that each doctor relates to the responsible officer of the organisation in which he or she works for the majority of his or her time. If there is no significant difference between the amount of work a doctor carries out for each designated body, then the doctor relates to the responsible officer of the organisation nearest to the doctor's registered address.
52. Responsible officers, as licensed doctors will also be required to have their fitness to practise confirmed and go through the revalidation process. As senior doctors in their organisations they will use the same systems as the doctors for whom they are responsible. They will have a responsible officer, outside their own organisation, who will ensure they are supported in the same way as those for whom they are responsible (regulation 10). Doctors must demonstrate their fitness to practise in the areas in which they work, rather than in the specialty in which they originally gained their Certificate of Completion of Training (CCT). For some doctors this will be the same speciality.
53. The Regional Agency for Public Health and Social Well-Being will provide the Responsible Officer for Responsible Offices of HSC Trusts, the Blood Transfusion Service, and the HSC Board.
54. The Department will provide the Responsible Officer for the Responsible Officers of the Regional Agency for Public Health and Social Well-Being, NIMDTA and RQIA.
55. The Permanent Secretary in the Department will nominate an appropriate responsible officer for the CMO from outside the Department.
56. For all other responsible officers, who cannot link to a responsible officer as set out in paragraphs 52-55, the Responsible Officer of RQIA will act as the Responsible Officer.
57. Doctors registered in the UK but working overseas or offshore should relate to the Responsible Officer of their employing or contracting organisation, where this is a designated body under the Regulations. For example, doctors in military service will relate to the Responsible Officer for the Defence Medical Services, regardless of where they happen to be at any particular time.

58. Locum doctors in primary care must be on the Performers List held by the HSC Board. The view across the UK is that a doctor on a Performers List should have a Responsible Officer in the primary care organisation responsible for that list. Therefore, locum doctors in primary care will relate to the Responsible Officer in the HSC Board.
59. Many locum doctors who provide services in secondary care are also employed by a designated organisation and will relate to the responsible officer of that designated organisation. Similarly, many Northern Ireland based doctors in training also act as locum doctors in secondary care but will relate to the Responsible Officer in NIMDTA.
60. There will remain a small number of doctors who practise exclusively in a locum capacity within the secondary care sector. They have a number of options in relating to a responsible officer. They may;
- link to a responsible officer in one of the organisations listed at paragraph 50
 - by virtue of the extent of work they perform for a single Trust, link to that Trust's Responsible Officer; or
 - by virtue of registration with a locum agency on the Office of Government Commerce Buying Solutions framework agreement (4), link to that agency's Responsible Officer.
61. It is recognised however that these arrangements may not facilitate this entire group of doctors in linking with a responsible officer. This will be the subject of further guidance.
62. The designation of organisations that are required to nominate or appoint a responsible officer ensures that the vast majority of doctors, and particularly those whose work affects the safety of patients, will relate to a responsible officer. We recognise however that there will be a number of doctors who do not work in clinical settings, and are not involved in direct patient care, but who nevertheless will wish to maintain a licence to practise. Examples include doctors working in law firms, universities, research companies and insurance companies. It is not considered either practical or appropriate to designate these types of organisation in the responsible officer Regulations. The arrangements for confirming the fitness to practise of these doctors are subject to further discussion with stakeholders, and possibly piloting. The Department will work with the GMC to bring forward proposals in relation to these doctors at a later date.

⁴ Contract reference number CM/AMN/07/4820; period of contract 1 July 2008 to 30 June 2011; responsibility for this agreement transferred from the NHS Purchasing and Supply Agency to Buying Solutions, an executive agency of the Office of Government Commerce, in October 2009. The agreement can be viewed at the following web site: <http://www.buyingsolutions.gov.uk/healthcms/Productsandservices/Agencystaffandoutsourcedservices/temporarystaff/Medicallocums/>.

How to Find Your Responsible Officer

Figure 2 illustrates how individual doctors can find out who their responsible officer is.



SECTION 3: GUIDANCE FOR THE RESPONSIBLE OFFICER

This section sets out guidance for responsible officers as it relates to their role in evaluating the fitness to practise of doctors, and provides guidance on the additional responsibilities of responsible officers which relate to clinical and social care governance. The section also provides guidance on who should be a responsible officer.

Roles and Responsibilities of the Responsible Officer

63. There are two principal processes for which the responsible officer has prime responsibility. These are:

- processes that will underpin the retention of doctors' licences; and
- processes underpinning referral of doctors to the GMC in those cases where there are doubts concerning fitness to practise.

64. The regulation of doctors is, and will remain, a matter for the GMC. Decisions about a doctor's fitness to practise will be taken by the GMC only after the appropriate procedures have been followed.

65. The responsible officer will be answerable to the GMC and their nominating or appointing organisation for ensuring that there are appropriate systems and processes in place for collecting and holding information that informs the evaluation of fitness to practise. This will include ensuring there are robust systems of appraisal in place as well as systems to identify, at an early stage, poor or deteriorating clinical performance and/or conduct. Where conduct or performance is falling below the usual high standards that doctors are expected to work to, the appropriate action must be taken to avoid potential harm to patients and to support doctors to get back on track. It is the responsibility of the organisation to ensure that these systems are properly resourced, reviewed and maintained.

66. Specifically, 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; and
- progress against doctors' personal development plans is monitored.

67. The responsible officer has to ensure that the organisation is advised of the resource consequences in terms of time, the processes for collection

of relevant supporting information, the staff and funds needed for rigorous processes of appraisal and for continuing professional development (CPD).

68. Medical Royal Colleges and Faculties may offer support to responsible officers if required to assist them to evaluate the specialist practice of doctors. The responsible officer may wish to avail of this resource, when required, to seek their input to the appraisal process, in terms of specialist practice.
69. The responsible officer has a statutory duty to co-operate with the GMC. The responsible officer will liaise with the GMC on matters connected with fitness to practise issues. In Northern Ireland it is likely that this liaison will build from the current arrangements where contact is made through the local GMC office.

Clinical and Social Care Governance

70. Responsible officers in Northern Ireland have a duty to ensure that the system of clinical and social care governance in their organisation is capable of supporting doctors in meeting the requirements of revalidation. Clinical and social care governance is defined ⁽⁵⁾ as “a framework through which (HSC) organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.” This definition reinforces the concept that, for the great majority of doctors, the focus of clinical and social care governance systems should be on quality improvement, in terms of the quality of care not only as delivered by each doctor but also by the entire team of which the doctor is part.
71. Responsible officers must be able to demonstrate that all associated governance systems are functioning effectively. For example, the responsible officer must ensure that the appraisal system is appropriately monitored and that a system of multi-source peer and patient feedback is in place and functioning effectively, as described in Assuring the Quality of Medical Appraisal for Revalidation ⁽⁶⁾. The function of appraisal, therefore, remains supportive and developmental but concurrently supports them in providing the evidence of the fitness to practise required for revalidation.
72. As part of the duties outlined above, the responsible officer must ensure that doctors are supported by the organisation in their efforts to improve their own performance and the quality of care they provide to patients. They must also ensure that:
 - contracts of employment or for provision of services (admission to the Primary Medical Services Performers’ List, for example)

⁵ *Best Practice, Best Care: a framework for setting standards, delivering services and improving monitoring and regulation in the HPSS*; DHSSPS (April 2001)

⁶ Assuring the Quality of Medical Appraisal for Revalidation (AQMAR); Revalidation Support Team; May 2009
http://www.revalidation.support.nhs.uk/Assuring_the_Quality_of_Medical_Appraisal_for_Revalidation.asp

are appropriate, effective, robust and designed to safeguard the patient;

- doctors' performance and conduct is monitored; and
- appropriate, timely action is taken when concerns about shortcomings in performance or conduct are identified.

73. The responsible officer duties in monitoring clinical performance and addressing concerns when they arise will also involve him/her in providing professional leadership and promoting a culture that celebrates and spreads best practice. If the culture does not support honesty, openness and a willingness to rectify and learn from failings, even the most sophisticated technology available will not deliver a system that works. Like any other system and process, the effectiveness of clinical and social care governance is dependent upon culture and attitudes. The responsible officer has a major role to play in creating and maintaining the appropriate culture to support good clinical and social care governance.

Revalidation of Doctors

74. In its consultation document, *The Way Ahead*, The GMC sets out instances where a responsible officer may not be able to make a recommendation that the doctor is fit to practise. These are;

- a. Where a doctor has not been in active practice and has clearly not engaged with any appraisal process or with his or her Responsible Officer. In these circumstances, there will be little or no evidence on which a Responsible Officer could make a positive recommendation that a doctor is up to date and fit to practise. In these circumstances the doctor will need to take an alternative route for revalidation or can expect to have his or her licence to practise withdrawn.
- b. If there are gaps in the evidence provided by the doctor, the GMC, based on the recommendation of the Responsible Officer, may decide to defer revalidation to enable the doctor to collect the necessary information. In the absence of negative information indicating that the doctor's fitness to practise is impaired, there would be insufficient grounds for referring the case to the GMC's fitness to practise procedures, but, equally, it would not be appropriate to renew the doctor's licence where there were significant gaps in the evidence required to show that the doctor was competent and fit to practise.
- c. Where there are concerns about a doctor's practice these should be identified as early as possible and, addressed through local processes in the first instance as set out in the next paragraph.

Conduct and Performance of Doctors

75. Responsible officers have responsibilities relating to the monitoring of conduct and performance of doctors who give rise to concern. Identifying a concern is merely the start of a process to safeguard patients. The responsible officer's responsibilities relate to the organisational systems which support local decision-making. For HSC Trusts in Northern Ireland this process is currently described in *Maintaining High Professional Standards in the Modern HPSS*⁷. Analogous guidance for the primary care sector is *Investigating Performance Concerns*⁸. It is crucially important that appropriate action is taken promptly. The responsible officer has a personal responsibility for initiating the action in relation to issues that arise from the conduct and performance of doctors. These actions may include:

- initiating an appropriate investigation, with trained investigators separate from the decision-making process;
- co-ordinating and co-operating with other concurrent investigations into broader systems failure;
- further monitoring;
- sharing information with, or seeking information from, other healthcare organisations (other organisations will be expected to share information appropriately);
- remediation, which may include re-skilling and rehabilitation training and development, mentoring, peer support, coaching or supervision; and
- excluding a doctor or placing local conditions or restrictions on their practice;

76. If an investigation confirms a valid concern, the root cause should also be traced. Many cases of apparent poor performance of an individual may in fact be due to a dysfunctional team or a wider organisational system. The responsible officer has a duty to support the quality of the environment and, if necessary, to initiate action to address wider systems or team issues that result in poor performance.

77. It is essential that the organisation continually learns and adjusts its systems on the basis of the findings of investigations. An investigation may reveal a system failure, the rectification of which may lie outside the responsible officer's or organisation's immediate control. Issues such as equipment failure, a design flaw, or poorly labelled drugs from a manufacturer, will need action on the part of the responsible officer to alert the appropriate bodies – Medicines and Healthcare products Regulatory Authority (MHRA) and the manufacturers, in addition to the immediate primary action needed to prevent harm to patients.

⁷ http://www.dhsspsni.gov.uk/hrd_suspensions_framework.pdf

⁸ INVESTIGATING PERFORMANCE CONCERNS: Primary Medical Services February 2009

http://www.dhsspsni.gov.uk/investigating_performance_concerns_guidance.pdf

Referral to the General Medical Council

78. In the event of concerns being raised about a doctor of a sufficiently serious nature to call into question the doctor's fitness to practise, the responsible officer will need to consider referral of the doctor to the GMC. The responsible officer is expected to co-operate with the GMC in establishing the appropriateness of the referral and will oversee the collation of the relevant information.
79. The responsible officer is not likely to make the decision to refer a doctor to the GMC in isolation; he/she must ensure that local performance procedures, where appropriate, are followed and that advice is sought from appropriate sources, for example from the Medical Royal Colleges and Faculties or the National Clinical Assessment Service (NCAS).
80. The responsible officer is also accountable for overseeing the process by which doctors whose practice is supervised and/or limited under conditions imposed by, or undertakings given to, the GMC. It is up to the responsible officer to ensure that the doctors they are responsible officer for comply with any conditions imposed upon them by the GMC. It is essential that good communication channels are set up and maintained to ensure that, for example, if a doctor is placed within an organisation for remediation, the host responsible officer is informed and oversees the monitoring process.
81. Whilst the responsible officer will, under normal circumstances, have a personal involvement in, and responsibility for, referral to the GMC where there is doubt about a doctor's fitness to practise, it is recognised that there may be specific circumstances in which another responsible officer should undertake the role. There may be a conflict of interest for the responsible officer – for example, a friendship, marriage, a business arrangement outside the organisation or long-standing acrimony. Whilst it is envisaged that these situations will be uncommon, it is important that appropriate governance arrangements are in place to address these.
82. External organisations in a sub-contracting relationship with the responsible officer function will need mechanisms in place locally to deliver the above actions, in accordance with the responsible officer's recommendations following a rigorous process of investigation.

Guidance from other sources

83. In addition to this guidance, responsible officers have a duty to have regard to guidance issued by specific organisations. These organisations include the Department, the GMC and the NCAS.

84. The responsible officer should ensure that clinicians delivering the service do so on the basis of the best evidence available on the effectiveness of interventions. This means having regard to National Institute of Clinical Excellence (NICE) guidance, to best practice guidance from recognised sources, to recognised national audits and to local audits of clinical practice. The responsible officer therefore also has a duty to ensure that this guidance is easily accessible and widely used within their organisation. It is the employing organisation's responsibility to ensure that clinicians have easy access to the best evidence so that they can practise to the highest standards. The onus is on both the clinician and the employer as partners in providing and using best practice guidelines and documentation.
85. The responsible officer has a duty to ensure that doctors are fit to practise. That may be difficult when the doctor is carrying out innovative treatments. Doctors carrying out procedures that are new, or for which they have no experience, have to gain approval through appropriate organisational research governance frameworks.

Relationships and accountabilities of the responsible officer across the UK

86. The responsible officer should be directly accountable to the organisation's Board or the highest level of management. The responsible officer also has a relationship with the GMC, in terms of a duty of co-operation on matters in connection with fitness to practise, including ethical issues.
87. Key relationships for the responsible officer at Executive Board level will be with the Chief Executive, Director of Human Resources and Director of Nursing. Within the organisation, the responsible officer will relate closely to the organisation's medical management, appraisal and clinical governance infrastructure. In the case of independent practitioners there may be a need for the responsible officer to relate to a number of organisations which provide these functions.
88. The responsible officer will also have a crucial set of relationships with the clinical leads of the various service lines of the organisation. This will be with clinical directors, clinical leads or service line leads in secondary care and clinical governance leads and clinical service leads in primary care, along with appraisal leads and trainers who will oversee the information processes and flows within the organisation. These individuals will be responsible for collating information on the performance of individual doctors to present to the responsible officer. The responsible officer will want to ensure that they are properly trained in appraisal and multi-source feedback and demonstrate that they are of the highest calibre and integrity.
89. The responsible officer will liaise, where appropriate, with the medical Royal Colleges and Faculties for information and support regarding specialist and GP practice and potential recommendations.

Who should be the Responsible Officer?

90. It is a basic requirement that a responsible officer must be a licensed doctor.
91. Each designated organisation will normally have only one responsible officer. He or she may devolve some aspects of the wider role to an assistant medical director or other medical manager as an “associate” to the responsible officer. However, the decision-making of the responsible officer, and recommendations made, are the responsibility of the responsible officer.
92. Organisations will need to make decisions as to how best to deliver the additional duties of the responsible officer on top of those already carried out by those who will absorb the role of responsible officer (e.g. Trust Medical Directors). This may necessitate some restructuring and strengthening of the organisation’s medical management infrastructure but this will vary according to existing arrangements that are in place and gaps that need to be filled.

Person specification

93. The responsible officer will be responsible to the Board/highest level of organisational management for assuring clinical performance in respect of doctors and, as a senior doctor, will also provide leadership to the medical workforce. As set out earlier, the discharge of this role will rely heavily on adequate clinical and social care governance systems across the organisation which may be the responsibility of another board member, for example the Executive Nurse Director.
94. The responsible officer must have practical experience as a senior doctor and have a licence to practise.
95. The responsible officer will be able to demonstrate evidence of continuing personal and professional development. Specifically, he/she must be able to demonstrate an ability to lead and manage change in complex healthcare organisations and have significant experience of medical management, including practical experience of performance management of colleagues, appraisal processes and audit. He/she must be able to demonstrate the ability to translate findings into remediation plans and to introduce new policies and strategies throughout an organisation. This will require being able to demonstrate knowledge both of the practicalities of clinical and social care governance and its crucial role in safeguarding quality of clinical care in the HSC.
96. In terms of special areas of skills and knowledge, the responsible officer will need to demonstrate a detailed, accurate and up-to-date knowledge of the law as it relates to medical regulation and interfacing structures and processes. He/she will need to be able to demonstrate expert knowledge

and skills in appraisal, quality assurance of appraisal systems and of appraisers, mediation, negotiation, remediation and rehabilitation.

97. The responsible officer will need to have an acute grasp of the management and interpretation of information gathered from the various reporting systems underpinning clinical and social care governance. In addition to data management, a sound knowledge of the principles of data protection are essential. He/she will need to understand how to access the resources of the employing organisation to enable the implementation of decisions made about individual doctors.
98. The responsible officer will need to be able to demonstrate that he/she is trained and skilled in his/her role as a medical manager and leader. He/she must be able to demonstrate to the public, their colleagues and to their organisation that he/she has the competences, skills, knowledge and attitudes required to deliver this important role. In addition to qualifications, responsible officers must be able to demonstrate their on-going development and training, with annual appraisals and assessments of performance.
99. The responsible officer will need to demonstrate the ability to communicate beyond the local organisation, with the public, GMC, medical Royal Colleges and Faculties.

Competences

100. There are also competences specific to the role of responsible officer, which are not appropriate to set out in the regulations. Instead they are set out in this guidance as competences that individuals must have before they can be nominated or appointed to the role of responsible officer.
101. These competences are:
 - communication skills;
 - mediation and arbitration skills;
 - evidence handling skills;
 - an understanding of the principles of investigation; and
 - an understanding of equality and diversity issues.
102. There is evidence that doctors from ethnic minorities are disproportionately represented in disciplinary procedures. It is important that responsible officers have a high level of understanding in this area to enable them to ensure that the organisation's systems and processes do not discriminate against any individual doctor or group of doctors.
103. A suitable range of skills, knowledge and behaviours is outlined in various competency frameworks for medical leaders. Across the broad competency domains of communication, managing and developing people, managing and developing the business (service), personal effectiveness, understanding the wider context of healthcare and improving quality, the responsible officer would be expected to function at the highest levels of competency.

104. The responsible officer will need to demonstrate his/her competence and the consistency of his/her decision-making, both within their organisation and in terms of supporting the decision-making of peer responsible officers. Regular assessments against an agreed set of standards should be undertaken to ensure that his/her decision-making is properly aligned with the regulations, with the GMC and with standards set by the appropriate professional bodies. Peer review with other responsible officers should also be undertaken on a regular basis.

Education and support

105. Every responsible officer will need to undergo initial and on-going education, assessment and support. Initial educational interventions will vary in scale and scope. There are significant differences in terms of needs between those who have been in medical director positions in large complex organisations for many years, with a wide range of experience and a well-developed medical management infrastructure, as opposed to those who are taking on the role in an organisation with a developing medical management infrastructure and less experience of management or clinical and social care governance.
106. For some, taking on the responsible officer role will mean adding on a new knowledge-base and a set of skills to already well-developed and honed medical management competences. For others it will mean a steep and rapid learning curve against a background of organisational change as the necessary structures and processes are put in place.
107. As a minimum, in addition to education and development in management and leadership required to the equivalent of the medical director, the responsible officer will need to develop an understanding of the following:
- the law underpinning medical regulation;
 - the process of medical revalidation as it is introduced;
 - natural justice and other legal processes and principles;
 - the processes underpinning, and resulting from, performance management of medical colleagues;
 - handling colleagues about whom there is concern, from investigation through to local remedy or referral to the GMC;
 - monitoring organisational systems of clinical governance, both in terms of the information output and the rigour of the systems themselves;
 - monitoring other associated information systems;
 - quality assurance and education of appraisers, the quality assurance of systems of appraisal and audit; and
 - structures of accountability, both within the organisation and externally.

Organisations should ensure that their responsible officer is facilitated to take part in peer networking and other forms of support and learning,

including periodic formal assessment of their performance in the role as it feeds into their own appraisal.

Conflict and its resolution

108. It is important that the evaluation of a doctor's fitness to practise is fair, honest and evidence based if it is to provide the assurances that patients and doctors require from the system. In some circumstances, doctors may find there is a conflict of interest or appearance of bias with their appraiser or responsible officer. The following are examples of where a conflict of interest or appearance of bias may occur:

Personal relationships:

- where there is or has been a personal relationship (marriage, partnership etc) between a responsible officer and a doctor or where the two are related in any other way;
- where there is a financial or business relationship between a responsible officer and a doctor;
- instances where a third party is involved e.g. an affair or marriage breakdown;
- where there is a known and long-standing personal animosity between a responsible officer and a doctor.

Managerial or organisational roles

The different roles of managers and clinicians might create a situation where a conflict of interest or appearance of bias might need further consideration:

- a clinical director might be called on to comment on the clinical practice of their own responsible officer; or
- a responsible officer who is appraised by a medical chief executive might then have to make a fitness to practise recommendation in respect of the chief executive.

109. If a conflict of interest or appearance of bias is identified between appraisee and appraiser, the responsible officer should be informed in writing, explaining the conflict and providing as much background information as is necessary and relevant. It may be appropriate for the responsible officer to request that another appraiser is assigned. The responsible officer will not themselves assign the new appraiser. It will be the responsibility of the appropriate clinical director or appraisal lead to assign a new appraiser in such cases.

110. If a conflict of interest or appearance of bias exists between a doctor and a responsible officer, the designated body should be informed in writing giving as much information as possible. It is important that every attempt is made to resolve the issue using the existing mediation procedures. If, after all processes are exhausted, a satisfactory resolution is not possible the evaluation of fitness to practise may be overseen by another responsible officer. In such circumstances, the designated body

should seek advice from the responsible officer's own responsible officer and the decision should be recorded in writing.

111. Whilst for the most part doctors will relate to the responsible officer in a non-confrontational manner, there may be occasions when there is conflict between an individual doctor and the responsible officer. This could be as a result of the decisions a responsible officer has made about an individual practitioner, or it may be a long-running conflict on an unrelated matter. There may be underlying conflicts of interest, business arrangements or close friendships and relationships.
112. It is essential to ensure that there are checks and balances on the decision-making of the responsible officer so that where there is a conflict of interest that may sway the process, and thereby potentially cause harm to patients, this is recognised, made explicit and other arrangements put in place. For example, if there is a conflict of interest, a responsible officer from another organisation may be sought to handle the evaluation of fitness to practise of the doctor concerned.
113. Every responsible officer must be a senior, licensed doctor and, as such, will be professionally accountable to the GMC for his or her ethics and decision-making. Influence by conflicts of interest represents a breach of the standards set out in *Good Medical Practice*.

SECTION 4: GUIDANCE FOR HEALTHCARE ORGANISATIONS

This section is aimed at designated bodies or organisations and defines their responsibilities in the Regulations.

The Duty to Nominate or Appoint a Responsible Officer

114. The Regulations require that designated bodies nominate or appoint a responsible officer. The designated bodies are either organisations providing healthcare or those with a role in setting the policy or standards for healthcare.

115. Some bodies always employ or contract with doctors and have been designated unconditionally while others will only have to nominate or appoint a responsible officer when they employ or contract with doctors. Some of the latter bodies may find that they do not need to nominate or appoint a responsible officer because the doctors they employ have connections with other organisations, for example, an out of hours provider of healthcare whose doctors are all on the Performers' List.

116. If there is any doubt about whether you are a designated body you should seek legal advice.

117. Unconditionally designated bodies include:

- HSC Trusts;
- The Regional Health and Social Care Board;
- The Regional Agency for Public Health and Social Well-Being;
- The Department of Health, Social Services and public Safety;
- The Northern Ireland Medical and Dental Training Agency.

118. Bodies that have to nominate or appoint a responsible officer only if they employ or contract with licensed doctors, as listed in Part 2 of Schedule 1 to the Regulations, include other providers of healthcare services and other government bodies.

119. In addition, the following organisations are also designated to provide responsible officer services to their members if they are not linked to any other designated body:

- The Independent Doctors Federation;
- The Faculty of Occupational Health of the Royal College of Physicians of London;
- The Faculty of Pharmaceutical Medicine of the Royal College of Physicians of London; and
- The Faculty of Public Health Medicine of the Royal College of Physicians of London.

Resourcing Responsible Officers

120. The Regulations require designated bodies to provide the responsible officer with sufficient resources to discharge their duties.
121. It is crucial that responsible officers are supported at the appropriate level in order for them to fulfil their role of improving the quality of care across all its dimensions, including patient safety. In the majority of organisations, the responsible officer will be employed by the same healthcare organisation as that which employs the doctors for whom he/she is responsible. The Regulations require that the organisation provide the resources needed to carry out the statutory duties.

Alternative Arrangements

122. If an organisation is designated to nominate or appoint a responsible officer, but considers it is not feasible to provide the function internally, the organisation may ask another designated body to provide the responsible officer function. The Regulations require designated organisations to provide the responsible officer with funds and other resources to carry out their statutory duties.
123. Where organisations are making a charge for providing the responsible officer function to doctors with whom they do not contract, nor employ, these charges should be reasonable and related to the marginal costs of providing the service. If the additional work of providing the responsible officer function escalates, however, and consumes significant time, then marginal costs will not suffice. A portion of the full costs of the responsible officer and the establishment may also be charged.
124. It is also essential that the organisation provides sufficient time for the responsible officer to perform his or her function effectively. The role is complex and demanding. It is likely to require a significant commitment, depending on the size of the organisation, the number of doctors its responsible officer is responsible for and the level of support for them. Organisations may have to strengthen and re-arrange medical management infrastructures to enable responsible officers to deliver their responsibilities.
125. The responsible officer is a senior role and should normally be nominated or appointed by means of a fair and open competition, with a rigorous process, involving assessment of the individual's competences. Initially it is anticipated that organisations will want to nominate an existing senior doctor such as the medical director who by virtue of that position will meet the above conditions.

Organisations will have to ensure that the responsible officer is properly developed and supported by education, skills training and personal development opportunities. The organisation should ensure that the responsible officer takes part in a peer network to ensure sharing of learning, challenge and support in tackling new situations. There will

undoubtedly be a learning curve and employing organisations must ensure that the Responsible Officer is as well supported and developed as possible. However since much of the role of the responsible officer is already undertaken by medical directors, the foundation for this support should on the whole come from existing procedures and systems.

126. The employing organisation has a responsibility to ensure that, on nomination or appointment to the responsible officer role, the responsible officer has the competences set out in paragraph 4.4.10. The competences of the responsible officer against an agreed and transparent set of standards must be reviewed on a regular basis, as part of his/her appraisal process. The responsible officer's appraisal process could include review by another responsible officer from a similar organisation, or by a clinical or academic colleague, with any recommendation arising from the evaluation of fitness to practise being made by the responsible officer's responsible officer.
127. The effectiveness of the responsible officer will necessitate timely access to the appropriate information. This means that the employing organisation will have to ensure that information systems underpinning the clinical elements of corporate governance and any other relevant processes (for example multi-source feedback) are properly resourced and functioning. Much of the data will already be held on systems of clinical and social care governance and the task will be mainly one of collation. It is essential that the staff charged with the responsibility of inputting or collating sensitive data concerning individual clinicians performance are of high calibre, have credibility in the organisation, understand the absolute need for security of the information, are well trained and are regularly assessed. They will be expected to work very closely with both those collecting the data and those using it.
128. Information will also be required from other organisations and individuals. These include:
 - other employers, immediately past and present;
 - all organisations in which the doctor works, including independent practice;
 - commissioners of services where appropriate; and
 - organisations and individuals who undertake appraisals of doctors.
129. The supporting information required will relate to concerns about the conduct or performance of individual doctors, and information from the individual's appraisals. Such information may include:
 - information on the quality of the doctor's performance;
 - information tailored to the minimum standards required by the relevant Royal College for certification;
 - feedback/letters from patients or colleagues;
 - multi-source feedback;
 - participation in clinical audit;
 - training and CPD activity;
 - records of complaints about the doctor; and
 - the outcomes of such complaints.

SOUTHERN HEALTH AND SOCIAL CARE TRUST
ANNUAL REPORT & ACCOUNTS
FOR YEAR ENDED 31 MARCH 2016

SOUTHERN HEALTH AND SOCIAL CARE TRUST
ANNUAL REPORT & ACCOUNTS
FOR YEAR ENDED 31 MARCH 2016



Laid before the Northern Ireland Assembly under Article 90(5) of the Health and Personal Social Services (NI) Order 1972 (as amended by the Audit and Accountability Order 2003) by the Department of Health, (formerly known as the Department of Health, Social Services and Public Safety)

on

26th August 2016

SOUTHERN HEALTH AND SOCIAL CARE TRUST

ANNUAL REPORT & ACCOUNTS FOR YEAR ENDED

31 MARCH 2016

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SOUTHERN HSC TRUST

ANNUAL REPORT AND ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

FOREWORD

These accounts for the year ended 31 March 2016 have been prepared in accordance with Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, in a form directed by the Department of Health, Social Services and Public Safety.

CONTACT US

Southern Health and Social Care Trust
Trust Headquarters
Southern College of Nursing
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Telephone: **028 3833 4444**

Email: Corporate.HQ@southerntrust.hscni.net

Web: www.southerntrust.hscni.net

COMMENTS

If you have any comments about this report or would like extra copies please telephone 028 3861 3954.

DIFFERENT FORMATS

This report can be made available on request in large print, on disk, via email, in Braille, on audiocassette or in minority languages for anyone not fluent in English. Telephone: 028 3861 3954.

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SOUTHERN HSC TRUST**PERFORMANCE REPORT****OVERVIEW****Message from Chair and Interim Chief Executive**

All of us who work in health and social care are very much aware that the pace of change, and increasing demand for our services, continues to present significant challenges to those responsible for delivering care.

As we reflect on yet another busy year, it is only right that we acknowledge the efforts of the over 14,000 staff who are engaged in health and social care in this area.

There are over 369,000 people living in the Southern Trust area – and virtually everyone who lives here will come into contact with our staff at some point during the year.

It might be in hospital, through care at home, in day care, being supported by mental health services – it might be for a few minutes, it might be for weeks or months - but no matter where, or for how long, what every member of staff brings to the service is vital to our success.

There is no doubt that once again our staff have risen to the challenges we face – and have not only met those challenges, but have demonstrated on a regional and national level, that the work we do here is amongst the best in the UK.

We are proud to once again have this opportunity to report on the many achievements across the Trust this year, to acknowledge the challenges we face and to look forward to a changing health and social care environment that will, no doubt, present many opportunities for development in the year ahead.

Any visitor to our acute hospital sites at Daisy Hill in Newry and Craigavon Area Hospital will notice how much development work is going on at both sites.

Our plans to modernise hospital services for children and young people are now well underway, with major construction work on both sites. The Department of Health has supported our plans with an investment of £14.5m on a new, dedicated children's surgical centre at Daisy Hill and a new children's centre on the Craigavon site.

We have also celebrated the official opening of the Banbridge Health and Care Centre and Day Care Facility, by Health Minister, Simon Hamilton. It's a fabulous new building, providing a wonderful environment for adults with a learning and physical disability and a range of health and social care services for the local community.

Staff, patients and visitors to Craigavon Hospital have been very tolerant while we carried out some essential maintenance work in the wards. It was a huge effort from everyone to complete the work in such a short time, so great credit must go to all those involved in improving the ward environments for the benefit of our patients.

Our Learning Disability Crisis Response team, the first of its kind in Northern Ireland, has been recognised nationally as an example of positive practice, and is now a model for the development of services elsewhere in Northern Ireland.

The Trust's 'Acute Care at Home' service is now offering hospital care to older people either in their own house or nursing/residential home and has been getting well deserved national recognition for this excellent initiative. Our Quality Improvement Day in October showcased this service and so much more that the Trust does well and was a credit to all who took part.

Many of our staff have been recognised both regionally and nationally for their work and we are very proud of their achievements, all of which contribute to ensuring we deliver excellent care. Two highlights have been the award for UK Radiography Team of the Year and the multi -award winning project to raise awareness of the signs and symptoms of lung cancer – there are too many winners to personally acknowledge here but you will see examples of ground-breaking work elsewhere in the report.

We continue to work closely with our partners outside the Trust. The Councils in the Southern Trust area have reduced from five to three – Armagh, Banbridge and Craigavon; Mid-Ulster and Newry, Mourne and Down. While there are some new faces, our working relationships remain strong and we continue to liaise closely with our colleagues on improving the health and well-being of our population.

Our staff have chosen to support Marie Curie as Charity of the Year. The enthusiastic response of our staff is a reflection of their generosity and their commitment to others – we look forward to the Southern Trust 'Strictly Come Dancing' event later this year.

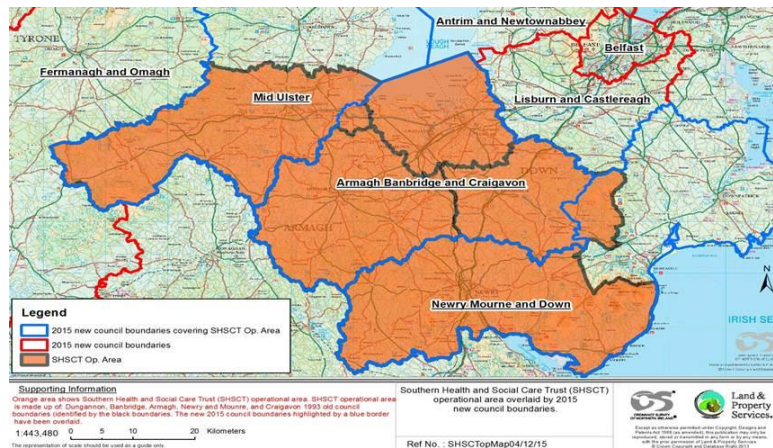
Next year will bring many challenges - a changing political environment, increasing patient and client numbers, financial pressures and a growing population in the Southern Trust.

It is critical to our future success that we have the skills, expertise and a quality infrastructure to support the high level of care we want to deliver – we remain committed to driving forward improvement, investing in our staff, continually enhancing the experience of the population we serve and being recognised as a high performing Trust.

About the Trust

The Southern Health and Social Care Trust was formed on 1 April 2007 following the Review of Public Administration.

Location and type of facilities provided



The Trust provides integrated health and social care services to the council areas of Armagh, Banbridge and Craigavon; Mid-Ulster and Newry, Mourne and Down.

The Trust provides a wide range of hospital, community and primary care services. Main in-patient hospital services are located at Craigavon Area Hospital and Daisy Hill Hospital. Working in collaboration with GPs and other agencies, staff deliver locally based services in Trust premises, in people's own homes and in the community. The Trust purchases some services including domiciliary, residential and nursing care from independent and community/voluntary agencies.

Population

Age	Population
0-14	79,208
15-64	221,033
65+	69,150
Total Population	369,391

Key Financial Facts

In 2015/16 the Trust incurred gross expenditure of £615m. The Trust employs around 9,893 (whole time equivalent) staff and manages an estate worth £304m.

Our Vision

To deliver safe high quality health and social care services, respecting the dignity and individuality of all who use them.

Our Values

We will:

- Treat people fairly and with respect;
- Be open and honest and act with dignity;
- Put patients, clients, carers and community at the heart of all we do;
- Value staff and support their development to improve our care;
- Embrace change for the better; and
- Listen and learn.

A year across the Southern Health and Social Care Trust

April

- The final phase of a major £15.5 million redevelopment of the main theatres at Craigavon Area Hospital was completed. Work began on the ambitious projects in May 2011 and completion of this final phase means that the hospital's main theatre department meets the highest modern quality standards.
- Two new theatres were constructed as part of the scheme which also included the refurbishment of existing theatres.



May

- Trainee anaesthetists from the Southern Health and Social Care Trust scooped the top three places in the prestigious Dundee Medal competition organised by the Northern Ireland Society of Anaesthetists.
- Two Anaesthetic Registrars based at Craigavon Area Hospital, Dr Stephen Cullen and Dr Alison Blair, came joint first place whilst Staff Grade, Dr Jill Cochrane, who works at Daisy Hill Hospital, took second prize at the annual awards in memory of Professor John W. Dundee OBE.



June

- The Craigavon Area Hospital team of physiotherapists was the first in the UK to introduce ground breaking aquatic therapy to treat critically ill patients.
- One patient who took part in the pioneering treatment was 27 year old Gareth Galway who, due to Guillain-Barré Syndrome, had complete paralysis and respiratory failure. Following seven weeks in Intensive Care, Gareth benefitted from aquatic therapy, improving his mobility and



assisting greatly in his recovery.



- Following a successful fundraising partnership with the Southern Area Hospice, this year staff nominated Marie Curie as the Trust's Charity of the Year. The enthusiasm and generosity of staff is already evident, with thousands of pounds already raised.

August

- The Southern Trust's Learning Disability Crisis Response Team received national recognition as an example of Positive Practice in the 'Strengthening the Commitment: Living the Commitment' National Report. This Crisis Response Service is the first of its kind in Northern Ireland and helps adults with learning disabilities avoid a hospital admission in a time of difficulty. It has also been identified by the Health and Social Care Board as a model upon which similar services are to be established regionally.

**September**

- We introduced a new web based system to help improve the way information from the Endoscopy Service is recorded. Prior to this around 80 staff and 300 patients across Daisy Hill, Craigavon and South Tyrone Hospitals had to complete paper surveys each year which had to be manually collated and summarised. The new electronic solution is much easier and more convenient to complete and the anonymous feedback is immediately submitted and automatically summarised.

**October**

- Our consultant-led 'Acute Care at Home' service began offering hospital care to older people either in their own house or nursing/residential home. In its first year, the pilot service has prevented around 400 hospital admissions and has supported a much earlier discharge for about 100 people.

**November**

- Radiology staff at Daisy Hill Hospital welcomed a major upgrade to their department. The £485,000 investment in digital technology follows an initial upgrade in 2014 so the entire department is now operating from a digital platform, as part of on-going modernisation of our hospital services.

**December**

- Daisy Hill was the first hospital in Northern Ireland to trial a new baby heart screening test. The paediatric team worked closely with their maternity colleagues to introduce a routine oxygen saturation test for all new babies before they are discharged home.

January

- On Monday 25 January 2016, the new £16 million Health and Care Centre and Day Care facility in Banbridge officially opened for business.
- The new centre, which includes the Linenbridge Day Care Centre for clients with physical and learning disabilities, is conveniently based beside local GP practices on the Health Village site. It brings three previous facilities together into a modern, purpose-designed centre, providing a superb environment for a wide range of patients and clients.



February

- Construction got underway on the £14.5 million plan approved by the Department of Health, to modernise hospital services for children and young people across the Trust. The development will see all planned paediatric surgery for the Trust centralised to a new £7.9m paediatric centre at Daisy Hill and a further £6.6m used to build a new paediatric centre on the Craigavon Area Hospital site.



March

- We are now smoke free. Since 9 March, 2016, smoking and the use of e-cigarettes is no longer permitted on any of the Trust sites (i.e. entrances, doorways, walkways, buildings, internal roads, bus shelters, car parks, cars, bicycle shelters etc.) The new policy applies to all staff and volunteers, patients, visitors, contractors and anyone who enters the Trust's hospitals, buildings and grounds.



Keers from Dromore shared his experience of the service, and was profiled on BBC Newsline.

- Also in March, the Trust hosted the launch of a new regional service to improve the treatment of people with cancer. Consultant in Respiratory Medicine, Dr Rory Convery, explained how the Acute Oncology Service improves patient safety and the overall care for people with cancer.
- One of our patients, Mr Samuel

- The finale to our year saw Health Minister Simon Hamilton MLA move the Helicopter Emergency Medical Service (HEMS) and the major trauma network a step closer to implementation.
- The Minister, during a visit to Craigavon Area Hospital, announced the key findings of the HEMS consultation including the management and funding models, home base location, target patient groups and collaboration with other services.



Staff Highlights 2015/16

One of our most important resources here at the Southern Trust is our staff and in 2015/16 it was great to see the following receive national recognition:

Angela Gemmell, Lead Physiotherapist currently working in Care of the Elderly Wards at Lurgan Hospital, picked up a Chartered Society of Physiotherapy (CSP) Excellence Award at the CSP's Annual Awards, for demonstrating patient involvement. Every year the CSP Awards recognise excellence and best practice throughout the physiotherapy profession and across the whole membership.



Donna McLoughlin, a midwife based at Daisy Hill Newry, has been honoured as the Emma's Diary Mums' Midwife of the Year 2016 for Northern Ireland. Donna was nominated by Aine Cunningham, a local mum and a midwife herself. The award is one of The Royal College of Midwives (RCM) Annual Midwifery Awards, recognising the work done by midwives across the country.



Two Biomedical Scientists from the Southern Health and Social Care Trust have recently gained their Higher Specialist Examination, a professional qualification from the Institute of Biomedical Science.

Mairead Caraher who specialises in Haematology and Graham Scott, in Transfusion Science, are the only two to hold this award in their respective fields in Northern Ireland.



A number of our staff were recognised at the prestigious Institute of Health Care Management Awards.

Consultant Geriatrician Dr Patricia McCaffrey won the Medical Leader of the Year and Kay Carroll, Head of Service for Cardiology, was awarded with Manager of the Year.



Institute of
Healthcare
Management

Head of Physiotherapy Teresa Ross, was shortlisted in the Allied Health Professional Manager of the Year category; the Rapid Access Respiratory Clinic was shortlisted for the Regional Excellence and Quality Award; Speech and Language Therapy Manager, Vivienne Williamson and Information Communications Technology Training Manager, Anna-Marie McCreanor, were both shortlisted in the Manager of the Year category.

Allied Health Professionals from the Southern Health and Social Care Trust have been recognised amongst the best in Northern Ireland at the 2016 Advancing Healthcare Awards.

The Macmillan Award for Rethinking the Patient Pathway and over all Award Winner at the prestigious event went to Craigavon Area Hospital Radiographers Janet Eagle and Helena Kincaid for their redesign of the diagnosis and treatment of fertility problems in women.



Dietitians were finalists in two categories: Head of Nutrition and Dietetics, Mandy Gilmore, and Community Dietitian, Elizabeth O'Connor, for developing the 'Health Call Under Nutrition Service' which is a remote monitoring service for adults at risk of malnutrition in care homes, and Specialist Dietitians, Vanessa McMin and Wendy Murray, for the X-PERT group patient education programme for people with Type 2 Diabetes.

Physiotherapist Cathy McKeown was recognised as a finalist for developing a Falls Pathway alongside Northern Ireland Ambulance Service colleagues. Dietitian, Elizabeth O'Connor, and Physiotherapist, Annette Kearney, alongside midwifery colleagues contributed to a Regional project 'Weigh to a Healthy Pregnancy' which was shortlisted.

Tara Davison, Peripetetic Assessor and Julie Mullen, Physiotherapy Support Worker, were finalists for their work in developing the Allied Health Professional (AHP) workforce.

Special Recognition as a 'Rising Star' was also given to Senior Occupational Therapist, Melanie Sheenan, who works at the Memory Centre helping people living with dementia.

Congratulations also go to Learning Disability Epilepsy Nurse Specialist Sandra Wylie, Epilepsy Nurse Clare McCooe and Daytime Opportunities Worker Linda Daly who scooped the Epilepsy Award at this year's Northern Ireland Healthcare Awards.

PERFORMANCE ANALYSIS 2015/16

Achievement of Ministerial priorities

In 2015/2016 the Minister directed a number of targets for all Trusts to work towards. The targets cover all aspects of planning and delivering health and social care. The Trust has in place senior clinical and management oversight to regularly monitor progress against these and other standards that are set by our commissioner.

This year has been a challenging year for the Trust in terms of securing the level of resources needed to meet demand in the southern area. The Trust has worked closely with our local commissioner and to secure recurrent resources in a number of key areas however, significant challenges remain.

At the same time the Trust's main priority is to strive to deliver care that is safe, personal and effective and seeks to continually improve and modernise the services offered to make the best use of its resources and improve the quality and experience of our service users.

Ministerial targets look at a range of areas including for example the following:

- Time patients wait to be seen in the Emergency Department;
- How long patients wait to receive their first assessments, diagnostics tests and treatments across our hospital and community services including services for the elderly, children and those with mental health or disability needs;
- How we support our carers;
- How stable our placements are for those children the Trust cares for;
- How well we manage patients admitted with stroke or waiting for surgery for hip fractures; and
- Infection rates in our hospitals.

Our performance reports go to the public Trust Board meetings with the information published on our website at www.southerntrust.hscni.net.

This level of performance management helps us to ensure that what we do is safe, that we are making best use of our resources and meeting targets which are there to benefit patients and clients.

Emergency Department

There are two Emergency Department (ED) standards, which the Trust aims to achieve. These include seeking to ensure 95% of patients attending should be treated, admitted or discharged within 4-hours and that no patient should wait longer than 12-hours.

The Trust works hard to ensure that patients do not wait unnecessarily long times in ED, but this does happen on occasions when patients are waiting to be admitted to a

hospital bed and/or where it is deemed that there might be a clinical risk in moving the patient from ED.

Our performance in relation to the 4-hour target was 80.1% with 93 patients waiting in excess of 12 hours during 2015/16. This was in a year when the Trust's total attendances at ED increased by 4% with over 6000 more people attending than the previous year. Whilst these 93 occurrences represent only 0.1% of our total ED attendances the Trust feels strongly that this is not an acceptable time to wait and the Trust is continually working to improve our processes and performance in this area to avoid any excess waiting.

In order to support staff in the delivery of patient care within the Emergency Department, the Trust maintains both a management and a clinical presence, in and out of hours, 7 days per week. The Trust also works closely with the Health & Social Board to identify demand and capacity issues that result in increased pressures in our Emergency Departments particularly during times of peak pressures.

Access Times – Out-Patients

In 2015/2016 the Trust aimed to have 60% of its general out-patients treated within 9 weeks, with no patient waiting longer than 18 weeks. Throughout Northern Ireland the demand for outpatient services has increased and within the Southern Trust there are shortfalls in our capacity to see all patients within the timescales set, however the Trust ensures that those patients that are urgent or have suspected cancer are always given priority and seen first. The Trust continues to review opportunities to address the shortages in capacity with the Health and Social Care Board, in line with available resources. In 2015/16 39% of patients were treated within 9 weeks and 12,521 patients waited longer than 18 weeks.

Within Mental Health services, the Trust aimed to have no patients waiting longer than 9 weeks for adult services, children and adolescent services and for dementia services and no patients waiting longer than 13 weeks for access to psychological therapy services. Our performance during 2015/16 demonstrated 81 adults and 69 dementia patients waiting longer than 9 weeks and 10 patients waiting longer than 13 weeks for psychological therapies. Whilst this is an improving position for mental health services the Trust continues to work to improve this.

Access Times – In-Patients

In 2015/2016 the Trust aimed to have 65% of in-patients or patients staying as a day case treated within 13 weeks, with no patient waiting longer than 26 weeks. Our performance demonstrated that 56.3% of patients were treated within 13 weeks and that 1,552 patients were waiting in excess of 26 weeks.

The Trust has a recognised shortfall in capacity across a number of specialist areas, which has impacted on our ability to see all patients within the timescales set, however the Trust ensures that those patients that are urgent or have suspected cancer are always given priority and treated first. The Trust continues to review opportunities to address the shortfalls in capacity with the Health and Social Care Board, in line with available resources.

Support to Carers

In 2015/16 the Trust aimed to continue to increase the number of carers, offered carer assessments; the targets set for 2015/16 represent an increase of 10% from the previous year, which equates to a total of 838 assessments. The Trust acknowledged this to be an extremely challenging target in 2015/16 following on from very high performance in 2014/15 as a baseline. At the end of December 2015 the Trust had offered 693 carers assessments. Whilst additional assessments will be offered up to the end of March 2016, it is not anticipated that the full target will be met.

This offering of assessment is one part of how we support carers. The Trust has a Carers Reference Group and Forum and ensures carers are involved with its various PPI (Patient and Public Involvement) plans to include their voice in our future planning.

Children in our Care

The Trust is subject to a number of standards in relation to looking after the children in our care including the target timescale for adoption processes to complete within 3 years. The Trust's performance against these standards remains an on-going priority and is influenced by a number of external factors such as the availability of carers, timing of court processes and changes from fostering to adoptive placements.

In 2014/15, which is the most recent information available, 25% of children were adopted within 3 years, with 65% adopted between 3 and 5 years. Whilst our timescale for adoption was beyond our target overall, the Trust secured successful adoption placements for 20 children which is the highest number of children adopted through an individual Trust and represents 28% of all children adopted in Northern Ireland in 2014/15.

Management of patients in our hospitals

The Trust has a number of standards which they aim to deliver in relation to the clinical management of our patients in hospital.

Within the area of stroke, the Trust achieved its target in 2015/16 of administering thrombolysis therapy to 13% of patients who had suffered an ischemic stroke and were considered suitable for this treatment.

For people that present with a broken hip the Trust's target is to have 95% of these patients surgically treated, as clinically appropriate, within 48 hours. In 2015/16 the Trust saw a significant increase in the number of people being admitted with trauma to our Trauma & Orthopaedic service. This means that our clinicians have to decide who will benefit from treatment first dependent on their clinical condition. In 2015/16 91% of patients had surgery within 48 hours.

Infection rates

In 2015/16 the Trust aimed to continue to improve its hospital infection rates and have no more than 5 cases of the Methicillin Resistant Staph Aureus (MRSA) infection and no more than 32 cases of Clostridium Difficile (C Diff) infection in the year. During 2015/16, the Trust had 2 cases of MRSA and achieved the target however, the C Diff target was not achieved with 54 cases reported.

Infection prevention and control is one of the Trust's key quality priorities and the Trust continues to put in place a range of actions to ensure effective prevention measures are undertaken, including training for staff and raising awareness with staff, patients, visitors and the public.

Southern Trust facts and figures 2015/16

The Trust spent £1.685m gross per day delivering services to local people. This was spent as follows.

During the past year:

- There were a total of 5,976 births in the Southern HSC Trust. There were 4,145 births in Craigavon Area Hospital and 1,831 in Daisy Hill Hospital;
- 84,125 people attended Craigavon Area Hospital Emergency Department and 51,267 attended Daisy Hill Hospital Emergency Department;
- A total of 28,765 people received treatment at the Minor Injuries Units at South Tyrone Hospital;
- Total Number of Outpatient Attendances – 392,790;
 - new outpatient attendances – 115,715
 - review outpatient attendances – 277,075

- Total number of inpatient admissions – 57,883;
 - Elective – 6,582
 - Non-elective – 51,301
- The Trust received 12,707 child care referrals;
- The GP Out of Hours (OOH) service received 93,769 initial patient telephone calls into the GP OOHs service;
 - 52,354 patients were assessed by a GP, Nurse or Pharmacist via telephone and provided with healthcare advice;
 - 36,265 patient appointments were provided in the Out of Hours centres at Daisy Hill, South Tyrone, Armagh, Craigavon and Kilkeel;
 - 502 patients did not attend for a booked appointment;
 - 5,150 home visits to patients were undertaken by GPs across the Trust area;
 - 203 patients chose to attend the Out of Hours centre in Castleblayney (via the Co-operation and Working Together (CAWT) cross border project);
- The Trust provides care and support through the following care packages:

Programme of Care	Residential Care	Nursing Home Care	Domiciliary Care	TOTAL
Elderly	232	763	2,903	3,898
Memory Service	135	598	644	1,377
Mental Health	52	100	431	583
Learning Disability	104	168	755	1,027
Physical and Sensory Disability	4	45	732	781
TOTAL	527	1,674	5,465	7,666

Financial Performance 2015/16

Financial Environment

In common with previous financial years, 2015/16 also proved to be a difficult period with significant financial and operational challenges facing the Trust. Staff at all levels of the organisation continued to work hard to reduce reliance on the vacancy control and other contingency measures necessary to bridge the time between funding reductions and the implementation of the reforms necessary to return the

service to a sustainable financial balance. The Trust is pleased to report that it has again delivered a breakeven position.

Financial Targets

The Trust's main funding source is its Revenue Resource Limit (RRL) from the DHSSPS. Expenditure remained within the RRL of £576m by £137k. The Trust also receives a limited amount to spend on capital, the Capital Resource Limit (CRL). It kept within the CRL of £21.4m by £310k.

The above achievements have been delivered through the concerted efforts of our staff, the continued implementation of service reform initiatives and sound financial management.

Profile of Income and Expenditure in 2015/16

As stated above, the majority of funding (94%) for the Trust comes from the DHSSPS, through the Health and Social Care Board and Public Health Authority. The remaining funding received is mainly for medical education as well as income from paying patients and clients in residential and nursing homes.

In 2015/16, this funding was spent on staff salaries (63%) and significant non-pay expenditure included 9% on clinical and general supplies such as drugs and medical supplies and a further 18% on residential, nursing and domiciliary care delivered by other organisations on the Trust's behalf.

Compliance with Prompt Payment Policy

The DHSSPS requires that Trusts pay their Non HSC suppliers in accordance with applicable terms and appropriate Government Accounting guidance i.e. it requires Trusts to pay 95% of Non HSC suppliers within 30 days of receipt of goods or a valid invoice (whichever is later). The Trust's payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is as follows (for both the number and value of payments made).

Public Sector Payment Policy (continued)

	2016 Number	2016 Value £000s	2015 Number	2015 Value £000s
Total bills paid in year	206,478	273,264	172,426	224,108
Total bills paid within 30 days or under agreed payment terms	193,206	250,692	151,068	200,413
Percentage of bills paid within 30 days or under agreed payment terms	93.6%	91.7%	87.6%	89.4%
Total bills paid within 10 days	173,700	226,085	121,745	170,785
Percentage of bills paid within 10 days	84.1%	82.7%	70.6%	76.2%

From 1 April 2015 the scope of the prompt payment compliance measurement increased to take account of all categories of supplier payments made by Trusts, with the only exception being payments made to other organisations within the broader HSCNI.

Achievement of the 30 day target of 95% is dependent both on procedures within BSO Accounts Payable Shared Service and appropriate action by Trust nominated approvers. During 2015/16 the Trust worked closely with BSO and Trust approvers to ensure an improvement in prompt payment compliance and continues this work in an effort to achieve the target of 95%.

During the year the SHSCT paid £343 interest and £210 compensation in respect of late payment of commercial debt.

Charitable Trust Funds

The Trust's Charitable Trust Fund account is, again, consolidated with the public funds account but this has no impact on the reported financial position. During 2015/16, charitable donations of £297k were received by the Trust, an increase of £57k from prior year. These funds were used to support expenditure in the following areas:

- Patient / Client / Relative / Visitor Comfort and Amenity;
- Staff education and training / skills enhancement; and
- Academic Research and Development.

Individual donors are too numerous to mention, but examples of improvements the Trust has been able to make during 2015/16 as a result of donations and legacies received include:

- The purchase of two portable machines for cardiac investigations;
- The purchase of a Stress System treadmill;
- ECG carts and cardiac monitors;
- CCTVs for visually impaired clients;
- Reflexology for patients;
- Christmas gifts for patients; and
- Flights, accommodation and course fees for staff education over and above that which would normally be provided.

Protecting the Environment

Sustainability

The Trust Sustainability Strategy 2020 incorporates the key environmental priorities for the Trust and DHSSPS Northern Ireland including the three key components of sustainability:

- Taking a holistic view of all activities and considering their environmental, social and economic implications;
- Thinking about whole life issues when planning, designing, building and maintaining the Estate; and
- Making sure that everyone thinks about the way resources are used each and every day within the Trust and at home.

Sustainability Policy

The policy articulates how the Trust will strategically meet its obligations in respect of sustainability issues both now and in the future.

Environmental Benchmarking

This year, the Trust took part in the 2015 Arena Network Environmental Survey – Northern Ireland's leading environmental benchmarking exercise. We were awarded Silver status scoring 78% (5% increase on last year) representing a high level of assurance in environmental performance.

Energy

Carbon Reduction Commitment (CRC)

The Trust continues to meet compliance under CRC legislation whereby there is a requirement to report on emissions for electricity and natural gas consumed. Since 2010/11 there has been an overall reduction of 6%.

There are a number of schemes now coming online that will help to improve carbon emissions over the next year including the use of the combined heat and power (CHP) system at Craigavon Area Hospital.

Display Energy Certificates

The Trust also achieves legal compliance in the display of Energy Certificates at relevant properties detailing the energy efficiency of each building above 250m².

Waste Management

The Southern Trust generates approximately 1,500 tonnes per annum of domestic waste and 800 tonnes of clinical waste. Domestic waste increased by 3% (1,297 tonnes (2014/15) to 1,336 tonnes in 2015/16). However, the recycling rate has also increased from 13% in 2014/15 to 13.65% in 2015/16 which includes both cardboard and MDR (Mixed Dry Recyclables). At Craigavon Area Hospital the Trust is recycling approximately 90 tonnes per annum or 1.73 tonnes per week. MDR across the Trust has increased significantly from 84 tonnes to 120 tonnes (increase of 42% on last year). This includes 13 tonnes generated at Craigavon Area Hospital where a number of wards/departments have commenced recycling. Other waste types generated within the Trust include all skip waste, Waste Electronic and Electrical Equipment (WEEE) and other specialist waste types which are managed at the main hospital sites.

Future Developments

2016/17 is likely to be another challenging year for the Trust. Some of the issues and risks already facing the Trust, both financial and non-financial are outlined in the Governance Statement on pages 29 to 60.

Long term Expenditure Trends and Plans

Revenue

The amount of expenditure that the Trust can incur is constrained by the amount of income made available by the NI Assembly. In response to prevailing economic

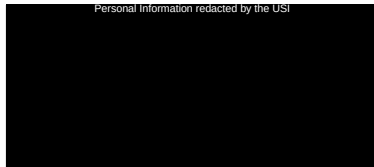
conditions, real growth in the amount of funding available for health and social services, as is the case for all aspects of public service provision throughout the United Kingdom, will be heavily curtailed for the foreseeable future.

The population of the southern area and the associated demand for services, however, continues to grow at a faster rate than that experienced in other areas. As in the recent past, this increase in demand has to be funded, at least in part, by continual improvements in efficiency and effectiveness and service transformation.

Capital

The Trust's estate is rapidly approaching the point at which significant renewal and redevelopment is required. The need to improve efficiency and the demands of a growing population also places significant pressure on capital resources. As with revenue funding, the amount of capital investment funding is equally influenced by the state of the economy. It is unlikely that the 'ideal' level of investment will be available in the near future and the Trust will continue to prioritise demands and direct funding to the maintenance and stability of core service provision.

Signed:



Mr Francis Rice

Accounting Officer

Date:

9/6/16

SOUTHERN HSC TRUST
ACCOUNTABILITY REPORT
GOVERNANCE REPORT

Directors' Report

Board of Directors

The Board of Directors during the year was as follows:



Mrs Roberta Brownlee

Chair

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

Executive Directors



Mrs Paula Clarke

Interim Chief Executive (to 31 March 2016)

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



Mr Francis Rice

Interim Chief Executive (from April 2016)

Director of Mental Health and Disability Services/
 Executive Director of Nursing and AHPs (Until April 2016)

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



Mr Stephen McNally

Director of Finance and Procurement

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



Dr Richard Wright
Medical Director (from July 2015)

Tel: [Personal Information redacted by the USI]
[Personal Information redacted by the USI]



Dr John Simpson
Medical Director (to August 2015)

Tel: [Personal Information redacted by the USI]
[Personal Information redacted by the USI]

Trust Directors



Mrs Aldrina Magwood
Acting Director of Performance and Reform

Tel: [Personal Information redacted by the USI]
[Personal Information redacted by the USI]



Mr Kieran Donaghy
Director of Human Resources and Organisational Development

Tel: [Personal Information redacted by the USI]
[Personal Information redacted by the USI]



Mr Miceal Crilly
Acting Director of Mental Health and Disability Services (to April 2015)

Tel: [Personal Information redacted by the USI]
[Personal Information redacted by the USI]



Mrs Angela McVeigh
Director of Older People and Primary Care

Tel: [Personal Information redacted by the USI]
[Personal Information redacted by the USI]



Mrs Esther Gishkori

Director of Acute Services (from August 2015)

Tel:

Personal Information redacted by the UST

Personal Information redacted by the UST



Mrs Debbie Burns

Acting Director of Acute Services (to August 2015)

Non-Executive Directors



Mrs Deirdre Blakely

(to 31 December 2015)



Mr Edwin Graham

(Chair of the Patient & Client Experience Committee)



Mrs Hester Kelly

(to 31 December 2015)

(Chair of Endowments and Gifts Committee to 31 December 2015)



Mrs Elizabeth Mahood

(Chair of Audit Committee)



Dr Raymond Mullan
(Chair of Governance Committee)



Mrs Siobhan Rooney
(Chair of Endowments and Gifts Committee from June 2015)



Mrs Hilary McCartan
(from 15 February 2016)



Ms Eileen Mullan
(from 15 February 2016)



Mr John Wilkinson
(from 15 February 2016)

A declaration of Board members' interests has been completed and is available on request from the Chief Executive's Office, Trust Headquarters, College of Nursing, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ. Telephone 028 3861 3960.

Related Party Transactions

The Trust is an Arm's length body of the DHSSPS and, as such, the Department is a related party with which the Trust has had various material transactions during the year:

Funding – Revenue Resource Limit £576m of which Non-Cash Revenue Resource Limit was £32.06m.

In addition to the above, during the year the Trust entered into transactions with the following related parties (as defined by IAS 24), which are organisations in which one or more Directors disclosed interests:

	Total Value of Transactions	Balance Outstanding at Year End
	£	£
Enable NI	Payments: 189,284 Receipts: 50 (32 transactions)	10,961 (Creditor)
Ann's Homecare Domiciliary Care Agency	Payments: 4,323,501 (150 transactions)	248,821 (Creditor)

Audit

The accounts and supporting notes relating to the Trust's activities for the year ended 31 March 2016 have been prepared in a form determined by the Department of Health, Social Services and Public Safety based on guidance from the Department of Finance and Personnel's Financial Reporting Manual (FReM). They have been audited by the Northern Ireland Audit Office. The report of the Comptroller and Auditor General is included on pages 83-84.

The Interim Chief Executive and each Director has taken all the steps that he/she ought to have taken as Chief Executive/Director to make himself / herself aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

So far as the Interim Chief Executive and each Director is aware, there is no relevant audit information of which the Trust's auditor is unaware.

The notional cost of the audit of the accounts for the year ended 31 March 2016 which pertained solely to the audit of the Public Funds Accounts was £59,000. The notional cost of the audit of the Charitable Funds Accounts was £5,000. No other audit or non-audit services were provided to the Trust in 2015/16.

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003), the Department of Health, Social Services and Public Safety has directed the Southern Health and Social Care Trust ('the Southern HSC Trust') to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of affairs of the Southern HSC Trust, of its income and expenditure, changes in taxpayers equity and cash flows for the financial year.

In preparing the financial statements the Accounting Officer is required to comply with the requirements of Government Financial Reporting Manual (FREM) and in particular to :

- observe the Accounts Direction issued by the Department of Health, Social Services and Public Safety including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- make judgements and estimates on a reasonable basis.
- state whether applicable accounting standards as set out in FREM have been followed, and disclose and explain any material departures in the financial statements.
- prepare the financial statements on the going concern basis, unless it is inappropriate to presume that the Southern HSC Trust will continue in operation.
- keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Southern HSC Trust.
- pursue and demonstrate value for money in the services the Southern HSC Trust provides and in its use of public assets and the resources it controls.

The Permanent Secretary of the Department of Health, Social Services and Public Safety as Accounting Officer for health and personal social services resources in Northern Ireland has designated Mr Francis Rice of Southern HSC Trust as the Accounting Officer for the Southern HSC Trust. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Southern HSC Trust's assets, are set out in the Accountable Officer Memorandum, issued by the Department of Health, Social Services and Public Safety.

Governance Statement for the year ended 31 March 2016

1. Scope of Responsibility

The Board of Directors of the Southern HSC Trust (the Trust) is accountable for internal control. As Accounting Officer and Interim Chief Executive of the Trust, I have responsibility for maintaining a sound system of internal governance that supports the achievement of the organisations policies, aims and objectives, whilst safeguarding the public funds and assets for which I am responsible in accordance with the responsibilities assigned to me by the Department of Health, Social Services and Public Safety (DHSSPS).

In delivering these responsibilities, I am accountable for the Trust's performance to the Health and Social Care Board (HSCB) and DHSSPS and report through agreed performance management arrangements and Service and Budget Agreements.

This has entailed regular performance management meetings at a senior level with the HSCB and both scheduled and ad hoc meetings between Trust officers and the Performance Management Service Improvement Directorate within the HSCB.

In order to improve the quality, safety, effectiveness and efficiency of services, the Trust works in partnership with the HSCB, Public Health Authority (PHA), other public sector partners and the independent sector. A range of processes are in place to facilitate and enable this partnership working with examples including:

- meetings with Trust, HSCB, Local Commissioning Group (LCG) and PHA senior teams collectively and on issue specific basis;
- monthly meetings between Trust and HSCB Chief Executives;
- regional and local Transformation Programme Boards to work together to implement Transforming Your Care (TYC);
- engagement with local GPs through locality forums and senior Trust attendance at Local Medical Committee (LMC) services development committee;
- regular meetings with Independent Health and Care Providers (IHCP) and other independent sector providers about key interface issues;
- forums such as the regional children's service planning project board that include HSC partners, community/voluntary sector and other statutory agencies such as Education; and
- promoting health and wellbeing processes involving a range of partners focussed on ensuring effective collaboration to address the specific and individual needs of local communities.

With respect to the Trust's inter-relationship with the DHSSPS, the framework within which the Trust is required to operate is defined and agreed in the Management Statement (MS) and Financial Memorandum (FM). This model MS/FM for executive

Non-Departmental Public Bodies (NDPBs) is intended to provide departments with a document that sets out a clear framework of strategic control for each of their executive NDPBs. The framework covers the operations, financing, accountability and control of the NDPB and the conditions under which any government funds are provided to the body. The specific requirements for the Trust as an Arm's Length Body ('ALB') are further defined and agreed annually in the Annual Business Plan.

2. Compliance with Corporate Governance Best Practice

The Trust applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The Trust does this by undertaking continuous assessment of its compliance with Corporate Governance best practice and the effectiveness of the Trust's governance arrangements are regularly considered by the Governance Committee on behalf of the Trust Board.

This incorporates, in line with best practice, the Board annual review of its effectiveness, which the Trust Board conducted during 2015/16, in addition to the completion of the DHSSPS Board Governance Self-Assessment Tool. During 2015/16, Internal Audit undertook a review of Board Effectiveness and this included independent assessment of the Trust's 2014/15 self-assessment. A satisfactory level of assurance was provided.

3. Governance Framework

In my role as Accounting Officer, I am supported by the Trust Board.

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

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

The Trust adopts an integrated approach to governance and risk management and an Integrated Governance Strategy is in place which covers all domains of governance associated with the delivery of health and social care services. A review

of this strategy is currently underway. Committee structures are in place to reflect this integrated approach and to support the Trust Board. The following describes in more detail the role of the Trust Board, its Committee structure and attendance during the reporting period.

The Trust Board

The composition and membership of the Trust Board is defined by the Membership, Procedure and Administration Arrangements Regulations and comprises a Chair, seven Non-Executive Directors, the Chief Executive and four Executive members. Four members of the Senior Management Team also attend Trust Board meetings. Non-Executive Directors are independent members and provide support, guidance and challenge to the Trust Board.

In the 2015/16 year, the Trust Board held eight formal Board meetings in public and, in accordance with Standing Orders, were quorate for each meeting.

Name of Board member	No. of Meetings attended	No. of Possible Meetings	Comments
Mrs R Brownlee Chair	8	8	
Mrs D Blakely Non Executive Director	5	6	Term expired 31/12/2015
Mr E Graham Non Executive Director	8	8	
Mrs H Kelly Non Executive Director	6	6	Term expired 31/12/2015
Mrs E Mahood Non Executive Director	8	8	
Mrs H McCartan Non Executive Director	1	1	Commenced 15/02/2016
Ms E Mullan Non Executive Director	1	1	Commenced 15/02/2016
Dr R Mullan Non Executive Director	8	8	
Mrs S Rooney Non Executive Director	8	8	
Mr J Wilkinson Non Executive Director	1	1	Commenced 15/02/2016
Mrs P Clarke Interim Chief Executive	7	8	Resigned 31/03/2016
Mrs D Burns Interim Director of Acute Services	2	2	Resigned 31/08/2015
Mr K Donaghy Director of Human Resources and Organisational Development	7	8	
Mrs E Gishkori Director of Acute Services	6	6	Commenced 17/08/2016
Mrs A Magwood Director of Performance and Reform (Acting)	8	8	
Mr S McNally Director of Finance and Procurement	8	8	

Mrs A McVeigh Director of Older People and Primary Care Services	6	8	
Mr P Morgan Director of Children and Young People's Services/Executive Director of Social Work	6	8	
Mr F Rice Director of Mental Health and Disability Services/Executive Director of Nursing	6	8	
Dr J Simpson Medical Director	2	2	Retired 31/07/2015
Dr R Wright Medical Director	6	6	Commenced 1/07/2015

During the reporting period, the following changes occurred with regard to Board membership:-

- Two Non-Executive Directors completed their tenure on 31 December 2015; three new Non-Executive Directors were appointed with effect from 15 February 2016; three have had their terms of office extended for a further one year period to 31 March 2017 and one commenced their second term of office with effect from 29 August 2015. The Chair is currently in her second term of office.
- The resignation of the Interim Chief Executive on 31 March 2016.
- With effect from 1 February 2016, a Deputy Chief Executive was appointed on a temporary basis to 31 March 2016.
- The appointment of a Medical Director on 1 July 2015 and Director of Acute Services on 17 August 2015.

Trust Board meetings were widely publicised through the press and the Trust website. Agendas, minutes and papers of all Trust Board meetings are publicly accessible on the Trust website.

The Trust Board has corporate responsibility for ensuring that the organisation fulfils the aims and objectives set by the Department/Minister and for promoting the efficient, economic and effective use of staff and other resources. It has a key role in overseeing sound financial management and corporate governance of the Trust.

Each Trust Board agenda comprises strategic, operational, quality and performance items. The Trust Board received management reports at each meeting on the financial position, workforce information and performance against targets to assist it in discharging its role.

Two Board workshops were held during the year, at which members explored strategic issues and planned service developments. The Trust Board held a Development Day on 12 November 2015 which provided members with the opportunity to take 'time out' to consider lessons and best practice from elsewhere

on leadership, teamwork and communication and explore the application of these to the role of the Board. Board Effectiveness was a key focus of the agenda and an action plan developed with areas identified for development and/or improvement.

All Trust Board Committees are chaired by a Non-Executive Director and have clear terms of reference and lines of reporting and accountability agreed by the Trust Board. Minutes of the Sub Committees are presented at Trust Board public meetings in a timely manner with the Chair of each Committee highlighting any specific issues for the attention of the Board via completion of a Board Report Summary Sheet. In addition, the Committee Chairs meet with the Trust Chair and Chief Executive after each meeting to provide feedback on the work of their respective Committees and raise any issues of concern.

In accordance with good practice, the Trust Chair meets with the Committee Chairs on an annual basis to reflect on the work of the Committees and to share any learning.

Audit Committee

The Audit Committee supports the Trust Board and my role as Accounting Officer with regard to our responsibilities for issues of risk, control and governance and provides associated assurance through a process of constructive challenge.

The committee comprises five Non-Executive Directors who are independent of Trust management. The Director of Finance, Head of Internal Audit (Business Services Organisation (BSO)), external auditors (Northern Ireland Audit Office (NIAO)) and their sub-contracted auditors are in attendance. The Committee is also attended by other Finance and Internal Audit staff as required.

During 2015/16, the Committee held 6 meetings to provide the Trust Board with independent assurance on the adequacy and effectiveness of internal control systems and that all regulatory and statutory obligations are met. There was full attendance at three out of these six meetings.

Name of Audit Committee member	No. of Meetings attended	No. of Possible Meetings	Comments
Mrs E Mahood (Chair) Non Executive Director	6	6	
Mrs D Blakely Non Executive Director	4	4	Term expired 31/12/2015
Mr E Graham Non Executive Director	4	4	Joined the Committee 01/06/2015. Stood down on 31/03/2016 to take up membership of the Remuneration Committee
Mrs H McCartan Non Executive Director	0	1	Commenced 15/02/2016
Ms E Mullan Non Executive Director	0	1	Commenced 15/02/2016

Dr R Mullan Non Executive Director	3	6	
Mrs S Rooney Non Executive Director	1	1	Stood down from the Audit Committee on 02/04/2015 to take up membership of the Remuneration Committee
Mr J Wilkinson Non Executive Director	1	1	Commenced 15/02/2016

To ensure linkages across the Audit and Governance Committees, the Chair of the Audit Committee is a member of the Governance Committee and likewise, the Chair of the Governance Committee is a member of the Audit Committee.

In carrying out its work, the Committee used the findings of Internal Audit, External Audit, assurance functions, financial reporting and Value for Money activities. It approved the Internal Audit programme of work and reviewed progress on implementing internal and external audit recommendations. It considered reports from Internal Audit at each meeting and overall accepted the findings and recommendations of Internal Audit in its reports for 2015/16. The Audit Committee particularly focused on bringing closure to the long standing internal audit recommendations from 2013/14 and prior. Fraud is a standing item on the Committee's agenda and there is on-going reporting to the Committee in respect of compliance with Departmental directions/circulars.

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

The Committee assessed its effectiveness against the National Audit Office (NAO) Audit Committee self-assessment checklist. One action emerged with regard to ensuring the effective induction and training of new Audit Committee members. This will be taken forward in 2016/17.

Governance Committee

The Governance Committee is the overarching strategic Committee responsible for providing assurance to the Board on all aspects of governance (except internal financial control) and during the year the Committee regularly considered the effectiveness of the Trust's governance arrangements.

The Committee comprises all Non-Executive Directors who are independent of Trust management. The Chief Executive, members of the Senior Management Team, the Director of Pharmacy and the Assistant Director of Clinical and Social Care Governance are in attendance at all meetings.

During 2015/16, the Governance Committee met on four occasions.

Name of Governance Committee member	No. of Meetings attended	No. of Possible Meetings	Comments
Dr R Mullan (Chair) Non Executive Director	4	4	
Mrs D Blakely Non Executive Director	2	3	Term expired 31/12/2015
Mr E Graham Non Executive Director	4	4	
Mrs H Kelly Non Executive Director	3	3	Term expired 31/12/2015
Mrs E Mahood Non Executive Director	4	4	
Mrs H McCartan Non Executive Director	0	0	Commenced 15/02/2016
Ms E Mullan Non Executive Director	0	0	Commenced 15/02/2016
Mrs S Rooney Non Executive Director	4	4	
Mr J Wilkinson Non Executive Director	0	0	Commenced 15/02/2016

In order to discharge its responsibilities, the Committee has a Schedule of Reporting in place and the key areas reported at meetings are in line with this. Assurance reports were received from lead Directors in relation to their areas of responsibility being Medical, Social Work and Social Care and Nursing and Allied Health Professions, as well as Medicines Governance.

In April 2015, a revisit of the outcomes of the 2010 Review of Clinical and Social Care Governance was undertaken and progress updates were provided to the Committee. As an outcome of the revisit, the Trust has commenced a project to review and further improve on how Serious Adverse Incidents, Adverse Incidents and Complaints are used to learn, improve patient safety and reduce risk. The Trust is currently developing and testing the reporting format to Governance Committee.

Reports and findings from external bodies/agencies were also presented to the Committee and discussed, particularly those that indicated practice below acceptable levels and areas of high risk. The Committee sought assurance that action plans were in place to address recommendations and were being effectively implemented through measurable outcomes. Where the organisation has challenges in meeting recommendations, the Governance Committee ensures these are appropriately escalated to the Trust Board.

The Governance Committee reviewed the Corporate Risk Register at each meeting and ensured that risks that are outside the Trust's ability to solely manage were escalated to the Trust Board and beyond.

The Chair of the Governance Committee undertook an evaluation of the performance of the Committee during the year and presented the Committee's Annual Report to the Trust Board.

Endowments and Gifts Committee

The Endowments and Gifts Committee is the committee responsible for providing assurance to the Board on all aspects of the stewardship and management of funds donated or bequeathed to the Trust.

The membership of the Endowments and Gifts Committee comprises three Non-Executive Directors, the Director of Acute Services and the Director with responsibility for Estates Services. The Director of Finance is in attendance. Two members had full attendance at all meetings during the year, with the remaining members missing one or more meetings.

During 2015/16, the Committee held four meetings to oversee the administration of the Endowments and Gifts funds, their investment and disbursement. The Committee also revised the Procedures for the Management of Charitable Trust Funds.

The Chair of the Endowments and Gifts Committee undertook an evaluation of the performance of the Committee during the year. One issue arose relating to the importance of Director attendance, however, where a Director was unable to attend a meeting, a nominated deputy attended.

Remuneration Committee

The Remuneration Committee makes recommendations to the Trust Board on all aspects of remuneration and terms and conditions of employment of the Chief Executive and other senior executives.

The committee comprises the Trust Chair and two Non-Executive Directors, who are independent of Trust management. The Director of Human Resources and Organisational Development is in attendance.

The Committee held three meetings during 2015/16. There was full attendance by all members during the year. The Chair brings recommendations of the Remuneration Committee following each meeting to the Trust Board.

Patient and Client Experience Committee

The Patient and Client Committee provides assurance to the Trust Board that the Trust's services, systems and processes provide effective measures of patient/client and community experience and involvement.

The membership of the Patient and Client Experience Committee comprises the Trust Chair, four Non-Executive Directors and four representatives from the Trust's

PPI Panel. Trust Directors, the Assistant Director of Promoting Wellbeing, the Assistant Director of Clinical and Social Care Governance and a representative from the Patient and Client Council are in attendance.

During 2015/16, the Committee held four meetings. Attendance across the four meetings in 2015/16 ranged from 89% to 67%.

This Committee leads the co-ordination, development, implementation and monitoring of the Trust's PPI Action Plan, monitors the Patient Client Experience Standards Audit programme and complaints across the organisation.

The Chair of the Patient and Client Experience Committee undertook an evaluation of the performance of the Committee during the year and presented the Committee's Annual Report to the Trust Board.

4. Business Planning and Risk Management

Business planning and risk management is at the heart of governance arrangements to ensure that statutory obligations and ministerial priorities are properly reflected in the management of business at all levels within the organisation.

The state of the economy continues to place severe restrictions on the funding available to the Trust at a time when the local population and the associated demand for service is growing at a faster rate than the rest of Northern Ireland. A requirement to review priorities and ways of working in order to generate internal savings is now a constant feature of service delivery and brings a new dimension to corporate governance and risk management.

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

The Trust's three year Strategic Plan “**Improving through Change**” aims to ensure clarity about the strategic direction for services delivered by the Trust during 2015-2018 and specifically to identify what implementing “*Transforming Your Care*” will mean locally for individual services. This plan builds on the Trusts 2013-2015 strategic plan “*Changing for a Better Future*”.

It sets out the actions the Trust will take in support of each of the corporate objectives. This will ensure that our local communities know what to expect from us, that all of our staff are aware of their role in delivering on these priorities and that we can demonstrate improvements and progress by the end of the plan.

This Strategy sets out the Trust's vision ‘to deliver safe, high quality health and social care services, respecting the dignity and individuality of all who use them’. This vision is underpinned by the Trust's values which shape what it does and how it does it.

The current strategic plan which runs until 2018 is underpinned on an annual basis by the Trust's Delivery Plan.

The **Trust Delivery Plan (TDP)** represents the annual response of the Trust to Regional and Local Commissioning Plans and to the specific targets signalled in the Minister's Commissioning Plan Direction. Within this document the Trust identifies how it will seek to deliver on each of the key commissioning and ministerial priorities for the incoming year. The Plan also sets out how the Trust will utilise its resources in the year ahead, including its financial strategy, workforce strategy, capital investment plans, governance strategy and plans to promote wellbeing, personal and public involvement (PPI) and the patient experience.

The targets set out within the Commissioning Plan are allocated to Directorates. It is the responsibility of Heads of Service to make their team aware of the targets relevant to their area of work and to ensure that issues which may impact on achievement are flagged up through Divisional Team meetings or staff supervision throughout the year.

The TDP is brought to SMT and Trust Board for approval prior to submission to HSCB.

Monitoring of performance subsequently occurs on a monthly basis. Operational Directors receive a monthly report which provides a tool for focus with escalation of areas which are in excess of the required commissioning plan targets and standards and Trust Board also receive a monthly report. This includes a summary of performance, key actions and issues. It is the responsibility of Directors to ensure that Directorates under their control have appropriate plans and monitoring arrangements in place.

Directorate Work Plans are developed annually on the basis of the Strategic Plan and TDP. These plans summarise the key deliverables falling under each objective in the Strategic Plan and TDP but will also detail the actions, action owner and timescales for achievements.

Progress updates are generally carried out on a quarterly basis and some Directorates have found it useful to apply a traffic light system to assist in the monitoring of their actions at a high level for this purpose with more detailed discussion and monitoring taking place through staff.

It is essential that linkages between plans at Corporate and Directorate level are clearly stated and there must be a clear understanding and connection at all levels between objectives and associated risks. This is evidenced through the business planning and risk management processes in the Trust.

Risk Management

Risk management is an organisation-wide responsibility.

The key components of the Trust's risk management strategy (2014) are underpinned by the HPSS Controls Assurance Standard for Risk Management. The purpose of this Strategy is to ensure that the Trust manages risks in all areas using a systematic and consistent approach. It provides the framework for a robust risk management process. All supporting procedures for the identification and management of risk also reflect this standard.

The Trust's Risk Assessment Tool ensures that a consistent approach is taken to the evaluation and monitoring of risk in terms of the assessment of likelihood and impact. Risks are monitored through a formal reporting process where the assessed level of risk and its strategic significance determines where it will be reviewed and monitored.

In the Trust, there are two key levels at which the risk management process is formally documented:

- The Trust's Corporate Risk Register, which focuses on the principal risks to the Trust's delivery of its statutory responsibilities and corporate objectives; and
- Directorate risk registers which focus primarily on the risks to the achievement of Directorate objectives.

The Corporate Risk Register is reviewed by the Governance Committee at each of its meetings. The Corporate Risk Register is complementary to and works in conjunction with the Board Assurance Framework which is presented to the Trust Board on a six-monthly basis. Examples of indicators which may identify risks within the organisation include reports from external bodies e.g. RQIA, Accreditation bodies, independent reviews; various occurrences such as complaints, incidents, litigation, staff turnover; and internal assessments/reporting such as self-assessments, monitoring reports etc.

Directors are responsible for ensuring that Directorates under their control have fully functioning Directorate Risk Registers.

Each operational Directorate is supported by a Governance Team who facilitates the Director, Assistant Directors and Associate Medical Directors to identify, assess and manage and report on risk within their area of responsibility. Risks identified and control measures in place are discussed monthly by the operational teams through the Directorate Governance Forums where they are reviewed, monitored and escalated as appropriate. The Senior Management Team reviews the Corporate Risk Register monthly.

All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust. There are structured processes in place for incident reporting, analysis and the investigation of serious incidents. The Trust has reviewed the arrangements in place for communicating and involving patients and their families in incident investigations also.

The content of the Trust's risk management training and awareness is presently under review; it was identified through an internal audit of risk management in 2015 that the Trust should improve on the numbers of staff trained in this area across all Directorates. This work stream remains on-going.

The system of internal governance is designed to help manage risk rather than to eliminate it and controls must at all times be commensurate with the nature of the risk. Internal Audit reviewed the Trust's Risk Management system in 2015/16 and provided a satisfactory level of assurance.

5. Information Risk

Safeguarding the Trust's information is a critical aspect of supporting the Trust in the delivery of its objectives and effective management of information risk is a key aspect of this. Arrangements in place to manage this risk include:

- A Trust Information Governance Framework which includes strategy, policy and a suite of procedures and guidance.
- An Information Governance Forum which is led by the Personal Data Guardian (Medical Director) and Senior Information Risk Owner (SIRO) (Acting Director of Performance and Reform). It reports to the Trust's Governance Committee.
- Information Asset Owners (IAOs) are in place to reduce the risk to personal information within the Trust and are aware of their responsibilities;
- An information sharing register is in place which records the details of all episodes of sharing of Trust data with other bodies;
- Monitoring of Freedom of Information and Data Protection requests

Information Governance incidents are reported in accordance with the HSC Risk Management strategy. Three incidents have been reported to the Information Commissioners Office (ICO) during 2015/16. None of these resulted in data loss. These have been fully investigated and action plans have been implemented. Internally, information governance incidents are monitored and reviewed at the Information Governance Forum; ensuring lessons learned are disseminated throughout the Trust.

Data protection and records management training is mandatory for all Trust staff, providing them with up to date awareness of information governance issues and risks.

6. Public Stakeholder Involvement

In line with the Regional Strategy (DHSSPS, 2004), Departmental Guidelines for Personal and Public Involvement (PPI) (DHSSPS, 2007 and 2012), sections 19 and 20 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Quality Standards for Health and Social Care (DHSSPS, 2006) the Trust continues to prioritise PPI within all aspects of its business agenda and operates a range of governance, management and reporting mechanisms that reflect this.

Arrangements in place include:

- PPI is a standing agenda item on the Trust Patient and Client Experience Committee, a sub-committee of the Trust Board;
- Each Trust Board agenda includes a patient/client centred service which incorporates feedback and learning from PPI activity;
- PPI arrangements have been subject to verification by PHA in 2015/16 and the Trust has completed a self-assessment PPI Performance Management Report for PHA;
- Corporate PPI Annual Action plan to ensure continuous improvement;
- Implementation of PPI Checklist - a tool to enable senior managers to determine compliance with the PPI Indicators across all programmes of care; and
- Influence in the design and development of the PHA-funded PPI training programme, Engage and Involve.

Further information on the Trust's involvement mechanisms, processes and resources to support staff and service users and carers is available at

<http://www.southerntrust.hscni.net/about/1600.htm>

7. Assurance

A systematic approach is taken to ensure that the systems upon which the Trust relies are challenged and tested. The Board Assurance Framework is a statutory requirement for the Trust and is an integral part of the Trust's governance arrangements. The Framework has been compiled in conjunction with all Directorates and provides the systematic assurances required by the Board on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary to ensure the achievement of corporate

objectives and the delivery of high quality health and social care. In its Board Assurance Framework, the Trust Board has determined the level of assurance it requires to manage the principal risks facing the organisation and the Trust Board reviews this on a six-monthly basis. A standard template attached to the Board Assurance Framework ensures that Board members consider, based on sufficient evidence, whether the current controls and assurance systems are sufficient and are working effectively. Trust Board minutes attest to the challenge and scrutiny applied to the Board Assurance Framework.

The Framework illustrates the wide range of assurance from internal and external sources. The sources of external assurance and system validation as identified in the Board Assurance Framework include, for example, the Regulation and Quality Improvement Authority, Internal and External Auditors, Royal Colleges and Professional Councils. These are supplemented from non-independent sources such as performance management, self-assessments and proposed work streams on national audits.

The Board Assurance Framework sits alongside the Corporate Risk Register, the Controls Assurance Standards process and performance reporting to provide structured assurance about how risks are effectively managed to deliver agreed objectives. Where risks are outside the Trust's ability to solely manage, these are escalated to the Trust Board and beyond.

Compliance with the controls assurance standards and the annual self-assessments against the standards provide an important assurance to the Trust Board. Separately, the Audit and Governance Committees review compliance with Controls Assurance Standards to provide assurance to the Trust Board that action plans are in place for all 22 standards to maintain/further improve compliance against each standard going forward.

The Trust Board agenda is structured to ensure assurance is provided on key areas such as patient safety and quality and performance in terms of finance, human resources and operational performance.

The quality of information presented to the Trust Board is regularly reviewed by members. A standard template is attached to the front of all Board papers ensuring that the report is aligned to specific corporate objectives and key issues/risks and decisions required are drawn to Board members immediate attention. Board members regularly discuss and challenge the quality of the information presented to them and collectively reflect on information received. A Non-Executive Director is a member of the Trust Information Governance forum which addresses assurance processes for data quality. In addition, Trust Board receives reports from external organisations which provide assurance in relation to some areas of data quality. No significant issues have been raised.

Members continue to consider further how to develop the searching questions and processes to ensure effective challenge by the Board. The Executive professional roles (Medical, Nursing and Social Work) ensure executive challenge as these posts are designed to give independent professional assurance to the Trust Board.

Controls Assurance Standards

Controls assurance standards are a central feature of the Trust's corporate governance system. The Trust assessed its compliance with the applicable Controls Assurance Standards which were defined by the Department and against which a degree of progress is expected in 2015/16. Each standard has an action plan in place to address any areas of non-compliance.

Substantive compliance is required across all 22 standards.

The table below provides a summary of the expected and achieved levels of compliance for 2015/16.

Standard	DHSS&PS Expected Level of Compliance	Trust Level of Compliance
Buildings, land, plant and non-medical equipment	75% - 99% (Substantive)	Substantive
Decontamination of medical devices	75% - 99% (Substantive)	Substantive
Emergency Planning	75% - 99% (Substantive)	Substantive
Environmental Cleanliness	75% - 99% (Substantive)	Substantive
Environment Management	75% - 99% (Substantive)	Substantive
Financial Management (Core Standard)	75% - 99% (Substantive)	Substantive*
Fire safety	75% - 99% (Substantive)	Substantive
Fleet and Transport Management	75% - 99% (Substantive)	Substantive
Food Hygiene	75% - 99% (Substantive)	Substantive
Governance (Core Standard)	75% - 99% (Substantive)	Substantive*
Health & Safety	75% - 99% (Substantive)	Substantive
Human Resources	75% - 99% (Substantive)	Substantive
Infection Control	75% - 99% (Substantive)	Substantive
Information Communication Technology	75% - 99% (Substantive)	Substantive

Standard	DHSS&PS Expected Level of Compliance	Trust Level of Compliance
Information Management	75% - 99% (Substantive)	Substantive*
Management of Purchasing	75% - 99% (Substantive)	Substantive
Medical Devices and Equipment Management	75% - 99% (Substantive)	Substantive
Medicines Management	75% - 99% (Substantive)	Substantive*
Research Governance	75% - 99% (Substantive)	Substantive
Risk Management (Core Standard)	75% - 99% (Substantive)	Substantive*
Security Management	75% - 99% (Substantive)	Substantive
Waste Management	75% - 99% (Substantive)	Substantive

**De-notes subject to verification by HSC Internal Audit in 2015/16*

The above table demonstrates that the required levels of compliance have been achieved in 2015/16.

8. Sources of Independent Assurance

The Trust obtains Independent Assurance from the following sources:

- ***Internal Audit;***
- ***RQIA;***
- ***External Review/Benchmarking;***
- ***Licensing and other Regulatory bodies***

Internal Audit

The Trust has an internal audit function which operates to defined standards and whose work is informed by an analysis of risk to which the body is exposed and annual audit plans are based on this analysis.

In 2015/16 Internal Audit reviewed the following systems:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
Finance Audits:	
Management of Client Monies in the Independent Sector (including St Francis Private Nursing Home)	Satisfactory - Most Facilities Limited - Glenview
Payments to staff	Limited
Non Pay Expenditure	Satisfactory
Bank and Cash	Satisfactory
Budgetary control	Satisfactory
FPL Systems Administration	Satisfactory
Asset Management	Satisfactory
Adult Supported Living – Mental Health and Disability Directorate	Satisfactory
Client Monies and cash and Valuables Handling in Social Care Facilities	Satisfactory
Income and debt management (including identification and charging of non-UK residents)	Satisfactory – Income/debt management Limited – Identification and charging of Non UK residents
Client Monies - Valley Nursing Home	Satisfactory
Management and use of Agency and Locum staff	Satisfactory
Laboratory procurement and contract management	Limited
Fostering and adoption payments	Limited
Management of Estates Contracts	Limited
Domiciliary care - Enable Care	Unacceptable
Corporate Risk Based Audits:	
Performance Management	Satisfactory

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
Directorate Risk Based Audit – Children and Young People's Directorate	Satisfactory
Corporate Mandatory Training and Appraisals	Satisfactory: Human Resources and Organisational Development (HROD) Limited - Directorates
Compliance with Standards and Guidelines	Satisfactory
Case Management	Limited
Management of Licences and Accreditations	Satisfactory
Governance Audits:	
Risk Management	Satisfactory
Clinical and Social Care Governance	Satisfactory
Board Effectiveness	Satisfactory
Whistleblowing and Fraud processes	Satisfactory
Complaints Management	Satisfactory

Consultancy and Other Assignments

A number of other assignments were undertaken by Internal Audit during the year which included:

- Review of GP Out of Hours financial procedures
- Verification of sample of re-imbursement of client monies by the Haven Nursing Home

Follow up work

342 of 460 previous priority one and two Internal Audit recommendations which were due to have been implemented, were fully implemented at year end (74%), a further 18% were partially implemented and 8% have not yet been implemented. There were 8 priority one findings which have not been implemented. Four of these relate to the HRPTS system, three of which require BSO input to address. One relates to implementation of KSF gateways under Agenda for Change which requires a regional approach and the other three are Trust clinical and social care governance

issues. Where it is within the control of the Trust to do so, these recommendations will be progressed in 2016/17.

Shared Services Audits

As the Trust is a customer of BSO Shared Services, the following audit reports have been shared with the Trust for information.

Shared Service Audit	Assurance
Payments Shared Service (as at September 2015)	Satisfactory
Payments Shared Service (as at March 2016)	Satisfactory
Payroll Shared Service (as at September 2015)	Limited
Payroll Shared Service (as at March 2016)	Limited
Income Shared Service	Satisfactory
Recruitment Shared Service	Unacceptable
Business Services Team	Satisfactory
Benefits Realisation	Satisfactory

Limited assurance has been provided again in 2015/16 in respect of the Payroll Shared Service Centre and a significant number of priority one findings and recommendations have been reported. Improvement is required particularly in the following areas: variance monitoring; management and reporting of overpayments; authorisation and processing of manual payments; accuracy of maternity payments; payroll information relating to pension calculations; and HRPTS access controls.

Unacceptable assurance has been provided in respect of the Recruitment Shared Service Centre. There are significant E-Recruitment system functionality issues and performance of the Recruitment Shared Service is not being effectively managed and monitored. Improvement is noted as required in the following areas: E-Recruitment system functionality; standing operating procedures; performance management; management of customer queries; information governance; and control of user access rights.

Internal Audit also followed up on the implementation of priority one and priority two BSO shared service recommendations at the end of 2015/16. In total, 294 BSO shared service recommendations were followed up. 78% of these recommendations have been fully implemented, a further 20% partially implemented and 2% were not yet implemented at the time of review.

Overall Opinion for 2015/16

In her annual report, the Head of Internal Audit reported that the Trust has a satisfactory system of internal control designed to meet the organisation's objectives. However, it was also noted that Limited assurance has been provided in a number of areas and Unacceptable assurance has been provided in relation to controls within an Independent Domiciliary Care contracting organisation.

Details of the significant issues identified within the limited and unacceptable assurance reports provided to the Trust are noted below:

Payments to staff: priority one issues were raised in relation to insufficient controls in place to check self-payment by staff; BSO reporting and management of overpayments; and evidence of insufficient validation of travel claims by Trust managers prior to authorisation.

Fostering and Adoption payments: priority one issues were identified in relation to a high level of errors in the rate of adoption payments sampled; and weaknesses in the completeness of foster care contract documentation.

Laboratory procurement and contract management: priority one issues related to the lack of contract documentation and contract performance processes with the Belfast HSC Trust for significant services provided to the Trust; and incomplete contract management and documentation for a number of smaller laboratory suppliers.

Management of Estates Contracts: two priority one issues were identified and relate to controls around the approval of measured term contract (MTC) invoices for payment and monitoring of the performance of quantity surveyors who conduct the financial review of MTC invoices.

Case Management: the priority one findings in this reported highlighted that the new case management procedures are not embedded and fully understood across all Trust teams tested. In addition, three service users in the community were highlighted where Trust staff are involved in managing their finances without adequate segregation of duties.

Management of Client Monies in Glenview Nursing Home: Particular issues were found in relation to Glenview Nursing Home which included lack of appropriate signed residents' agreements; no procedures in place for the Clients' Comfort Fund, including no dedicated receipt book, no double signing of withdrawals and no evidence of review of account reconciliations.

Corporate Mandatory Training and Appraisals: compliance with mandatory training requirements by a number of Directorates in the Trust was noted, where compliance was less than 60% in 9 out of 14 mandatory training areas.

Income and debt management (including identification and charging of non-UK residents): Internal Audit noted several weaknesses within the current arrangements in the Trust for capturing potential income associated with treatment of patients who are not ordinarily resident.

Domiciliary Care - Enable Care: this report identified eight priority one issues, six concerning controls within the supplier and two regarding controls in the Trust. The systems in place within the supplier were very basic and weak. Internal Audit was unable to validate hours actually worked by care workers due to the failure to retain rotas and timesheets for the periods tested. The management of Enable Care have accepted the audit findings and are working with the Trust on their implementation.

The recommendations of the Internal Auditor to address control weaknesses have been considered by the Audit Committee. They have been or are being taken forward by the management of the Trust and their implementation will continue to be monitored by the Audit Committee regularly during 2016/17.

Northern Ireland Audit Office (External auditor)

The external auditor undertakes an examination of the annual financial statements in accordance with auditing standards issued by the Auditing Practices Board. Based on the findings of this audit, the Comptroller and Auditor General (C&AG) will report his opinion to the NI Assembly as to the truth and fairness of the annual financial statements, that expenditure and income have been applied to the purposes intended by the Assembly and that the transactions conform to the authorities which govern them (regularity).

In addition, the external auditor will provide a Report to those charged with Governance which brings to the attention of the Accounting Officer findings during the course of the external audit. The external auditor reports all of these findings to the Audit Committee. In the course of the external audit for 2015/16, the external auditor has brought to the attention of management one priority one issue.

The Northern Ireland Audit Office also conducts a number of Value for Money studies across the health sector on an annual basis and these are presented to the Audit Committee.

A representative of the NIAO attends Audit Committee four times per year.

RQIA

The RQIA provides independent assurance by conducting a rolling programme of planned clinical and social care governance and thematic reviews across a range of subject areas in HSC organisations.

As part of the revisit of its Clinical and Social Care Governance arrangements, the Trust is presently establishing a better system to track and monitor RQIA thematic

reviews and inspections and the Trust responses. This will further improve governance arrangements and enhance assurance to be gained from this area.

External Review/Benchmarking

The Trust participates in a service which facilitates external benchmarking of hospital based data against a UK peer group of like hospitals. The service provider provides annual reporting on a range of key performance indicators including efficiency and safety measures, and quarterly reporting on mortality issues which is a key area of review. It provides independent assessment of performance against peer and against the top percentile, supporting this function with analysis and support at Directorate level.

Licensing and other Regulatory bodies

Trust services are subject to a range of standards and regulations from external licensing and regulatory authorities to ensure appropriate standards of care are delivered. The four main licensing authorities are the Human Tissue Authority (HTA), the Medicines and Healthcare Products Regulatory Agency (MHRA), the Human Fertilisation and Embryology Authority (HFEA) and the Administration of Radioactive Substances Advisory Committee (ARSAC). The Trust is developing an IT system for the corporate logging, monitoring and reporting on these licenses.

The management of licences and accreditations in the Trust was subject to Internal Audit in 2015/16 and a satisfactory level of assurance provided.

In 2014/15, the Trust highlighted that its Biochemistry laboratory had not maintained its CPA accreditation. The inspection for re-accreditation took place on 12, 13 and 14 of April 2016.

9. Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance. My review of the effectiveness of the Trust's system of internal governance is informed by the work of the internal auditors, the executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Senior Management Team, Trust Board, Head of Internal Audit, Audit Committee and Governance Committee. I have referred to the Annual Report from the Head of Internal Audit which details the assurance levels provided from reports in 2015/16 and also the Trust's implementation of accepted

internal audit recommendations. A plan to address weaknesses and ensure continuous improvement to the system is in place.

10. Internal Governance Divergences

Prior Year Issues

A number of governance matters arising in previous years have now been addressed and no longer represent reportable governance issues for the Trust.

Compliance by Independent Sector Homes with circular HSS (F) 57/2009

The DHSSPS issued HSC (F) 15/2016 “Safeguarding of Service User’s Finances within Residential and Nursing Homes and Supported Living Settings” in February 2016. Compliance with this circular by homes and facilities improved during 2015/16. Learning has been incorporated for the annual process now underway and any remaining issues are being taken forward under normal business arrangements.

Safeguarding of Residents’ Interests

In 2012/13 the Trust commenced two adult safeguarding investigations into two independent sector residential homes. The Trust continues to liaise with the Home Owners, their legal representatives and external agencies in relation to the issues identified.

However, new case management procedures were introduced in the Trust as part of the learning outcomes from these investigations. These procedures were introduced in February 2015 and have been embedding. An audit of compliance was conducted in 15/16 by Internal Audit and limited assurance provided to the Trust. The areas identified for improvement will be taken forward under normal business arrangements.

Progress on Prior Year Issues which continue to be considered as control issues

A number of governance matters arising in prior years are still considered to represent internal governance divergences for 2015/16. These are as follows:

Contract & Procurement Management

Estates

The appropriate procurement of Service and Maintenance contracts, which are within the scope of the Centre of Procurement Excellence (CoPE), has been an area of concern for a number of years.

A new HSC regional model, involving both BSO Procurement and Logistics Service (PaLS) and Trust Estates teams has been agreed during 2015/16 to address this procurement need and to ensure compliance with procurement legislation and guidelines. The establishment of this model is being overseen by a Regional Estates Procurement Group.

It is envisaged that it will take approximately five years to establish this model in full across both BSO PaLS and Trusts.

In the interim, the Trust continues to manage the associated risks by ensuring the provision of appropriate training to Estates staff, the use of robust procedures and direct award contracts as appropriate and regular monitoring and review.

Estates Contracts were the subject of Internal Audit in 2015/16 and a limited assurance was provided. This report verified that previous audit recommendations in this area had been largely implemented, however new issues were identified in relation to the management and control of Measured Term Contracts. Management will take forward the recommendations as appropriate.

Social Care Procurement

Progress has been made regionally, with agreement on an approach for the procurement of social care and other specific contracts further to the new 2015 Public Contract Regulations and guidance on the 'Light Touch Regime'. Further guidance is awaited on the scope of the regulation and approach to practical management of social care contracts, particularly those under the agreed threshold.

In 2015/16 the Trust agreed a temporary approach to increase procurement capacity for social care, in the absence of an agreed regional approach, to address priority procurements. A temporary procurement resource established, operating under the influence of the Social Care Procurement Unit, has undertaken a number of procurements related in the main to operational need and strategic change.

The Trust also continues to operate a discipline around the roll forward of contracts which provides assurance that:

- That objectives of the provider are/continue to be in line with objectives of the Trust.
- That a service specification has been prepared or reviewed defining the service delivery outcomes with clear measures of performance.
- That value for money has been examined and efficiencies sought or obtained accordingly.

The Trust will continue to work with the Social Care Procurement Group of the Regional Procurement Board, HSCB to develop an agreed regional approach for social care procurement.

General Contract Management

Due to lack of resource, the implementation of a central contracts database or improvement in general contract management arrangements/training in the Trust during 2015/16 has not progressed. The Trust continues to highlight this risk of lack of central monitoring and assurance regarding general contract management in the Trust.

Following a prioritisation exercise to manage this risk, the Trust decided that the estates procurement issues were more pressing and therefore worked actively with PaLS and the other Trusts to address these issues. The new arrangements are now active. The Trust continues to periodically remind all contract managers and their Directors of their roles and responsibilities. The establishment of a central contract management team with supporting systems continues to be a priority and as with the estate issue, will be reviewed on a regular basis as further opportunities for managerial / administrative changes arise and open the potential for reinvestment.

Estate Risks

Water Borne Risks (Legionella, Pseudomonas etc.)

The Trust continues to manage Water Borne Risks through implementation of the arrangements set out in its Water Safety Plan. Performance against this plan will be reviewed in early 2016/17 by an independent specialist.

Installation of a Copper Silver ionisation system for the treatment of water and control of pathogens such as Legionella and Pseudomonas in Craigavon Area Hospital has exhibited success in reducing the instances of positive legionella detections. Based on this, similar systems are being implemented across other hospital sites and facilities and should be operational in early 2016/17.

A Water Safety testing contract was awarded effective from 1 June 2015; however it has been terminated due to under-performance and will be re-procured in 2016/17.

Trust Estate Risks

The age, condition and nature of the estate continue to pose potential risks and are exacerbated by limited capital investment in major renewal and replacement projects. All key risks are included on the Trust Corporate Risk Register ensuring regular scrutiny and follow up on action plans. The Trust prioritises available funding to the mitigation of these estates risks and continues to pursue additional funding through all appropriate streams. Specific risks which continued during 2015/16 were:

Electrical infrastructure, Craigavon Area Hospital: The action plan for this area focussed around a three phased approach for low/high voltage works. Only one aspect of this plan remains outstanding: Installation of new NIE High Voltage supply and upgrade of LV/HV infrastructure. The programmed completion date for these works is September 2016.

Fire Safety: The internal audit recommendations concerning this area in 2013/14 have been substantially addressed. However a number of fire incidents in 2015/16 have raised concerns and procedures are currently under review to ensure their effectiveness.

Business Continuity: Progress continues to be made in Estates to support business continuity. The new electricity supply arrangements for Craigavon Area Hospital are almost complete and a Trust wide telecoms infrastructure upgrade is underway. These initiatives include increased resilience in support of patient services.

Estates Staffing

Trust financial contingency measures in 2014/15 meant that a number of vacancies remained unfilled within the Estates Structure during 2014/15 and 2015/16. The risk associated with these vacancies and the impact upon the service delivered was reflected on the Trust's Corporate Risk Register during the year. Whilst a number of key vacancies were filled in 2015/16, the impact of internal appointments has maintained vacancies at high levels. It is anticipated these vacancies will be filled in early 2016/17, mitigating the risks in this area.

Sewage

The sewage system serving the wards at Craigavon Area Hospital had reached a critical point with frequent blockages leading to bursts and subsequent contamination of patient and support areas. This presented a serious infection control risk; caused disruption to services; and has been reported in the press potentially damaging service user confidence. An extensive sewage pipe replacement programme commenced in August 2015 and involved a carefully coordinated and phased programme of ward decants which was required due to limited decanting provision and Winter Pressures. Works were carried out to the most critical areas. Although a significant amount of works have been completed, thus reducing the risk level, further work and funding is required to complete this programme of work in 2016/17.

Fire Safety

Internal Audit recommendations (2013/14) have now been addressed including the completion of baseline fire risk assessments and the establishment of a review programme. Staff training has increased to approximately 70% and there is an on-going programme of training for evacuation aids and Fire Extinguishers. A number of fire incidents occurred in 2015/16 relating to hot works on 'built-up felt roofs'. All similar work was suspended until investigations were completed and further robust control measures were introduced (including extended fire watch procedures and the use of Thermal Imaging post works, controlled under Permit). A number of unwanted fire alarm signals caused by contractors (dust etc.) prompted the Trust to develop new procedures aimed at reducing such occurrences.

Clinical and Social Care Risks

Inquiry into Hyponatraemia-related Deaths

The Inquiry into Hyponatraemia- related deaths in five children concluded its public hearings in 2013/14. The Trust contributed to the governance section of the above Inquiry. The Trust will consider the learning points and recommendations from that Inquiry when available and take forward as appropriate.

Child Sexual Exploitation/Marshall Inquiry/Safeguarding Board for Northern Ireland (SBNI) Thematic Review

The Trust fully participated in the Marshall Inquiry and SBNI Thematic Review. The SBNI Thematic Review report was published in December 2015 and action from the review will be taken forward as part of the Safeguarding Board NI Business Plan 2016/17 and Southern Safeguarding Panel Business Plan 2016/17. Following the publication of the Thematic Review, the Trust has completed 4 case management review notifications to the SBNI regarding young people who were subject to the thematic review and suffered significant harm as a result of abuse. These cases will be considered by the SBNI CMR Panel in May 2016. CSE is a standing item on a number of Trust and Regional Fora to ensure appropriate training; improved assessments; interagency working and good governance arrangements.

Elective Care

The Trust continued to have a number of specialty areas with capacity gaps in 2015/16 resulting in the target that the majority of patients should waiting no longer than 9 weeks for an outpatient/diagnostic appointment and 13 weeks for allied health professions and inpatient/day case treatment not being met.

In the absence of recurrent investment in 2015/16, a level of non-recurrent funding was allocated by the HSCB in quarters 3 and 4 to provide additional capacity. As a result a number of time limited areas of performance improvement were demonstrated within elective access times and within the unscheduled care pathway as follows:

- The number of patients waiting less 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.
- The number of patients waiting in excess of 9 weeks, for diagnostic imaging, decreased by 1,945, from 3,892 at 31 December 2015 to 2,180 at 31 March 2016.
- The number of patients waiting less than 13 weeks, for in-patient/day case treatment, increased by 2.2% (105 patients), from 56.5% at 31 December 2015 (3,892 patients) to 58.7% at 31 March 2016 (3,997 patients). The number of patients waiting in excess of 26 weeks demonstrated a more significant decrease - 344 patients, from 1,709 patients at 31 December 2015 to 1,365 patients at 31 March 2016.
- The Trust demonstrated an improvement in discharge performance for non-complex discharges within 6 hours. Performance at 31 March 2016 demonstrated 95.5% in comparison to 90.9% at 31 December 2015. The Trust further demonstrated improvement in complex discharges within 48 hours. Performance at 31 March 2016 demonstrated 100% in comparison to 90.1% at 31 December 2015.

Despite this time limited improvement, the non-recurrent allocation was insufficient to address the demand in excess of capacity and waits continued to increase. Further, the ability to increase capacity, where funding was available, has been challenged in a number of areas by workforce issues and an inability to continue to flex up short term temporary staffing arrangements in key professional areas. The Trust expects that the position will deteriorate further if no funding is made available for areas with agreed capacity gaps in 2016/17; however it is continuing to work with the HSCB and continues to ensure that available capacity is directed to areas of clinical priority in the first instance.

Unscheduled Care

The Trust continues to be challenged in respect of significant service demand for unscheduled care services on both acute sites and specifically peaks in demand for ED attendances and emergency admissions. Specifically targets were not achieved in 2015/16 in respect of unscheduled care relating to the 4 and 12 hour Emergency Department targets and non-complex discharges from Acute hospitals where unscheduled care has been subject to sustained demand and heightened pressures.

The Trust received funding from the regional task group for unscheduled care to implement a range of measures to improve patient flow in the unscheduled care pathway, including 7 day working models including AHP and social work support to ED, and access to radiology, as well as funding for a dedicated minor injuries stream in ED. These measures have contributed to maintaining performance. However, full effectiveness has been limited mainly by workforce/ recruitment pressures. The Trust will continue to work with the HSCB through the newly formed unscheduled care governance structures to challenge and review current service profile and service design and to test new models of care to support improved performance.

A range of regional and local indicators of quality are in place which provide assurance on safety and quality of services.

Financial Risks

Performance of Finance Functions within BSO Shared Services Centres

The Head of Internal Audit has reviewed the shared services functions provided by BSO as noted on page 47 during 2015/16. Payroll Shared Service has continued to receive a limited assurance throughout 2015/16, showing no improvement in assurance levels from 2014/15. The other finance functions have received a satisfactory assurance.

There have continued to be a number of difficulties experienced with the HRPTS system and Internal Audit have highlighted that improvement is required by BSO Payroll in the areas noted on page 47.

In correspondence from the Interim Chief Executive of BSO, BSO acknowledge that a continued combination of systems in operation between HSC organisations, in relation to the submission of payroll and travel information for payment, and the increased workload associated with this, has reduced the controls within the BSO Payroll process, particularly around the authorisation of transactions.

The Trust Board are disappointed that there remains no improvement in assurance levels in respect of the payroll shared service and that satisfactory assurance has still not been achieved. Whilst BSO management have accepted the recommendations and provided assurance that action plans are in place, this situation continues to present reputational and other difficulties for the Trust.

The Trust will continue to monitor progress at Audit Committee.

New Control Issues in 2015/16

Clinical and Social Care Risks

The Donaldson Report

In April 2014 a review was undertaken by Sir Liam Donaldson which examined the HSC in its entirety in respect of its openness and transparency; appetite for inquiry and learning; and approach to re-dress and to making amends. The publication of the Donaldson Report 'The Right Time, The Right Place' in January 2015 made a range of recommendations across HSC. In response to the report's recommendations the Minister announced a number of actions in 2015/16 which focus on elements of Clinical & Social Care Governance as follows:

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

The Trust is participating in a number of work streams with the DHSSPS, HSCB, RQIA and GAIN in respect to strengthening and modifying our existing incident reporting and investigation processes to maximise learning, highlight risk and improve patient safety both internally within the Trust and across the region. The Child death notification process has been embedded into the Trust's Morbidity and Mortality processes. The Trust is preparing to begin implementation of the regional mortality and morbidity systems in August 2016. Progress will be monitored by the Trust's Governance Committee during 2016/17.

Food safety testing

In June 2015, the results of routine sampling by an external laboratory detected possible E. Coli 0157 in the kitchen at Craigavon Area Hospital. As a result, the Trust immediately introduced precautionary measures in the interests of public safety at a cost of some £79k. Subsequently, the external laboratory partner recalled the original test results following further investigatory analysis. The Trust is currently working with PaLS and the Directorate of Legal Services regarding the contractual position with this supplier and seeking appropriate compensation. The Trust reviewed its own processes following this incident to ensure their effectiveness.

Recruitment

Throughout 2015/16, the Trust has experienced difficulties in meeting its demand for recruitment of medical, nursing and GP staff for the provision of high quality and safe services. Whilst the Trust has worked with the HSCB and DHSSPS on a number of

measures to address this, the situation has not been assisted by the existence of internal competition within the HSC for limited staff resources. The Trust will seek to generate discussion with other Trusts, the HSCB and the DHSSPS on how these competitive tensions can be minimised and managed going forward.

Emergency Department at Daisy Hill Hospital

Throughout 2015/16, a Strategic Oversight Group that included representatives from Senior Management Team and senior HSCB Commissioning representatives agreed additional measures to sustain the ED service 24 hours and 7 days a week in Daisy Hill Hospital. This included actions to recruit and stabilise the medical workforce in ED and additional support to junior staff in the ED in the out of hours period, ongoing recruitment for Medical staff at all levels offering enhanced terms and conditions, augmented locum cover at middle grade in medicine and surgery out of hours, two additional short stay observation beds opened overnight for patients requiring senior review, appointment of additional Emergency Nurse Practitioners and additional Band 6 Clinical Sisters.

These actions have secured the service to date however there remain significant concerns regarding the sustainability of the current service model.

Finance Risks

Fraud cases

In 2015/16 there have been 22 reported cases of fraud. Two of these cases have been referred to the PSNI following investigation by the Counter Fraud and Probity Services. One case involves inappropriate claims by an employee and the second, inappropriate claims by a contractor. The Trust is pursuing recovery of losses incurred.

The Trust has a zero tolerance approach to fraud.

All identified actual, suspected and potential frauds are reported to the Audit Committee as a standing agenda item.

BSO Recruitment Shared Services

Following the roll out of the E-Recruitment system and Recruitment Shared services to a number of other large HSC organisations during 2015/16, issues have emerged regarding the length of time taken to complete the overall recruitment process. The Southern Trust has experienced significant delays in filling vacancies during 2015/16.

Recruitment Shared Services had only developed a limited ability to generate management and performance information from the E-Recruitment system, which has meant that information, has not been available to provide robust evidence of, and reasons for, the delays reported.

The further roll out of recruitment shared services has been put on hold until the current service is stabilised and a formal recovery plan instigated. BSO Senior Management will be monitoring and reviewing progress against this plan weekly, until the service is stabilised.

Internal Audit has provided an unacceptable assurance in 2015/16 as noted on page 47.

BSO management have accepted the recommendations and provided assurance that action plans are in place to assist with the implementation of the recommendations in 2016/17. The Trust will continue to monitor progress at the Audit Committee.

Conclusion

The Trust has a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in Managing Public Money NI. The system operates on a principle of continuous improvement where the performance and effectiveness of governance arrangements are subject to regular review.

As outlined above, the internal audit review of control systems has resulted in a number of limited assurances and one unacceptable assurance in the Trust. A number of priority one issues have been raised with management and extensively examined by the Audit Committee. The findings of these reports and others such as those issued by RQIA will be incorporated into action plans aimed to address the weaknesses/gaps in control.

Further to considering the accountability framework within the Trust and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the Trust has operated a sound system of internal governance during the period 2015/16.

REMUNERATION REPORT FOR THE YEAR ENDED 31 MARCH 2016

Fees and allowances paid to the Chairman and other Non-Executive Directors are as prescribed by the Department of Health and Social Services and Public Safety.

The remuneration and other terms and conditions of Executive Directors are by the Remuneration and Terms of Service Committee. Its membership includes the Chair and all Non-Executive Directors. The terms of reference of the Committee are based on Circular HSS (PDD) 8/94 Section B.

For the purposes of this report the pay policy refers to Senior Executives, defined as Chief Executive, Executive Director and Functional Director and is based on the guidance issued by the Department of Health and Social Services and Public Safety on job evaluation, grades, rate for the job, pay progression, pay ranges and contracts.

Pay progression is determined by an annual assessment of performance. It is the responsibility of the Remuneration and Terms of Service Committee to monitor and evaluate the performance of the Chief Executive ensuring that any discretionary awards in terms of performance related pay are justifiable in light of the Trust's overall performance against the annual Trust Delivery Plan. During 2015/16, emphasis continued to be on patient safety and quality improvement, ministerial targets and financial balance. The Chief Executive in turn is responsible for the assessment of performance of the Senior Executives based on the attainment of individual objectives established at the outset of the year, and for the submission of recommendations to the Remuneration and Terms of Service Committee for its annual review of salaries which are conducted in accordance with the relevant circulars issued by the Department of Health, Social Services and Public Safety.

The levels of performance pay permitted applied by the Remuneration and Terms of Service Committee are prescribed by Department of Health and Social Services and Public Safety. Pay progression as at 1 April 2015 based on performance for Senior Executives in the period 1 April 2014 to 31 March 2015 has been set at 2% for fully acceptable performance for those employed on contracts before 23 December 2008 and 1% (non-consolidated) for those employed on contracts after 23 December 2008. There is no 'Superior Performance Award'. No award is made for unsatisfactory performance. Senior Executive pay ranges have not been increased with effect from 1 April 2015.

During 2015/16, all contracts were permanent and provided for three months' notice for both parties, with the exception of:

- Mrs Paula Clarke, who undertook the role of Interim Chief Executive from 1 April 2015 to 31 March 2016.
- Mrs Aldrina Magwood, who continued to undertake the Director of Performance and Reform on an acting basis during 2015/16.
- Mr Kieran Donaghy, who undertook the role of Temporary Deputy Chief Executive from 1 February 2016 to 31 March 2016.

As far as all Senior Executives are concerned, the provisions for compensation for early termination of contract are in accordance with the appropriate Departmental guidance.

Senior Employees' Remuneration (Audited)

The salary and the value of any taxable benefits in kind of the most senior members of the Southern HSC Trust were as follows:

	2015/2016				2014/2015			
Name	Salary £000s	Bonus/ Performance pay £000s	Benefits in Kind (rounded to nearest £100)	Total £000s	Salary £000s	Bonus/ Performance pay £000s	Benefits in Kind (rounded to nearest £100)	Total £000s
Non-Executive Members								
Mrs R Brownlee (Chair)	25-30	0	0	25-30	25-30	0	0	25-30
Mrs E Mahood	5-10	0	0	5-10	5-10	0	0	5-10
Mrs D Blakely (to 31 December 2015)	5-10	0	0	5-10	5-10	0	0	5-10
Mr E Graham	5-10	0	0	5-10	5-10	0	0	5-10
Mrs H Kelly (to 31 December 2015)	5-10	0	0	5-10	5-10	0	0	5-10
Dr R Mullan	5-10	0	0	5-10	5-10	0	0	5-10
Mrs S Rooney	5-10	0	0	5-10	5-10	0	0	5-10

	2015/2016					2014/2015				
Name	Salary £000s	Bonus / Performance pay £000s	Benefits in Kind (rounded to nearest £100)	Pension Benefits £000s	Total £000s	Salary £000s	Bonus/ Performance pay £000s	Benefits in Kind (rounded to nearest £100)	Pension Benefits £000s	Total £000s
Mrs H McCartan (from 15 February 2016)	0-5 (5-10 full year equivalent)	0	0	0	0-5 (5-10 full year equivalent)	0	0	0	0	0
Ms E Mullan (from 15 February 2016)	0-5 (5-10 full year equivalent)	0	0	0	0-5 (5-10 full year equivalent)	0	0	0	0	0
Mr J Wilkinson (from 15 February 2016)	0-5 (5-10 full year equivalent)	0	0	0	0-5 (5-10 full year equivalent)	0	0	0	0	0
Executive Members										
Mrs P Clarke – Interim Chief Executive (from 1 April 2015 to 31 March 2016)	95-100	0	0	110	205-210	75-80	0	0	66	140-145
Mrs M McAlinden - Chief Executive (Resigned 31 March 2015)	0	0	0	0	0	100-105	0	0	20	120-125
Mr S McNally - Director of Finance & Procurement	90-95	0	0	N/A	90-95	90-95	0	0	18	105-110

	2015/16					2014/15				
Name	Salary £000s	Bonus / Performance pay £000s	Benefits in Kind (rounded to nearest £100)	Pension Benefits £000s	Total £000s	Salary £000s	Bonus/ Performance pay £000s	Benefits in Kind (rounded to nearest £100)	Pension Benefits £000s	Total £000s
Dr J Simpson - Medical Director (to 31 July 2015)	30-35 (100-105 full year equivalent)	0	0	N/A	30-35 (100-105 full year equivalent)	165-170	0	0	(7)	155-160
Dr R Wright – Medical Director (from 1 July 2015)	75-80 (100-105 full year equivalent)	0	0	125 (166 full year equivalent)	200-205 (265-270 full year equivalent)	0	0	0	0	0
Mr P Morgan - Director of Children & Young People's Services	75-80	0	0	8	80-85	75-80	0	0	15	85-90
Mr F Rice – Director of Mental Health & Disability Services & Executive Director of Nursing & AHPs	100-105	0	0	38	135-140	95-100	0	0	27	120-125
Other Members										
Mr K Donaghy - Director of Human Resources & Organisational Development (Also temporary Deputy Chief Executive effective from 1 February to 31 March 2016)	85-90	0	0	99	185-190	80-85	0	0	17	95-100

	2015/16					2014/15				
Name	Salary £000s	Bonus / Performance pay £000s	Benefits in Kind (rounded to nearest £100)	Pension Benefits £000s	Total £000s	Salary £000s	Bonus/ Performance pay £000s	Benefits in Kind (rounded to nearest £100)	Pension Benefits £000s	Total £000s
Mr M Crilly – Acting Director of Mental Health & Disability Services (to 30 April 2015)	5-10 (70-75 full year equivalent)	0	0	1 (9 full year equivalent)	5-10 (80-85 full year equivalent)	70-75	0	0	8	80-85
Mrs A McVeigh - Director of Older People & Primary Care	80-85	0	0	9	90-95	80-85	0	0	16	95-100
Mrs D Burns - Interim Director of Acute Services (Resigned 31 August 2015)	30-35 (65-70 full year equivalent)	0	0	(2) ((5) full year equivalent)	25-30 (60-65 full year equivalent)	70-75	0	0	13	85-90
Mrs E Gishkori – Director of Acute Services (from 19 August 2015)	46-50 (65-70 full year equivalent)	0	0	32 (47 full year equivalent)	75-80 (120-125 full year equivalent)	0	0	0	0	0
Mrs A Magwood – Acting Director of Performance & Reform (from 1 March 2015)	75-80	0	0	16	90-95	5-10 (65-70 full year equivalent)	0	0	4 (45 full year equivalent)	10-15 (110-115 full year equivalent)

The value of pension benefits accrued during the year is calculated as: (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increase or decreases due to a transfer of pension rights.

Two Non-Executive Directors came to the end of their term of office in December 2015 and three new Non-Executive Directors were appointed from February 2016.

Senior Executive remuneration stated above includes a pay award for two years – 2013/14 and 2014/15. The comparative figures did not include a pay award for 2013/14 due to the late issue and finalisation of the DHSSPS circular for that year.

Pensions of Senior Management (Audited)

The pension entitlements of the most senior members of the Southern HSC Trust were as follows:

	2015/2016				
Name	Real Increase in pension and related lump sum at age 60 £000s	Total Accrued pension at age 60 and related lump sum £000s	CETV at 31/03/15 £000s	CETV at 31/03/16 £000s	Real Increase in CETV £000s
Executive Members					
Mrs P Clarke – Interim Chief Executive (from 1 April 2015 to 31 March 2016)	5-7.5 plus 12.5-15 lump sum	25-30 plus 85-90 lump sum	415	519	89
Mrs M McAlinden - Chief Executive(Resigned 31 March 2015)	0	0	0	0	0
Mr S McNally - Director of Finance & Procurement Note 1	0	0	0	0	0
Dr J Simpson - Medical Director (to 31 July 2015) Note 2	0	0	0	0	0
Dr R Wright – Medical Director (from 1 July 2015)	7.5-10 plus 22.5-25 lump sum	50-55 plus 160-165 lump sum	182	1,069	155
Mr P Morgan – Director of Children & Young People's Services	0-2.5 plus 0-2.5 lump sum	30-35 plus 90-95 lump sum	661	703	18

	2015/16				
Name	Real Increase in pension and related lump sum at age 60 £000s	Total Accrued pension at age 60 and related lump sum £000s	CETV at 31/03/15 £000s	CETV at 31/03/16 £000s	Real Increase In CETV £000s
Mr F Rice – Director of Mental Health & Disability Services & Executive Director of Nursing & AHPs	0-2.5 plus 7.5 lump sum	40-45 plus 125-130 lump sum	716	781	40
Other Members					
Mr K Donaghy - Director of Human Resources & Organisational Development (Also temporary Deputy Chief Executive effective from 1 February to 31 March 2016)	2.5-5 plus 12.5-15 lump sum	40-45 plus 125-130 lump sum	846	986	109
Mr M Crilly – Acting Director of Mental Health & Disability Services (to 30 April 2015)	0-2.5 plus 0-2.5 lump sum	30-35 plus 90-95 lump sum	597	634	16
Mrs A McVeigh – Director of Older People & Primary Care	0-2.5 plus 2.5-5 lump sum	35-40 plus 105-110 lump sum	709	752	18
Mrs D Burns - Interim Director of Acute Services (Resigned 31 August 2015)	0-2.5 plus (0-2.5) lump sum	15-20 plus 50-55 lump sum	252	264	4
Mrs E Gishkori – Director of Acute Services (from 19 August 2015)	0-2.5 plus 5-7.5 lump sum	10-15 plus 40-45 lump sum	212	261	43
Mrs A Magwood – Acting Director of Performance & Reform	0.2-5 plus (0-2.5) lump sum	15-20 plus 50-55 lump sum	276	297	12

Note 1: Mr S McNally is beyond the threshold for calculation of CETV, so this is not applicable in 2015/16.

Note 2: Dr J Simpson retired during the year. No CETV is disclosed for Pensioners.

Mrs P Clarke resigned her post as Interim Chief Executive with effect from 31 March 2016.

Mr K Donaghy was temporary Deputy Chief Executive from 1 February to 31 March 2016.

Dr J Simpson, Medical Director, retired in July 2015. Dr R Wright commenced as Medical Director from July 2015.

Mrs D Burns Interim Director of Acute Services resigned with effect from 31 August 2015.

Mrs E Gishkori was appointed to the post of Director of Acute Services from 19 August 2015.

Mr M Crilly was Acting Director of Mental Health & Disability Services to the 30 April 2015.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of Pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSC pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or

arrangement) and uses common market valuation factors for the start and end of the period.

Staff Report (Audited)

The Trust employs 14,702 staff with 78.5% of staff providing direct hands on care to patients and clients. This figure includes staff with more than one job position.

14% of employees are male (1,680 headcount) and 86% are female (10,253 headcount). These figures include bank, staff on employment breaks and staff seconded out of the Trust. Of the nine Directors (including the Chief Executive) within the Trust at 31 March 2016, 5 are male and 4 are female.

Staff sickness and absenteeism

The cumulative sickness and absenteeism rate for the Trust as at 31 January 2016 was 5.27%.

Employee Policies

The Trust's Joint Consultative & Negotiating Forum is committed to the involvement of staff at all levels in shaping service delivery and being part of the decision making which affects their working lives and the delivery of health and social care. Significant efforts have been made by the Trust and the Trade Unions to develop a partnership working approach to how business is conducted. The Trust's Partnership Agreement sets out the approach to partnership working and a clear set of values to promote a culture of involvement. This partnership approach has continued to develop across all directorates and clearly has resulted in staff and management working together to deliver a number of very significant change initiatives and service reforms over the past number of years. A Staff Involvement Framework is in place to govern how the Trust involves staff in decisions that affect them through a range of processes, procedures and initiatives to develop a consistent approach to involving staff.

Significant work is on-going across the Trust to continually improve services for patients and clients, and a key focus with many of these improvement initiatives is the involvement of staff who work day by day within the services. Many of these improvement initiatives are reported and showcased in the Trust's Continuous Improvement Newsletters prepared by the Directorate of Performance & Reform, which are distributed via global email.

The Trust has in place an Equal Opportunity Policy which emphasises its continuing commitment to the provision of equality of opportunity. The scope of the current policy covers age, marital or civil partnership status, sex, sexual orientation, gender reassignment, religious belief, political opinion, race (including colour, nationality, ethnic

or national origins, or being an Irish Traveller), disability, pregnancy or maternity leave and with/without dependants. Key achievements during the year included mainstreaming equality, disability and human rights considerations within policy development and decision making processes; participation in a regional workshop on 'HSC Procurement, Commissioning and Planning' - ensuring a human rights, equality and disability perspective is embedded in good procurement practice and contracts management; supporting deployment of an IT portal to ensure the timely and cost effective use of qualified interpreters for all service users and revision of an information booklet on access to health and social care services.

The Trust also recognises that attention needs to be given to the position of people with disabilities in the service and it is for this reason that the Trust also has a Policy on the Employment of People with Disabilities in place. This Policy takes account of the Disability Discrimination Act 1995 (the DDA), as amended. In developing this policy, the Trust has taken account of its duty under Section 49A of the DDA (as amended), which requires the Trust, when carrying out its functions, to have due regard to the need to promote positive attitudes towards people with disabilities and the need to encourage their participation in public life.

Staff Costs and Numbers

Staff costs comprise:

	2016		2015	
Staff costs comprise:	Permanently employed staff £000s	Others £000s	Total £000s	Total £000s
Wages and salaries	288,012	15,576	303,588	296,485
Social security costs	19,034	1,200	20,234	18,965
Other pension costs	37,713	166	37,879	29,936
Sub-Total	344,759	16,942	361,701	345,386
Capitalised staff costs	(339)	0	(339)	(319)
Total staff costs reported in Statement of Comprehensive Expenditure	344,420	16,942	361,362	345,067
Less recoveries in respect of outward secondments			(252)	(498)
Total net costs			361,110	344,569
			£000s	£000s
Southern HSC Trust			361,110	344,569
Total			361,110	344,569

Staff Costs exclude £339k charged to capital projects during the year (2015: £319k).

Pension Liabilities

The Trust participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. A full valuation for Resource Accounts purposes as at 31 March 2012 was certified in February 2015 and is used in the 2015/16 accounts.

The accounting treatment of pension liabilities is explained in Note 1.19 of the annual accounts on page 102.

Retirements due to ill-health

During 2015/16 there were 19 early retirements from the Trust (2014/15: 13), agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £10k (2014/15: £12k). These costs are borne by the HSC Pension Scheme.

Median Remuneration

	2015/16	2014/15
Band of Highest Paid Director's Total Remuneration (£000s)	155-160	165-170
Median Total Remuneration (based on paid salary)	£29,300	£29,079
Ratio	5.4	5.8

The median reflects the aggregation of earnings where staff have multiple contracts.

Reporting entities are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce, excluding the highest paid director.

In 2015/16, 27 (2014/15: 18) employees received remuneration in excess of the highest paid director. Remuneration ranged from £155k to £285k (2014/15: £165k to £250k). All of these employees were clinicians.

Total remuneration includes salary, non-consolidated performance-related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

In 2015/16 and 2014/15 the most highly paid Director was the Medical Director.

Average Number of Persons Employed

The average number of paid whole time equivalent persons employed during the year was as follows:

	2016			2015 Restated
	Permanently employed staff	Others	Total	Total
	No.	No.	No.	No.
Medical and dental	638	71	709	670
Nursing and midwifery	3,386	32	3,418	3,232
Professions allied to medicine	1,070	9	1,079	1,045
Ancillaries	713	141	854	787
Administrative & clerical	1,612	50	1,662	1,626
Estates & Maintenance	104	0	104	101
Social services	1,198	5	1,203	1,158
Domiciliary/Homecare Workers	875	0	875	920
Total average number of persons employed	9,596	308	9,904	9,539
Less average staff number relating to capitalised staff costs	(7)	0	(7)	(8)
Less average staff number in respect of outward secondments	(4)	0	(4)	(11)
Total net average number of persons employed	9,585	308	9,893	9,520

Of which:

Southern HSC Trust	9,893
Charitable Trust Fund	0
	9,893

A number of minor changes have been made to the numbers of staff disclosed within categories in 2015 to correct classifications.

Number of Senior Staff by Band (Assistant Director and above but excluding Senior Management)

Gender Breakdown by Earnings Range 2015/16 – Senior Staff (Assistant Director and above)			
Earnings Range £'000	Female	Male	Total
95-100	1	0	1
65-70	14	8	22
60-65	2	1	3
55-60	4	0	4
45-50	0	1	1
40-45	0	1	1
30-35	1	0	1
15-20	2	6	8
Total	24	17	41

Gender Breakdown by Earnings Range 2014/15 – Senior Staff (Assistant Director and above)			
Earnings Range £'000	Female	Male	Total
95-100	1	0	1
65-70	13	9	22
60-65	3	0	3
55-60	5	0	5
40-45	0	2	2
30-35	1	0	1
15-20	2	6	8
Total	25	17	42

The earnings rates disclosed above are *pro rata*: not all individuals work full-time.

Associate Medical Directors (AMD) receive an allowance in addition to earnings from clinical duties; AMD additional allowance only is included in above.

**Reporting of Early Retirement and Other Compensation Scheme – exit packages
(Audited)**

Exit Package Cost Band	Number of Compulsory Redundancies		Number of other Departures Agreed		Total Number of Exit Packages by Cost Band	
	2015/16	2014/15	2015/16	2014/15	2015/16	2014/15
<£10,000	0	0	6	0	6	0
£10,001- £25,000	0	0	4	0	4	0
£25,001- £50,000	0	0	1	0	1	0
£50,001- £100,000	0	0	3	2	3	2
Total number of exit packages	0	0	14	2	14	2

	£000s	£000s	£000s	£000s	£000s	£000s
Total Resource Cost	0	0	289	182	289	182

Total Number of Exit Packages by Types		
	2015/16	2014/15
Change of Management	0	2
Voluntary Exit Scheme	14	0
Total	14	2

The above exit costs of £289k (2014/15: £182k) are reflected in Note 3.2 of the Annual Accounts within operating expenses.

The exit packages in 2015/16 which impact net expenditure represent voluntary leavers as a consequence of the HSC Voluntary Exit Scheme.

Where early retirements have been agreed, the additional costs are met by the employing authority and not by the HSC Pension Scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

Staff Benefits

There were no staff benefits in 2015/16 or 2014/15.

Trust Management Costs

	2016	2015
	£000s	£000s
Trust management costs	21,066	20,905
Income:		
RRL	576,154	565,143
Income	39,224	38,656
Non cash RRL for movement in clinical negligence provision	(16,120)	(6,089)
Less interest receivable	(1)	(2)
Total Income	599,257	597,708
% of total income	3.5%	3.5%

The above information is based on the Audit Commission's definition "M2" Trust Management costs as detailed in HSS (THR) 2/99.

Expenditure on Consultancy

The Trust did not incur expenditure on external consultancy during 2015/16.

Off Payroll Engagements

The Trust is required to disclose the details of off-payroll engagements at a total cost of over £58,200 per annum that were in place during the year.

The Trust's use of Off Payroll Staff Resources in 2015/16 and 2014/15 is shown below:

	2015/16		2014/15
	Number of staff		Number of staff
Off Payroll Staff as 1st April 2015	10	Off Payroll Staff as 1st April 2014	11
New engagements during the year	9	New engagements during the period	1
Number of engagements transferred to payroll	0	Number of engagements transferred to payroll	0
Number of engagements that have come to an end during the year	(7)	Number of engagements that have come to an end during the year	(2)
Off payroll staff as at 31 March 2016	12	Off payroll staff as at 31 March 2015	10

The current contract for medical agency is in place following a procurement exercise carried out before 1 October 2014.

ACCOUNTABILITY AND AUDIT REPORT

Compliance with regularity of expenditure guidance

The Trust Management Statement (MS) and the Financial Memorandum (FM) which exists between the DHSSPS and the Trust, outlines the framework in which the Trust will operate and details certain aspects of financial provisions which the Trust will observe.

The discharge of the responsibilities within the MS/FM is supported by the Standing Financial Instructions (SFIs) of the Trust. These were updated during the year and approved by Trust Board in October 2015.

The Standing Financial Instructions are the “business rules” that Directors and employees must follow when acting on behalf of the Trust. They outline the key financial responsibilities which apply to everyone working for the Trust and are mandatory. SFIs are then further supported by finance policies and detailed financial procedures which must be kept up to date with DHSSPS circulars as appropriate. This overall framework is designed to ensure that the Trust has assurance that the income and expenditure recorded in its financial statements have been applied to the purposes as intended by the NI Assembly and the financial transactions recorded in the financial statements of the Trust conform to the authorities which govern them.

Both Internal Audit and External Audit provide an independent assessment of the Trust’s adherence to this framework of financial governance and control, with the External Auditor providing an annual opinion on regularity within the certified financial statements of the Trust. The External Auditor’s opinion on regularity for 2015/16 is unqualified.

Formal Complaints Management

To help the Trust identify areas in which it needs to improve we welcome all comments and complaints regarding our services. Information about how you can make a complaint is explained in our “We Value Your Views” leaflet on the Southern Trust website. We recognise that at times, patients, families and carers may have concerns about their care or treatment. We are committed to engage with patients and their families to ensure that we learn from their experiences.

The total number of complaints received for the period 1 April 2015 – 31 March 2016 was 1,045.

The Trust uses issues raised through the complaints process as an important source of information for safety and quality improvement. This information informs learning and development and is fed back to staff involved. Within the Trust it is the responsibility of all Trust Directors, Assistant Directors, Heads of Service and Senior Managers to utilise

the information and trends from their complaints to ensure learning and development and to monitor learning. Complaint reports are shared at Senior Management Governance meetings, Governance Committee meetings and Directorate meetings to highlight complaint themes across the Trust to ensure improvement and learning takes place.

Statement of Losses and Special Payments recognised in the year

Losses and special payments are items of expenditure that the NI Assembly would not have contemplated when it agreed funding to the Trust. They are subject to special controls and procedures and require specific approval in accordance with limits set by the DHSSPS. The limit delegated to the Trust, for approval of losses, differs depending on the type of loss but all losses and special payments, irrespective of value, require approval by the Trust Board. Losses over a particular threshold require approval by the DHSSPS.

Losses and special payments are reported to the Audit Committee for review and to Trust Board for approval annually. They are audited as part of the audit of the Annual Accounts.

Statement of Losses and Special Payments recognised in the year (continued)

Type of Loss and Special Payment	2015/16		2014/15 Restated	
	CASES	£	CASES	£
Cash Losses				
Cash Losses – Other causes	6	5,168	95	7,208
Claims abandoned				
Waived or abandoned claims	0	0	3	54,679
Administrative write-offs				
Bad debts	821	346,354	394	223,305
Fruitless payments				
Late Payment of Commercial Debt	5	553	9	365
Other Fruitless payments and constructive losses	2	65,183	2	1,719
	7	65,736	11	2,084
Stores Losses				
Losses of accountable stores through any deliberate act	0	0	1	1,800
Other stores losses (Note 1)	919	31,830	4,892	65,598
	919	31,830	4,893	67,398
Special Payments				
Compensation payments				
- Clinical Negligence	85	2,015,585	89	6,911,848
- Public Liability	11	106,984	17	101,395
- Employers Liability	28	198,048	32	459,081
- Other	1	1,300	0	0
	125	2,321,917	138	7,472,324
Ex-gratia payments	4	3,999	5	3,571
TOTAL (Note 2)	1,882	2,775,004	5,539	7,830,569

Note 1: The number of cases of other stores losses was omitted in 2014/15.

Note 2: Eight of the above losses, which range from £12,539 to £64,383, require DHSSPS approval. Seven of these are in respect of debts relating to deceased clients and / or statute barred cases. One loss (£64k) is in respect of costs incurred in activating the Trust's catering contingency plan on receipt of independent microbiological food testing information which was inaccurate. The total loss, inclusive of £15k lost income, was £79k as referenced on page 58 however only the costs involved are reflected in the statement above.

Losses and Special Payments over £250,000

	2015/16		2014/15	
Losses and Special Payments over £250,000	Number of Cases	£	Number of Cases	£
Special Payments Clinical Negligence Cases	2	614,835	3	2,989,600
TOTAL	2	614,835	3	2,989,600

There were 2 clinical negligence cases on which payments recognised in the year exceeded £250,000 – one of £425k, the second £289k.

Gifts made over limits in Managing Public Money Northern Ireland

The Trust made no gifts in 2015/16.

Remote Contingent Liabilities

In addition to Contingent Liabilities reported within the meaning of IAS37, (included in the Annual Accounts Note 21), the Southern HSC Trust also reports liabilities for which the likelihood of a transfer of economic benefit in settlement is too remote to meet the definition of Contingent Liability. There are no remote contingent liabilities of which the Trust is aware.

Signed:

Personal Information redacted by the USI

Mr Francis Rice

Accounting Officer

Date:

9/6/16

SOUTHERN HEALTH AND SOCIAL CARE TRUST**THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE
NORTHERN IRELAND ASSEMBLY**

I certify that I have audited the financial statements of the Southern Health and Social Care Trust and its group for the year ended 31 March 2016 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. The financial statements comprise the Consolidated Statements of Comprehensive Net Expenditure, Financial Position, Changes in Taxpayers' Equity, Cash Flows, and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration and Staff Report and Accountability and Audit Report within the Accountability Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the group's and Southern Health and Social Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Southern Health and Social Care Trust; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the group's and of Southern Health and Social Care Trust's affairs as at 31 March 2016 and of the net expenditure, cash flows and changes in taxpayers' equity for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health (formerly Department of Health, Social Services and Public Safety) directions issued thereunder.

Opinion on other matters

In my opinion:

- the parts of the Remuneration and Staff Report and the Accountability and Audit Report to be audited have been properly prepared in accordance with Department of Health directions made under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended; and
- the information given in the Performance Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the parts of the Remuneration and Staff Report and Accountability and Audit Report to be audited are not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with Department of Finance's (formerly Department of Finance and Personnel) guidance.

Report

I have no observations to make on these financial statements.

Personal Information redacted by the USI

*KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast
BT7 1EU*

24th June 2016

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Annual Accounts for the Year Ended 31 March 2016

FOREWORD

These accounts for the year ended 31 March 2016 have been prepared in accordance with Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, in a form directed by the Department of Health, Social Services and Public Safety.

Southern HSC Trust**ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****CERTIFICATES OF DIRECTOR OF FINANCE, CHAIR AND CHIEF EXECUTIVE**

I certify that the annual accounts set out in the financial statements and notes to the accounts pages 87 to 142 which I am required to prepare on behalf of the Southern Health and Social Care Trust (Southern HSC Trust) have been compiled from and are in accordance with the accounts and financial records maintained by the Southern HSC Trust and with the accounting standards and policies for HSC bodies approved by the DHSSPS.

Director of Finance (Southern HSC Trust)

Date

09/06/2016

I certify that the annual accounts set out in the financial statements and notes to the accounts pages 87 to 142 as prepared in accordance with the above requirements have been submitted to and duly approved by the Board.

Chair (Southern HSC Trust)

Date 09/06/2016.

Interim Chief Executive (Southern HSC Trust)

Date 9/6/16

SOUTHERN HSC TRUST

CONSOLIDATED STATEMENT OF COMPREHENSIVE NET EXPENDITURE for the year ended 31 March 2016

		2016			2015		
	NOTE	Trust £000s	CTF £000s	Consolidated £000s	Trust £000s	CTF £000s	Consolidated £000s
Income							
Income from activities	4.1	29,483	0	29,483	27,972	0	27,972
Other Operating Income	4.2	9,741	298	10,039	10,682	241	10,923
		39,224	298	39,522	38,654	241	38,895
Expenditure							
Staff costs	3.1	(361,362)	0	(361,362)	(345,067)	0	(345,067)
Purchase of Goods and Services	3.2	(160,864)	(29)	(160,893)	(157,218)	(23)	(157,241)
Depreciation, amortisation and impairment charges	3.2	(15,213)	0	(15,213)	(38,188)	0	(38,188)
Provision Expense	3.2	(16,789)	0	(16,789)	(6,610)	0	(6,610)
Other Expenditures	3.2	(61,013)	(404)	(61,417)	(56,675)	(238)	(56,913)
Total Operating Expenditure		(615,241)	(433)	(615,674)	(603,758)	(261)	(604,019)
Net Operating Expenditure		(576,017)	(135)	(576,152)	(565,104)	(20)	(565,124)
Finance Income	4.2	1	125	126	2	109	111
Finance Expense	3.2	(1)	0	(1)	0	0	0
Net Expenditure for the year		(576,017)	(10)	(576,027)	(565,102)	89	(565,013)
Revenue Resource Limit (RRL)	24.1	576,154	0	576,154	565,143	0	565,143
Add back charitable trust fund net expenditure		0	10	10	0	(89)	(89)
Surplus against RRL		137	0	137	41	0	41

OTHER COMPREHENSIVE EXPENDITURE

Items that will not be reclassified to net operating costs:

Net gain/(loss) on revaluation of property, plant and equipment	5.1/ 8/ 5.2/ 8	11,830	0	11,830	(5,115)	0	(5,115)
Net gain/(loss) on revaluation of intangibles	6.1/ 8/ 6.2/ 8	0	0	0	0	0	0
Net (loss)/gain on revaluation of charitable assets	7	0	(174)	(174)	0	167	167

Items that may be reclassified to net operating costs:

Net gain/(loss) on revaluation of available for sale financial assets		0	0	0	0	0	0

TOTAL COMPREHENSIVE

EXPENDITURE for the year ended 31

March 2016

	(564,187)	(184)	(564,371)	(570,217)	256	(569,961)

The notes on pages 91 to 142 form part of these accounts.

SOUTHERN HSC TRUST

CONSOLIDATED STATEMENT OF FINANCIAL POSITION as at 31 March 2016

		2016		2015	
	NOTE	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Non Current Assets					
Property, plant and equipment	5.1/5.2	304,076	304,076	284,328	284,328
Intangible assets	6.1/6.2	0	0	69	69
Financial assets	7.0	0	2,671	0	2,845
Trade and other receivables	12.0	694	694	906	906
Total Non Current Assets		304,770	307,441	285,303	288,148
Current Assets					
Assets classified as held for sale	9.0	1,381	1,381	1,108	1,108
Inventories	10.0	2,987	2,987	2,880	2,880
Trade and other receivables	12.0	13,532	13,600	15,771	15,834
Other current assets	12.0	3,035	3,035	4,526	4,526
Financial assets	7.0	0	0	0	0
Cash and cash equivalents	11.0	1,184	1,416	1,575	1,750
Total Current Assets		22,119	22,419	25,860	26,098
Total Assets		326,889	329,860	311,163	314,246
Current Liabilities					
Trade and other payables	13.0	(68,267)	(68,383)	(65,756)	(65,800)
Provisions	15.0	(7,439)	(7,439)	(5,231)	(5,231)
Total Current Liabilities		(75,706)	(75,822)	(70,987)	(71,031)
Total Assets Less Current Liabilities		251,183	254,038	240,176	243,215
Non Current Liabilities					
Provisions	15.0	(35,673)	(35,673)	(23,888)	(23,888)
Total Non Current Liabilities		(35,673)	(35,673)	(23,888)	(23,888)
Total Assets less Total Liabilities		215,510	218,365	216,288	219,327
Taxpayers' Equity					
Revaluation reserve		47,080	47,080	34,585	34,585
SoCNE reserve		168,430	168,430	181,703	181,703
Other reserves - charitable fund		0	2,855	0	3,039
Total Equity		215,510	218,365	216,288	219,327

The notes on pages 91 to 142 form part of these accounts.

Signed [redacted] (Chairman)

Date: 07/04/16

Signed [redacted] (Interim Chief Executive)

Date: 9/6/16

SOUTHERN HSC TRUST**CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2016**

	NOTE	SoCNE Reserve £000s	Revaluation Reserve £000s	Charitable Fund £000s	Total £000s
Balance at 1 April 2014		183,158	40,540	2,783	226,481
Changes in Taxpayers Equity 2014-15					
Grant from DHSSPS		562,750	0	0	562,750
Transfers between reserves		840	(840)	0	0
(Comprehensive expenditure for the year)		(565,102)	(5,115)	256	(569,961)
Transfer of asset ownership		0	0	0	0
Non cash charges - auditors remuneration	3.2	57	0	0	57
Balance at 31 March 2015		181,703	34,585	3,039	219,327
Changes in Taxpayers Equity 2015-16					
Grant from DHSSPS		563,350	0	0	563,350
Transfers between reserves		(665)	665	0	0
(Comprehensive expenditure for the year)		(576,017)	11,830	(184)	(564,371)
Non cash charges - auditors remuneration	3.2	59	0	0	59
Balance at 31 March 2016		168,430	47,080	2,855	218,365

The notes on pages 91 to 142 form part of these accounts.

SOUTHERN HSC TRUST**CONSOLIDATED STATEMENT OF CASHFLOW FOR THE YEAR ENDED 31 MARCH 2016**

	NOTE	2016 £000s	2015 £000s
Cash flows from operating activities			
Net expenditure after interest		(576,027)	(565,013)
Adjustments for non cash costs		32,057	44,688
Decrease/(Increase) in trade and other receivables		3,937	(1,458)
(Increase)/Decrease in inventories		(107)	180
Increase/(Decrease) in trade payables		2,583	(16,210)
<i>Less movements in payables relating to items not passing through the NEA</i>			
Movements in payables relating to the purchase of property, plant and equipment		(1,314)	11,860
Use of provisions	15	(2,796)	(7,756)
Net cash outflow from operating activities		(541,667)	(533,709)
Cash flows from investing activities			
Purchase of property, plant & equipment	5	(22,126)	(29,956)
Proceeds of disposal of property, plant & equipment		109	169
Proceeds on disposal of assets held for resale		0	130
Drawdown from investment fund		0	100
Share of income reinvested		174	(167)
Net cash outflow from investing activities		(21,843)	(29,724)
Cash flows from financing activities			
Grant in aid		563,350	562,750
Movement in Charitable Trust Funds		(174)	167
Net financing		563,176	562,917
Net (decrease) in cash & cash equivalents in the period		(334)	(516)
Cash & cash equivalents at the beginning of the period	11	1,750	2,266
Cash & cash equivalents at the end of the period	11	1,416	1,750

The notes on pages 91 to 142 form part of these accounts.

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****STATEMENT OF ACCOUNTING POLICIES****1. Authority**

These accounts have been prepared in a form determined by the Department of Health, Social Services and Public Safety based on guidance from the Department of Finance and Personnel's Financial Reporting Manual (FReM) and in accordance with the requirements of Article 90(2) (a) of the Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14) as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003.

The accounting policies follow IFRS to the extent that it is meaningful and appropriate to HSC Trusts. Where a choice of accounting policy is permitted, the accounting policy which has been judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The Trust's accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Currency and Rounding

These accounts are presented in UK Pounds Sterling. The figures in the accounts are shown to the nearest £1,000.

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Land, Buildings, Dwellings, Transport Equipment, Plant and Machinery, Information Technology, Furniture and Fittings, and Assets under Construction.

Recognition

Property, plant and equipment must be capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and
- The item has cost of at least £5,000; or

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

- collectively, a number of items have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

On initial recognition property, plant and equipment are measured at cost including any expenditure such as installation, directly attributable to bringing them into working condition. Items classified as “under construction” are recognised in the Statement of Financial Position to the extent that money has been paid or a liability has been incurred.

Valuation of Land and Buildings

Land and buildings are carried at the last professional valuation, in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation - Professional Standards in so far as these are consistent with the specific needs of the HSC.

The last valuation was carried out on 31 January 2015 by Land and Property Services (LPS) which is part of the Department of Finance and Personnel. The valuers are qualified to meet the ‘Member of Royal Institution of Chartered Surveyors’ (MRICS) standard.

Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

Land and buildings used for the Arm’s Length Body (ALB) services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

Land and buildings used for the Trust’s services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

Fair values are determined as follows:

- Land and non-specialised buildings – open market value for existing use;
- Specialised buildings – depreciated replacement cost; and
- Properties surplus to requirements – the lower of open market value less any material directly attributable selling costs, or book value at date of moving to non-current assets.

Modern Equivalent Asset

DFP has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. Land and Property Services (LPS) have included this requirement within the latest valuation.

Assets under Construction (AuC)

Properties in the course of construction for service or administration purposes are carried at cost less any impairment loss. Cost includes professional fees as allowed by IAS 16 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Short Life Assets

Short life is defined as a useful life up to and including 5 years. From 1 April 2008 HSC entities had the option to elect to cease indexing all short life assets (other than IT which is not indexed). The Trust did not elect to cease indexing all short life assets, (other than IT), as these assets are not held separately on its fixed asset register. Therefore, fixtures and equipment, whether they are short life or have an estimated life in excess of 5 years, are indexed each year and depreciation will be based on the indexed amount. All other short life assets are not indexed but carried at depreciated historic cost as this is not considered to be materially different from fair value and are depreciated over their useful life.

Revaluation Reserve

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

1.4 Depreciation

No depreciation is provided on freehold land since land has unlimited or a very long established useful life. Items under construction are not depreciated until they are commissioned. Properties that are surplus to requirements and which meet the definition of “non-current assets held for sale” are also not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and similarly, amortisation is applied to intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over the lower of their estimated useful lives and the terms of the lease. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. The following asset lives have been used:

Asset Type	Asset Life
Freehold Buildings	Up to 88 years
Leasehold property	Remaining period of lease
IT Assets	3 – 10 years
Intangible assets	3 – 10 years
Other Equipment	3 – 15 years

1.5 Impairment Loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure within the Statement of Comprehensive Net Expenditure. If the impairment is due to the consumption of economic benefits the full amount of the impairment is charged to the Statement of Comprehensive Net Expenditure and an amount up to the value of the impairment in the

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

revaluation reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.6 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure which meets the definition of capital restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.7 Intangible Assets

Intangible assets comprise software and licences. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

from contractual or other legal rights. Intangible assets are considered to have a finite life. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised while intangible assets which fall within the grouped asset definition must be capitalised if their individual value is at least £1,000 each and the group is at least £5,000 in value.

The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

Intangible assets acquired separately are initially recognised at fair value. Following initial recognition, intangible assets are carried at fair value by reference to an active market, and as no active market currently exists depreciated replacement cost has been used as fair value.

1.8 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. In order to meet this definition IFRS 5 requires that the asset must be immediately available for sale in its current condition and that the sale is highly probable. A sale is regarded as highly probable where an active plan is in place to find a buyer for the asset and the sale is considered likely to be concluded within one year. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value, less any material directly attributable selling costs. Fair value is open market value, where one is available, including alternative uses. Assets classified as held for sale are not depreciated.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount. The profit from sale of land, which is a non-depreciating asset, is recognised within income. The profit from sale of a depreciating asset is shown as a reduced expense. The loss from sale of land or from any depreciating assets is shown within operating expenses. On disposal, the balance for the asset on the Revaluation Reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve.

Property, plant or equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****1.9 Inventories**

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Income

Operating income relates directly to the operating activities of the Trust and is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Grant in Aid

Funding received from other entities, including the Department of Health, Social Services and Public Safety and the Health and Social Care Board is accounted for as grant in aid and is reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.11 Investments

The Trust does not have any investments.

1.12 Other Expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.13 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases is initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land may be either an operating lease or a finance lease depending on the conditions in the lease agreement and following the general guidance set out in IAS 17. Leased buildings are assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.15 Private Finance Initiative (PFI) Transactions

The Trust has had no PFI transactions during the current or prior year.

1.16 Financial Instruments

- **Financial assets**

Financial assets are recognised on the balance sheet when the Trust becomes party to the financial instrument contract or, in the case of trade receivables,

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

- **Financial liabilities**

Financial liabilities are recognised on the balance sheet when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

- **Financial risk management**

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within Trusts in creating risk than would apply to a non public sector body of a similar size, therefore Trusts are not exposed to the degree of financial risk faced by business entities. Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Trusts in undertaking activities. Therefore the HSC is exposed to little credit, liquidity or market risk.

- **Currency risk**

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

- **Interest rate risk**

The Trust has limited powers to borrow or invest and therefore has low exposure to interest rate fluctuations.

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

- **Credit risk**

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

- **Liquidity risk**

Since the Trust receives the majority of its funding through its principal Commissioner which is voted through the Assembly, it is not exposed to significant liquidity risks.

1.17 Provisions

In accordance with IAS 37, provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, it is assumed the settlement is made at the beginning of the year rather than its cessation and its carrying amount is the present value of those cash flows using DFP's discount rate of -1.55% (negative real rate) for 1 year up to and including 5 years, -1.00% (negative real rate) after year 5 up to 10 years and -0.80% in real terms for 10 years or more (+1.37% for employee early departure obligations for all periods).

The Trust has also disclosed the carrying amount at the beginning and end of the period, additional provisions made, amounts used during the period, unused amounts reversed during the period and increases in the discounted amount arising from the passage of time and the effect of any change in the discount rate.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an

asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.18 Contingencies

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to the Assembly separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to the Assembly. Under IAS 37, the Trust discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

In addition to contingent liabilities disclosed in accordance with IAS 37, HSC Trusts should disclose for Assembly reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to the Assembly in accordance with the requirements of Managing Public Money Northern Ireland.

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****1.19 Employee Benefits****Short-term Employee Benefits**

Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been estimated using staff numbers and costs applied to the average untaken leave balance determined from the results of a survey to ascertain leave balances as at 31 March 2015. It is not anticipated that the level of untaken leave will vary significantly from year to year. Untaken flexi leave is estimated to be immaterial to the Trust and has not been included.

Retirement Benefit Costs

Past and present employees are covered by the provisions of the HSC Pension Scheme.

The Trust participates in the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Pension Scheme can be found in the HSC Pension Scheme Statement in the Departmental Resource Account for the Department of Health, Social Services and Public Safety.

The costs of early retirements are met by the Trust and charged to the Statement of Comprehensive Net Expenditure at the time the Trust commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. The 2012 valuation for the HSC Pension Scheme will be used in the 2015/16 accounts.

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****1.20 Reserves****Statement of Comprehensive Net Expenditure Reserve**

Accumulated surpluses are accounted for in the Statement of Comprehensive Net Expenditure Reserve.

Revaluation Reserve

The Revaluation Reserve reflects the unrealised balance of cumulative indexation and revaluation adjustments to assets.

1.21 Value Added Tax

Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets.

1.22 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 24 to the accounts.

1.23 Government Grants

Government assistance for capital projects whether from UK, or Europe, are treated as a Government grant even where there are no conditions specifically relating to the operating activities of the entity other than the requirement to operate in certain regions or industry sectors. Such grants (does not include grant-in-aid) were previously credited to a government grant reserve and were released to income over the useful life of the asset.

DFP issued new guidance effective from 1 April 2011. Government grant reserves are no longer permitted. Income is generally recognised when it is received. In exceptional cases where there are conditions attached to the use of the grant, which, if not met, would mean the grant is repayable, the income should be deferred and released when obligations are met. The note to the financial statements distinguishes between grants from UK government entities and grants from European Union.

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****1.24 Losses and Special Payments**

Losses and special payments are items that the Assembly would not have contemplated when it agreed funds for the HSC or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had HSC Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.25 Charitable Trust Account Consolidation

In accordance with IAS 27, the Trust consolidates the accounts of the SHSCT Charitable Trust Funds with the Trust's financial statements. It is important to note, however, the distinction between public funding and the other monies donated by private individuals still exists.

As far as possible, donated funds have been used by the Trust as intended by the benefactor. It is for the Endowments and Gifts Committee within the Trust to manage the internal disbursements. The committee ensures that the charitable donations received by the Trust are appropriately managed, invested, expended and controlled in a manner that is, as far as possible, consistent with the purposes for which they were given and with the Trust's Standing Financial Instructions, Departmental guidance and legislation.

1.26 Accounting Standards that have been issued but have not yet been adopted

The IASB have issued new and amended standards (IFRS 10, IFRS 11 & IFRS 12) that affect the consolidation and reporting of subsidiaries, associates and joint ventures. These standards are effective with EU adoption from 1 January 2014.

Accounting boundary IFRS' are currently adapted in the FReM so that the Westminster departmental accounting boundary is based on ONS control criteria, as designated by Treasury. A review of the NI financial process, which

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

will bring NI departments under the same adaptation, has been presented to the Executive, but a decision has yet to be made. Should the Executive agree to the recommendations, the accounting boundary for departments will change and there will also be an impact on departments around the disclosure requirements under IFRS 12. ALBs apply IFRS in full and their consolidation boundary may change as a result of the new Standards.

Management considers that any other new accounting standards issued but not yet adopted are unlikely to have a significant impact on the accounts in the period of the initial application.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 2 ANALYSIS OF NET EXPENDITURE BY SEGMENT

<u>Directorate</u>	2016			2015		
	Staff Costs £000s	Other Expenditure £000s	Total Expenditure £000s	Staff Costs £000s	Other Expenditure £000s	Total Expenditure £000s
Children's Services	53,609	20,129	73,738	49,138	20,239	69,377
Acute Hospital Services	164,619	64,225	228,844	154,028	63,528	217,556
Older People's Services	69,736	83,210	152,946	64,674	80,370	145,044
Mental Health and Disability Services	55,270	42,175	97,445	52,129	40,443	92,572
Planning, Performance Management and Support Services	18,128	12,083	30,211	25,098	9,423	34,521
Expenditure for Reportable Segments net of Non Cash Expenditure	361,362	221,822	583,184	345,067	214,003	559,070
Non Cash Expenditure			32,057			44,688
Total Expenditure per Net Expenditure Account			615,241			603,758
Income Per Net Expenditure Account			39,224			38,656
Net Expenditure			576,017			565,102
Revenue Resource Limit			576,154			565,143
Surplus against RRL			137			41

The Trust is managed by way of a directorate structure, each led by a Director, providing an integrated healthcare service for the resident population. The Directors along with Non-Executive Directors, Chair and Chief Executive form the Trust Board which coordinates the activities of the Trust and is considered to be the Chief Operating Decision Maker. The information disclosed in this statement does not reflect budgetary performance and is based solely on expenditure information provided from the accounting system used to prepare the accounts.

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 2 (continued) ANALYSIS OF NET EXPENDITURE BY SEGMENT****Acute Directorate**

- Cancer and clinical services (includes Laboratory & Radiology Services)
- Surgery and Elective Care
- Medicines and Unscheduled Care
- Integrated maternity and Women's Health
- Functional Support Services (includes all hotel services, health records, laundry and CSSD)
- Pharmacy

These services are delivered at the Acute Hospital Sites at Craigavon Area Hospital and Daisy Hill Hospital. Services including outreach clinics, day procedure services and diagnostic services are also delivered on South Tyrone Hospital Site, Lurgan Hospital Site and at Banbridge Health and Care Centre, Kilkeel and Crossmaglen Health Centres and Armagh Community Hospital.

Directorate of Mental Health and Disability Services

- Provides a range of hospital and community services, including social services, community nursing, home treatment, crisis response, Allied Health Professionals and specialist teams.
- Acute Mental Health Services are provided at the Bluestone Unit, Craigavon and at St Lukes Hospital, Armagh.
- On the St Lukes site there is a long-stay hospital
- Longstone Hospital for Learning Disability patients
- Nursing & residential home, domiciliary, respite and day care services as well as support to tenants who reside in supporting people accommodation
- Trust Transport services

Older People and Primary Care Services

- Domiciliary care, residential and nursing care and dementia support
- District nursing and allied health professionals supporting the elderly population
- Specialist services such as family planning, continence and GP out of hours and minor injuries units and all aspects of supporting people in the community
- Partnership working with Voluntary and community organisations incorporating grant aid payments and community support.

Children and Young People Services

- Includes all health services provided for children and adolescents
- Paediatric wards and special care baby units located in Acute facilities
- Disability services including respite, CAMHS, Children Community nursing of complex needs, Dental services and Allied Health Services
- Corporate Parenting
- Family support, Early Years, Health visiting and school nursing are included together with all Sure Start Projects.
- Social Services Training Unit

Planning, Performance Management and Support Services

- Office of the Chief Executive, including Trustwide Communication Team
- Finance and Procurement Directorate
- Human Resource Directorate, (including Health & Safety, Occupational Health and Estates)
- Performance & Reform (IT, Corporate Planning and Performance Improvement)
- Medical Directorate (Governance Patient/Client Safety, Medical Management, Clinical Audit and Emergency Planning).

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 3 STAFF COSTS AND OPERATING EXPENSES**

3.1 Staff Costs	2016			2015
	Permanently employed staff £000s	Others £000s	Total £000s	Total £000s
Staff costs comprise:				
Wages and salaries	288,012	15,576	303,588	296,485
Social security costs	19,034	1,200	20,234	18,965
Other pension costs	37,713	166	37,879	29,936
Sub-Total	344,759	16,942	361,701	345,386
Capitalised staff costs	(339)	0	(339)	(319)
Total staff costs reported in Statement of Comprehensive Expenditure	344,420	16,942	361,362	345,067
Less recoveries in respect of outward secondments			(252)	(498)
Total net costs			361,110	344,569
			£000s	£000s
Southern HSC Trust			361,110	344,569
Total			361,110	344,569

Staff Costs exclude £339k charged to capital projects during the year (2015: £319k)

The Trust participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. A full valuation for Resource Accounts purposes as at 31 March 2012 was certified in February 2015 and is used in the 2015/16 accounts.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 3.2 Operating Expenses

	2016			2015		
	Trust £000s	CTF £000s	Consolidated £000s	Trust £000s	CTF £000s	Consolidated £000s
Operating Expenses are as follows:-						
Purchase of care from non-HPSS bodies	105,546	0	105,546	102,507	0	102,507
Revenue grants to voluntary organisations	5,498	0	5,498	5,375	0	5,375
Personal social services	6,445	0	6,445	6,371	0	6,371
Recharges from other HSC organisations	1,645	0	1,645	1,730	0	1,730
Supplies and services - Clinical	43,760	0	43,760	43,029	0	43,029
Supplies and services - General	6,078	0	6,078	6,530	0	6,530
Establishment	11,691	0	11,691	11,032	0	11,032
Transport	2,600	0	2,600	2,619	0	2,619
Premises	28,417	0	28,417	24,347	0	24,347
Bad debts	48	0	48	803	0	803
Rentals under operating leases	960	0	960	835	0	835
Interest charges	1	0	1	0	0	0
BSO services	3,606	0	3,606	3,075	0	3,075
Training	1,187	0	1,187	871	0	871
Professional fees	229	29	258	347	23	370
Patients travelling expenses	378	0	378	445	0	445
Costs of exit packages not provided for	289	0	289	182	0	182
Other charitable expenditure	0	404	404	0	238	238
Miscellaneous expenditure	3,445	0	3,445	3,905	0	3,905

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 3.2 Operating Expenses (continued)

	2016			2015		
	Trust £000s	CTF £000s	Consolidated £000s	Trust £000s	CTF £000s	Consolidated £000s
Non cash items						
Depreciation	17,753	0	17,753	16,171	0	16,171
Amortisation	69	0	69	145	0	145
Impairments	(2,609)	0	(2,609)	21,872	0	21,872
(Profit) on disposal of property, plant & equipment (excluding profit on land)	(106)	0	(106)	(179)	0	(179)
Loss on disposal of property, plant & equipment (including land)	102	0	102	12	0	12
Provisions provided for in year	16,832	0	16,832	6,709	0	6,709
Cost of borrowing of provisions (unwinding of discount on provisions)	(43)	0	(43)	(99)	0	(99)
Auditors remuneration	59	5	64	57	6	63
Add back of notional charitable expenditure	0	(5)	(5)	0	(6)	(6)
Total	253,880	433	254,313	258,691	261	258,952

The Southern HSC Charitable Trust Funds Auditors remuneration of £5,000 (2015: £5,750) related solely to the audit, with no other additional work undertaken.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 4 INCOME

	2016			2015		
	Trust £000s	CTF £000s	Consolidated £000s	Trust £000s	CTF £000s	Consolidated £000s
4.1 Income from Activities						
GB/Republic of Ireland Health Authorities	367	0	367	309	0	309
HSC Trusts	265	0	265	214	0	214
Non-HSC:- Private patients	436	0	436	376	0	376
Non-HSC:- Other	1,504	0	1,504	1,199	0	1,199
Clients contributions	26,911	0	26,911	25,874	0	25,874
Total	29,483	0	29,483	27,972	0	27,972
4.2 Other Operating Income						
Other income from non-patient services	8,175	0	8,175	9,022	0	9,022
Seconded staff	252	0	252	498	0	498
Charitable and other contributions to expenditure by core trust	725	0	725	830	0	830
Donations / Government grant / Lottery funding for non current assets	395	0	395	130	0	130
Charitable Income received by charitable trust fund	0	298	298	0	241	241
Investment Income	0	125	125	0	109	109
Other Income	194	0	194	202	0	202
Interest Receivable	1	0	1	2	0	2
Total	9,742	423	10,165	10,684	350	11,034
4.3 Deferred Income						
Income released from conditional grants	0	0	0	0	0	0
Total	0	0	0	0	0	0
TOTAL INCOME	39,225	423	39,648	38,656	350	39,006

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.1 Consolidated Property, Plant & Equipment Year Ended 31 March 2016

	Land	Buildings (excluding dwellings)	Dwellings	Assets under Construction	Plant and Machinery (Equipment)	Transport Equipment	Information Technology (IT)	Furniture and Fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or Valuation									
At 1 April 2015	26,839	190,498	11,828	12,217	53,320	6,438	26,433	950	328,523
Indexation	200	12,264	802	0	638	37	0	5	13,946
Additions	15	11,646	0	6,158	1,889	24	3,302	11	23,045
Donations / Government grant / Lottery funding	0	152	0	0	228	0	15	0	395
Reclassifications	0	16,807	0	(16,849)	42	0	(4)	4	0
Transfers	0	(287)	0	0	0	0	0	0	(287)
Revaluations	114	0	0	0	0	0	0	0	114
Impairment charged to the SoCNE	0	(4,988)	0	0	(655)	0	(1)	(3)	(5,647)
Impairment charged to the revaluation reserve	0	(1,097)	0	0	(98)	0	0	0	(1,195)
Reversal of impairments (indexn)	1,431	6,023	242	0	5	0	0	0	7,701
(Disposals)	0	(5)	0	0	(1,374)	(756)	(1,665)	0	(3,800)
At 31 March 2016	28,599	231,013	12,872	1,526	53,995	5,743	28,080	967	362,795

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.1 (continued) Consolidated Property, Plant & Equipment Year Ended 31 March 2016

	Land	Buildings (excluding dwellings)	Dwellings	Assets under Construction	Plant and Machinery (Equipment)	Transport Equipment	Information Technology (IT)	Furniture and Fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Depreciation									
At 1 April 2015	0	1,277	61	0	30,707	3,318	8,040	792	44,195
Indexation	0	631	30	0	383	21	0	4	1,069
Reclassifications	0	0	0	0	1	0	(1)	0	0
Transfers	0	(14)	0	0	0	0	0	0	(14)
Revaluation	0	0	0	0	0	0	0	0	0
Impairment charged to the SoCNE	0	(4)	0	0	(551)	0	0	0	(555)
Impairment charged to the revaluation reserve	0	(1)	0	0	(33)	0	0	0	(34)
Reversal of Impairments (indexn)	0	0	0	0	0	0	0	0	0
(Disposals)	0	0	0	0	(1,278)	(753)	(1,664)	0	(3,695)
Provided during the year	0	8,100	374	0	3,281	688	5,262	48	17,753
At 31 March 2016	0	9,989	465	0	32,510	3,274	11,637	844	58,719
Carrying Amount									
At 31 March 2016	28,599	221,024	12,407	1,526	21,485	2,469	16,443	123	304,076
At 31 March 2015	26,839	189,221	11,767	12,217	22,613	3,120	18,393	158	284,328

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.1 (continued) Consolidated Property, Plant & Equipment Year Ended 31 March 2016

	Land £000s	Buildings (excluding dwellings) £000s	Dwellings £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Asset Financing									
Owned	28,599	221,024	12,407	1,526	21,485	2,469	16,443	123	304,076
Carrying Amount									
At 31 March 2016	28,599	221,024	12,407	1,526	21,485	2,469	16,443	123	304,076
Of which:									
Southern HSC Trust at 31 March 2016	28,599	221,024	12,407	1,526	21,485	2,469	16,443	123	304,076
Charitable Trust Fund at 31 March 2016	0	0	0	0	0	0	0	0	0
	28,599	221,024	12,407	1,526	21,485	2,469	16,443	123	304,076

Southern HSC Trust at 31 March 2015	26,839	189,221	11,767	12,217	22,613	3,120	18,393	158	284,328
Charitable Trust Fund at 31 March 2015	0	0	0	0	0	0	0	0	0
	26,839	189,221	11,767	12,217	22,613	3,120	18,393	158	284,328

Of which:

Trust

304,076

Charitable Trust Funds

0

Any fall in value through negative indexation or revaluation is shown as an impairment.

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure Account in respect of assets held under finance leases and hire purchase contracts is £Nil (2014/15: £Nil).

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 5.1 (continued) Consolidated Property, Plant & Equipment Year Ended 31 March 2016**

The fair value of assets funded from the following sources during the year was:

	2016	2015
	£000s	£000s
Donations	395	130
Government grant	0	0
Lottery funding	0	0

Professional revaluations of land and buildings are undertaken by Land and Property Services (LPS) at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS. The last valuation was carried out on 31 January 2015. See Accounting policy note 1.3 for more details of valuation of Property, Plant & Equipment.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.2 Property, Plant & Equipment Year Ended 31 March 2015

	Land £000s	Buildings (excluding dwellings) £000s	Dwellings £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Cost or Valuation									
At 1 April 2014	37,246	245,005	14,492	9,356	51,016	6,696	23,746	935	388,492
Indexation	0	0	0	0	858	0	0	0	858
Additions	0	8,937	0	9,508	3,435	673	7,820	15	30,388
Donations / Government grant / Lottery funding	0	0	0	0	130	0	0	0	130
Reclassifications	0	6,305	0	(6,305)	0	0	0	0	0
Revaluations	(4,873)	(47,428)	(2,183)	0	37	(312)	(9)	0	(54,768)
Impairment charged to the SoCNE	(5,414)	(16,227)	123	(342)	0	0	0	0	(21,860)
Impairment charged to the Revaluation Reserve	(120)	(5,827)	(604)	0	0	0	0	0	(6,551)
Reversal of Impairments (indexn)	0	0	0	0	0	0	0	0	0
(Disposals)	0	(267)	0	0	(2,156)	(619)	(5,124)	0	(8,166)
At 31 March 2015	26,839	190,498	11,828	12,217	53,320	6,438	26,433	950	328,523

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 5.2 (continued) Property, Plant & Equipment Year Ended 31 March 2015**

	Land £000s	Buildings (excluding dwellings) £000s	Dwellings £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Depreciation									
At 1 April 2014	4,950	41,480	2,185	0	28,883	3,546	9,243	720	91,007
Indexation	0	0	0	0	503	0	0	0	503
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	(4,950)	(48,124)	(2,500)	0	(45)	(312)	59	0	(55,872)
Impairment charged to the SoCNE	0	0	0	0	0	0	0	0	0
(Disposals)	0	(14)	0	0	(1,888)	(592)	(5,120)	0	(7,614)
Provided during the year	0	7,935	376	0	3,254	676	3,858	72	16,171
At 31 March 2015	0	1,277	61	0	30,707	3,318	8,040	792	44,195
Carrying Amount At 31 March 2015	26,839	189,221	11,767	12,217	22,613	3,120	18,393	158	284,328
At 1 April 2014	32,296	203,525	12,307	9,356	22,133	3,150	14,503	215	297,485

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.2 (continued) Property, Plant & Equipment Year Ended 31 March 2015

	Land £000s	Buildings (excluding dwellings) £000s	Dwellings £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Asset Financing									
Owned	26,839	189,221	11,767	12,217	22,613	3,120	18,393	158	284,328
Carrying Amount									
At 31 March 2015	26,839	189,221	11,767	12,217	22,613	3,120	18,393	158	284,328

Asset financing

Owned	32,296	203,525	12,307	9,356	22,133	3,150	14,503	215	297,485
Carrying Amount									
At 1 April 2014	32,296	203,525	12,307	9,356	22,133	3,150	14,503	215	297,485

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.2 (continued) Property, Plant & Equipment Year Ended 31 March 2015

	Land £000s	Buildings (excluding dwellings) £000s	Dwellings £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Southern HSC Trust at 31 March 2015	26,839	189,221	11,767	12,217	22,613	3,120	18,393	158	284,328
Southern HSC Trust charitable trust fund at 31 March 2015	0	0	0	0	0	0	0	0	0
Southern HSC Trust at 31 March 2015	26,839	189,221	11,767	12,217	22,613	3,120	18,393	158	284,328

Southern HSC Trust at 31 March 2014	32,296	203,525	12,307	9,356	22,133	3,150	14,503	215	297,485
Southern HSC Trust charitable trust fund at 31 March 2014	0	0	0	0	0	0	0	0	0
Southern HSC Trust at 31 March 2014	32,296	203,525	12,307	9,356	22,133	3,150	14,503	215	297,485

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 6.1 Consolidated Intangible Assets Year Ended 31 March 2016**

	Software Licenses	Software	Total
	£000s	£000s	£000s
Cost or Valuation			
At 1 April 2015	1,399	0	1,399
Indexation	0	0	0
Additions	0	0	0
Donations / Government grant / Lottery funding	0	0	0
Disposals	0	0	0
At 31 March 2016	1,399	0	1,399
Amortisation			
At 1 April 2015	1,330	0	1,330
Reclassifications	0	0	0
Disposals	0	0	0
Provided during the year	69	0	69
At 31 March 2016	1,399	0	1,399
Carrying Amount			
At 31 March 2016	0	0	0
At 31 March 2015	69	0	69
Asset financing			
Owned	0	0	0
Carrying Amount			
At 31 March 2016	0	0	0

There were no assets funded by Donations/Government Grant or Lottery Funding during the year. (2014/15: £Nil)

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 6.2 Consolidated Intangible Assets Year Ended 31 March 2015**

	Software Licenses	Software	Total
	£000s	£000s	£000s
Cost or Valuation			
At 1 April 2014	1,399	0	1,399
Indexation	0	0	0
Additions	0	0	0
Donations / Government grant / Lottery funding	0	0	0
Disposals	0	0	0
At 31 March 2015	1,399	0	1,399
Amortisation			
At 1 April 2014	1,185	0	1,185
Reclassifications	0	0	0
Disposals	0	0	0
Provided during the year	145	0	145
At 31 March 2015	1,330	0	1,330
Carrying Amount			
At 31 March 2015	69	0	69
At 31 March 2014	214	0	214
Asset financing			
Owned	69	0	69
Carrying Amount			
At 31 March 2015	69	0	69

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 6.2 Consolidated Intangible Assets Year Ended 31 March 2015****Carrying amount comprises:**

	Software Licenses £000s	Software £000s	Total £000s
Southern HSC Trust at 31 March 2015	69	0	69
Southern HSC Trust charitable trust fund at 31 March 2015	0	0	0
	<u>69</u>	<u>0</u>	<u>69</u>
Southern HSC Trust at 31 March 2014	214	0	214
Southern HSC Trust charitable trust fund at 31 March 2014	0	0	0
	<u>214</u>	<u>0</u>	<u>214</u>

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 7 FINANCIAL INSTRUMENTS****NOTE 7 Financial Instruments**

	2016			2015		
	Investments	Assets	Liabilities	Investments	Assets	Liabilities
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April	2,845	0	0	2,678	100	0
Additions	0	0	0	0	0	0
Disposals	0	0	0	0	(100)	0
Revaluations	(174)	0	0	167	0	0
Balance at 31 March	2,671	0	0	2,845	0	0
Trust						
Charitable trust fund	2,671	0	0	2,845	0	0
	2,671	0	0	2,845	0	0

NOTE 7.1 Market value of investments as at 31 March 2016

	Held in	Held	2016	2015
	UK	outside	Total	Total
	£000s	UK	£000s	£000s
Investments in a Common Deposit Fund or Investment Fund	2,671	0	2,671	2,845
Total market value of fixed asset investments	2,671	0	2,671	2,845

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 8 IMPAIRMENTS

	2016		
	Property, Plant & Equipment	Intangibles	Total
	£000s	£000s	£000s
Total value of impairments for the period	(1,448)	0	(1,448)
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	(1,161)	0	(1,161)
Impairments credited to Statement of Comprehensive Net Expenditure	(2,609)	0	(2,609)

	2015		
	Property, Plant & Equipment	Intangibles	Total
	£000s	£000s	£000s
Total value of impairments for the period	28,432	0	28,432
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	(6,560)	0	(6,560)
Impairments charged to Statement of Comprehensive Net Expenditure	21,872	0	21,872

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 9 ASSETS CLASSIFIED AS HELD FOR SALE

	Land		Buildings		Total	
	2016	2015	2016	2015	2016	2015
	£000s	£000s	£000s	£000s	£000s	£000s
Cost						
At 1 April	0	0	1,193	1,482	1,193	1,482
Transfers in	0	0	287	0	287	0
(Disposals)	0	0	(85)	(168)	(85)	(168)
Impairment	0	0	0	(121)	0	(121)
At 31 March	0	0	1,395	1,193	1,395	1,193
Depreciation						
At 1 April	0	0	85	197	85	197
Transfers in	0	0	14	0	14	0
(Disposals)	0	0	(85)	(26)	(85)	(26)
Impairment	0	0	0	(86)	0	(86)
At 31 March	0	0	14	85	14	85
Carrying amount at 31 March	0	0	1,381	1,108	1,381	1,108

Non current assets held for sale comprise non current assets that are held for resale rather than for continuing use within the business.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 10 INVENTORIES

Classification	2016			2015		
	Trust £000s	CTF £000s	Consolidated £000s	Trust £000s	CTF £000s	Consolidated £000s
Pharmacy supplies	2,034	0	2,034	1,835	0	1,835
Building & engineering supplies	75	0	75	70	0	70
Fuel	155	0	155	239	0	239
Community care appliances	324	0	324	225	0	225
Laboratory materials	158	0	158	184	0	184
Stationery	0	0	0	0	0	0
Laundry	57	0	57	55	0	55
Other	184	0	184	272	0	272
Total	2,987	0	2,987	2,880	0	2,880

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 11 CASH AND CASH EQUIVALENTS

	2016			2015		
	Core Trust £000s	CTF £000s	Consolidated £000s	Core Trust £000s	CTF £000s	Consolidated £000s
Balance at 1st April	1,575	175	1,750	2,168	98	2,266
Net change in cash and cash equivalents	(391)	57	(334)	(593)	77	(516)
Balance at 31st March	1,184	232	1,416	1,575	175	1,750

The following balances at 31 March were held at

	2016			2015		
	Core Trust £000s	CTF £000s	Consolidated £000s	Core Trust £000s	CTF £000s	Consolidated £000s
Commercial banks and cash in hand	1,184	232	1,416	1,575	175	1,750
Balance at 31st March	1,184	232	1,416	1,575	175	1,750

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 12 TRADE RECEIVABLES AND OTHER CURRENT ASSETS

	2016				2015			
	Trust	CTF	Consolidation	Consolidated	Trust	CTF	Consolidation	Consolidated
	£000s	£000s	Adjustments	£000s	£000s	£000s	Adjustments	£000s
			£000s				£000s	
Amounts falling due within one year								
Trade receivables	8,534	0	0	8,534	10,013	0	0	10,013
VAT receivable	4,600	0	0	4,600	5,421	0	0	5,421
Other receivables - not relating to fixed assets	398	68	0	466	337	91	(28)	400
Trade and other receivables	13,532	68	0	13,600	15,771	91	(28)	15,834
Prepayments and accrued income	3,035	0	0	3,035	4,526	0	0	4,526
Other current assets	3,035	0	0	3,035	4,526	0	0	4,526

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 12 (continued) TRADE RECEIVABLES AND OTHER CURRENT ASSETS

	Trust £000s	CTF £000s	2016 Consolidation Adjustments £000s	Consolidated £000s	Trust £000s	CTF £000s	2015 Consolidation Adjustments £000s	Consolidated £000s
Amounts falling due after more than one year								
Trade receivables	694	0	0	694	906	0	0	906
Trade and other receivables	694	0	0	694	906	0	0	906
TOTAL TRADE AND OTHER RECEIVABLES	14,226	68	0	14,294	16,677	91	(28)	16,740
TOTAL OTHER CURRENT ASSETS	3,035	0	0	3,035	4,526	0	0	4,526
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	17,261	68	0	17,329	21,203	91	(28)	21,266

The balances are net of a provision for bad debts of £5,796k (2015: £6,095k).

The Southern HSC Trust did not have any intangible current assets at 31 March 2016 or at 31 March 2015.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 13 TRADE PAYABLES AND OTHER CURRENT LIABILITIES

13.1 Trade Payables and Other Current Liabilities

	2016				2015			
	Trust	CTF	Consolidation	Consolidated	Trust	CTF	Consolidation	Consolidated
	£000s	£000s	Adjustments	£000s	£000s	£000s	Adjustments	£000s
			£000s				£000s	
Amounts falling due within one year								
Other taxation and social security	11,963	0	0	11,963	11,342	0	0	11,342
Trade capital payables - property, plant and equipment	8,529	0	0	8,529	7,215	0	0	7,215
Trade revenue payables	17,579	0	0	17,579	16,377	0	0	16,377
Payroll payables	21,556	0	0	21,556	21,310	0	0	21,310
Clinical negligence payables	554	0	0	554	1,027	0	0	1,027
VER payables	146	0	0	146	538	0	0	538
BSO payables	3,342	0	0	3,342	1,449	0	0	1,449
Other payables	279	116	0	395	990	72	(28)	1,034
Accruals and deferred income	4,319	0	0	4,319	5,508	0	0	5,508
Trade and other payables	68,267	116	0	68,383	65,756	72	(28)	65,800

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 13.2 Loans**

The Southern HSC Trust did not have any loans payable at 31 March 2016 or at 31 March 2015.

NOTE 14 PROMPT PAYMENT POLICY**NOTE 14.1 Public Sector Payment Policy – Measure of Compliance**

The Department requires that Trusts pay their non HSC trade suppliers in accordance with applicable terms and appropriate Government Accounting guidance. The Trust's payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is:

	2016 Number	2016 Value £000s	2015 Number	2015 Value £000s
Total bills paid	206,478	273,264	172,426	224,108
Total bills paid within 30 day or under agreed payment terms	193,206	250,692	151,068	200,413
% of bills paid within 30 day target or under agreed payment terms	93.6%	91.7%	87.6%	89.4%
Total bills paid within 10 day target	173,700	226,085	121,745	170,785
% of bills paid within 10 day target	84.1%	82.7%	70.6%	76.2%

14.2 The Late Payment of Commercial Debts Regulations 2002

	£
Amount of compensation paid for payment(s) being late	210
Amount of interest paid for payment(s) being late	343
Total	553

This is also reflected as a fruitless payment in the Statement of Losses and Special Payments in the Accountability Report.

New late payment legislation (Late Payment of Commercial Debts Regulations 2013) came into force on 16 March 2013. The effect of the new legislation is that a payment is normally regarded as late unless it is made within 30 days after receipt of an undisputed invoice.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 15 PROVISIONS FOR LIABILITIES AND CHARGES – 2016

	Pensions relating to former directors	Pensions relating to other staff	Clinical negligence	CSR restructuring	Other	2016
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	277	3,964	20,681	0	4,197	29,119
Provided in year	0	0	18,627	0	1,002	19,629
(Provisions not required written back)	(5)	(201)	(2,399)	0	(192)	(2,797)
(Provisions utilised in the year)	(15)	(191)	(2,016)	0	(574)	(2,796)
Cost of borrowing (unwinding of discount)	4	52	(108)	0	9	(43)
At 31 March 2016	261	3,624	34,785	0	4,442	43,112

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 15 (continued) PROVISIONS FOR LIABILITIES AND CHARGES – 2016

Comprehensive Net Expenditure Account charges	2016 £000s	2015 £'000
Arising during the year	19,629	10,540
Reversed unused	(2,797)	(3,831)
Cost of borrowing (unwinding of discount)	(43)	(99)
Total charge within Operating expenses	16,789	6,610

Analysis of expected timing of discounted flows

	Pensions relating to former directors £000s	Pensions relating to other staff £000s	Clinical negligence £000s	CSR restructuring £000s	Other £000s	2016 £000s
Not later than one year	15	194	6,035	0	1,195	7,439
Later than one year and not later than five years	62	803	10,023	0	1,999	12,887
Later than five years	184	2,627	18,727	0	1,248	22,786
At 31 March 2016	261	3,624	34,785	0	4,442	43,112

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 15 (continued) PROVISIONS FOR LIABILITIES AND CHARGES – 2015

	Pensions relating to former directors	Pensions relating to other staff	Clinical negligence	CSR restructuring	Other	2015
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	262	3,949	21,504	0	4,550	30,265
Provided in year	27	165	9,662	0	686	10,540
(Provisions not required written back)	0	0	(3,422)	0	(409)	(3,831)
(Provisions utilised in the year)	(15)	(199)	(6,912)	0	(630)	(7,756)
Cost of borrowing (unwinding of discount)	3	49	(151)	0	0	(99)
At 31 March 2015	277	3,964	20,681	0	4,197	29,119

Provisions have been made for 7 types of potential liability: Clinical Negligence, Employer's and Occupier's Liability, Early Retirement, Injury Benefit, Employment Law, Agenda for Change and Restructuring in connection with Transforming Your Care (TYC). The provision for Early Retirement and Injury Benefit relates to the future liabilities for the Trust based on information provided by the HSC Pension Branch. For Clinical Negligence, Employer's and Occupier's claims and Employment Law the Trust has estimated an appropriate level of provision based on professional legal advice. The costs of exit packages associated with TYC are included on the basis of the policy outlined in TYC and HR advice.

SOUTHERN HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 15 (continued) PROVISIONS FOR LIABILITIES AND CHARGES – 2015

Analysis of expected timing of discounted flows

	Pensions relating to former directors	Pensions relating to other staff	Clinical negligence	CSR restructuring	Other	2015
	£000s	£000s	£000s	£000s	£000s	£000s
Not later than one year	14	202	3,911	0	1,104	5,231
Later than one year and not later than five years	61	833	7,670	0	1,953	10,517
Later than five years	202	2,929	9,100	0	1,140	13,371
At 31 March 2015	277	3,964	20,681	0	4,197	29,119

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 16 CAPITAL COMMITMENTS**

	2016	2015
	£000s	£000s
Contracted capital commitments at 31 March not otherwise included in these financial statements		
Property, Plant & Equipment	16,757	11,139
	16,757	11,139

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 17 COMMITMENTS UNDER LEASES****Note 17.1 Operating Leases**

Total future minimum lease payments under non-cancellable operating leases are given in the table below for each of the following periods.

	2016 £000s	2015 £000s
Obligations under operating leases comprise		
Land & Buildings		
Not later than 1 year	316	311
Later than 1 year and not later than 5 years	203	659
	519	970
Other		
Not later than 1 year	746	477
Later than 1 year and not later than 5 years	940	797
	1,686	1,274

Note 17.2 Finance Leases

The Southern HSC Trust did not have any finance leases at 31 March 2016 or at 31 March 2015.

Note 17.3 Operating Leases

Total future minimum lease income under operating leases are given in the table below for each of the following periods.

Obligations under operating leases issued by the Trust comprise:

	2016 £000s	2015 £000s
Land and Buildings		
Not later than 1 year	117	79
Later than 1 year and not later than 5 years	84	68
Later than 5 years	125	119
	326	266

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 18 COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENT CONTRACTS****18.1 Off balance sheet PFI and other service concession arrangements schemes**

The Trust has no off balance sheet (SoFP) PFI and other service concession arrangement schemes.

18.2 On balance sheet (SoFP) PFI Schemes

The Trust has no on balance sheet (SoFP) PFI and other service concession arrangements schemes.

18.3 Charge to the Statement of Comprehensive Net Expenditure account and future commitments

As the Trust has no commitments there is no charge to the Statement of Comprehensive Net Expenditure account .

NOTE 19 OTHER FINANCIAL COMMITMENTS

The Southern HSC Trust did not have any other financial commitments at either 31 March 2016 or 31 March 2015.

NOTE 20 FINANCIAL GUARANTEES, INDEMNITIES AND LETTERS OF COMFORT

Because of the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within Trusts in creating risk than would apply to a non public sector body of a similar size, therefore Trusts are not exposed to the degree of financial risk faced by business entities. Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Trusts in undertaking activities. Therefore the HSC is exposed to little credit, liquidity or market risk.

The Southern HSC Trust has not entered into any quantifiable guarantees, indemnities or provided letters of comfort, at either 31 March 2016 or 31 March 2015.

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 21 CONTINGENT LIABILITIES**

Material contingent liabilities are noted in the table below, where there is a 50% or less probability that a payment will be required to settle any possible obligations. The amounts or timing of any outflow will depend on the merits of each case.

Contingent Liabilities

	2016 £000s	2015 £000s
Clinical negligence	2,308	2,045
Public Liability	58	5
Total	<u>2,366</u>	<u>2,050</u>

There are a number of active employment claims against the Trust. The expenditure which may arise from such claims cannot be determined as yet.

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 22 RELATED PARTY TRANSACTIONS**

The Southern HSC Trust is an Arm's length body of the Department of Health, Social Services and Public Safety and as such the Department is a related party with which the Southern HSC Trust has had various material transactions during the year

- Funding – Revenue Resource Limit of £576,154k (2015: £565,143k) of which the Non Cash Revenue Resource Limit is £32,057k (2015: £44,590k)

During the year, none of the board members, members of key management or other related parties has undertaken any material transactions with the Southern HSC Trust, apart from the transactions with the Department noted.

Interests in the following organisations were declared by non-executive, executive and other Directors and recorded on the Trust's Register of Interests. Where an interest is disclosed, the related party is not involved directly in the award of a contract with the related organisation.

The interests declared and the value of the related party transactions was as follows:

Mr Edwin Graham, Committee Member of Enable NI. The value of transactions between related parties was £189,334 (32 transactions) in respect of grant payments for respite services and day care and provision of training to voluntary organisations. Balance outstanding at year end was £10,961.

Mrs Angela McVeigh, has a personal friend who is the owner of Ann's Homecare Domiciliary Care Agency. The value of transactions between related parties was £4,323,501 (150 transactions) in respect of Domiciliary Care Provision. The balance outstanding at year end: £248,821.

NOTE 23 THIRD PARTY ASSETS

The Southern HSC Trust held £7,816k cash at bank and in hand at 31 March 2016 (31 March 2015: £7,184k) which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts. A separate audited account of these monies is maintained by the Trust.

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 24 FINANCIAL PERFORMANCE TARGETS****NOTE 24.1 Revenue Resource Limit**

The Southern HSC Trust is given a Revenue Resource Limit which it is not permitted to overspend

The Revenue Resource Limit (RRL) for Southern HSC Trust is calculated as follows:

	2016	2015
	Total	Total
	£000s	£000s
HSCB	531,668	508,453
PHA	5,848	5,458
SUMDE & NIMDTA	6,976	6,772
Non cash RRL (from DHSSPS)	32,057	44,590
Total agreed RRL	576,549	565,273
Adjustment for income received re Donations / Government grant / Lottery funding for non current assets	(395)	(130)
Total Revenue Resource Limit to Statement Comprehensive Net Expenditure	576,154	565,143

24.2 Capital Resource Limit

The Trust is given a Capital Resource Limit (CRL) which it is not permitted to overspend.

	2016	2015
	Total	Total
	£000s	£000s
Gross capital expenditure	23,045	30,388
Prepayment for Capital Scheme	0	1,227
Release of Prior Year Prepayment for Capital Scheme	(1,848)	0
(Receipts from sales of fixed assets)	(109)	(299)
Net capital expenditure	21,088	31,316
Capital Resource Limit	21,398	31,596
Underspend against CRL	(310)	(280)

SOUTHERN HSC TRUST**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016****NOTE 24 FINANCIAL PERFORMANCE TARGETS****24.3 Financial Performance Targets**

The Southern HSC Trust is required to ensure that it breaks even on an annual basis by containing its net expenditure to within 0.25 % of the Revenue Resource Limit.

	2015/16 £000s	2014/15 £000s
Net Expenditure	(576,017)	(565,102)
RRL	576,154	565,143
Surplus against RRL	137	41
Break Even cumulative position(opening)	(2,097)	(2,138)
Break Even cumulative position (closing)	(1,960)	(2,097)

Materiality Test:

	2015/16 %	2014/15 %
Break Even in year position as % of RRL	0.02%	0.01%
Break Even cumulative position as % of RRL	(0.34)%	(0.37)%

The Southern HSC Trust reduced its cumulative overspend by achieving a small surplus in 2015/16. However, as the Trust continues to face a challenging financial position, it is unclear when the cumulative reported overspend will be recovered.

NOTE 25 POST BALANCE SHEET EVENTS

There are no post balance sheet events having a material effect on the accounts.

NOTE 26 DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 24 June 2016.

**ACCOUNT OF MONIES HELD ON BEHALF OF
PATIENTS/RESIDENTS**

YEAR ENDED 31 MARCH 2016

SOUTHERN HSC TRUST

ACCOUNT OF MONIES HELD ON BEHALF OF PATIENTS/RESIDENTS

YEAR ENDED 31 MARCH 2016

**STATEMENT OF TRUST'S RESPONSIBILITIES IN RELATION TO PATIENTS/RESIDENTS
MONIES**

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, the Trust is required to prepare and submit accounts in such form as the Department may direct.

The Trust is also required to maintain proper and distinct accounting records and is responsible for safeguarding the monies held on behalf of patients/residents and for taking reasonable steps to prevent and detect fraud and other irregularities.

SOUTHERN HEALTH AND SOCIAL CARE TRUST – PATIENTS’ AND RESIDENTS’ MONIES**THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY**

I certify that I have audited Southern Health and Social Care Trust’s account of Patients’ and Residents’ Monies for the year ended 31 March 2016 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended.

Respective responsibilities of the Trust and auditor

As explained more fully in the Statement of Trust Responsibilities in relation to Patients’ and Residents’ Monies, the Trust is responsible for the preparation of the account in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health (formerly Department of Health, Social Services and Public Safety) directions made thereunder. My responsibility is to audit, certify and report on the account in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

Scope of the audit of the account

An audit involves obtaining evidence about the amounts and disclosures in the account sufficient to give reasonable assurance that the account is free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Southern Health and Social Care Trust’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Southern Health and Social Care Trust’s; and the overall presentation of the account. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited Patient’s and Resident’s Monies account and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the financial transactions recorded in the account conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects the financial transactions recorded in the account conform to the authorities which govern them.

Opinion on account

In my opinion:

- the account properly presents the receipts and payments of the monies held on behalf of the patients and residents of Southern Health and Social Care Trust for the year ended 31 March 2016 and balances held at that date; and

- the account has been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health directions issued thereunder.

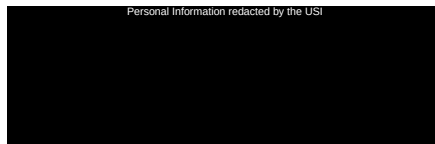
Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the account is not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with Department of Finance's (Department of Finance and Personnel) guidance.

Report

I have no observations to make on this account.



*KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast
BT7 1EU*

24th June 2016

SOUTHERN HSC TRUST**ACCOUNT OF MONIES HELD ON BEHALF OF PATIENTS/RESIDENTS****YEAR ENDED 31 MARCH 2016**

Previous Year	<u>RECEIPTS</u>		
£	Balance at 1 April 2015	£	£
5,794,912	1. Investments (at cost)	6,249,213	
860,443	2. Cash at Bank	930,592	
3,936	3. Cash in Hand	4,171	7,183,976
6,659,291			
2,222,976	Amounts Received in the Year	2,639,882	
54,301	Interest Received	41,879	2,681,761
8,936,568	TOTAL		9,865,737

<u>PAYMENTS</u>			
1,752,592	Amounts paid to or on Behalf of Patients/Residents		2,049,325
	Balance at 31 March 2016		
6,249,213	1. Investments (at Cost)	6,291,092	
930,592	2. Cash in Bank	1,520,173	
4,171	3. Cash in Hand	5,147	
7,183,976			7,816,412
8,936,568	TOTAL		9,865,737

Cost Price £	Schedule of investments held at 31 March 2016	Nominal Value £	Cost Price £
6,249,213	Bank of Ireland	6,291,092	6,291,092

I certify that the above account has been compiled from and is in accordance with the accounts and financial records maintained by the Trust.

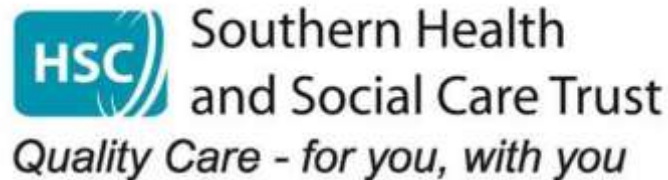
Director of Finance

Date:

I certify that the above account has been submitted to and duly approved by the Board.

Interim Chief Executive

Date:



Notes from the Medical Forum Meeting
Friday 17th September 2015 at 2.00 pm

Present: Dr R Wright, Angela McVeigh, Lesley Leeman, Dr P Sharpe, Dr G McCracken, Dr S Moan, Mr S Hall, Dr B Aljarad, Dr D Duffin, Dr C McAllister, Dr A Khan, Dr N Chada, Dr P Murphy, Dr D Gracey, Dr P McCaffrey, Dr M Hogan, Mr E Mackle, Dr J Hughes

ITEM	NOTES	ACTION
1.0	APOLOGIES Dr S Hall, Dr P Beckett, Dr R Black, Dr D Scullion, P Clarke, K Donaghy, E Gishkori, F Rice, S McNally, A Magwood, P Morgan	
2.0	MINUTES OF LAST MEETING Minutes of last meeting 12th June 2015 were agreed with the exception that Mr Sam Hall was in attendance rather than Dr Stephen Hall.	
3.0	MATTERS ARISING 3.1 UPDATE ON M&M PROJECT Dr Wright advised that Dr Lauren Megahey, an SPR in Psychiatry had commenced with the Trust for a year to take forward the regional M&M project. The regional project board were due to meet soon to decide on the system to be adopted across the region which looked most likely to be a variation of the system being used by the Belfast Trust. There were therefore likely to be some changes to the system currently being used locally. All other Matters Arising were on the agenda.	

4.0	GOVERNANCE 4.1 CHIEF EXECUTIVE BUSINESS Dr Wright advised that a Review of Governance structures was currently ongoing which was likely to be completed by Autumn. If anyone would like an opportunity to provide an input to the review then they should contact M Marshall. 4.2 CHANGES IN SENIOR MANAGEMENT TEAM – DR WRIGHT It was acknowledged that Dr R Wright had taken up post as Medical Director and Esther Gishkori had taken up post as Director of Acute Services.	<i>Action: M Marshall to issue information on the Review to AMDs/CDs.</i>
5.0	TRANSFORMING YOUR CARE REGIONAL UPDATE L Leeman advised that the Trust had a number of strategic enabling projects ongoing which are being monitored by the Programme Board, albeit it was recognised that there were still constraints as per the Trust's Financial Plan. She also advised that a number of consultations were taking place at the moment that feed into the bigger programme.	
6.0	MEDICAL ENGAGEMENT / LEADERSHIP – DR - WRIGHT 6.1 INFECTION PREVENTION AND CONTROL UPDATE Dr Wright advised of the recent outbreak of CPE that is resistant to all antibiotics and where a patient is vulnerable then the mortality rate tended to be extremely high. There had been a number of outbreaks in the Belfast Trust and there had been three in the Southern Trust and four in the South. This particular infection is transmitted hand to mouth and can therefore can be contained with good IPC measures. As this particular outbreak was almost certainly caused by poor antibiotic prescribing practices, a number of measures are being put in place to deal with this and it was hoped that the Southern Trust's outbreak was coming to an end. 6.2 GUIDANCE FOR ANTIMICROBIAL STEWARDSHIP FOR SHSCT	

	Dr Wright advised that this was new guidance that highlights poor usage around some of the drugs. The IPC Team will be visiting individual Divisions to discuss this further. In addition, an Expression of Interest (EOI) is being circulated for Antibiotic Stewardship Champions which attracted a small PA. Dr Wright asked those present to identify / encourage staff from within their Divisions to apply. Some additional Pharmacy support will also be provided at ward level to try and improve antibiotic use and there were also some outreach measures being implemented in the wider community outside of the hospital. He also reminded everyone of the need to ensure their staff / juniors are following best practice and asked that there is a renewed push in relation to basic IPC measures over the next six months as there had been some lapses particularly with those transient staff visiting wards. Dr Wright also advised of major issues with the sewage works in CAH which in itself creates a major IPC problem. Therefore works will be commencing on this soon with a view to it being completed by Christmas.	<i>ACTION: Members to remind staff of their IPC responsibilities.</i>
7.0	ORGANISATIONAL ISSUES 7.1 FINANCE Dr Wright advised the Trust is on target to meet its financial objectives for the year. If anyone had any small capital or staffing bids that would not extend past the end of the financial year then these should be submitted soon. L Leeman advised there was a little bit of movement from savings made internally and the Trust had taken the opportunity to use these savings to undertake targeted / prioritised, non-recurrent work. Due to the current demand pressures, the Trust has approached the HSC Board for recurring monies as we are unable to contract with any independent providers in order to meet the demand. It had therefore been agreed that the Trust could undertake additional capacity up to 5% over normal levels. She asked those present to consider whether they had capacity to undertake some additional sessions.	<i>ACTION: Members to submit bids as appropriate.</i> <i>ACTION: Members to consider undertaking additional sessions.</i>

	7.3 HOT TOPICS It was noted that there was currently no Health Minister due to the breakdown of the NI Assembly.	
8.0	ANY OTHER BUSINESS 8.1 UPDATE ON DAISY HILL EMERGENCY DEPARTMENT – DR R WRIGHT Dr Wright advised that due to the difficulties around securing middle grade staffing in the ED, DHH this was a huge area of concern and a number of options were currently being explored in order to alleviate the situation. One was to close the ED from 10 pm at night and there were alternative measures being considered to support the ED out of hours. Another option was increasing the seniority of nursing staff i.e. nurse practitioners, in order to stabilise staffing levels. All of these options were being considered by an oversight committee chaired by P Clarke. The Trust has been in close contact with the HSC Board in relation to this and has developed a contingency plan in the event the situation destabilised and the ED was to close. This would have an obvious impact on CAH and a full new medical ward may have to be opened and an out of hours ambulance would need to be procured which in itself may prove difficult. In any event, a decision will not be made for a few months and the impact on both sites will be fully explored before a decision is made. Dr S Moan advised that the preferred option is to provide safe care on a 24/7 basis on the DHH site and recognised the efforts underway to sustain this. 8.2 CURRENT OUTPATIENT WAITING LISTS Dr S Moan advised that new red flags / referrals were being managed well however there was a huge backlog / waiting list for appointments. He asked how information can be filtered to doctors. L Leeman advised of a report on Sharepoint that breaks down information by individual Division/Specialties and also Operational Support Leads	<i>L Leeman to provide link to Sharepoint and send info</i>

	should be able to provide any information required. Dr Khan advises that within CYP they receive a monthly report of backlog lists. Dr Wright advised that review times had also been raised at the LNC meeting and he would welcome any further suggestions on how to resolve the issue. 8.3 TECHNOLOGY ENABLED CHANGE UPDATE This was deferred until the next meeting. 8.4 QUALITY IMPROVEMENT EVENT L Leeman advised a series of engagement events had been held within the Trust and had been very well attended by a cross-section of staff. Further events are currently being organised with a view to consulting with the commissioner and service users on the Trust's QI agenda. It was recognised there were really good pockets of work across the Trust however these were not being shared widely. An SMT development day was being held on 2nd October and work was underway to develop a virtual QI network and elearning modules. L Leeman advised of the QI Event being held on 13th October (one morning and one afternoon session) for which there had been a call for speakers and posters with over 80 responses received to date, quite a few of which were from medical colleagues. This QI Event will cover practical tips on media, involving service users, QI tools etc. Dr Wright suggested that it would be good if each medical member of staff was involved in a QI project each year as part of their appraisal (this is also one of the requirements of GMC Revalidation) and that all new staff were advised of this on commencement to the Trust so that QI was embedded in every day practice.	<i>to S Moan.</i>
9.0	DATE OF NEXT MEETING: Friday 18th December 2015, at 2pm Boardroom, Trust HQ video-lined with Committee Room 1, DHH.	



Quality Care - for you, with you

**Minutes of a meeting of the Governance Committee held on
Tuesday, 3rd February 2015 at 9.30 a.m.
in the Boardroom, Trust Headquarters**

PRESENT:

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

IN ATTENDANCE:

Mrs M McAlinden, Chief Executive
Mrs P Clarke, Director of Performance and Reform/Deputy Chief Executive
Mrs D Burns, Interim Director of Acute Services
Mr M Crilly, Acting Director of Mental Health & Disability Services
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Mr P Morgan, Director of Children & Young People's Services/Executive Director of Social Work
Dr J Simpson, Medical Director
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs M Marshall, Acting Assistant Director, Clinical and Social Care Governance
Mrs S Judt, Board Assurance Manager
Mrs S McLoughlin, Acting Committee Secretary (Minutes)

APOLOGIES:

None

1. **CHAIRMAN'S WELCOME**

Dr Mullan welcomed those present to the meeting and reminded members of their responsibilities in keeping with Board Etiquette and asked that mobile phones are turned to silent and laptops are to be used for accessing Governance Committee papers only during the meeting.

2. **DECLARATION OF INTERESTS**

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

3. **CHAIRMAN'S BUSINESS**

None.

4. **MINUTES OF MEETING HELD ON 9TH DECEMBER 2014**

The minutes of the meeting held on 9th December 2014 were agreed as a true and accurate record. These were duly signed by the Chairman.

5. **MATTERS ARISING FROM PREVIOUS MINUTES**

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

Item 9: Mrs Mahood thanked Mrs McVeigh for providing further detail on category of delay regarding incidents in OPPC Directorate. Mrs Burns to provide further detail on the category of delay regarding incidents within the Acute Directorate.

Item 14: Mr Graham asked if regional clarity had been obtained on the definition of unmet need to which Mr Morgan advised that he had written to the Department on this matter, but there had been no response to date.

6. CORPORATE RISK REGISTER

Mrs McAlinden presented the Corporate Risk Register and reminded members that this had been discussed in detail at the confidential meeting of the Trust Board the previous week.

In terms of potential new risks, Mrs McAlinden spoke of the current high demand on the hospital and community systems drawing attention to the high volume of ambulance arrivals at the Emergency Departments on both hospital sites. She stated that this increased demand is impacting on admissions and staffing levels. Mrs McAlinden acknowledged the efforts of staff during this time of high demand.

A short discussion ensued on nurse staffing levels.

Mrs Blakely asked at what stage would the Trust highlight that the current demands were unsustainable. Mrs McAlinden responded by stating that Mrs Clarke and herself have signalled the difficulties through the regional Unscheduled Care Meeting with the Chief Medical Officer and Chief Nursing Officer. Mrs McAlinden highlighted the need for strategic decisions to be made and more nursing and medical staff to be trained.

Mr Graham paid tribute to all staff who have been working hard, many doing extra shifts to help with the current demand. Mr Graham expressed his concern at the potential increased risk to patients if they are being discharged earlier than normal to which Mrs McAlinden responded that the situation is closely monitored and any unexpected re-admissions are flagged up by the ward.

In concluding the discussion, Mrs McAlinden advised that the the current demands on the hospital and community systems would be reflected in the next update of the Corporate Risk Register.

7. MEDICINES GOVERNANCE REPORT

Dr Boyce presented her report for the second quarter of 2014/15. She stated that during this period there were 250 medication incidents reported in the Southern Trust and that the average number of reported medication incidents each month was 84, representing a decrease from 140 per month in the previous quarter. She advised that there were no trends of specific concern and that the number of reported medication incidents is set against a figure of approximately 7,500 medication transactions, including prescribing, dispensing and administration, happening in the Trust every day.

Dr Boyce informed members that the most common prescribing incident in the Trust was 'Omitted/delayed medicine' which differed from the region's top prescribing incident of 'Dose of strength wrong/unclear'. She stated that the Trust's top administration incident was 'Omitted or delayed medicine' which was the same as the region's top administration incident and that the Trust's most common dispensing incident was 'wrong quantity' which was different from the region's top dispensing incident 'Omitted/delayed medicine'. Dr Boyce provided assurance that this is an area of continued focus within the Trust.

Members discussed the actions resulting from the Trust's Incident Monitoring and Dr Boyce outlined the other medicine governance activities within the Trust, the detail of which was included in her report.

Members welcomed the update from the recent meeting of the Drugs and Therapeutics Committee and the Medication Safety Today Newsletter included in their papers.

Mrs Rooney enquired about Oxygen safety in hospitals to which Dr Boyce stated that there were on-going multi-factorial aspects to this, but provided assurance that the Medical Gas Committee continues to progress work on medical gas cylinder storage and supply.

Mrs Kelly sought further confirmation that Warfarin patients still carried a yellow information card and asked to which Dr Boyce agreed this was the case and explained the process.

Dr Mullan asked for an explanation as to why the number of medication incidents had decreased rapidly this quarter to which Dr Boyce responded the increase was attributable to recording as a result of a proactive initiative targeted at Junior Doctors at the August and January intake each year in an attempt to prevent medication errors. Mrs McAlinden asked if this trial had helped with learning for new Junior Doctors to which Dr Boyce agreed that it was very educational for them.

Electronic prescribing was raised and Dr Boyce advised of continuing discussions regarding funding of the system and stated that she envisaged that roll out would be during 2016. Dr Mullan asked that any progress on electronic prescribing would be brought back to Governance committee.

Action: Dr Boyce

Mrs Mahood drew attention to the increased number of c-diff cases and asked about antibiotic prescribing. Dr Simpson provided assurance that a multi-disciplinary Root Cause Analysis is undertaken to identify and promote learning for all clinical staff. Dr Simpson referred to the C.Diff action plan and part of this work is liaison and collaborative working with Primary Care.

8. **CLINICAL AND SOCIAL CARE GOVERNANCE**

i) Incidents and Complaints Management Report

Incidents were discussed. Mrs Marshall drew members attention to Fig 1.1 in the report which provides the number of incidents by Directorate for the quarter 1 October 2014 – 30 December 2014 (3419 incidents) compared with the same period last year (2860). Members discussed Fig 1.2 which provides a breakdown of the catastrophic incidents by Directorate, the action taken and the engagement with family. Members requested that all incidents are graded for the next report.

Action: M Marshall

Dr Mullan noted the increased number of incidents in the OPPC Directorate from October 2013 – October 2014 and asked if there were any concerns. Mrs McVeigh advised that she had no concerns around these incidents and advised that falls was an area of continued focus.

Dr Mullan drew attention to missing detail on a catastrophic incident in figure 1.2. Mrs Marshall undertook to provide this for the next meeting.

Action M Marshall

Complaints received by Directorate for the quarter were discussed. Mrs Marshall drew member's attention to the tables in the report which provides information on complaints acknowledgement letters and those complaints (letters) responded to within 20 working days and those which required 30 working days.

Mrs Marshall concluded her report by drawing attention to learning from complaints for each Directorate for the quarter ended 31 December 2014.

ii) Update on Ombudsman Cases

Mrs Marshall referred members to this report which provides a summary of new cases received within the time period 1 October 2014 – 31 December 2014 as well as an update on existing cases.

Mrs McAlinden drew attention to the fact that only one case had been closed during this period and asked if there were any recommendations from the Ombudsman in terms of action for the Trust. In response, Mrs Marshall advised that the Trust has sent a letter of apology in relation to this case.

iii) Serious Adverse Incidents Report for the period 1.10.2014 – 30.12.2014

Members discussed the SAI Investigation Reports submitted and awaiting closure by the Health and Social Care Board.

Members were advised that a total of 122 serious adverse incidents have been received in 2014/15 to date.

Mrs McAlinden expressed her concern at the number of cases which remain open and explained that discussions continue with the HSCB and PHA to get these closed. Mrs Marshall responded stating that there have been no SAI's closed during the quarter ended December 2014 and she informed members that the HSCB have strengthened their processes and a lot of additional questions are now being asked through the Designated Officers at the HSCB.

iv) HSCB SAI Learning Report: 1 April – 30 September 2014

Members discussed the above-named report which demonstrates how learning has been disseminated across the region. It was noted that there was a lot of work across Trust Work Streams and Directorates and attention was drawn to the increase in SAI's from 28 in 2012/13 to 73 in 2013/14.

Mrs Mahood asked if the learning was disseminated to Team Meetings to which Mrs Marshall gave assurance that all learning is shared with individual directorate meetings and also at SMT for corporate learning.

Mrs Rooney drew attention to prescribing and dispensing incidents saying that the learning from this would be useful for staff working in residential and children's Homes.

Mrs McAlinden drew attention to the Learning Lessons Newsletter and made the point that a summary of the top tips would be a useful guide for staff which could be displayed prominently at ward and team levels. Mrs Marshall agreed to take this on board.

9 i) Medical Director Report

Dr Simpson highlighted the key aspects of his report.

HCAI performance year to date (26th January 2015) was discussed. Dr Simpson reported 36 cases of C-Difficile with one further case in February 2015.

Summarising the 8 C-Difficile cases in December 2014, Dr Simpson advised that antibiotic prescribing and stewardship

are an issue in at least 4 of the cases. A detailed action plan will be written by Microbiology. In relation to MRSA infections, Dr Simpson reported 7 year to date against a target of 3 with 29 MSSA infections year to date against an internal target of 34. 9 of these cases have been identified as being preventable.

ii) Annual Mortality Report 2013/14

Dr Simpson advised that the range of the Trust monthly crude mortality is between 0.82% and 1.5% for the period which is unchanged from the previous report. The Trust RAMI for the period January 2013 - December 2013 is 77, meaning there were 23% less deaths than were expected based on the casemix.

Dr Simpson reported that the average RAMI for the 'CHKS Top UK Hospital' is 83. The Trust RAMI Score of 77 is below this and demonstrates that the Trust is performing in the top 50% of the 'CHKS Top UK Hospitals' group.

Mrs McAlinden thanked Dr Simpson for this report and referring to the Annual Risk Adjusted Mortality graph on page 10, asked if there was any learning from those Trusts in the green quartile. Dr Simpson undertook to check with CHKS.

iii) Report on compliance of Core and Professional Specific Quality Indicators for Allied Health Professions

Mr Rice spoke to this report which presents an update on compliance of Core and Profession Specific Quality Indicators for Allied Health Professions. This demonstrates significant progress in a number of areas.

10. RQIA REVIEWS STATUS UPDATE

The report for the period 1 October 2014 – 31 December 2014 was discussed. Mrs McAlinden drew attention to the updates which were recorded in red font.

Mrs McAlinden referenced the Failure to Comply notices which had been issued to [irrelevant information redacted by the] and [irrelevant information redacted by the] and reported on

at the previous meeting. Mr Morgan reminded members of the reason and complexities involved relating to a particular case. He provided an update for members which provided assurance that both units are no longer in breach of their Statement of Purpose and the failure to comply notices will cease.

Mrs Rooney drew attention to the fact that there were 9 not 8 recommendations made for Statutory Domiciliary Care.

Mrs McAlinden referred members to the Review of Discharge Arrangements from Acute Hospitals along with the Trust response and action plan and she thanked Ms Charlotte-Anne Wells from the Acute Directorate who has been responsible for completing this piece of work. Members requested a further update on the action plan to the Governance Committee in 6 months time.

Action – Mrs Burns

Dr Mullan drew attention to the variance between Trusts in their discharge arrangements. Mrs McAlinden spoke of the use of the electronic discharge letter for clarity of information. She also drew attention to the accreditation given to the SHSCT for being the only Trust that e-mails the majority of its discharge summaries to GPs as well as having the best developed IT system, supplying accurate information on all patients and also information regarding multidisciplinary input.

11. FREEDOM OF INFORMATION, ENVIRONMENTAL INFORMATION AND SUBJECT ACCESS REQUESTS – SUMMARY REPORT FOR THE PERIOD OCTOBER – DECEMBER 2014

Mrs Clarke presented the summary report and stated that in comparison with 2013 statistics, 2014 had seen a 27% increase in the volume of FOI requests with compliance rates dropping by 10.5% (from 84.5% in 2013 to 74% in 2014). Members noted that the reducing performance in 2014 regarding FOI response times is linked to capacity issues across teams.

Mrs Burns left the meeting at 12.05pm

12. REPORT OF PHA QUALITY ASSURANCE VISIT TO CERVICAL SCREENING SERVICES, SHSCT

Dr Mullan welcomed Mrs Anne McVey, Assistant Director of Acute Services, and Mr James Heaney, Biomedical Scientist, to give feedback following the NI Quality Assurance Reference Centre visit to the Trust's cervical screening service.

Mrs McVey explained this was the first full formal Quality Assurance (QA) Visit carried out by the NI Quality Assurance Reference Centre – this incorporates the cytopathology laboratory at Craigavon Area Hospital, and colposcopy clinics at Craigavon and Daisy Hill Hospitals. Overall, she stated, the QA Visit Team found an enthusiastic and committed group of staff, maintaining a high standard of work within the cervical screening programme for the Southern Trust. The QA team identified a number of points of good practice, for which the staff should be commended. She said while the overall quality of service provision is good, the QA team highlighted a number of main areas for improvement or consideration which were identified before the visit.

Dr Mullan thanked Mrs McVey and Mr Heaney for an informative presentation.

In response to a query from Mrs Rooney regarding the fact that one colposcopist had not performed any colposcopies this year, Mr Heaney advised of recent expressions of interest for a Lead Colposcopist.

13. NIAO REPORT SAFER BIRTHS: USING INFORMATION TO IMPROVE QUALITY

Dr Mullan welcomed Dr Martina Hogan, Associate Medical Director of Integrated Maternity and Women's Health Services to the meeting. Members had received a copy of the NIAO report in their papers.

Dr Hogan gave a short presentation on Perinatal statistics and members asked a number of questions to which Dr Hogan responded. A discussion took place on the rate of C-Sections within the Trust and it was agreed that it would be useful to have a presentation on C-sections at the September meeting.

Action: Mrs D Burns

Dr Mullan thanked Dr Hogan for her informative presentation.

14. NIAO REPORT WHISTLEBLOWING IN THE PUBLIC SECTOR

Mr Donaghy referred members to this report which had been issued by the Northern Ireland Audit Office.

Following discussion, Mr Donaghy undertook to provide a list of the reasons for whistleblowing cases to a future Governance Committee meeting.

Action: Mr Donaghy

15. NORTHERN IRELAND CARE LEAVERS REPORT 2013/14

Mr Morgan spoke to this report which is based on information returns collated by the DHSSPS to monitor and assess outcomes for children in care and after leaving care during the year 2013/14. The returns focus primarily on education, health and training and employment.

Mr Morgan referred members to the challenge by the Senior Management Team on why the Southern Trust had the highest number of care leavers with no qualifications. Mr Morgan advised of what the Trust is doing in relation to education for its Looked After Children population. Mr Morgan noted that for the purpose of this report education has only been focused on GCSE and A Level qualifications while many care leavers have been on vocational programmes.

Members asked a number of questions to which Mr Morgan responded. Dr Mullan referred to the fact that a third of the Southern Trust Care leavers are aged 16-17. Mr Morgan agreed to pick up on some of the issues raised and report back as part of his Executive Director of Social Work Report to Trust Board.

Action: Mr Morgan

Mr Morgan left the meeting at 1.00pm

16. UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE

Mr Graham, Chair of the Patient and Client Experience Committee provided a verbal update on the recent meeting held on 4th December 2014. Mr Graham explained that this meeting was not quorate and was therefore conducted in information sharing mode only. He advised that there was good discussion on complaints and the Trust responses to same.

17. LEADERSHIP WALKABOUTS SUMMARY REPORT FOR THE PERIOD OCTOBER 2014 – DECEMBER 2014

Members discussed the above report. Mrs McAlinden thanked the Non Executive Directors for undertaking these walkabouts which are a good assurance mechanism within the Trust and provide staff with the opportunity to raise issues.

18. TERMS OF REFERENCE

Members reviewed the Terms of Reference and agreed to an amendment to reflect the requirement for papers to be distributed no less than 5 working days in advance of the meeting.

19. ANY OTHER BUSINESS

There was no further business.

The meeting concluded at 1.10pm

SIGNED: _____

DATED: _____

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 27 August 2015
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
Summary of Key Areas:	High level context: This report reviews performance at the end of July 2015 against the Commissioning Plan standards and targets for 2015/2016. The targets for 2015/2016 include a roll forward of existing targets, some amended targets and a number of new targets against which the Trusts performance will be monitored during 2015/2016. Note: The DHSSPSNI Board are seeking to improve consistency, scope and timeliness of the performance management reporting across the Department, HSCB and Trusts. The Trust is involved in a short-life working group established to bring forward proposals on the core elements and format for all organisations published performance reports. The objective is to ensure that there is appropriate consistency between all organisations in relation to what is reported that allows comparison between organisations and regionally. When an initial draft is agreed this will be brought to Trust Board for views. It is anticipated this draft will be available by end of August. Key issues/risks for discussion: The report highlights a number of areas of risk predominantly with respect to elective access standards and growing access times in the absence of any confirmed funding to establish additional capacity. • Elective Access –The Trust continues to work to the access standards of 9-weeks/13-weeks with maximum backstops of 18-weeks/26-weeks for out-patients and in-patients. However, as indicated in previous reports to the Trust Board, performance against this target has become increasingly challenging and is not achievable associated with, in the main, lack of

commissioned capacity to meet demand. This is particularly problematic in the Acute Service Directorate.

Whilst levels of activity continue to improve in line with the agreed Service & Budget Agreement (SBA), there are a number of specialty areas with capacity gaps where no allocation for additional activity in out-patients, in-patients and day cases has been provided by HSCB since Quarters 3/4 2014/2015; this compounds the backlog accrued in Quarters 1/2 2014/2015 and has resulted in increased access times at March 2015 and into this year.

Based on current demand and in the absence of funding for additional capacity, this position will continue to deteriorate. The Trust has formally highlighted a number of emergent risks to the HSCB.

The HSCB have confirmed an allocation for funding for additional capacity in diagnostic imaging and endoscopy for Quarters 1/2 2015/2016. The Trust has reviewed this allocation against additional in-house and IS capacity and while contributing to improvement, it is not expected this will achieve 9 weeks by September 15 in all areas.

The following actions are being taken to manage the situation:

- o Monitoring access times for red flag and urgent cases and prioritising capacity to this demand;
- o Strict chronological management to ensure routine patients are treated in turn;
- o Trying to minimise lost capacity from those who do not attend or cancel on their appointments/procedures on the day, and
- o Monthly information to General Practitioners to ensure referrers and patients are aware of current and projected waiting times.

Appendix 2 details the access times achieved at the end of July 2015.

Other key risks affecting performance remain, relating to a number of common factors:

- o Recurrent investment has not been secured for all services with a recognised capacity gap although this position improved somewhat in 2014/2015;
- o The impact of workforce controls related to Trust financial contingency plans;
- o Particular issues relating to sickness, maternity and other absences in the medical workforce and associated challenges in securing backfill capacity in general;
- o Continued pressures on demand in some areas including non-elective demand, urgent and red flag referrals; and
- o The need to allocate appropriate levels of capacity for service areas not subject to regional standards/targets eg. review appointments and planned repeat procedures.

- **Emergency Department** – The Trust continues to focus on effecting improvement and sustainability in performance against the ED Target and has dedicated senior staff to provide a focus on service improvement in ED and on patient flow throughout the hospital system.

A high volume of attendances and the % of admissions via ED experienced throughout the Winter period has continued into the Spring/Summer period.

- **Cancer Pathways** – Whilst the Trust has experienced increased demand for cancer (red flag) referrals, which has affected performance against the 62-day pathway, the Trust has no patients waiting over 85-days for definitive treatment. The performance in June was below that in May but better than the same period last year.

In respect of the 14-day breast cancer performance the Trust has maintained its increased performance. Additional capacity, to focus on routine waits saw the access time for routine patients decrease to 9-weeks at the end of March 2015. This has been maintained from April to June with additional capacity however increasing demand, which has been felt regionally, is now presenting risk to this position which has increased to 13-weeks for routine waits. Urgent waits are maintained within the 14 day standard.

- **AHP** –The Trusts internal review of AHP has identified a number of areas for improvement, including workforce, performance and professional best practice. The Trust has engaged with staff side and key AHP representatives to discuss terms for a workforce review of skill and band mix to ensure the profile of staffing is consistent with the needs of the service.

Key performance challenges relate to demand and capacity, predominantly in paediatric areas, and performance against access standards continues to reflect longer waits. The Trust sought support from the HSCB to bring ongoing work on a regional capacity and demand exercise to a conclusion and has since met with PHA & HSCB colleagues to progress this work in order to secure an agreement on capacity gaps. It is expected that resolution will be reached by Quarter 3 however it is unlikely that there will be additional funding to address any agreed capacity gap in year from elective funding streams.

In addition, waits beyond the clinically indicated date have occurred for review and treatment in a number of AHP areas. Temporary capacity put in place to address these backlogs ceased at the end of April however, the Trust will continue to re-divert resources into these areas of greatest need where possible.

- **Dementia Service** –The Trust in conjunction with HSCB and SLCG has reviewed this service area in light of the current

performance issues across the pathway. New agreed reporting arrangements have been implemented from the end of January.

The SHSCT has the majority of breaches within the Region, for this target, and is progressing a demand and capacity analysis to define capacity gaps. This work will link into the implementation of the Regional Dementia Strategy. Additional investment has been provided by HSCB and work is ongoing to implement this.

- **Adult Mental Health Care** – Demand and capacity issues are impacting on Adult Mental Health Care. The service has seen an increase in referrals overall and an increase in the volume of urgent cases. In addition there are challenges with capacity associated with staff sickness/absence. Whilst interim plans are in place it is anticipated these plans will not be able to stem the increasing access times. Trust has procured additional capacity for low level referrals which will be implemented in September and should see the position improve.
- **Psychological Therapies** – Due to medical staffing vacancies access times with Psychological Therapies have been affected. The service has attempted to secure temporary staff and additional in-house capacity without success. Whilst permanent recruitment has been successful, with staff commencing, further long-term sick leave has again impacted on capacity. Revisions to the pathway should see the position improve in Q3.

Summary of SMT challenge/discussion

- Review of the reduced performance position at the end of 2014/15 and challenge to continue to deliver the agreed SBA levels in the context of 2015/2016 financial climate.
- Discussion regarding the need for continued re-direction of temporary internal resources to address key areas of emergent clinical risk into 2015/2016.
- 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 continue targeting of senior capacity to support improvement in a number of high risk specialties/services with initial focus in ED/unscheduled care and AHP.
- 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

**August 2015 Report for
July 2015 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
	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

3.0 COMMISSIONING PLAN STANDARDS/TARGETS AND ASSOCIATED PERFORMANCE

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

Comments: Reporting three months in arrears – April update available

Reporting is provided against unplanned admissions for COPD, Diabetes, Heart Failure, Asthma and Stroke as defined in HSCB technical guidance. Achievement of a 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.

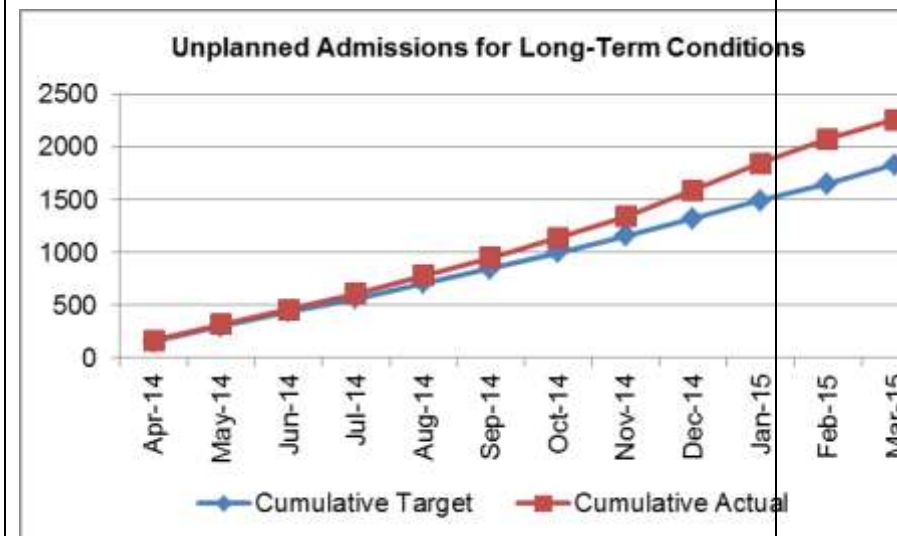
The cumulative position at 31 March 2015 demonstrates a performance of +23.4% against the target of -5%. None of the identified condition areas achieved the -5% reduction at the end of March 2015. Current information indicates that admissions are continuing to increase, therefore a reduction in unplanned admissions, against this target for 2015/2016, will be extremely challenging.

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:

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 managed by the Community Team through self-management plans, good education and awareness;
- Identification and follow-up of Heart Failure and COPD patients who have been admitted to CAH / DHH;
- Focus remains on the Heart Failure and COPD 0 – 2 LOS admissions to see if there is an opportunity for future admission avoidance.
- Established pulmonary rehabilitation plans and maintenance support programmes in place are particularly focused on 'frequent flier' patients who may have had multiple admissions due to COPD/anxiety issues.
- 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.

Further initiatives including development of the Acute Care at Home model & Re-ablement model will continue to support unplanned admissions.

	Monthly Position:												Cum Asses	T r e n d
	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015		
Target Admission s	148	136	125	146	136	157	155	162	175	159	181	N/A		
Total Actual Admission s	155	137	152	173	172	188	200	250	254	233	185	N/A		
Cumulative Target and Actual	T 303 A 320	T 439 A 457	T 564 A 609	T 711 A 782	T 846 A 954	T 1003 A 1142	T 1158 A 1342	T 1321 A 1592	T 1495 A 1846	T 1654 A 2079	T 1835 A 2264	T N/A A N/A	R	↓

Note: T = Target / A = Actual In-Year

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: To be confirmed (April – December 2014 1586 which indicates a 4% increase on the same period 2013)

TDP Assessment: Unlikely to be achieved/affordable

Target: To be confirmed

Comments: Reporting three months in arrears – Not Available

This target will 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) usually managed in primary care.

The Acute Information Team are working through this guidance to develop routine monitoring information.

The drivers for this target are to provide high quality care, only referring patients when it is clinically appropriate to do so. It 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. Achievement of this target will require contribution from primary care, public health and include the provision of high quality social care.

It is of note that information previously reported for indicator of performance area (B36), on the number of emergency admissions for acute conditions, which should not usually require hospital admissions, is similar to this requirement and may form the basis of future monitoring (See Appendix 3).

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		

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.**

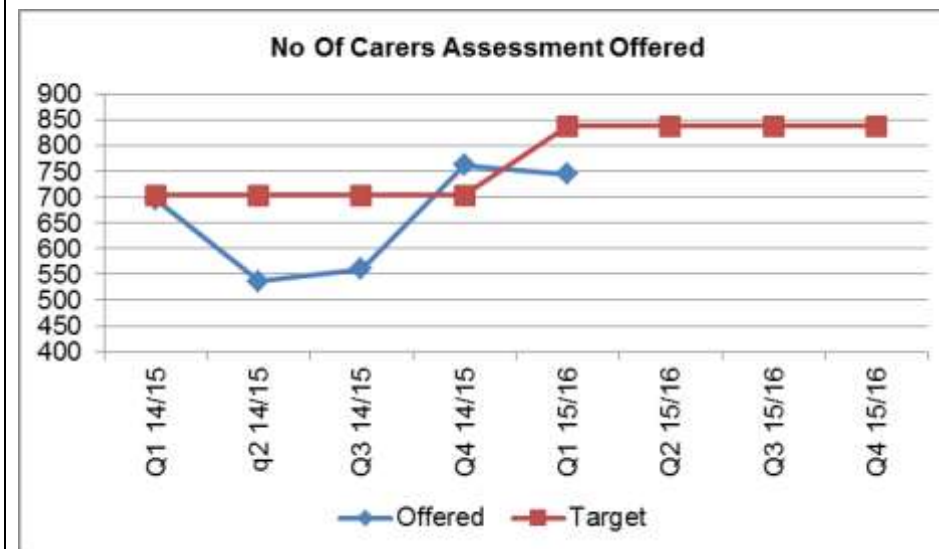
This target is challenging for the Trust. The baseline and target was set based on the volume of carer's assessments undertaken in the Quarter Ending March. In this period additional assessments in Physical and Sensory Disability and in Child and Adolescent Mental Health Services resulted in the the total number of assessments being offered higher than the previous periods. As this position forms the baseline for 2015/2016 this will be challenging. It is also of note that the target for the SHSCT (838) is the highest in the region which ranges from 393 in WHSCT to 795 in NHSCT.

The Trust will, however, continue to work towards a 10% increase in the number of carer's assessments by encouraging active uptake of carer's assessment and holding teams to account for performance. The need to promote the uptake/offer of carer's assessments will be stressed as part of the Standard Operating Procedures.

Regional performance for Quarter 1 is not comparable as targets are set on an individual Trust basis however the trend against individual targets demonstrates a cumulative performance of -2% with no Trust achieving the profiled target for the planned 10% increase in Quarter 1.

Actions to Address:

- The Trust has established a 'Carers Reference Group' at which each Directorate is represented by a 'Champion'.
- The CYPS Directorate has further established a 'Young Carers Group'; and
- Promotion of the uptake/offer of carer's assessments will be stressed as part of the Standard Operating Procedures.



	Quarterly Position:				Cum Assess	Trend
	Quarter 2 (July to September 2014)	Quarter 3 (October to December 2014)	Quarter 4 (January to March 2015)	Quarter 1 (April to June 2015)		

Offered	537	560	762 (+58 above target)	745 (-93 below target)		↓

Comments: July update not available

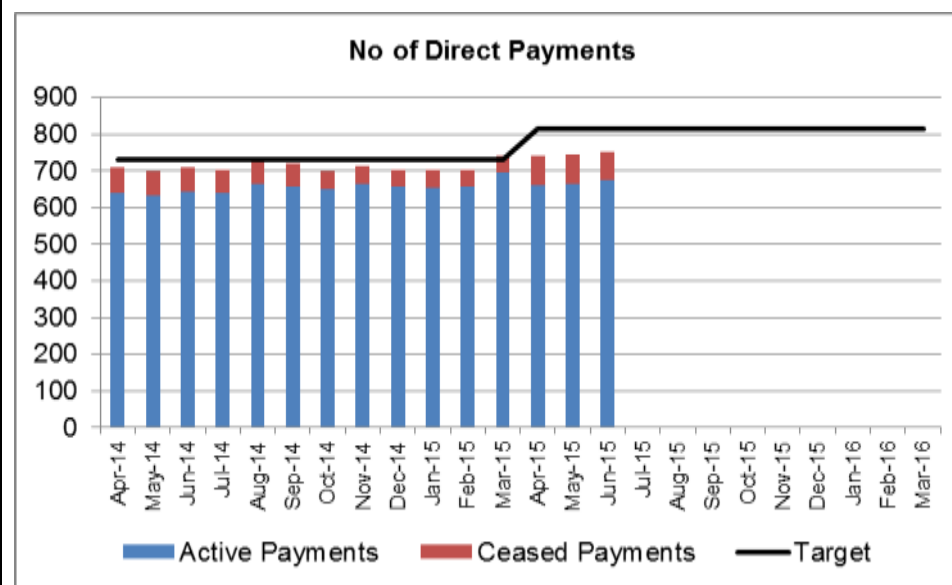
This target is made up of active payments and payments which were previously made and ceased within the quarter. Information is available monthly on the active payments, however is only available at the quarterly point for ceased payments. Therefore the performance can only accurately be measured at each quarter end.

It is of note that the target for the SHSCT (816) is the highest in the region which ranges from 485 in WHSCT Trust to 686 in NHSCT.

Regional performance for Quarter 1 is not comparable as targets are set on an individual Trust basis however the trend against individual targets demonstrates only two Trusts were on track against their profiled target for Quarter 1.

Action

- The Trust will continue to promote Direct Payments and to roll out training to staff on the new guidance;
- The Trust will monitor returns across all programmes and target any programmes with lower uptake; and
- The Trust will also continue with the introduction of Self Directed Support payments.



	Monthly Position:												Cum Assess	Trend
	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015		
Trust Total	726	720	699	713	707	702	704	742	709	712	753	N/A	Y	↔
Trust Ceased (Quarterly Only)	63		48			47			79			N/A		
Trust Active (Monthly)	663	657	651	665	657	655	657	695	662	665	674	N/A		
Breakdown by Programme of Care:														
	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Cum Assess	Trend
Primary Health & Adult Community	0	0	0	0	0	0	0	0	0	0	0	-		
Physical & Sensory Disability	176	174	173	177	174	173	175	216	174	174	178	-		
Mental Health	51	52	50	52	54	53	56	55	57	56	56	-		
Learning Disability	264	267	264	269	265	270	270	267	271	272	273	-		
Elderly	172	164	164	167	164	169	156	157	160	163	167	-		

* Children with disabilities included in the appropriate Learning Disability or Physical & Sensory Disability category

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

Comments:

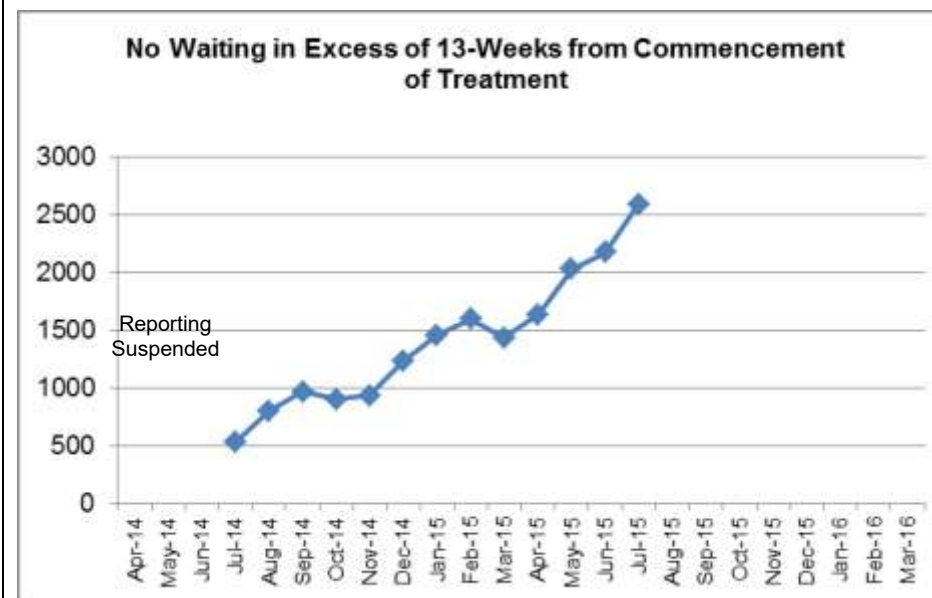
At the end of July the following professions were in excess of the 13-week access standard:

- Dietetics – 30-weeks (106 (4.1%) patients waiting >13 weeks)
- Occupational Therapy (OT) – 32-weeks (275 (10.6%) patients waiting >13 weeks)
- Orthoptics – 24-weeks (2 (0.1%) patients waiting >13-weeks) (2 patients who were late triage have been appointed in August)
- Physiotherapy – 17-weeks (289 (11.1%) patients waiting >13 weeks)
- Podiatry – 27-weeks (1042 (40.2%) patients waiting >13 weeks)
- Speech and Language Therapy (SLT) – 38-weeks (877 patients (33.8%) >13 weeks)

The volume of patients waiting in excess of 13-weeks has increased from 30 June 2015 to 31 July 2015 by +16.1% (+418). This increase has occurred predominantly within Podiatry, with a slight increase in Physiotherapy.

June Regional performance demonstrates a total of 8,741 patients waiting in excess of 13-weeks, excluding BHSCT. Using May proxy figures for BHSCT this would account to 12,924 regionally Volumes range from 276 (SEHSCT) to 4,057 (NHSCT). SHSCT accounts for 17% (2,173) of the proxy regional total of patients waiting in excess of 13-weeks.

Areas of particular note include Paediatric specialist areas, including OT, dietetics and SLT where manpower issues coupled with demand/demography and accrued backlog is particularly affecting access times. Similarly Podiatry services are also challenged by



Note: Data represented in graph is for 6 reported AHP professions

manpower issues and have lost considerable new and review capacity over the last 6-8 months associated with this affecting access times. Reviews and treatments beyond their clinically indicated timescale has become an increasing challenge throughout a range of AHP areas. It is of note however that the wait time for reviews and treatment has been significantly improved over the last 6 months with focused actions plans and the re-direction of non recurrent resources where this is available. The Board and PHA are working with the Trust to agree the available capacity and any recurrent capacity gaps within each of the AHP services. This exercise has been completed for the Western Trust and the Board/PHA have met the Trust on two occasions to further this work locally. It is anticipated the work on planning assumptions which will define the model outputs will be completed in September and the exercise concluded in its entirety within Quarter 3. Actions to Address: • Ongoing focus on urgent waits and planned reviews; arrangements have been established for reporting of these patients monthly to increase visibility and action planning; • On-going flexing of new capacity to ensure appropriate management of reviews and treatments; within Podiatry the number of new appointment slots has been decreased to facilitate the clinically required review appointments, which had been identified as a clinical governance risk; • Actions in place to return Physical and Sensory Disability access time to 13-weeks by end of Q2; • Internal review of AHP on-going with fortnightly Director-led meetings; • The Trust has written to the Chief Executive of HSCB to seek support in bringing the Regional demand and capacity exercise to a conclusion.							
	Monthly Position:			Cum	Trend		

	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2014	Feb 2014	Mar 2014	April 2015	May 2015	Jun 2015	July 2015	Assess	
>9-weeks	1837	1696	1611	1773	2437	2890	2527	2425	-	-	-	-		
>13 weeks	801	968	902	938	1238	1460	1596	1436	1638	2032	2173	2591	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 fractures. (No change in target)

Baseline: 91.5%

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 95%

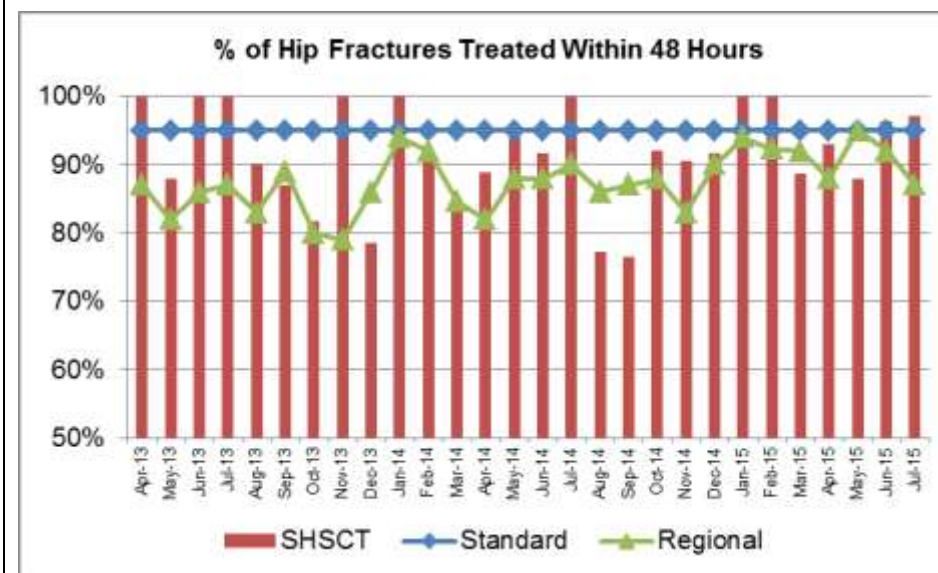
Comments:

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 38 elective orthopaedic operative cases cancelled (excludes previously counted lost slots) from 1 April 2015 to mid-June 2015.

June Regional performance demonstrates an average of 93%, with SHSCT just above this average at 96% and a range of performance from 97% (BHSCT) to 81% (SEHSCT).

Actions to Address:

- The Trust continues with the T&O in-year implementation plan. Consultants 1, 2 and 3 are in post, with the recruitment process on-going for the 4th Consultant. The Trust has secured a Locum Consultant who is providing interim additional consultant capacity within Trauma;
- The Trust continues to work with the HSCB Director of Commissioning 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 working with the Commissioner to respond to a number of on-going queries in relation to this proposed model; 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 and the trauma list for that day.



	Monthly Position:												Cum Assess	Trend
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015		
Trust	78.3% (17 out of 22)	76.5% (13 out of 17)	92% (23 out of 25)	90.5% (19 out of 21)	91.7% (33 out of 36)	100% (30 out of 30)	100% (26 out of 26)	88.6% (23 out of 26)	92.9% (26 out of 28)	88% (22 out of 25)	96.3% (26 out of 27)	97.1% (33 out of 34)	G	↑
Regional	86%	87%	88%	83%	90%	94%	92.3%	92%	88%	95%	92%	87%		

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: No update available for July

There is an agreed capacity gap within this service. Whilst routine waits had extended out to 24-weeks in Quarter 3 2014/2015 the Trust put in place additional capacity through re-directed resources and achieved, a maximum wait of 9-weeks for routine referrals at the end of March 2015.

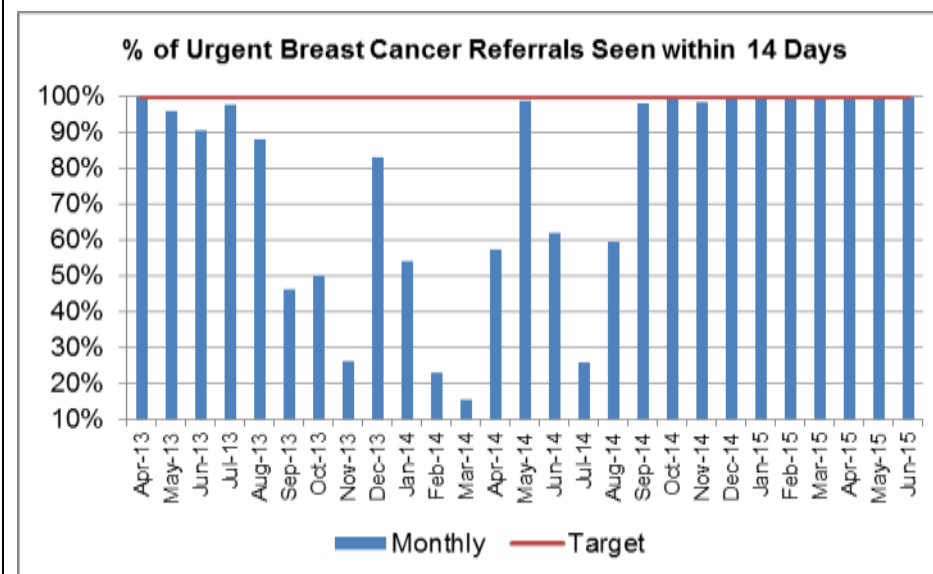
The Trust re-direct resources in April to maintain the level of additional capacity required to ensure routine waits were seen within 9-weeks. Additional capacity has been funded in May, June and July by HSCB. The Trust submitted an investment template proposal and recurrent investment has now been approved by commissioner which will increase capacity in this area recurrently.

Routine demand is 11% higher in the period April – July 15 compared to the same period in 2014. This is impacting on routine access time which increased to 13 weeks in July and, if the same pattern continues, will increase further in September. There is no subsequent increase in confirmed cancers in the same period. This increased demand has been mirrored in other Trust areas.

June Regional performance demonstrates an average of 81% and a range from 27% (BHSCT) to 100% (NHSCT; SHSCT; and WHSCT).

Actions to Address:

- The Chief Executive has written and met with HSCB to seek a way forward in relation to the ongoing management of this specialty;
- The Trust has submitted its IPT, to SLCG, for the recurrent capacity gap within the Symptomatic Breast Clinic and the Breast Family History Clinic. An allocation letter for recurrent funding has been received from HSCB, and
- SLCG has approved the use of non-recurrent slippage funding for use



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to secure additional capacity for routine patients until IPT is resolved.													
Trust will work to implement the additional resources required to establish this increase capacity recurrently.													
Monthly Position:												Cum Assess	Trend
Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2014	Feb 2014	Mar 2014	April 2015	May 2015	Jun 2015	July 2015		
59.5% (115 out of 284)	98% (244 out of 248)	100% (233 out of 233)	98.6% (218 out of 221)	100% (249 out of 249)	99.5% (221 out of 222)	100% (218 out of 218)	99.1% (220 out of 222)	100% (255 out of 255)	99.6% (269 out of 270)	100% (243 out of 243)	N/A	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%

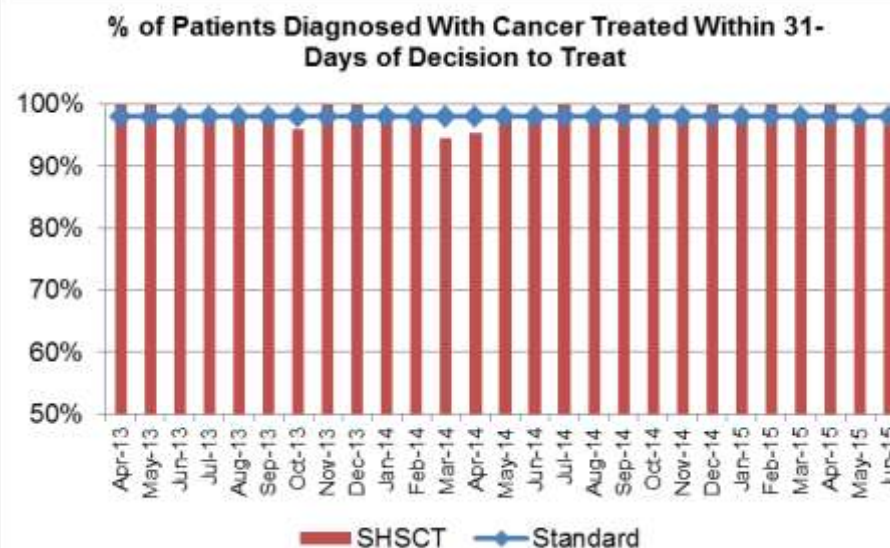
TDP Assessment: Partially achievable/achievable with additional resources

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.

June Regional performance demonstrates an average of 97% and a range of performance from 94% (BHSCT) to 100% (WHSCT).



Monthly Position:												Cum Assess	Trend
Jul 2014	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	June 2015		
100%	99.06%	100%	99.2%	99.08%	100%	99.18%	100%	98.35%	100%	99.05%	99.13%	G	↔

Note: Adjustment to May data

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%

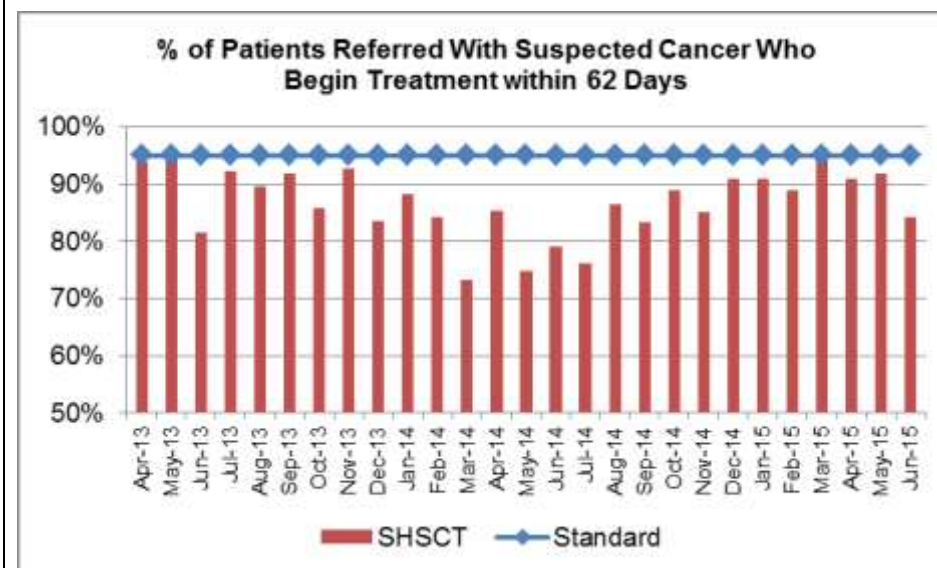
Comments: Reporting two months in arrears.

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 June there were 12 patients in excess of the 62-day standard: 1 Lower GI (Internal); 2 Urology (Internal); 4 Lung (External); 2 Lower GI (External); 1 Upper GI (External), 1 ENT (External) and 1 Urology (External) equating to 84.2% against the target. The July position, subject to validation, is reflecting a similar position at 85%. Both June and July 2015 positions are significantly better than that recorded in June and July 2014 when percentages were in the 70s.

Day-85: There were no breaches of Day 85 target in June and none projected in July.

June Regional performance demonstrates an average of 69% and a range of performance from 58% (BHSCT) to 90% (WHSCT).



Monthly Position:												Cum Assess	Trend
Jul 2014	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	June 2015		
76.23%	86.41%	83.33%	88.89%	85.14%	90.91%	90.99%	88.89%	96.43%	90.91%	91.84%	84.21%	A	↓

Note: Adjustment to May data

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%

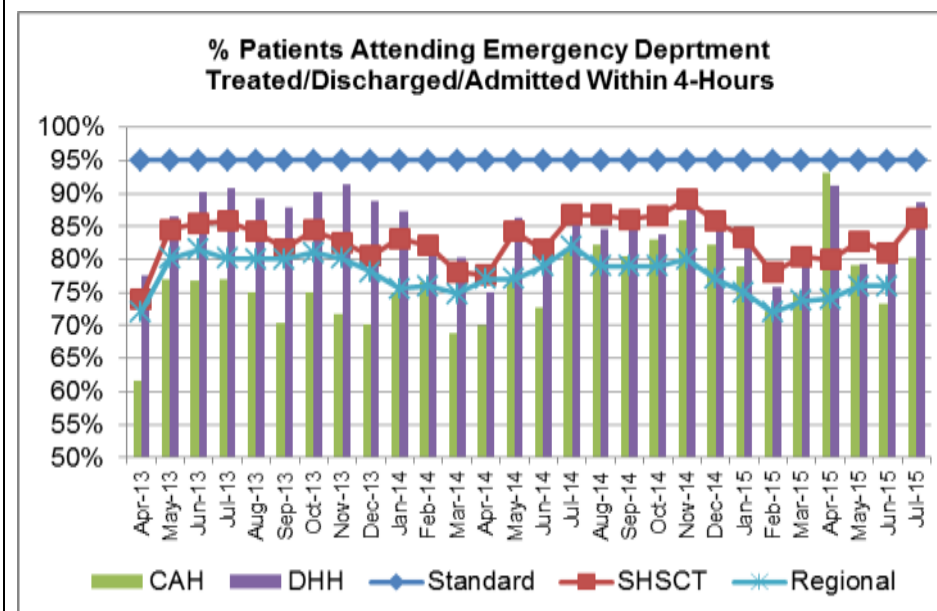
Comments:

Performance continues to be challenging and a range of initiatives have been implemented to improve this position.

June Regional performance demonstrates an average of 78% and range of performance from 68% (NHSCT) to 82% (WHSCT).

Actions to Address:

- Sustained management & clinical focus in and out of hours to maintain focus and support to staff during this prolonged period of Winter pressures;
- Renewed focus on key aspects of the 60-minute plan and other key flow indicators, specifically:
 - o ED triage within 15 minutes;
 - o ED decisions to admit within 2.5 hours;
 - o Availability of ready beds to receive admissions;
 - o Discharge before 1pm – target at least 35%;
 - o Encouraging more use of discharge lounge; and
 - o Patient Centre Flow Action Cards produced and circulated.
- Improvement work focused on throughput in the minor stream, to ensure early assessment, prompt treatment post assessment and escalation to Band 6 clinical sister has been initiated and ED is working to a culture whereby 'no minor patients should breach';
- Daily patient flow processes are in place with the objective of pulling discharges forward and working towards having the hospital settled by 8.00pm. This is to avoid a build-up of admissions in the ED in the evening which impact on the patient experience and cause longer waiting times. Monday - Friday calls continue with Alamac, assessing performance against the 4 hour standard and highlighting areas for further improvement;



- Regional agreement has been reached on the establishment of a set of unscheduled care system measures that will be put in place, facilitated by Alamac. This will commence in mid-August using the Alamac Kit Bag approach with daily and weekly reporting and monthly analysis. This will provide a Regional overarching view of pressures by Trust, which can be viewed by all five Trusts and HSCB. It is anticipated that this will assist in understanding cause and also to assist to know what 'good' looks like, enabling alerts and forecasting; and
- The implementation of the Expeditor Role in CAH ED is now anticipated to be in place in July/August 2015 is to be introduced from 12 midday to 11.00pm, 7-days a week, for a period of 6-months, initially. This is to be progressed through existing resources.

The Trust has developed its Unscheduled Care Plan and focuses as follows:

- Section A
 - o 5 key areas for improved flow – including ED Minor Stream and 7 Day working.
 - o 3 IPTs have now been submitted with a request for preparation of 2 further IPTs received.
- Section B
 - o 16 additional fast turnover beds in CAH (co-owned by ED and Acute Medicine). A provisional plan has been agreed with Estates for the location of 10 new additional beds for Acute Medicine in CAH. The new beds are to be opened adjacent to the MAU with a target of May 2016. As an interim measure 6 new additional beds are to be provided through a modular solution with a target of December 2015;
 - o Implementation of a new Ambulatory Care Area adjacent to CAH ED;
 - o Rollout of Acute Care at Home, with links to the new 16 bedded fast turnover beds;
 - o This plan will have a significant primary care focus and will be linked to the roll out of Acute Care at Home and will also promote the option of direct discussions with the CAH Acute Physician.
 - o IPTs in development in parallel with ongoing discussions with commissioners.
 - o Target is to have some of the above in place before next winter to support patient flows and delivery of 4-hours.

	Monthly Position:												Cum Assess	Trend
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015		
Trust 4-Hour	86.7% (10849 out of 12510)	86.1% (11240 out of 13052)	86.6% (10925 out of 12615)	89.1% (10517 out of 11797)	85.8% (10295 out of 11994)	83.3% (9751 out of 11699)	78% (8983 out of 11520)	80.4% (10691 out of 13304)	79.9% (10427 out of 13043)	82.8% (11026 out of 13324)	81% (11317 out of 13966)	86.3% (11232 out of 13018)	R	↑
Trust 6-Hour	96.4% (12055 out of 12510)	95.7% (12487 out of 13052)	95.5% (12050 out of 12616)	96.7% (11408 out of 11797)	95.7% (11484 out of 11994)	94.1% (11011 out of 11699)	91.9% (10584 out of 11520)	92.9% (10584 out of 11520)	93.2% (12154 out of 13043)	95.5% (12731 out of 13324)	94.07% (13138 out of 13966)	96.4% (12553 out of 13018)		
CAH 4-Hour	82.3% (5004 out of 6078)	80.4% (5168 out of 6430)	83% (5268 out of 6349)	86% (5403 out of 6284)	82.2% (5462 out of 6645)	79% (5032 out of 6371)	72.2% (4408 out of 6103)	74.7% (5241 out of 7027)	74.2% (4850 out of 6533)	79.1% (5376 out of 6794)	73.2% (5194 out of 7092)	80.2% (5289 out of 6593)	R	↑
CAH 6-Hour	95.1% (5778 out of 6078)	93.8% (6029 out of 6430)	93.7% (5947 out of 6349)	95.6% (6005 out of 6284)	94.5% (6281 out of 6645)	92.2% (5876 out of 6371)	89.9% (5486 out of 6103)	92.4% (6491 out of 7027)	91.1% (5951 out of 6533)	94.8% (6442 out of 6794)	90.9% (6447 out of 7092)	94.1% (6206 out of 6593)		
DHH 4-Hour	84.5% (3209 out of 3796)	85.8% (3316 out of 3866)	83.7% (3111 out of 3719)	88.6% (3109 out of 3508)	86% (3174 out of 3689)	83.1% (2984 out of 3593)	75.9% (2658 out of 3500)	79.2% (3183 out of 4020)	77.7% (3236 out of 4167)	79.4% (3393 out of 4272)	82.3% (3499 out of 4249)	88.6% (3740 out of 4222)	R	↑
DHH 6-Hour	95.9% (3641 out of 3796)	95.8% (3702 out of 3866)	95.6% (3555 out of 3719)	96.9% (3398 out of 3508)	96.1% (3544 out of 3689)	94.6% (3400 out of 3593)	90.9% (3181 out of 3500)	93.9% (3775 out of 4020)	92.7% (3862 out of 4167)	94.4% (4033 out of 4273)	95.7% (4066 out of 4249)	98.2% (4144 out of 4222)		
Regional Average	79%	79%	79%	80%	77%	75%	72%	73.7%	74%	76%	76%	No update		

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

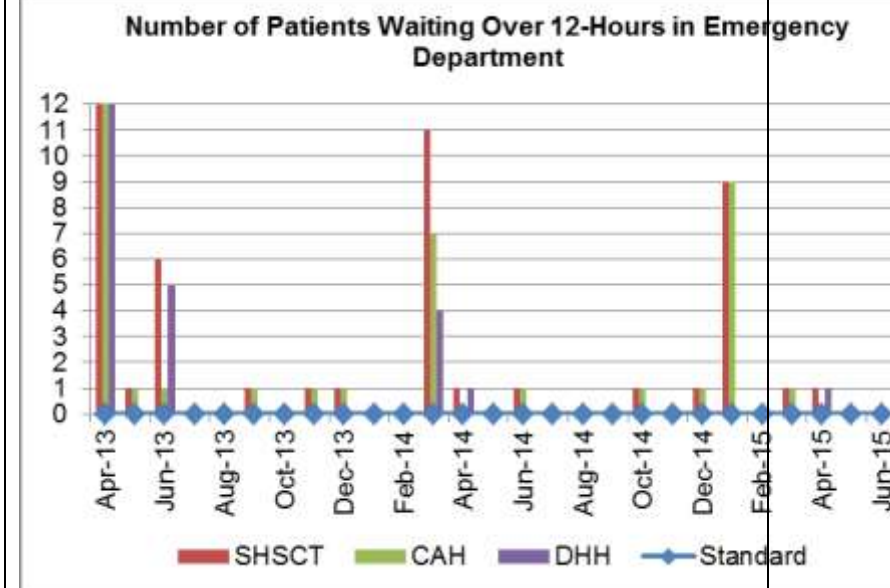
TDP Assessment: Partially achievable/achievable with additional resources

Standard: 0

Comments:

There were no breaches of the 12-hour standard in July.

June Regional performance demonstrates a total of 236 patients in excess of 12-hours ranging from 0 (SHSCT and WHSCT) to 136 (SEHSCT).



Note: The volume of 12-hour breaches in April 2013 was 75.

	Monthly Position:												Cum Asses s	T r e n d
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015		
Trust	0	0	1	0	1	9	0	1	1	0	0	0	G	←
CAH	0	0	1	0	1	9	0	1	0	0	0	0	G	←
DHH	0	0	0	0	0	0	0	0	1	0	0	0	G	←

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**Routine triage (RT)** 90% within 60 minutes**Urgent face to face (UF2F) appointment** 90% within 2-hours**Routine face to face (RF2F) appointment** 90% within 6-hours**Comments:**

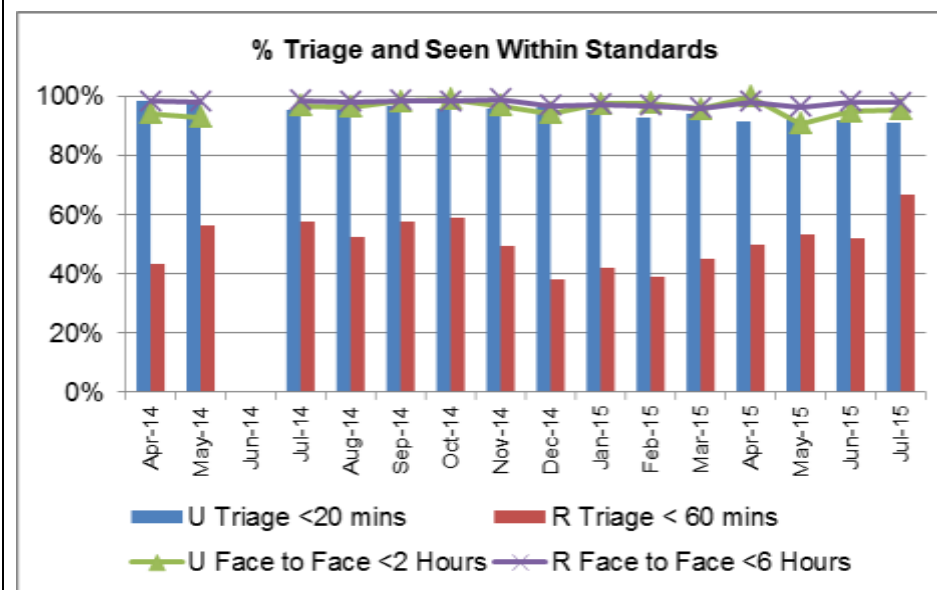
In order to reflect the totality of pressures on the 'unscheduled system' information on GP Out of Hours performance has been included. Whilst this is not a Commissioning Plan Standard or Indicator of Performance its activity / performance can have a direct relationship to ED.

The ability to maintain adequate service provision and standards for triage relate to ongoing challenges presented in filling vacant GP shifts. Efforts to recruit additional GPs and Locum staff have not been successful.

- Triage - The % of urgent patients triaged within 20 minutes has remained fairly static over the last 4 months however there has been a clear increase in % of routine patients triaged within 60 minutes. Whilst this area is still below the target it is improving.
- Face to Face – The % of urgent patients seen within two hours decreased post April, however has seen an increase in July; this position will continue to be monitored. The % of routine patients seen within 6 hours is maintained above the target; waits in excess of the target continue to be monitored.

Actions to Address:

- The Trust has successfully recruited 25 nurses to undertake nurse triage, with 22 now competent to work as Nurse Triage Advisors. 3 nurses are currently being trained and mentored;
- 5 Nurse Practitioners have received training and are working as Nurse Practitioners.
- Performance management is being taken forward for both GPs and nurses;



- 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 October in the first instance whilst evaluation is being finalised.
- A capacity and demand analysis has been undertaken and will be concluded in the next month; and
- Trust is exploring pilot of enabling IT equipment to support Out of Hours processes including remote triage. It is anticipated a pilot of remote triage will be established in Quarter 3.

	Monthly Position:												Cum Assess	Trend
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2014	Feb 2014	Mar 2014	April 2015	May 2015	Jun 2015	July 2015		
UT <20 mins	97.19%	96.7%	96.04%	95.95%	96.21%	95.31%	92.91%	94.27%	91.68%	92.57%	92.18%	91.01%	G	↔
No. >20 mins	35	36	50	64	75	92	127	101	129	126	102	117		↓
RT <60 mins	52.34%	57.67%	58.83%	49.28%	38.36%	41.99%	39.09%	45.29%	49.86%	53.6%	52.08%	66.75%	R	↑
No. >60 mins	2913	2293	2309	3296	4498	3839	3577	3341	3047	3079	2432	1791		↑
UF2F <2 hrs	96.55%	98.34%	99.15%	96.89%	94.36%	97.6%	97.74%	95.79%	100%	90.91%	94.87%	95.55%	G	↑
No. >2 hrs	10	5	3	14	26	10	9	15	0	2	13	13		↔
RF2F <6 hrs	98.20%	98.69%	98.48%	98.97%	96.86%	97.38%	96.98%	96.08%	98.15%	96.41%	98.11%	97.99%	G	↔
No. >6 hrs	43	34	43	34	107	80	78	75	49	109	42	49		↓

Comments: Reporting three months in arrears.

Regional performance data for 2014/2015 is not currently available.

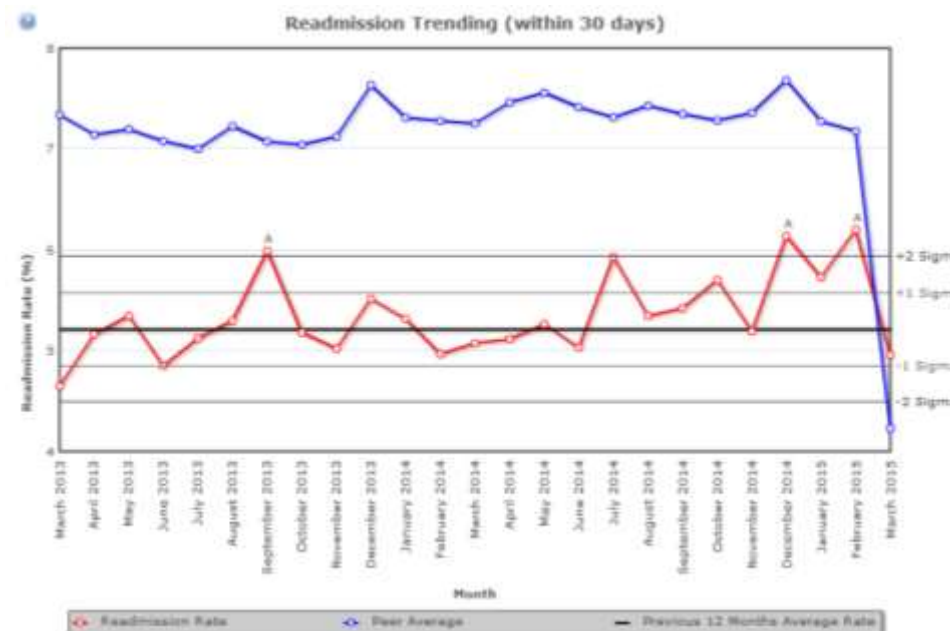
CHKS, the comparative benchmarking system, measures re-admissions against the top hospital peers. Whilst this definition and the comparators are slightly different from those used by HSCB this is a useful guide to performance against our peers and in providing assurance regarding appropriate patient care.

CHKS indicates the Trusts re-admission rate at 5.5% (April 2014 – March 2015) which is performing well, below the Peer average of 6.7%. During 2014/2015 the re-admission rate was above the normal variation for the SHSCT in December 2014 and February 2015. Whilst these periods were still significantly lower than the peer they have been reviewed to identify specialty areas where the pattern is outside that expected. These areas are being reviewed by Associate Medical Directors to identify any patterns and, or emerging themes.

Longer term trending on the chart demonstrates the average % of re-admissions for the SHSCT over the last two years (March 2013 to March 2015) against the mean position for the previous 12-months. This red line shows some variability, however, it is significantly below the peer average which is represented by the blue line.

Actions to Address:

- A detailed analysis of re-admissions, including analysis of the top 10 condition groups, has been undertaken and discussed with clinicians; this analysis will be undertaken every 6 months routinely; and
- Analysis of peaks in re-admissions above the normal variation have been undertaken and will be reviewed to identify any patterns/emerging themes.



	Monthly Position:												Cum Assess	Trend
	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015		
Cumulative	Not Available													
Target	Not Available													
Variance	Not Available													

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

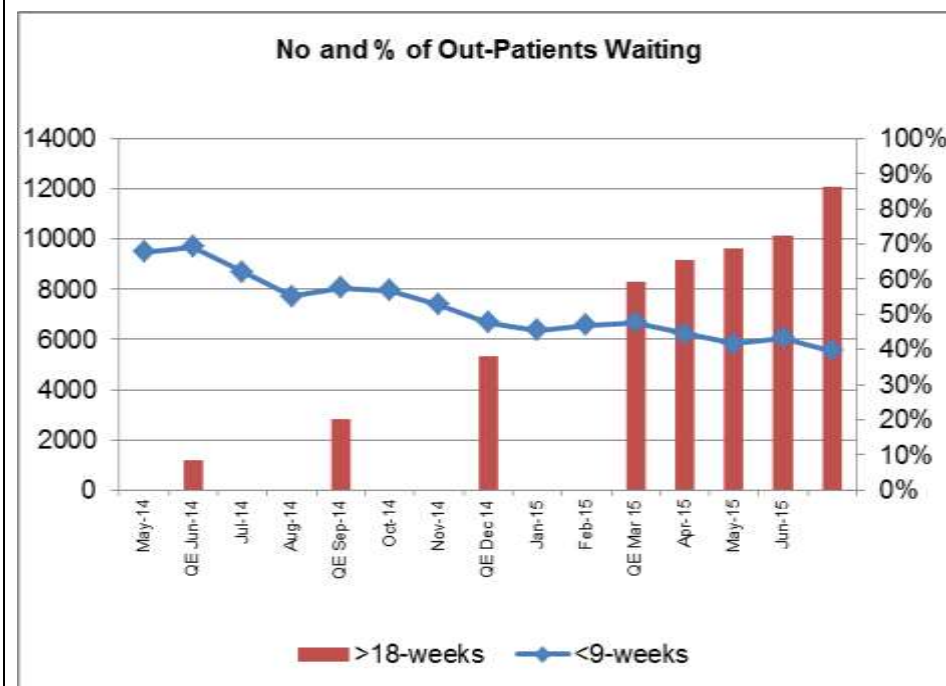
Standard: 60% <9-weeks

0 >18-weeks

Comments:

At the end of July the following specialties were in excess of the maximum backstop of 18-weeks (SBA performance @ 24/7/15):

- Dermatology (inc ICATS) – 226 patients, longest wait 32-weeks; (*SBA underperforming – no capacity gap*)
- Urology (inc ICATS) – 1161 patients, longest wait 56-weeks (*SBA underperforming – minor capacity gap*)
- Ortho-Geriatrics – 47 patients, longest wait 58-weeks; (*SBA under performing – capacity gap*)
- Neurology – 655 patients, longest wait 40-weeks; (*SBA over performing – capacity gap*)
- Orthopaedic (Consultant Led) – 622 patients, longest wait 44-weeks; (*SBA underperforming as a consequence of trauma pressures – previous capacity gap/accrued backlog*)
- Cardiology (Consultant Led and ICATS) – 781 patients, longest wait 35-weeks (*SBA underperforming – capacity gap*)
- Orthopaedic ICATS – 395 patients, longest wait 29-weeks (*SBA underperforming – previous capacity gap/accrued backlog*)
- ENT (Consultant Led) – 1996 patients, waiting 37-weeks; (*SBA under performing – residual capacity gap*)
- General Surgery – 612 patients, longest wait 26-weeks; (*SBA under performing – residual capacity gap*)
- Pain Management – 300 patients, longest wait 29-weeks; (*SBA under performing – capacity gap*)
- Endo-Diabetes – 303 patients, longest wait 48-weeks; (*SBA over performing – capacity gap*)
- Respiratory – 283 patients, longest wait 30-weeks; (*SBA underperforming – capacity gap*)
- Rheumatology - 603 patients, longest wait 50-weeks; (*SBA underperforming – previous capacity gap/accrued backlog*)



- Gynaecology – 427 patients, longest wait 27-weeks; (*SBA under performing – previous capacity gap/accrued backlog*)
- Gastroenterology (including General Medicine) – 470 patients, longest wait 38-weeks; (*SBA underperforming – emergent capacity gap*)
- Haematology – 28 patients, longest wait 24-weeks; (*SBA over performing – emergent capacity gap*)
- Paediatrics – 34 patients, longest wait 23-weeks; (*SBA underperforming*)

Access times have been impacted by the decreased level of non-recurrent funding available in 2014/2015 for in-house additionality and independent sector. No non-recurrent funding allocations have been received for Out-Patients in Quarter 1/2 2015/2016. 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. A number of specialty areas are currently underperforming against SBA, which is an established normal variation at this time of year; plans are in place to recover this position by end of September.

When capacity is limited it is important that robust booking and chronological management practices are in place. An audit was undertaken by HSCB to review the Trust's current chronological management practices within out-patients. This report whilst generally positive identified a number of areas for improvement in paediatrics and geriatric medicine.

Discussions are on-going with the Commissioner in respect of the future management of Ophthalmology. In the meantime SHSCT will still report on the two visiting specialties of Ophthalmology and Paediatric Cardiology for completeness.

Two external (visiting specialties) in excess of 18 weeks:

- Ophthalmology – 3,390 patients, longest wait 70-weeks; and
- Paediatric Cardiology – 105 patients, longest wait 59-weeks.

A summary of actual access times for July 2015 is attached in Appendix 2.

June Regional performance demonstrates an average of 39% waiting less than 9-weeks. The volume of patients waiting in excess of 18-weeks at 30 June 2015 is 86,127 ranging from 39,958 (BHSCT) to 7,891 (WHSCT). The

SHSCT equates to 11.7% (10,148) of the total volume.

Actions to Address:

- Focus remains on the delivery of core SBA activity with the bi-weekly Director level performance meetings undertaken with the Acute Services Directorate. 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 at end of May;
- Head of Service level performance meetings are held with Paediatrics fortnightly to review both Acute and Community performance. Agreed SBAs are reviewed at these meetings, with remaining SBAs under review; and
- Acute, OPPC and CYP Directorates to implement recommendations from the HSCB audit of outpatient management.

	Monthly Position:												Cum Assess	Trend
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015		
<9-weeks	55.1% (13461)	57.5% (14090)	56.8% (14521)	52.8% (13625)	47.7% (12692)	45.5% (12504)	46.9% (13327)	47.6% (14477)	44.5% (13839)	41.6% (13320)	43.2% (14168)	39.7% (13405)	R	↓
>15-weeks	17.3% (4236)	18.7% (4578)	21.4% (5473)	24.7% (6378)	28% (7477)	32% (8731)	34% (9527)	36% (10847)	-	-	-	-	R	
>18-weeks	QE Sep 14 11.6% (2837)		QE Dec 14 20.7% (5334)			QE Mar 15 29.2% (8309)			29.5% (9173)	30% (9616)	30.9% (10148)	35.7% (12057)	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:

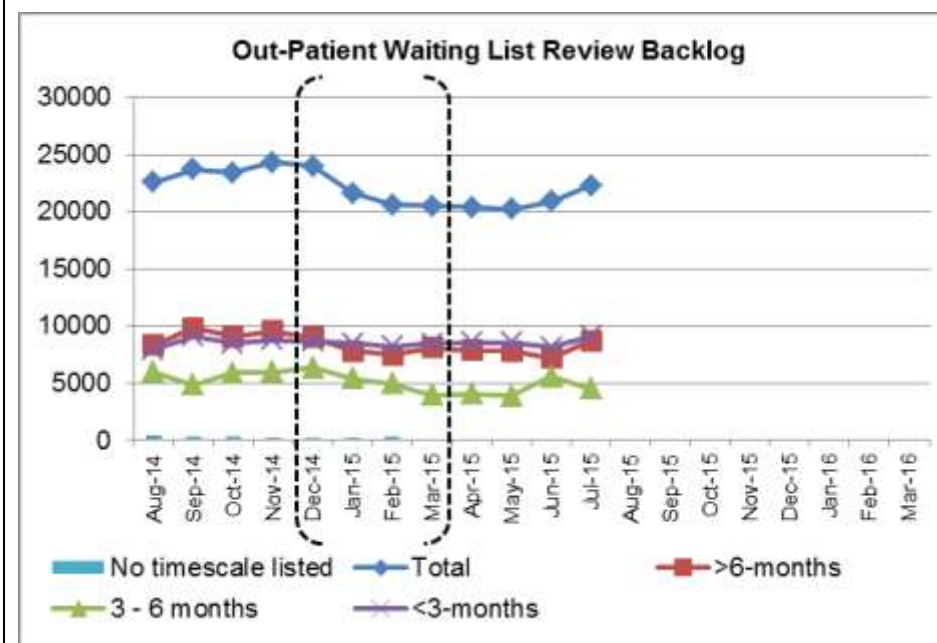
Of the 22,294 patients waiting for review appointments beyond their clinically indicated date at 3 August 2015:

- 39% (8680) of these are waiting in excess of 6-months;
- 20% (4514) of these are waiting between 3 – 6 months; and
- 41% (9096) waiting less than 3-months.

Focus on the longest waiters, with validation and additional capacity created via internal redirection of resources, saw the cohort of patients waiting over 6-months decrease by over 1500 from December to February as per the red line on the chart. The total waiters however are beginning to increase again.

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;
- Additional capacity for review patients was resourced internally by the Trust from December 2014 to March 2015 to reduce the volume of patients and longest waits;
- The Trust has continued to provide resource in April and May 2015 for a small number of specialities with longest waits; and
- In April; May and 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 and sought their response on a way forward. A response has been received from HSCB acknowledging the importance of validating the OP review waiting list and encouraging continued good practice within the Trust on this, however, acknowledged that they had currently no additional resources available to support this.



Note: () Period of validation programme and additional capacity

HSCB have, however, indicated that should additional monies become available they would be happy to consider this.														
• The Trust will continue to re-direct internal resources to this area as it becomes available.														
	Monthly Position:												Cum Assess	Trend
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015		
Total	22552	23715	23431	24286	23970	21645	20608	20521	20391	20223	20874	22294		↓
>6-months	8284	9811	9028	9563	8970	7798	7455	8074	7839	7786	7189	8680		
3 – 6 months	5970	4823	5919	5944	6325	5384	4958	3903	4035	3886	5562	4514		
<3-months	7931	9081	8484	8779	8675	8463	8195	8464	8517	8551	8123	9096		
No date listed	367	259	272	238	240	231	258	86	58	53	6	4		

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

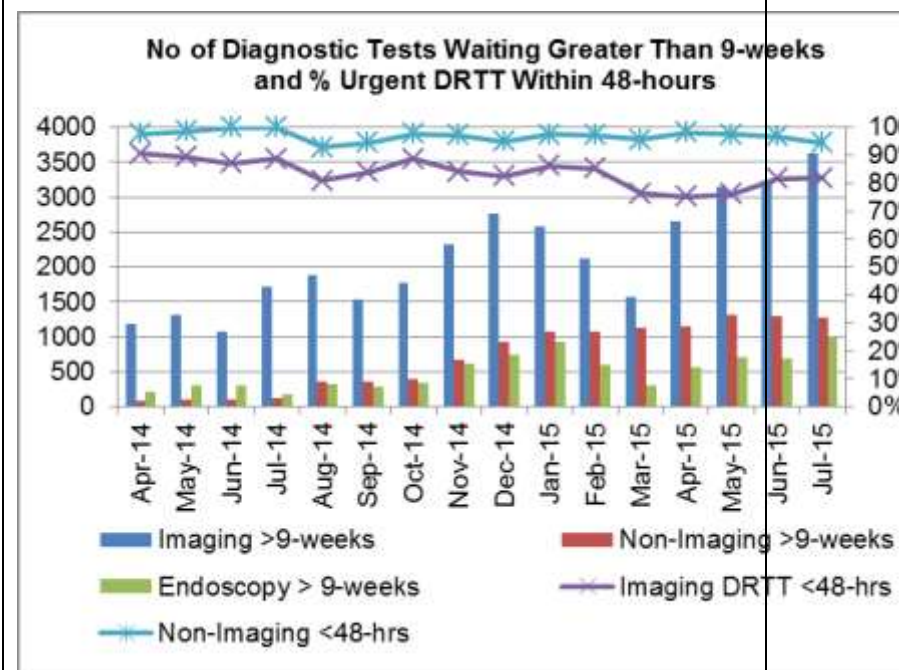
Comments:

- **Imaging** – 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. HSCB has confirmed additional non-recurrent funding for additional capacity for MRI, CT, non-obstetric ultrasound and plain film reporting in Quarter 1/2 2015/2016.

Additional capacity will not be sufficient to see the achievement of 9-weeks by September 2015 in all areas. The Trust has confirmed to HSCB the estimated access time achievable with the level of resource allocated and identified additional capacity levels that can be undertaken should funding become available. Estimated access time at end of September, for modalities where additionality has been funded, are as follows;

- o CT: General 18-weeks, CT Colongraphy 9-weeks.
 Achievement of this position, particularly for CTC, is reliant upon the delivery of additional capacity in the Independent Sector. Current waits for CTC are at 53 weeks)
- o MRI: 15-weeks
- o Non-Obstetric Ultrasound: 17-weeks

No allocation for additionality has been made in relation to DEXA scanning for which a small capacity gap exists. Without additional capacity it is estimated that DEXA will be 21-weeks by end of September 2015. The Trust has made a proposal to HSCB to seek some additional capacity to



be directed to this area and awaits a formal position on this.

Actions to Address:

- o The Trust continues to utilise the (2nd) MRI scanner on the CAH site which became operational wc: 22 June 2015; the contract for the leased MRI scanner has been ended;
 - o Trust has confirmed the allocation of funding and additional activity it can undertake in Quarter 1/2 to HSCB and additional work has commenced;
 - o HSCB have provided additional non-recurrent funding, over and above the original Quarter 1/2 allocation, for CTC. No further in-house capacity is available for this activity and therefore, the Trust has issued a mini-competitive tender to the Independent Sector to secure the required additional capacity, and
 - o The Trust is developing an investment proposal for additional CT capacity and is in liaison with HSCB regarding options for an interim mobile solution in 2015/2016 funded non-recurrently.
- **Non-Imaging** – At the end of July 1,287 patients were waiting in excess of 9-weeks; 109 waiting for urodynamics; 35 waiting for Sleep Studies with the majority, 1143, waiting for cardiac investigations.

Within Cardiac Investigations it is Echocardiogram examinations, both general (TTE) and Stress (DSE) that are in excess of the 9-week access standard. Whilst the volumes in excess of 9-weeks are increasing, associated with a general demand for cardiology input, it should be noted that whilst SBA is minimally underperforming at 31 May 2015 (-3%, -47 patients) it overperformed at 31 March 2015 by +5.26% (+440 patients).

The HSCB has recognised the capacity gap in cardiac investigations and made an allocation of additional capacity for echocardiogram and ambulatory monitoring in Quarter 1/2 2015/2016. Whilst a level of in-house additional capacity has been secured the Trust is unable to secure the total additional capacity offered due to the inability to make temporary appointments to this area. An IPT is in developed for the identify capacity gap in this area.

Actions to Address:

- o The Trust has highlighted increased demand related to cardiac investigations to the Commissioner; the commissioner has agreed a capacity gap exists in this service - o An IPT has been submitted; formal response awaited from HSCB. - o Directorate to consider preparatory work to initiate recruitment • 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 posts a residual capacity gap exists. HSCB has made an allocation of additional capacity for Quarter 1/2 2015/2016, however, this is insufficient to achieve 9-weeks. Further non-recurrent funding has been received for endoscopy, however, with no further in-house additionality available an independent sector solution is required. If the IS capacity is secured, and all appropriate patients transferred, a potential access time of 18-weeks could be achieved by 30 September 2015. If this additional capacity is not secured then the estimated access time is 36-weeks. Two mini-competitive tenders have been issued to the Independent sector to secure the additional capacity required. One has been awarded; the second should be award w/c 18 August. Any delay in award of contract or transfer of patients will result in inability to achieve the projected access times in September. Actions to Address: - o The Trust is implementing the agreed investment for endoscopy; - o The Trust has secured capacity in-house to provide additional HSCB funding capacity; June Regional performance demonstrates a total of 22,821 patients in excess of 9-weeks ranging from 9,120 (BHSCT) to 114 (WHSCT). The SHSCT equates to 19.8% (4,535) of the total volume. A summary of <u>actual</u> access times for July is attached in Appendix 2.	

	Monthly Position:												Cum Asses s	T r e n d
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015		
Imaging >9-weeks	1876	1535	1769	2326	2772	2583	2130	1566	2660	3155	3233	3628	R	↓
Non- Imaging >9-weeks	359	366	396	672	925	1079	1084	1123	1156	1311	1302	1287	R	↑
Endoscopy >9-weeks	321	285	348	623	752	933	594	302	567	709	686	991	R	↓
Imaging DRTT Urgents <48-hrs	80.9% (2249 out of 2779)	83.9% (2608 out of 3108)	88.8% (2701 out of 3042)	84% (2417 out of 2877)	82.5% (2412 out of 2924)	86.1% (2792 out of 3242)	85.2% (2546 out of 2988)	76.3% (2638 out of 3457)	75.1% (2447 out of 3258)	76% (2455 out of 3230)	81.6% (2665 out of 3262)	81.7% (2498 out of 3058)	R	←
Non- Imaging DRTT Urgents <48-hrs	92.9% (130 out of 140)	94.4% (151 out of 160)	97.6% (202 out of 207)	97.1% (136 out of 140)	94.9% (168 out of 177)	97.4% (189 out of 194)	97.1% (136 out of 140)	95.6% (175 out of 183)	98.1% (158 out of 161)	97.4% (187 out of 192)	96.8% (183 out of 189)	94.4% (169 out of 179)	Y	↓

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-

Baseline: 68.5% <13-weeks and 1162 >26-weeks
TDP Assessment: Partially achievable/achievable with additional resources

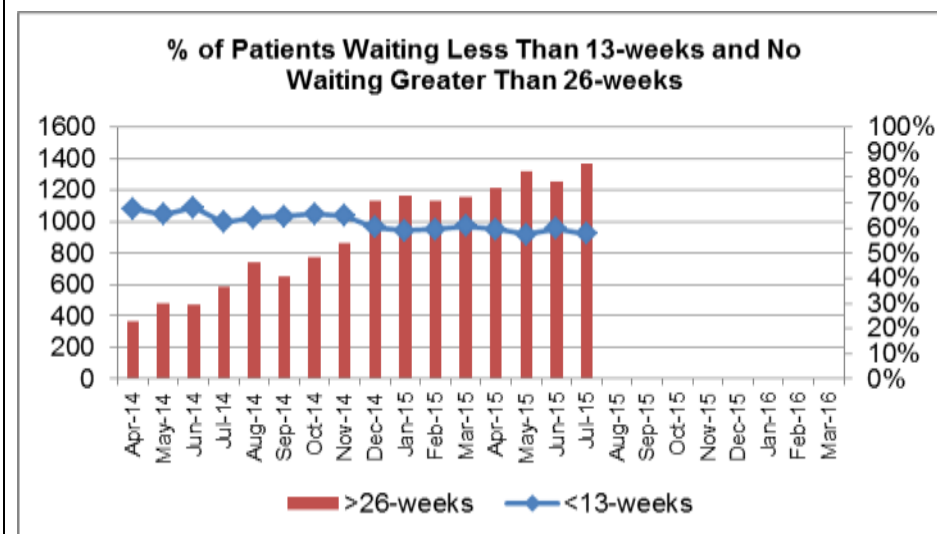
Standard: 65% <13-weeks
 0 >26-weeks

Comments:

In respect of patients waiting in excess of 13-weeks there is a total of 3542 patients at end July. At the end of July the following specialties were in excess of the maximum 26-week backstop (SBA performance @ 24/7/15):

- General Surgery – 336 patients – longest wait 66-weeks; (*SBA underperforming – previous capacity gap/accrued backlog*)
- Breast Surgery – 5 patients – longest wait 38-weeks; (*SBA underperforming – emergent capacity gap*)
- Gynaecology – 22 patients – longest wait 35-weeks; (*SBA underperforming – previous capacity gap/accrued backlog*)
- Pain – 349 patients – longest wait 56-weeks; (*SBA underperforming – capacity gap*)
- Urology – 290 patients – longest wait 102-weeks; (*SBA underperforming – no capacity gap*)
- Orthopaedics – 385 patients – longest wait 75-weeks. (*SBA underperforming, due to impact of Trauma pressures – previous capacity gap/accrued backlog*)
- Cardiology – 49 patients – longest wait 37-weeks (*SBA over performing – capacity gap*)

Access times have been impacted by the decreased level of non-recurrent funding available in 2014/2015 for in-house additionality and independent sector. No non-recurrent funding allocations have been received for In-Patients/Day Cases in Quarter 1/2 2015/2016. 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 this position by end of September.

HSCB has made arrangements for patients waiting for treatment in the Independent Sector, previously paused, to continue their treatment in Quarter 1 2015/2016.

June Regional performance demonstrates an average of 52% of patients waiting less than 13-weeks, ranging from 40% (BHSCT) to 75% (NHSCT). There are a total of 29,028 patients waiting in excess of 26-weeks ranging from 15,983 (BHSCT) to 1,613 (NHSCT). The SHSCT equates to 11% (3,221) of the total volume.

A summary of actual access times for July is attached in Appendix 2.

Actions to Address:

- Focus remains on the delivery of core SBA activity with the bi-weekly Director level performance meetings undertaken with the Acute Services Directorate. 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 at end of May;
- Discussions have commenced to develop a project plan to review chronological management practices within the Acute Services Division. This project will review current chronological management practices and will also identify underlying issues ie. Consultant practice; administrative errors; short notice booking etc. An action plan will then be developed to implement necessary changes to improve the chronological management, where required, and
- Internal focus continues on the need to balance the access time for urgent and routine waits within the agreed acceptable levels in each specialty area.

	Monthly Position:	Cum	Trend

	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015	Assess	
<13- weeks	63.9% (3858)	64.6% (3977)	65.5% (4155)	64.7% (4132)	60.1% (3904)	58.9% (3829)	59.4% (3872)	60.8% (3867)	59.4% (3839)	57.5% (3835)	59.8% (4061)	57.7% (3920)	R	↓
>26- weeks	12.3% (742)	10.6% (653)	12.2% (776)	9% (864)	17.4% (1130)	17.9% (1167)	17.3% (1128)	18.2% (1159)	18.8% (1213)	19.7% (1316)	18.5% (1255)	20.1% (1366)	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. April update not available. Note reporting will continue on 12% until the end of March 2015 data is produced. Reporting against 13% will commence in Quarter 2, 2015/2016.

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.

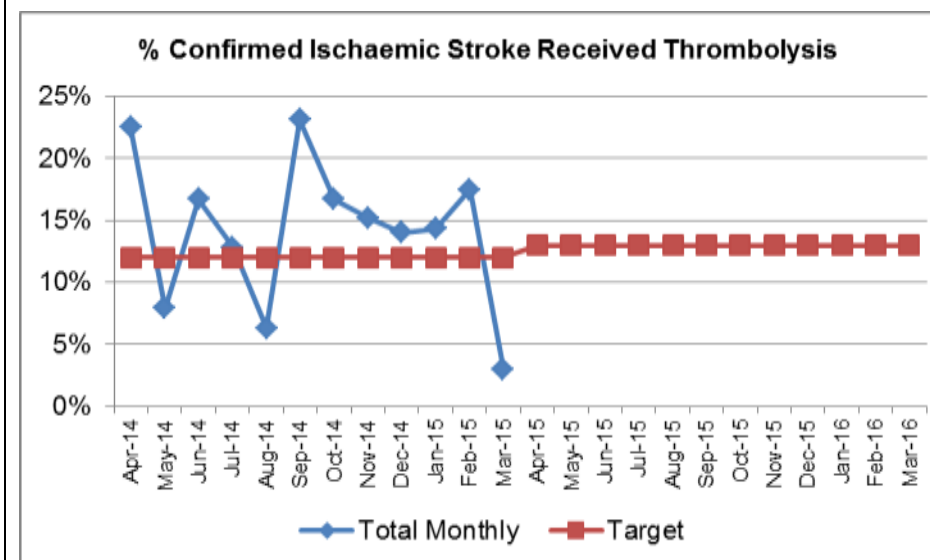
Performance at 31 March 2015 demonstrates a cumulative performance of 14.1%, which is above the target of 12%.

Monthly performance against this target is impacted by the variable presentation of strokes, which is affected both seasonally and geographically. It should be noted that as strokes vary in type they will vary in time presentation and whilst no patient has been missed, clinical decisions will determine whether the drug is to be delivered considering the risks and benefits. Reviewing the performance data on an annual basis will demonstrate the performance taking into consideration the seasonal differences and atypical presentations.

Regional performance data for 2014/2015 is not currently available due to the 3-month period allowed for clinical coding.

Actions to Address:

- A multi-disciplinary group has been established across



Note:

- 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 on 13% will commence in Quarter 2

- 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.

	Monthly Position:												Cum Assess	Trend
	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015		
Trust	7.9 %	16.7 %	12.8 %	6.3%	23.1 %	16.7 %	15.2%	14.0%	14.3 %	17.5%	3%	N/A	G	↔
Trust Admissions	A 38 T 3	A 30 T 5	A 39 T 5	A 32 T 2	A 26 T 6	A 30 T 5	A 33 T 5	A 50 T 7	A 42 T 6	A 40 T 7	A 33 T 1	N/A		
Trust Cumulative	-	-	-	-	-	-	-	-	-	-	14.1 %	-		
CAH	3.6 %	12.5 %	4.3%	11.8 %	10.5 %	9.5%	13%	8.6 %	20.7 %	15.4%	3.7%	N/A	Y	↑
CAH Admissions	A 28 T 1	A 24 T 3	A 23 T 1	A 17 T 2	A 19 T 2	A 21 T 2	A 23 T 3	A 35 T 3	A 29 T 6	A 26 T 4	A 27 T 1	N/A		
CAH Cumulative	-	-	-	-	-	-	-	-	-	-	10.6 %	-		
DHH	20%	33.3 %	25%	0%	57.1 %	33.3 %	20%	26.7%	0.0%	21.4%	0%	N/A	G	↓
DHH Admissions	A 10 T 2	A 6 T 2	A 16 T 4	A 15 T 0	A 7 T 4	A 9 T 3	A 10 T 2	A 15 T 4	A 13 T 0	A 14 T 3	A 6 T 0	N/A		
DHH Cumulative	-	-	-	-	-	-	-	-	-	-	22.1 %	-		

Note: Stroke: A = Stroke Admissions / T = Patients Who Had Thrombolysis Administration

Note: Adjustment to January 2015 data

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:**

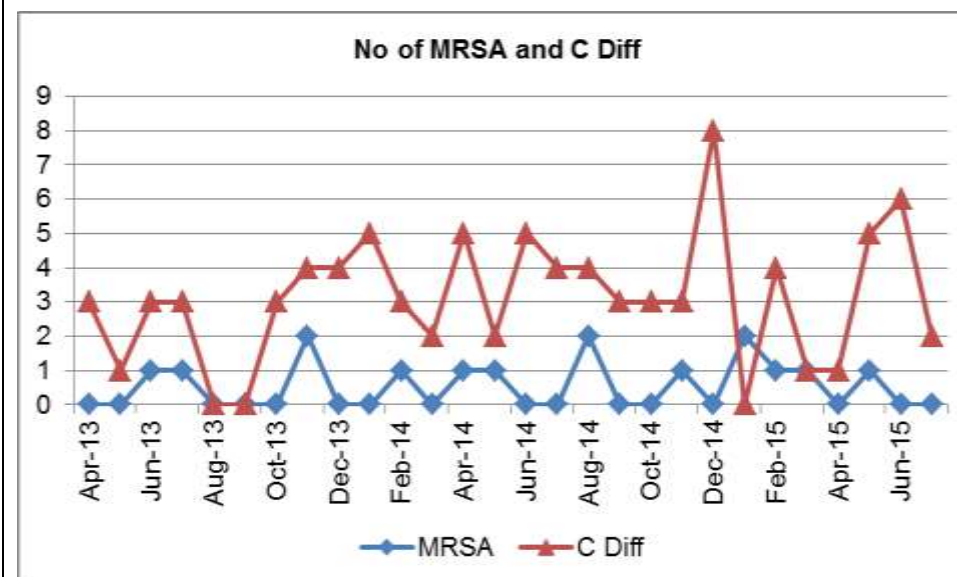
- **MRSA:** June performance varied across the Region from 9 (BHSCT) to 1 (SEHSCT and SHSCT) with a Regional total of 20.
- **C Diff:** June performance varied across the Region from 37 (BHSCT) to 10 (WHSCT) with a Regional total of 101.

Within the Trust the cumulative number of cases of C Diff reported is slightly above the profiled level that would be expected at this point in the year should the target be maintained, however it is of note that there was a decrease in cases reported the month of July. Regionally only one Trust is on profile to achieve this target at this point in the year.

Actions to Address:

In order to ensure a continuous reduction of C Difficile and MRSA bacteraemia cases that are considered preventable, the Trust has taken the following actions:

- Implementation of a revised Root Cause Analysis [RCA] process for HCAs which focuses on greater clinical accountability and shared learning;
- Creation of a CDI database allowing for information from RCAs to be placed in the database in a timely fashion. This also facilitates extracting information in relation to CDI in a timely fashion;
- IPCT have created a CDI sub-Group who will focus on RCAs on a monthly basis and aim to identify any trends in relation to CDI;
- Maintaining a continuous focus on antibiotic stewardship including the appointment of a part time Speciality Grade doctor to support antibiotic



ward rounds;

- Data collection from antibiotic ward rounds has increased across the Trust and this is being fed back to clinical teams as appropriate;
- A Trust antimicrobial management team is well established to oversee the stewardship programme;
- IPCT are aiming to deliver on a multidisciplinary ward round for patients diagnosed with CDI. This will be initiated in the near future;
- A daily review meeting between IPC and acute bed management staff has been initiated to review appropriate use of isolation facilities for potentially infectious cases within the Trust;
- Monitoring the commencement of treatment for C. Difficile patients and their daily assessment by the multidisciplinary team; and
- Decontamination colleagues bedpan washers now undergo a rigorous form of regular testing and validation giving assurances that they are functioning as expected or if not inadequacies are addressed in a timely way.

The Trust has also put in place requirements to maintain a continued focus on monitoring and auditing of adherence to good infection prevention and control standards including:

- Regular Hand Hygiene and environmental self-audits in clinical areas;
- The appointment of two independent auditors to perform independent audit of hand hygiene, commode cleanliness, IV trolley and sluice cleanliness;
- The IPC Team continue to provide training and education programmes for all staff involved in patient care in the acute and non-acute sector, clinical and non-clinical. Adherence to attendance is monitored by the ward sister; and
- Introduction of Aseptic Non-Touch Technique (ANTT) training program initially into all augmented care areas. Compliance and progress is presently monitored by self-audit in augmented care areas.

The Trust has also appointed 3 Public and Patient representatives as members of the HCAI Strategic Forum.

	Monthly Position:												Cum Assess	Trend
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015		
MRSA Actual	2	0	0	1	0	2	1	1	0	1	0	0		↑
MRSA Cum	9 (cumulative for 2014/2015)								0	1	1	1	G	
C Diff Actual	4	3	2	3	8	0	4	1	1	5	6	2		↑
C Diff Cum	41 (cumulative for 2014/2015)								1	6	12	14	A	

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**

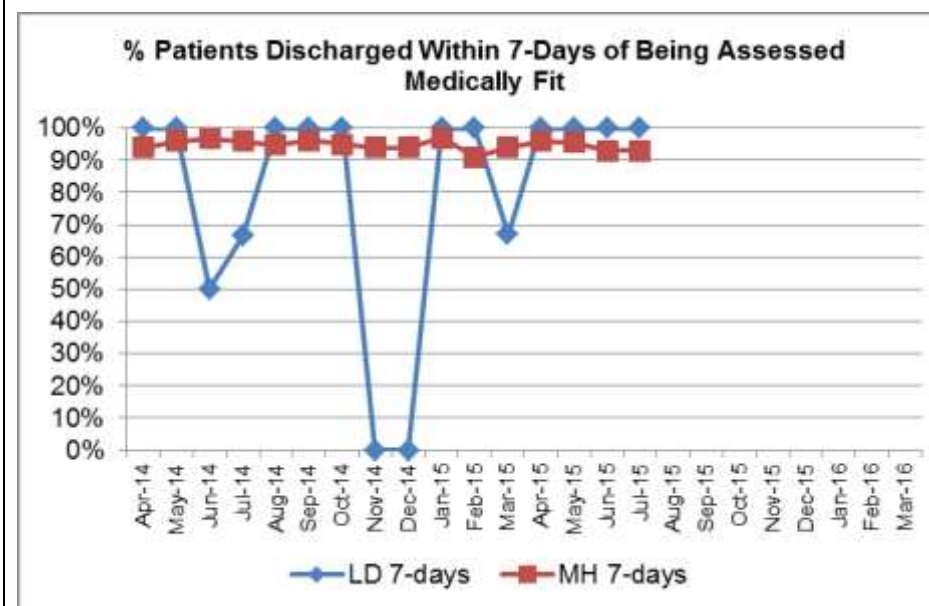
The relatively low level of patients in this cohort presents challenge in maintaining a 99% target, however in the four months of this financial year this has been achieved.

Regional performance in June demonstrates an average of 89% with performance ranging from 50% (SEHSCT) to 100% (BHSCT; SHSCT; and WHSCT). In June there was only 1 patient discharged in excess of 28-days (SEHSCT).

Mental Health

Discharge performance has been fairly static over the Summer period, however the 99% target remains challenging. Cumulatively year to date the Trust has achieved 94.5%. 8 patients in total have waited more than 28 days for discharge.

June Regional performance demonstrates an average of 96% with performance ranging from 94% (SHSCT) to 100% (NHSCT). The volume of patients discharged in excess of 28-days varied across the Region from 6 (WHSCT) to 0 (NHSCT) with a Regional total of 11.



	Monthly Position:												Cum Assess	Trend
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015		
LD 7-days	100% (2 out of 2)	100% (1 out of 1)	100% (0 out of 0)	0% (0 out of 2)	0% (0 out of 1)	100% (3 out of 3)	100% (1 out of 1)	67% (2 out of 3)	100% (2 out of 2)	100% (2 out of 2)	100% (5 out of 5)	100% (1 out of 1)	G	↑
LD >28-days	0	0	0	1	1	0	0	1	0 Cum: 0	0 Cum: 0	0 Cum: 0	0 Cum: 0	G	↔
MH 7-days	94.8% (111 out of 117)	96.2% (126 out of 131)	95% (95 out of 100)	94% (120 out of 127)	94% (94 out of 100)	97% (108 out of 111)	91% (80 out of 88)	94% (90 out of 96)	96% (98 out of 102)	95.6% (88 out of 92)	93% (115 out of 123)	93% (80 out of 86)	Y	↔
MH >28-days	1	2	1	1	3	2	3	1	0 Cum: 0	2 Cum: 2	3 Cum: 5	3 Cum: 8	A	↔

Comments:**Delayed Discharge Coding**

Performance against the delayed discharge standard is based on the discharged that have been coded and not the totality of the discharges. CAH demonstrates a higher level of coded activity versus DHH. Efforts to increase the level of coding has seen continued improvement in DHH, from an initial low base, but a slight reduction in performance at CAH the level of delayed discharges coded were as follows:

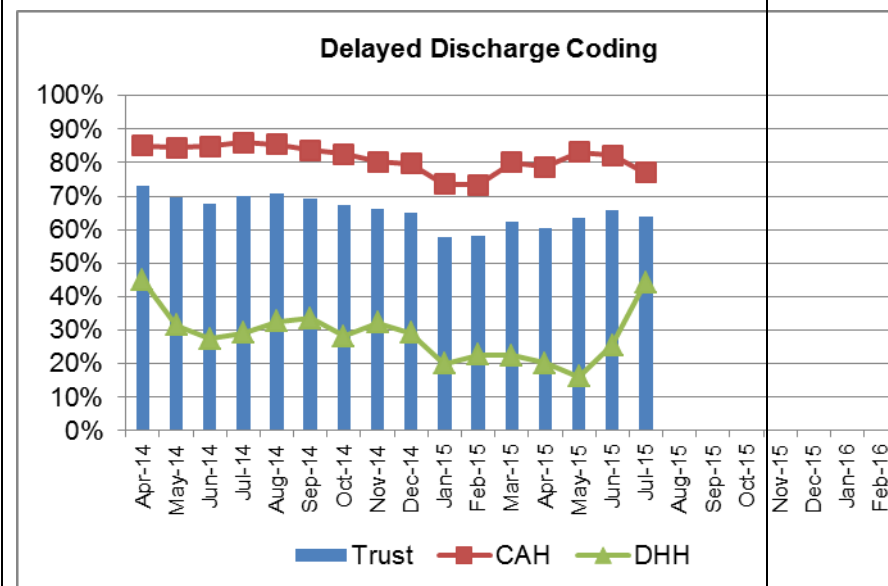
- CAH 76.94% (1755 out of 2281) – decreased performance compared to 82.21% in June;
- DHH 44.28% (399 out of 901) – improved performance compared to 25.93% in June.

Actions to address:

- Processes for the coding of discharges reviewed across both CAH and DHH; and
- Re-freshed focus on coding recovery action plan developed by the Acute Services Directorate to effect the improvement required

Non-Complex Discharges – Performance against the 6-hour standard remains challenging and is affected by a number of challenges:

- Conflicting pressures on staff, causing delays in discharge letters and discharge scripts;
- An audit is on-going on the accuracy of discharge prescriptions which is slowing down the discharge process;



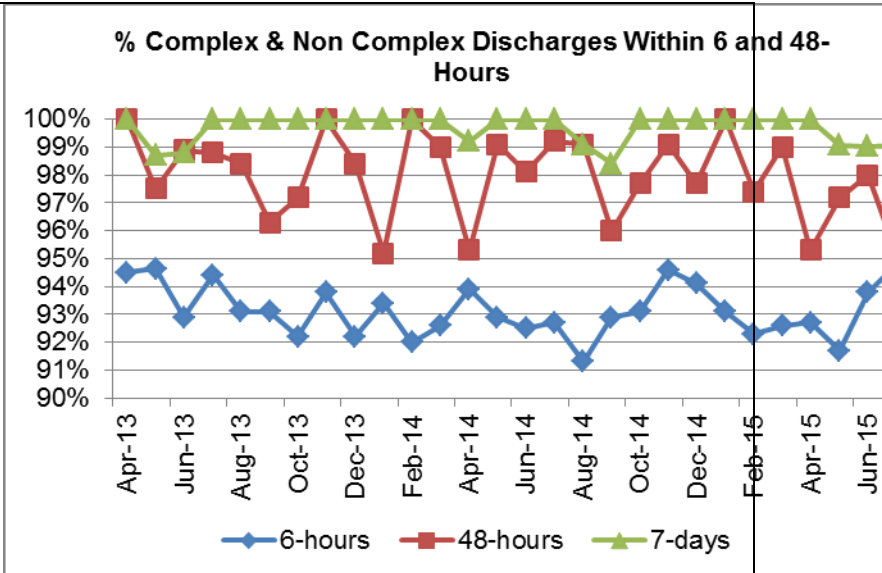
- Delays in discharge transportation;
- Issues with re-starting community packages;
- Issues with delivery of community equipment; and
- Families being able to collect relatives or be at home to receive them.

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.

April performance showed minimal variance across the Region from 98% (BHSCT) to 91% (SEHSCT) with a Regional average of 95%.

Actions to Address:

- An Admission & Discharge Steering Group has been established with a work plan focussing on 3 main areas:
 - o Use of the Information Hub, so that Acute and Community staff are aware of existing services to patients;
 - o Medication; and
 - o Equipment.
- An increased focus on discharges before 1.00pm, which will in-turn assist with improving the 6-hour performance. Of note, performance against discharges before 1.00pm, cumulatively, for 2014/2015 was 18%. Performance, cumulatively, from April to June 2015 is 17%, with performance on the CAH site at 19% and DHH site 12%.



	Monthly Position:												Cum Asses s	T r e n d
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	June 2015	July 2015		
% of Coded Delayed Discharges	71%	69%	67%	66%	65%	58%	58%	62%	60%	63%	66%	64%		↔
6-hours	91.3% (1764 out of 1932)	92.9% (1882 out of 2026)	93.1% (1975 out of 2121)	94.6% (1858 out of 1964)	94.1% (1957 out of 2079)	93.1% (1668 out of 1792)	92.3% (1651 out of 1788)	92.6% (1837 out of 1983)	92.7% (1631 out of 1759)	91.7% (1816 out of 1980)	93.8% (1970 out of 2100)	94.8% (1943 out of 2050)	A	↑
48-hours	99.1% (111)	96.0% (119)	97.7% (125)	99.1% (110)	97.7% (126)	100% (85)	97.4% (74 out of 76)	99% (100)	95.4% (103)	98.2% (111)	98% (100)	95.2% (99)	G	↓

	out of 112)	out of 124)	out of 128)	out of 111)	out of 129)	out of 85)		out of 101)	out of 108)	out of 113)	out of 102)	out of 104)		
7-days	99.1% (111 out of 112)	98.4% (122 out of 124)	100% (128 out of 128)	100% (111 out of 111)	100% (129 out of 129)	100% (85 out of 85)	100% (76 out of 76)	100% (101 out of 101)	100% (108 out of 108)	100% (113 out of 113)	99.02 % (101 out of 102)	99.04 % (103 out of 104)	G	←

Comments: Data for July not available Adult Mental Health Care – This area continues to be impacted by increase in demand equating to 33% over the past 6 months, with a 50% rise in referrals prioritised as “urgent” within this cohort. Additional capacity to address low level referrals has been commissioned and a new contract with Independent Sector is due to commence on 1 September which should see an increase in performance in Q3. June Regional performance demonstrates a total of 121 patients waiting in excess of 9-weeks at 30 June 2015 ranging from 66 (BHSCT) to 0 (SEHSCT). The SHSCT equates to 12% (16) of the total volume. Actions to Address: - Service have undertaken analysis of PMHC and prepared an action plan to mitigate as far as possible the anticipate impact on performance which includes: - Refocus of internal resources with additional capacity established to try and mitigate the increase in referrals:	No Patients Waiting in Excess of 9 and 13-weeks Access Standards <table><caption>Approximate data points from the line graph</caption><thead><tr><th>Month</th><th>CAMHS</th><th>Adult Mental Health</th><th>Dementia</th><th>Psychological Therapies</th></tr></thead><tbody><tr><td>Apr-14</td><td>0</td><td>0</td><td>121</td><td>0</td></tr><tr><td>May-14</td><td>0</td><td>0</td><td>105</td><td>0</td></tr><tr><td>Jun-14</td><td>0</td><td>0</td><td>85</td><td>0</td></tr><tr><td>Jul-14</td><td>0</td><td>15</td><td>85</td><td>10</td></tr><tr><td>Aug-14</td><td>0</td><td>30</td><td>100</td><td>20</td></tr><tr><td>Sep-14</td><td>0</td><td>35</td><td>100</td><td>25</td></tr><tr><td>Oct-14</td><td>0</td><td>10</td><td>85</td><td>20</td></tr><tr><td>Nov-14</td><td>0</td><td>30</td><td>55</td><td>30</td></tr><tr><td>Dec-14</td><td>0</td><td>15</td><td>80</td><td>35</td></tr><tr><td>Jan-15</td><td>0</td><td>30</td><td>35</td><td>40</td></tr><tr><td>Feb-15</td><td>0</td><td>50</td><td>35</td><td>50</td></tr><tr><td>Mar-15</td><td>0</td><td>65</td><td>40</td><td>60</td></tr><tr><td>Apr-15</td><td>0</td><td>121</td><td>50</td><td>70</td></tr><tr><td>May-15</td><td>0</td><td>85</td><td>65</td><td>85</td></tr><tr><td>Jun-15</td><td>0</td><td>15</td><td>60</td><td>100</td></tr><tr><td>Jul-15</td><td>0</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Aug-15</td><td>0</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Sep-15</td><td>0</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Oct-15</td><td>0</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Nov-15</td><td>0</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Dec-15</td><td>0</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Jan-16</td><td>0</td><td>0</td><td>0</td><td>0</td></tr></tbody></table>	Month	CAMHS	Adult Mental Health	Dementia	Psychological Therapies	Apr-14	0	0	121	0	May-14	0	0	105	0	Jun-14	0	0	85	0	Jul-14	0	15	85	10	Aug-14	0	30	100	20	Sep-14	0	35	100	25	Oct-14	0	10	85	20	Nov-14	0	30	55	30	Dec-14	0	15	80	35	Jan-15	0	30	35	40	Feb-15	0	50	35	50	Mar-15	0	65	40	60	Apr-15	0	121	50	70	May-15	0	85	65	85	Jun-15	0	15	60	100	Jul-15	0	0	0	0	Aug-15	0	0	0	0	Sep-15	0	0	0	0	Oct-15	0	0	0	0	Nov-15	0	0	0	0	Dec-15	0	0	0	0	Jan-16	0	0	0	0
Month	CAMHS	Adult Mental Health	Dementia	Psychological Therapies																																																																																																																
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Jan-16	0	0	0	0																																																																																																																

- o Procurement of additional capacity in the Independent Sector with award of contract. Implementation of Services September 2015; - o Position escalated to Commissioner; and - o The Performance Team are commencing a process to establish a robust Service and Budget Agreement baseline. This baseline will facilitate the Trust in identifying any recurrent capacity gap in order to engage with the Commissioner to seek additional recurrent funding. • Child and Adolescent Mental Health Services – Whilst there are currently no breaches of the 9-week standard within CAMHS the ability to maintain this position is potentially unsustainable. The Performance Team have commenced a process to establish a robust Service and Budget Agreement baseline. June Regional performance demonstrates a total of 138 patients waiting in excess of 9-weeks at 30 June 2015 ranging from 95 (NHSCT) to 0 (SEHSCT and SHSCT). The SHSCT equates to 0% (0) of the total volume. • Memory/Dementia Services – New reporting arrangements have been established in January to bring reporting into line with Regional definitions. Additional temporary capacity for consultant activity was put in place via re-directed resources in 2014/15, which reduced the waits, however the numbers of those waiting in excess of 13-weeks are now continuing to increase again. IPT investment confirmed. June Regional performance demonstrates a total of 65 patients in excess of 9-weeks at 30 June 2015 ranging from 63 (SHSCT) to 2 (WHSCT). The SHSCT equates to 96.9% (63) of the total volume. Actions to Address: - o Work to establish capacity has been initiated. This will link into Regional implementation of the Dementia Strategy which will look at capacity and demand issues; and - o Trust will work to implement additional capacity from IPT investment and establish if any residual capacity gaps remain.	

- **Psychological Therapies** – Recruitment for the vacancies had been successful with staff commenced, however, further long-term sick leave has again reduced capacity. New ways of working have been implemented which should see an increase in this position over the next few months. Regionally all Trusts are breaching this target

June Regional performance demonstrates a total of 920 patients waiting in excess of 9-weeks ranging from 437 (SEHSCT) to 85 (WHSCT). The SHSCT equates to 11.6% (107) of the total volume.

Actions to Address:

- o Head of Service level performance meetings are held with Mental Health Directorate monthly to review performance against the access standards.
- o The Performance Team are commencing a process to establish a robust Service and Budget Agreement baseline. This baseline will facilitate the Trust in identifying any recurrent capacity gap in order to engage with the Commissioner to seek additional recurrent funding.

	Monthly Position:												Cum Ass ess	T r e n d
	Aug 2014	Sep 201 4	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015		
Adult Mental Health	30	35	10	31	14	23	54	65	115	85	16	N/A	R	↑
CAMHS	0	0	0	0	0	0	0	0	0	0	0	N/A	G	←
Dementia	99	99	85	58	79	36	37	41	50	67	63	N/A	R	↓
Psychological Therapy	18	27	22	29	32	40	42	54	66	81	107	N/A	R	↓

Comments:

Of the 1488 review patients waiting beyond their clinically indicated timescales:

- 2% (39) of these are waiting in excess of 6-months;
- 20% (307) of these are waiting between 3 – 6 months; and
- 78% (1142) 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 over 6-months decrease by almost half (749) from August to March. However, the June position demonstrates an ongoing increase in patients waiting beyond their clinically indicated timescale.

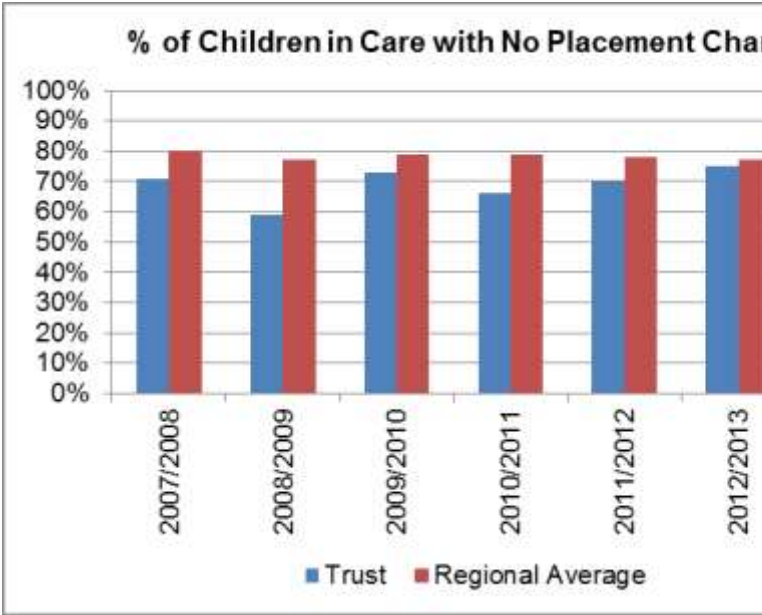
Actions to Address:

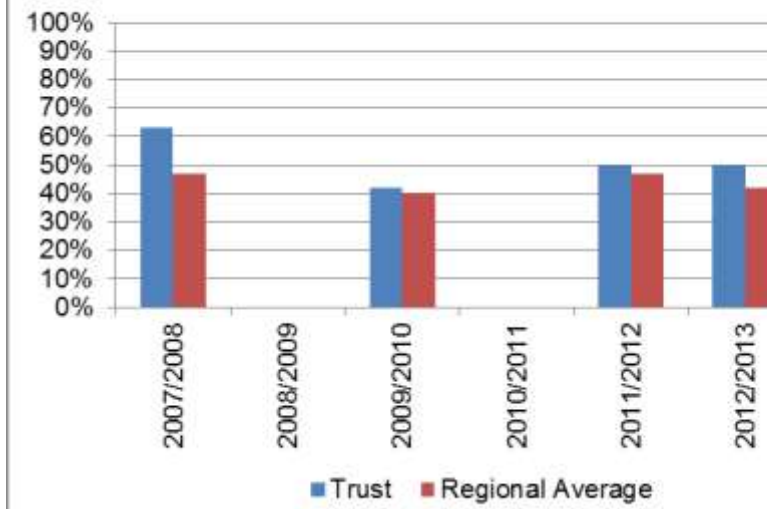
- Discussion paper submitted to HSCB and SLCG to highlight ongoing issues (July);
- HSCB have acknowledged the importance of validating the OP review waiting list and encouraging continued good practice within the Trust on this, however, acknowledged that currently no additional resources are available to support backlog clearance. HSCB have, however, indicated that should additional monies become available they would be happy to consider this, and
- Trust to continue to re-divert resources into this areas as this becomes available.



	Monthly Position:												Cum Asses s	T r e n d
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015		
Total	1526	1456	1176	1174	1064	819	676	777	904	1034	1131	1488		↓
>6-months	125	97	51	50	48	36	32	23	28	25	13	39		↓

3 – 6 months	339	277	206	188	202	153	99	147	127	139	224	307		↓
<3-months	1062	1082	919	936	814	630	545	607	749	870	894	1142		↓

Comment/Actions: 2014/2015 performance information will not be available until later in 2015/2016 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 impacted upon by a number of influences including availability of carers and 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).					 <table><caption>% of Children in Care with No Placement Change</caption><thead><tr><th>Year</th><th>Trust</th><th>Regional Average</th></tr></thead><tbody><tr><td>2007/2008</td><td>71%</td><td>80%</td></tr><tr><td>2008/2009</td><td>59%</td><td>77%</td></tr><tr><td>2009/2010</td><td>73%</td><td>79%</td></tr><tr><td>2010/2011</td><td>66%</td><td>79%</td></tr><tr><td>2011/2012</td><td>70%</td><td>78%</td></tr><tr><td>2012/2013</td><td>75%</td><td>77%</td></tr><tr><td>2013/2014</td><td>79%</td><td>79%</td></tr></tbody></table>				Year	Trust	Regional Average	2007/2008	71%	80%	2008/2009	59%	77%	2009/2010	73%	79%	2010/2011	66%	79%	2011/2012	70%	78%	2012/2013	75%	77%	2013/2014	79%	79%
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Regional	80%	77%	79%	79%	78%	77%	79%																									

Average																																
By March 2016, ensure a 3-year time frame for 90% of children who are to be adopted from care. (No change in target)																																
Comment/Actions: 2014/2015 performance information will not be available until later in 2015/2016 due to the annual reporting cycle associated with this target area. During 2014/2015 information to date puts the average time from entry to care to adoption was 2 years and 11 months. The Trust will continue to work to meet the 3-year timescale consistently Detailed below is Trust and Regional performance (sourced from HSCB Trust Board Performance Report), against this standard for 2007/2008; 2009/2010; 2011/2012; 2012/2013; and 2013/2014. Trust performance has been in excess of the Regional average except in 2013/14. Cumulative performance in 2013/2014 across the Region varied from 64% (SEHSCT) to 19% (WHSCT).					% of Children Adopted from Care  <table><thead><tr><th>Year</th><th>Trust (%)</th><th>Regional Average (%)</th></tr></thead><tbody><tr><td>2007/2008</td><td>63%</td><td>47%</td></tr><tr><td>2008/2009</td><td></td><td></td></tr><tr><td>2009/2010</td><td>42%</td><td>40%</td></tr><tr><td>2010/2011</td><td></td><td></td></tr><tr><td>2011/2012</td><td>50%</td><td>47%</td></tr><tr><td>2012/2013</td><td>50%</td><td>42%</td></tr><tr><td>2013/2014</td><td>56%</td><td>61%</td></tr></tbody></table>				Year	Trust (%)	Regional Average (%)	2007/2008	63%	47%	2008/2009			2009/2010	42%	40%	2010/2011			2011/2012	50%	47%	2012/2013	50%	42%	2013/2014	56%	61%
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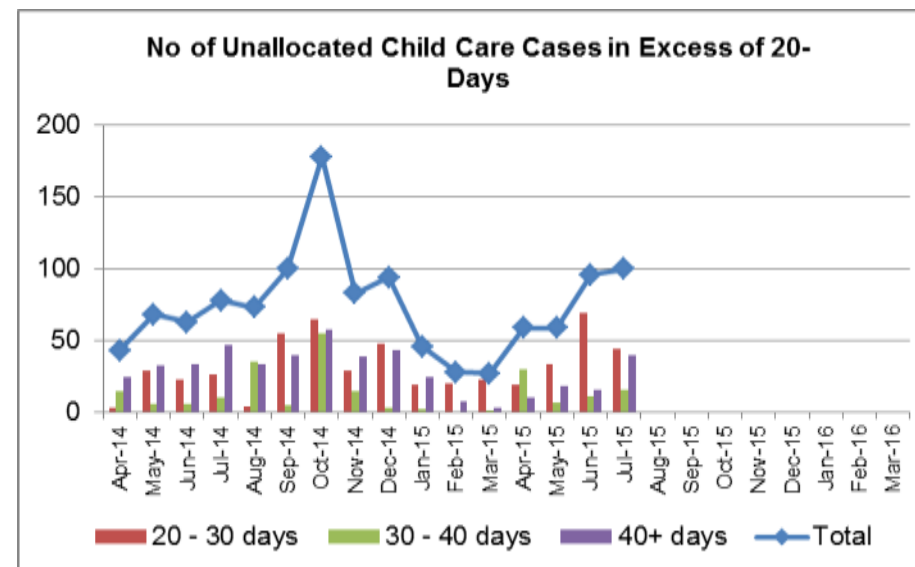
	Monthly Position:							Cum Asses s	T r e n d
	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014		
Trust	63%	No data	42%	No data	50%	50%	56%		←
Regional Average	47%	No data	40%	No data	47%	42%	61%		←

**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 July there were a total of 100 unallocated child care cases in excess of 20 days, which whilst not a substantial increase from the June position, does show a growth in the >40 days position.

44% (44) of these are waiting between 20 and 30 days; 16% (16) between 30 and 40 days; with 40% (40) in excess of 40-days.

Further information on the Unallocated Child Care Cases is provided within the Director of CYPS Trust Board Report.



	Monthly Position:												Cum Assess	Trend
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April *2015	May *2015	Jun *2015	Jul 2015		
Total	73	100	178	83	94	46	28	27	59	59	96	100		↓
>20 and <30-days	4	55	65	29	48	19	20	23	19	34	69	44		↔
>30 and <40-days	35	5	55	15	3	2	0	1	30	7	11	16		↔
>40-days	34	40	58	39	43	25	8	3	10	18	16	40		↓

*Note updated data from April – June 2015 from last report.

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	
Baseline: Clarification waited from HSCB on technical definitions TDP Assessment: Partially achievable/achievable with additional resources	Standard: To be confirmed by HSCB
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 2015/16 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. The Acute Information Team are working through this guidance to develop routine monitoring information. The drivers for this target will include • Implementation of recommendations from RQIA reviews of a) Acute Hospitals at Nights and Weekends (July 2013) b) Care of Patients Following Stroke (11/12/2014) and c) Care of Older People in Acute Hospital Wards (when Published) • Implementation of safety initiatives around: a) Early Warning Systems b) Sepsis c) Reducing Falls d) VTE Risk Assessments It is of note that information previously reported for indicator of performance area (B18), which presents a % position for the crude death rate for emergency admissions (all diagnoses) separating patients admitted at the weekend and patients admitted during the week, is similar to this requirement and may form the basis of future monitoring (see Appendix 3).	

	Monthly Position:												Cum Asses s	T r e n d
	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015		
Weekend	N/A													
Weekday	N/A													
Variation	N/A													

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

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 95%

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. This funding will enable progress towards the implementation of agreed nurse staffing levels. It should be noted that whilst funding has been agreed to enable achievement of this target, the Southern Trust is beginning to experience difficulties with the supply of registered nursing staff and predicts that this situation is set to worsen.

The Trust will continue to investigate and document any shortfall between the accepted position in relation to nursing numbers (beyond medical and surgical).

The Trust's ability to progress any additional recruitment will be progressed through discussions with the Commissioner in relation to recurring funding.

Actions

- The Trust is currently working towards submission of an Implementation Plan to the HSCB.

Monthly Position:												Cum Assess	Trend
Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015		
N/A													

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: Reporting three months in arrears.

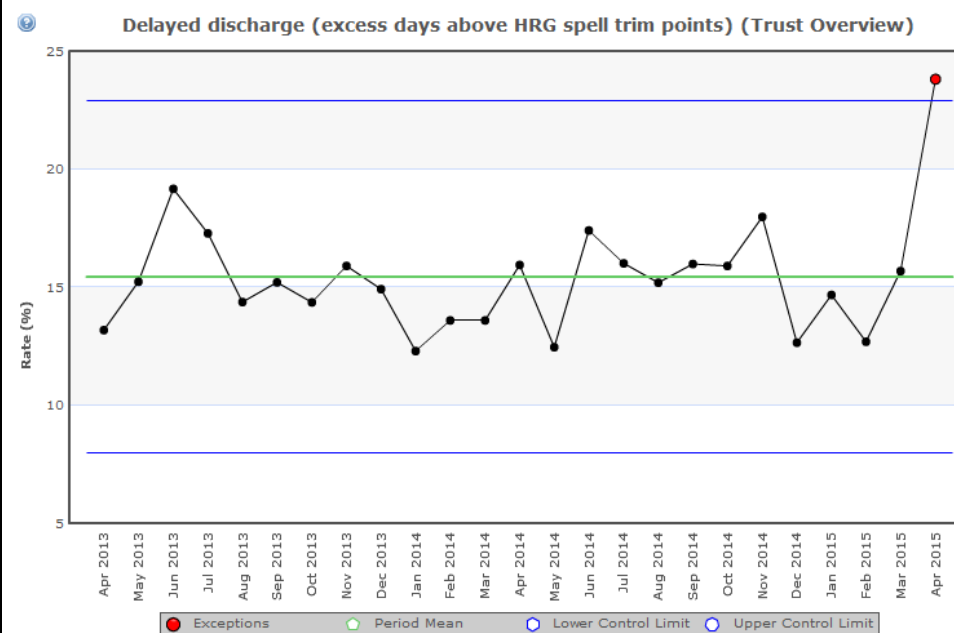
HSCB information against this target, for the 2014/2015 period will not be available until July 2015 associated with the time delay allowing for clinical coding.

CHKS, the comparative benchmarking system, measures excess beddays 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 or 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, April 2013 to April 2015 demonstrates the Trust with excess beddays of 15.4% against the HES Peer Average of 15%. Peer benchmarks against the 25th Percentile and 75th Percentile are 17.1% and 11.9% respectively.

The chart opposite demonstrates a timeline analysis of excess beddays at Trust level over the last two years. The April position shows a peak in excess beddays just outside the normal variation which will be reviewed to identify if there are any key drivers.

Target: Reduce by 10%



	Monthly Position:												Cum Assess	Trend
	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015		
HSCB Data	Not Available													

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%

Comments:

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 where cancelled; 3% of new patients were cancelled 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 related to a further reduction challenging.

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:						Cum Assess	Trend
	April 2014 – March 2015			April 2015	May 2015	June 2015		
	New OP	Review OP	Total OP	Total OP	Total OP	Total OP		
Attendances	72,947	126,903	199,850	15128	15128	18070		
Cancellations 'Put back'	1,318 (1.8%)	4,101 (3.2%)	5,419 (2.7%)	347 (2.3%)	347 (2.3%)	466 (2.6%)		
Cancellations 'Brought Forward'	424	1,389	1,823	99 (0.65%)	99 (0.65%)	160 (0.89%)		
Cancellation of Time/ Location	530	1,293	1,813	124 (0.82%)	124 (0.82%)	113 (0.63%)		
Total Cancellations	2272 (3%)	6783 (5.3%)	9055 (4.5%)	570 (3.76%)	570 (3.76%)	739 (4.09%)		

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 will contribute to this target by developing and implementing a number of commissioned community based schemes, such as Acute Care at Home and Re-ablement, which further the direction of TYC agenda in terms of shift left.

SBA PERFORMANCE SUMMARY FOR TRUST BOARD – MONTH END JULY 2015

APPENDIX 1

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 SBA; 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.

This position below reflect the variation against SBA for New OP; Review OP; Elective IP; Day Cases with Non-Elective IP; Births; as at 24 July 2015 and Diagnostics as at 30 June 2015. Two areas are presenting risk performing below the -5% tolerance limit at corporate level, Review Out-Patients and Elective IP.

Table 1

		Trend	
New Out-Patients (@ 24/7/15)	-2.02% (+535)	↓	SBA Performance Legend: Previous Period (Blue), Current Period (Red)
Review Out-Patients (@ 24/7/15)	-10.02% (-4464)	↓	
Elective In-Patients (@ 24/7/15)	-12.20% (-262)	↓	
Day Cases (@ 24/7/15)	-3.23% (-305)	↔	
Non-Elective In-Patients (@ 30/6/15)	+64.71% (+5106)	↑	
Births (@ 30/6/15)	-4% (-59)	↑	
Diagnostics (@ 30/6/15)	+12% (+8131)	↑	
Allied Health Professionals	SBA not yet agreed	-	

* **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

ACCESS TIMES – MONTH END JULY 2015 AND PROJECTED MONTH END SEPTEMBER 2015

APPENDIX 2

OUTPATIENTS

Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of July 2015							End of September 2015 position
		End of July 2015 position	Actual Volume of patients waiting in excess of 18-week backstop	Timebands (in weeks)					
				18 - 20	21 - 30	31 - 40	41 - 50	50 +	
Anti-Coagulant	9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Breast Family History	9-weeks	10-weeks	-	-	-	-	-	-	13-weeks
Cardiology	9-weeks	35-weeks	781	183	481	117	0	0	34-weeks
Cardiology ICATS	9-weeks								
Cardiology – Rapid Access Chest Pain	2-weeks	3-weeks	-	-	-	-	-	-	3-weeks
Chemical Pathology	9-weeks	15-weeks	-	-	-	-	-	-	20-weeks
Colposcopy	9-weeks	< 9-weeks	-	-	-	-	-	-	7-weeks
Community Paediatrics	9-weeks	5-weeks ¹	-	-	-	-	-	-	9-weeks
Dermatology	18-weeks	32-weeks	226	125	100	1	0	0	24-weeks
Dermatology ICATS	18-weeks								
Endocrinology / Diabetes	9-weeks	48-weeks	303	65	130	70	38	0	52-weeks
ENT	9-weeks	37-weeks	1996	1521	1502	19	0	0	

¹ Community Paediatrics figure excluding Education referrals which do not follow the 9-week access standard.

Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of July 2015							End of September 2015 position
		End of July 2015 position	Actual Volume of patients waiting in excess of 18-week backstop	Timebands (in weeks)					
				18 - 20	21 - 30	31 - 40	41 - 50	50 +	
ENT ICATS	9-weeks								37-weeks
Gastro-enterology	9-weeks	38-weeks	470	94	300	76	0	0	40-weeks
General Medicine	9-weeks								
Geriatric Medicine	9-weeks	12-weeks	-	-	-	-	-	-	9-weeks
Geriatric Medicine – Ortho Geriatric	9-weeks	58-weeks	47	4	10	21	8	4	55-weeks
General Surgery	9-weeks	26-weeks	612	372	240	0	0	0	40-weeks
Gynaecology	9-weeks	27-weeks	427	228	199	0	0	0	24-weeks
Haematology	9-weeks	24-weeks	28	12	16	0	0	0	30-weeks
Nephrology	9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Neurology	9-weeks	40-weeks	655	101	350	204	0	0	38-weeks
Orthopaedics	13-weeks	44-weeks	622	129	332	144	17	0	50-weeks
Ortho ICATS	9-weeks	29-weeks	385	175	210	0	0	0	24-weeks
Paediatrics	9-weeks	23-weeks	35	31	4	0	0	0	26-weeks
Pain Management	9-weeks	29-weeks	300	89	211	0	0	0	35-weeks
Rheumatology	18-weeks	50-weeks	603	37	182	206	178	0	48-weeks
Symptomatic Breast Clinic	9-weeks	2-weeks (Red Flag) & 10-weeks (Routine)	-	-	-	-	-	-	2-weeks (Red Flag) & 15-weeks (routine)

Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of July 2015							End of September 2015 position
		End of July 2015 position	Actual Volume of patients waiting in excess of 18-week backstop	Timebands (in weeks)					
				18 - 20	21 - 30	31 - 40	41 - 50	50 +	
Thoracic Medicine	9-weeks	30-weeks	283	66	217	0	0	0	24-weeks
Urology	9-weeks	56-weeks	1136	94	301	334	283	124	56-weeks
Urology ICATS	9-weeks								

IN-PATIENTS / DAY CASES

Specialty	Access Standard or Backstop	Actual Access Time and Volume of Waits (By Time Band) at end of July 2015						End of September 2015 position
		End of July 2015 position	Actual Volume of patients waiting in excess of 26-week backstop	Timebands (in weeks)				
				26 - 40	41 - 60	61 - 80	80 +	
Breast Surgery	26-weeks	38-weeks	5	5	0	0	0	44-weeks
Cardiology	13-weeks	37-weeks	49	49	0	0	0	38-weeks
Community Dentistry	13-weeks	< 13-weeks	0	0	0	0	0	13-weeks
Dermatology	13-weeks	24-weeks	-	-	-	-	-	20-weeks
ENT	13-weeks	22-weeks	-	-	-	-	-	18-weeks
Gastro-enterology (Non Scopes)	13-weeks	17-weeks	-	-	-	-	-	13-weeks
General Surgery	26-weeks	66-weeks	336	239	88	9	0	66-weeks
Gynaecology	13-weeks	35-weeks IP & 13-weeks DC	22	22	0	0	0	37-weeks IP & 13-weeks DC
Haematology	13-weeks	13-weeks	-	-	-	-	-	13-weeks
Orthopaedics	26-weeks	75-weeks	385	207	170	37	0	82-weeks
Pain Management	26-weeks	56-weeks	349	195	154	0	0	60-weeks
Rheumatology	26-weeks	20-weeks	-	-	-	-	-	16-weeks
Urology	26-weeks	102-weeks	290	95	115	77	3	111-weeks

DIAGNOSTICS

Specialty	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of July 2015						End of September 2015 position
			End of July 2015 position	Actual Volume of patients waiting in excess of target	Timebands (in weeks)				
					9 - 13	13 - 21	22 - 26	26 +	
Endoscopy	-	9-weeks	Routine 34-weeks	991	335	339	189	128	Routine 36-weeks (18-weeks dependent on IS) Urgent 12-weeks
	Cardiac Investigations – non Echo Pacing ECG BP CM Tapes (inc 28 hr 48 hr and 72 hr) Tilts Treadmill DSE TOE	9-weeks	22-weeks	84	44	36	4	0	27-weeks
	Cardiac Investigations - Echo		29-weeks	1059	480	465	111	3	19-weeks

Specialty	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of July 2015						End of September 2015 position
			End of July 2015 position	Actual Volume of patients waiting in excess of target	Timebands (in weeks)				
					9 - 13	13 - 21	22 - 26	26 +	
	Neurophysiology		<9-weeks						< 9-weeks

Specialty	Sub Specialty	Access Standard or Backstop	Actual Access Time and Volume of Waits (by Time Band) at end of July 2015						End of September 2015 position
			End of July 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)				
					9 - 13	13 - 21	22 - 26	26 +	
	Respiratory Physiology – Sleep Studies		12-weeks	35	-	-	-	-	9-weeks
	Urodynamics (Urology)		47-weeks	109	15	32	26	36	52-weeks
	Urodynamics (Gynae)		<9-weeks	-	-	-	-	-	<9-weeks
Imaging	Plain Film	9-weeks	9-weeks	22	16	6	0	0	9-weeks
	CT		17-weeks	307	138	100	27	42	CT:18-weeks CTC:53-weeks
	CTC		53-weeks						
	USS		23-weeks	1973	1094	876	3	0	17-weeks
	Dexa		19-weeks	465	176	289	0	0	21-weeks
	MRI		16-weeks	752	507	245	0	0	14-weeks
	Fluoroscopy		15-weeks	99	65	32	0	2	18-weeks
	Barium Enema		9-weeks	4	4	-	-	-	9-weeks

Specialty	Sub Specialty	Access Standard or Backstop	Actual Access Time and Volume of Waits (by Time Band) at end of July 2015						End of September 2015 position
			End of July 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)				
					9 - 13	13 - 21	22 - 26	26 +	
	Gut Transit Studies		9-weeks	-	-	-	-	-	9-weeks
	Obstetrics Ultrasound		9-weeks	-	-	-	-	-	9-weeks
	Radio Nuclide		9-weeks	6	6	0	0	0	9-weeks

MENTAL HEALTH AND DISABILITY

Specialty	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of July 2015							End of September 2015 position
			End of July 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)					
					9 - 13	13 - 18	18 - 26	26 - 39	39 +	
Adult Mental Health Services	Primary Mental Health Care	9-weeks	14-weeks	33	26	7	0	0	0	13-weeks
	Memory / Dementia Services		20-weeks	86	51	30	5	0	0	19-weeks
CAMHS	-	9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Learning Disability	-	9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Psychiatry of Old Age	-	9-weeks	20-weeks	9	5	3	1	-	-	17-weeks
Autism	-	13-weeks	13-weeks	-	-	-	-	-	-	13-weeks
Psychological Therapies	-	13-weeks	32-weeks	120	75	36	9	0	0	24-weeks

Note: Psychological Therapies – improved position due to implementation of Assessment Clinics in Support and Recovery in August and September. Longest waiter now in CBT – lost capacity due to vacancy – 1 WTE retired in July. Review of capacity and demand now underway – should impact in October.

ALLIED HEALTH PROFESSIONALS

Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of July 2015				End of September 2015 position
		End of July 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)		
				13 - 26	26 +	
Dietetics – Acute	13-weeks	9-weeks	-	-	-	9-weeks
Dietetics – Elderly and Primary Health Care	13-weeks	13-weeks	0	0	0	17-weeks
Dietetics – Paediatrics	13-weeks	30-weeks	106	102	4	31-weeks
Occupational Therapy – Acute	13-weeks	13-weeks	0	0	0	13-weeks
Occupational Therapy – Elderly and Primary Health Care	13-weeks	30-weeks	92	84	8	TBC
Occupational Therapy – Paediatric	13-weeks	27-weeks	122	117	5	30-weeks
Occupational Therapy – Physical Disability	13-weeks	17-weeks	10	10	0	13-weeks

Specialty	Access Standard	Actual Access Time and Volumes of Waits (by Time Band) at end of July 2015				End of September 2015 position
		End of July 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)		
				13 - 26	26 +	
Occupational Therapy – Learning Disability	13-weeks	25-weeks	9	9	-	13-weeks
Orthoptics	13-weeks	24-weeks	2	2	0	13-weeks
Physiotherapy – Adult	13-weeks	18-weeks	286	286		19-weeks
Physiotherapy – Paediatrics	13-weeks	15-weeks	2	2	0	17-weeks
Podiatry – Adult	13-weeks	28-weeks	1042	1040	2	28-weeks
Podiatry – Paediatrics						
Speech & Language Therapy Elderly & Primary Health	13-weeks	13-weeks	0	0	0	13-weeks
Speech & Language Therapy Paediatrics	13-weeks	39-weeks	877	535	342	40-weeks

Note: Orthoptics – 2 patients who were late triage, but who have been appointed in August.

OT Learning Disability and Physical Disability – did not achieve 13-weeks at end July, but patients have now been appointed and anticipate this will be achieved in July.

Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of July 2015				End of September 2015 position
		End of July 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)		
				13 - 26	26 +	
Speech & Language Therapy Physical Disability	13-weeks	13-weeks	-	-	-	13-weeks
Speech & Language Therapy Learning Disability	13-weeks	9-weeks	0	0	0	9-weeks

Indicator of Performance (IoP) Information

Appendix 3

IoP Reporting 2014/2015

IoP	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	June 2015	July 2015
B18. Variation in death rate for emergency admissions (all diagnoses) comparing patients admitted at the weekend and patients admitted during the week	Weekday 1.9%	Weekday 2.9%	Weekday 2.1%	Weekday 2.0%	Weekday 2.7%	Weekday 3.1%	Weekday 3.5%	Weekday 2.7%	Weekday 2.5%	Weekday 2.3%	Weekday 2.4%	Weekday 2.1%
	Weekend 2.5%	Weekend 2.1%	Weekend 3.0%	Weekend 1.5%	Weekend 2.4%	Weekend 2.7%	Weekend 2.9%	Weekend 3.0%	Weekend 2.1%	Weekend 3.7%	Weekend 2.3%	Weekend 1.6%
B36. Note – Performance reported 3-months in arrears Number of Emergency admissions for acute conditions which should not usually require hospital admissions.	159	175	180	177	193	178	188	182	214	205	182	No update

Wright, Elaine

From: Stinson, Emma M <BAD_f76e719a3c65cf7839b555f31c149804@bogus.address>
Sent: 08 June 2015 16:27
To: Clarke, Paula; 'Dean Sullivan' Personal Information redacted by the USI; 'Sara Long'; 'David McCormick' Personal Information redacted by the USI; 'Magwood, Aldrina; Waddell, Sandra; Trouton, Heather; 'Caroline Cullen' Personal Information redacted by the USI;
Cc: Corrigan, Martina; Wright, Elaine; 'Dean SullivanPA' Personal Information redacted by the USI; Metcalfe, Fionnuala T
Subject: Meeting re blue skies pilots with SHSCT & HSCB (Urology)
Attachments: image001.png; image002.png; 8th June.pptx; image003.jpg

Dear all

Further to this morning's meeting please find attached the slides presented from the Urology team.

Many Thanks
 Emma

Emma Stinson
 PA to Mrs Deborah Burns
 Interim Director of Acute Services
 Southern Health and Social Care Trust
 Admin Floor
 Craigavon Area Hospital

Direct Line: Personal Information redacted by the USI

Direct Fax: Personal Information redacted by the USI

EmmaM.Stinson Personal Information redacted by the USI

P Please consider the environment before printing this email

Click on the link below to access the Acute Services Page

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SHSCT Urology Vision Review

June 2015

Approach

- Demand / Capacity / Efficiency
- Efficiency of Consultant time
- Operative capacity primary challenge
 - Benchmarked against another trust.
 - By procedure type (not case number).
- Core capacity delivered by all equally.

Delivery

- Outpatient
 - New patient clinic
 - Triage
 - Nursing
 - Review capacity
- Elective Inpatient
- Emergency
 - Consultant of the Week

Delivery 1 – Elective new referrals

- New patient clinic
 - All new patients.
 - Aim where possible all required tests performed prior to attending OPD (bloods, Imaging).
 - Deliver diagnostics at time of attendance.
 - **Efficiency of consultant time.**
 - End of clinic aim = list or discharge with treatment plan to GP.
 - Phased implementation, full implementation from Jan 2015.
- Impact
 - Reduction in dedicated elective TRUS biopsy sessions from 2 per week to 1 every fortnight at present.
 - Reduction in Consultant delivered diagnostic Flexible cystoscopy and haematuria sessions.
 - New outpatient waiting list (>9 week wait);
 - March to July 2014 increase from 522 to 1006 patients
 - Dec 2014 to Feb 2015 1169 to 1144 patients
 - New outpatient waiting list (total) 1812 Jan 2015 to 1775 April 2015

Delivery 1 – Elective new clinic

- Impact
 - Reduction in dedicated elective TRUS biopsy sessions from 2 per week to 1 every fortnight at present.
 - NB also during this time have absorbed loss of 50% of radiology provided TRUS service.
 - Reduction in Consultant delivered diagnostic Flexible cystoscopy and haematuria sessions.
 - Flexible cystoscopy waiting list, as at 27/05/2015 60 patients without planned dates, median wait 9 weeks, range 0-39 weeks.
 - New outpatient waiting list (>9 week wait);
 - March to July 2014 increase from 522 to 1006 patients
 - Dec 2014 to Feb 2015 1169 to 1144 patients
 - New outpatient waiting list (total) 1812 Jan 2015 to 1775 April 2015
- Cancer targets
- (SABA -4%)

Delivery 2 – Triage / demand reduction

- Part of COTW duties.
- CCG Advice functionality
 - Take-up slow, 7 requests during last month.
 - Minimal impact
- Direct Listing
 - Pilot in some procedures
 - Not able to quantify due to recording challenges
 - Seems to be acceptable to GPs and patients
- Virtual investigation and discharge
 - Being done but again recording challenges
- Estimate 9% of referrals been managed in virtual manner

New Outpatients Demand vs Capacity

- Projected demand 336 patients per month Jan 2015 rising to 407 per month Jan 2016.
- Actual referrals received Jan-May 2015 vs 2014 has increased by 20%, with demand reduction this falls to 11%.
- Although capacity met demand at start of year, rising demand with static capacity means we are now seeing a growing mismatch.
- Review suggested requirement of additional consultant capacity to meet demand, experience suggests these calculations are holding true.

Delivery 3 - Outpatient Nursing

- At Risk funding outpatient nursing posts
- Currently delivering
 - Flexible cystoscopy
 - TRUS
 - Urodynamics
 - Review outpatient activity
 - Cancer support
- Quality vs Quantity – Cancer support activity
- Recording challenges
- Provision requires training
- Requires permanent funding to move forward

Delivery 4 – Review capacity

- Total waiting list 3140 January 2015 >> 2739 May 2015.
- Primarily Consultant Delivered.
- Nurse delivery will impact further but requires permanent funding, training and therefore lead in prior to impact being demonstrable.
- Additional funding to see longest overdue patients and bring down to <6 months required.

Delivery 5 – Elective Operating

- Extended day operating (8am-8pm).
- No cross cover of leave.
- Impact
 - Increased available inpatient theatre time (28hrs per week average with cross cover to 31hrs per week with no cross cover).
 - Cessation of cross cover smooths out delivery of service outside of operating (not cancelling outpatient activity during times of annual leave)
 - Elective operating increased (322 vs 295 Jan- March 2015 vs 2014).
 - Inpatient waiting list >13 weeks static (499 March 2015 vs 494 March 2014).
- Additional funding required to reduce historical backlog to acceptable levels.
- (SABA -13%, needs understanding, could be case mix (eg increase in nephrectomies) or coding (eg diagnostic flexible cystoscopy carried out during first outpatient attendance)).
- Challenges (observations for others)
 - Day case provision on extended day
 - Support services and impact on theatre efficiency
 - Mixed speciality days

Delivery 6 – Inpatient Care

- Consultant of the week
- Impact;
 - Jan-March 2015 vs Jan-March 2014
 - Non elective LOS reduced (4.5 days vs 5.0 days)
 - Non-elective admissions reduced (203 vs 232)
 - Non elective operating (82 cases vs 80 cases)
 - Urology Bed-days reduced (1741 vs 2009)
- Triage (9% demand reduction)

Summary

- Demand
 - Met demand at inception but demand increases will result in growing new patient waiting lists.
- Historic Backlog major challenge
 - Requires additional solution outside of current capacity
- Capacity analysis suggested additional staffing required to deliver required capacity
 - Nursing delivery requires permanent funding to realise potential in service delivery.
 - Demand vs Capacity prediction appear to hold true, ie to deliver a sustainable service additional consultant required.
 - Without additional staffing waiting lists will grow from now.
- Key is that core capacity is delivered by all.

Moving Forwards

- Demand / Capacity models.
 - Case mix
 - Bench marking
- Capacity must be responsive.
 - Commission to meet demand.
 - Performance data compared against agreed benchmark data.
 - Operating capacity.
- Demand management.
- Primary care capacity critical.
- Delivery of core services with networked delivery of sub-speciality services.

Wright, Elaine

From: Radcliffe, Sharon <BAD_23d1d25c63cf43ab59c673106e3c101e@bogus.address>
Sent: 26 March 2015 10:36
To: 'Dean Sullivan' [Personal Information redacted by the USI]; 'lyn.donnelly' [Personal Information redacted by the USI]; Clarke, Paula; Waddell, Sandra; Burns, Deborah
Cc: 'Dean SullivanPA' [Personal Information redacted by the USI]; 'Siobhan Casey' [Personal Information redacted by the USI]; Wright, Elaine; Grattan, Sterling; Stinson, Emma M
Subject: Confirmation Blue Skies Pilots with HSCB - Learning from Pilot work in Urology and T&O

Please confirm Monday 8th June 2015, 9:30-11:30am, Meeting Room, Admin Floor, Craigavon Area Hospital for above meeting (Urology 9:30-10:30) (T&O 10:30-11:30). The hold in diaries on the 15th June can now be removed.

Lucyna – can you please forward confirmation to Sara & David

Emma – can you please forward confirmation to Urology and T&O reps

Many thanks
Sharon for Paula

Sharon Radcliffe
PA to Paula Clarke
Deputy Chief Executive/Director Performance & Reform *Southern
Health & Social Care Trust
College Of Nursing
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

([Personal Information redacted by the USI]
[Personal Information redacted by the USI]

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SOUTHERN HEALTH & SOCIAL CARE TRUST
MINUTES OF END YEAR ASSURANCE AND ACCOUNTABILITY MEETING
TUESDAY 16TH JUNE 2015
CASTLE BUILDINGS

Attendees

DHSSPS

Deborah McNeilly

Hilda Hagan

Jacqueline Burns

SHSCT

Paula Clarke

Roberta Brownlee

1. Welcome and Introduction

- 1.1 Deborah McNeilly welcomed the SHSCT Chief Executive and Chair to the 2014/15 End Year Strategic Accountability Review meeting and set out the context of the meeting, stating that the ground clearing meeting paved the way for issues to be resolved prior to the Strategic Accountability Review meeting. She said that she has been assured that there are no outstanding governance and accountability issues that need escalated. She emphasised that the mid-year and end year accountability meetings form only part of the accountability process.

2. Minutes & Action points arising from Accountability meeting 19th December 2014

- 2.1 The minutes were agreed.
- 2.2 Regarding the action point at paragraph 2.9 (delegated limits for capital projects) Deborah McNeilly advised that a report on the recent test-drilling exercise is scheduled for consideration at a Departmental Board meeting, and it will be used to form part of a risk assessment for a review of existing delegations. In relation to CPD supported capital projects, she advised that a recent audit across all ALBs had identified a number of weaknesses which need to be addressed before an increased delegated limit could be considered for projects below £500k not requiring CPD support. She added

that the Department would be following up on this audit's recommendations, none of which would have a major impact on the Southern Trust.

- 2.3 Regarding the action point at paragraph 3.4 (payment of nursing home fees for continuing healthcare), Deborah McNeilly advised that all trusts had returned completed survey questionnaires and these are being considered. On completion, estimated for September, an options paper will be submitted to the Minister. Paula Clarke stressed that this issue has been ongoing for some time and trusts need clarity given the growing financial implications associated with an increasing elderly population. She asked that the Department discuss the options with trusts before the options paper is submitted to the Minister, to which Deborah McNeilly agreed, adding that PHA and HSCB would also be consulted prior to submitting the paper.

Action: DHSSPS

- 2.4 Regarding action point at paragraph 3.5 (medicines management compliance) Deborah McNeilly advised that the issue was not on the agenda for the meeting between the Department and RQIA on 29th April but it would be raised again. Paula Clarke asked that this matter be addressed as soon as possible.

Action: DHSSPS

3. Performance against Departmental standards

- 3.1 Deborah McNeilly acknowledged SHSCT's good performance in unscheduled care and asked if there were practices which could be shared with other trusts. Roberta Brownlee said that visible and involved leadership were key drivers and Paula Clarke added that a relentless focus on ED pathways, discharge practice and the new medical model introduced last September had all contributed and would be shared with other trusts.
- 3.2 In response to Deborah McNeilly's question on planned actions to deal with winter pressures in 2015/16, Paula Clarke said the new medical model, additional beds, a move to 7-day working and the provision of acute care at home would all help meet these pressures, although she acknowledged that

some of these proposals need further work and resources before they could be introduced. Regarding acute care at home, Roberta Brownlee advised that some work had been progressed on this with the HSCB although no additional funding has been provided. Paula Clarke said that increased demand at EDs needs to be factored into performance against targets, and that further work on redefining pathways to reduce numbers visiting EDs as the first port of call needs to be undertaken. She also said workforce planning and filling vacancies are essential to address the shortage of GPs and nurses.

- 3.3 Deborah McNeilly said that while we need to do all we can to keep Daisy Hill ED open 24hr a day the safety and quality of service was of paramount importance.
- 3.4 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. Roberta Brownlee added that performance data is being scrutinised in detail to identify causes / areas for improvement, for example increased GP referrals for food allergies in children. Other areas being reviewed regionally include psychological therapies and podiatry.
- 3.5 Deborah McNeilly asked if the Trust is on course to deliver to full capacity in 2015/16. Paula Clarke advised that difficulties with recruitment / retention of staff are likely to impact on performance. The Trust is trying to mitigate this by encouraging good forward planning by clinical teams and ensuring that where operations are cancelled these are rescheduled as soon as possible. She confirmed that the Trust already takes into account key peak periods in EDs when planning elective services.
- 3.6 In relation to poorer performance in mental health and dementia services, Paula Clarke explained that lack of capacity is the main cause, as the full

model of care cannot be put in place and a bid has been submitted to HSCB for funding to enable this.

- 3.7 Regarding issues in levels of clinical coding, Paula Clarke said she would review the data.

Action: SHSCT

4. Potential extension of Shared Services

- 4.1 Deborah McNeilly advised that the BSO scoping studies covering IT, employment banks (both 'bank only' and 'bank medical and agency medical'), leadership development, business intelligence and corporate services should be completed later this month, with subsequent rapid progress expected on implementing 'quick wins' where this is feasible.

5. AOB

Trust Delivery Plans

- 5.1 Paula Clarke confirmed that a number of issues are currently out for consultation, with information available on the Trust's website and soon to be posted to Facebook. Roberta Brownlee stressed the impact on planning of not having an agreed budget and of late offers of additional in-year funding.

Funding for Capital Projects

- 5.2 Paula Clarke stressed the need for funding to support the Craigavon redevelopment plan which is key to delivering on the Trust Delivery Plan going forward. She said a business case will be submitted to the Department in September.

Chief Executive post / Senior Executive pay

- 5.3 Roberta Brownlee asked for an update on when the Chief Executive post would be filled substantively and on the issue of Senior Executive pay, given that posts cannot be filled due to the pay offered attracting a very small pool of candidates. Deborah agreed to provide this.

Action: DHSSPS

HSC Sponsorship Branch
July 2015

Wright, Elaine

From: Mallagh-Cassells, Heather <BAD_1eb7038b700df9d6d835836dd92da8ba@bogus.address>
Sent: 23 July 2015 12:47
To: esthergishkor [Personal Information redacted by the USI]
Cc: Wright, Elaine; Clarke, Paula; Donaghy, Kieran
Subject: For Meeting on Tuesday 28th July
Attachments: SEPT 15 - MARCH 16 PDP_FINAL 4 meeting on 280715.doc

23 July 2015

Dear Esther,

Further to my previous e-mail and your subsequent conversation with Elaine to secure a date in the diary for yourself, Paula and Kieran to meet, please see the attached document for discussion at the meeting arranged for Tuesday 28th July at 12.00 noon in Paula's office, Trust HQ.

Regards,

Heather

Heather Mallagh-Cassells
Personal Assistant to Kieran Donaghy
Director of Human Resources & Organisational Development Southern
Health & Social Care Trust

[Redacted signature block containing contact information and a closing parenthesis ' (']

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Southern Health
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INDIVIDUAL PERFORMANCE REVIEW

Name: *Esther Gishkori*

Year: September 2015 – March 2016



Southern Health
and Social Care Trust

Individual Performance Review

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key Objectives for the coming period	2. Action Required (who needs to do what, by when for each key objective)	3. Notes on Attainment (for completion by manager prior to major review)	4. Rating 1 - 5 (if applicable) see guidance notes
Complete the implementation of the outcome of the review of service provision in DHH ED in the context of the availability of senior medical cover out of hours. N.B. subject to amendment until way forward is clear. <u>Measure of Success</u> - Positive feedback from Senior Clinicians, Senior Management and staff on the ground in DHH - Defined operational protocols and escalation pathways are in place and working well - Evidence that CAH is coping with any additional activity - Evidence that bed occupancy in DHH does not reduce significantly			

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Implement the Service Development Proposals which have been presented to HSCB for 2015/16 as follows:- a) Ensure the successful implementation of the New Medical Model in DHH by Winter 2015 <u>Measure of Success</u> - The required number and quality of medical staff are recruited and in place - Job Plans provide for the re-provisions of elective work and 2 daily senior ward based decision making teams - Evidence of the average Length of Stay decreasing in DHH by end of March 2016			

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Implement the Service Development Proposals which have been presented to HSCB for 2015/16 as follows:- b) Ensure that the HDU Proposal is successfully implemented and well underway operationally by March 2016 <u>Measure of Success</u> - The required number and quality of Critical Care Clinicians and Anaesthetists are recruited and in place - Nursing staff are appropriately trained and utilised to provide optimum rotational cover between both CAH and DHH site - Operational protocols are in place and working well			

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Implement the Service Development Proposals which have been presented to HSCB for 2015/16 as follows:- c) Ensure that the 10 rapid turnover beds in ED/MAU are successfully in place no later than March 2016 <u>Measure of Success</u> - A rapid capital solution is found and associated staff recruited - Protocols are in place for maximisation of rapid diagnostics, assessment by acute care at home and monitoring of performance			

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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 <u>Measure of Success</u> 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			

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Ensure safe, effective care over the Winter 2015/16 <u>Measure of Success</u> - A comprehensive "Winter Plan" is in place and agreed with all groups of clinicians to maximise capacity, provide safe care and effectively use space available in a planned way. This needs to encompass associated staffing issues in any of the relevant areas and should be in place for commencement by 1st December 2015 - The ED 4 and 12 hour performance targets are maintained over the Winter period - Elective capacity is kept protected in all but exceptional circumstances.			

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Identify priority areas for further service reform and development to inform negotiations with Commissioner before 2016/17. <u>Measures of success</u> • <i>Priority developments for further implementation in unscheduled care to be made by February 2016 working with Directors of OPPC and MHD.</i> • <i>Priority developments for elective care capacity gaps to be worked up by December 2015.</i>			

Individual Performance Review

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Demonstrate clear ability to effectively manage emergent issues ensuring, safety, quality, clinical consensus, managing and maintaining good relationships with external stakeholders and protecting the Trust reputation.			

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Maintain/improve performance against Ministerial standards and targets and Trust priorities <u>Measure of Success</u> • <i>Ensure there is no reduction in the delivery of Service and Budget Agreement (SABA) volumes for Outpatient, Day Case, Diagnostic and Inpatient specialties compared with 2014/15 i.e that 2015/16 is finished with no red card financial reductions due to under performance and as in 2014/15 with less than 3 specialties in breach of the -5% tolerance level on SABA performance</i> • <i>Evidence that waiting times are monitored closely, lists are validated and the specific measures put in place to monitor urgent new, review and cancer review waiting times are operational and the risks are managed and highlighted</i> • <i>All elective access money is used and levels of activity re: same are measured and patients waiting managed in chronological order</i>			

• Evidence that clinical risk is managed effectively in long waiting time specialties • A high level of working knowledge on current access times and issues contributing to strong or weak performance is evidenced and maintained • Evidence that there is maximum efficiency on elective performance and maintain the CHKS Top 40 Hospitals Award as per last 3 years • The ED 4 and 12 hour performance targets are maintained and raised by 5% over the course of the implementation of service developments • Maintain the Trust position of best ED performance and timely discharge in NI • Maintain/improve Trust position of high HCAI performance in NI and nationally			

Individual Performance Review

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Ensure that the Directorate has a highly skilled, appropriately qualified, flexible and motivated workforce to provide high quality Acute care <u>Measure of Success</u> • Evidence of the successful implementation of the recruitment / retention programmes for nursing staff as discussed and agreed with HR at a local level. This includes rotational programmes, succession planning, time out for teams, etc. • Evidence of on-going monitoring and reduction in bank and agency spend and maintenance of low levels in the nursing workforce • Evidence of innovation in the recruitment and retention of medical staff			

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Ensure the delivery of effective Clinical and Social Care governance, agreed Patient Safety Programmes and Quality Improvement throughout the Acute Services Directorate <u>Measure of Success</u> • Evidence of improvement in action implementation and learning from SAI's, incidents and complaints • SAI's reporting levels are maintained at a rate of no less than the first half of 2015/16 • Quality improvement priorities are identified alongside action plans for 2015/16 and 2016/17 in context of QIF (2015/16 to include implementation of NEAT within nursing KPIs) • Maintain/improve performance against Control Assurance standards for 2015/16			

Individual Performance Review

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Progress the development of an Acute Services Strategy aligned with the capital plan for redevelopment of CAH <u>Measure of Success</u> - OBC completed by September 2015 - Acute strategy completed with staff and stakeholder involvement and recommendations for timing/process to secure Trust Board approval by December 2015			

Individual Performance Review

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Ensure the effective delivery of all in-year financial targets set for the Acute Services Directorate <u>Measure of Success</u> <i>The year is completed with no increase in the budgetary deficit at April 2015 once the budgets have been allocated for 2015/16</i> <i>A savings plan is in place to maximise the Directorate's contribution to Trust savings and to achieve internal target set</i>			



Southern Health
and Social Care Trust

Individual Performance Review

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Reputational/Stakeholder Management • Maintain good relationships with HSCB, PHA, LCG and Primary Care colleagues. • Proactively ensure Trust recognition for strong performance and achievements. • Engage effectively with elected representatives and media, etc.			

We agree that the above objectives are a fair basis on which this work will be planned and reviewed.

Attainment and Rating

7. Individual's Signature	8. Manager's Signature	Date	9. Grandparent's Signature	Date

Date(s) agreed for Interim Review

10. Manager's Overall Rating	11. "Grandparent's" Comments and Signature

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 24 th November 2015
Title:	Board Assurance Framework
Lead Director:	Chief Executive
Corporate Objective:	All
Purpose:	Approval
Summary of Key Issues for Trust Board	
<u>High level context:</u> This paper provides an update on the Board Assurance Framework as at 13th November 2015. It presents the principal areas of risk to the delivery of the Trust's Corporate Objectives and identifies the systems of control and actions for the management of these risks. It sets out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes. The Corporate Risk Register is a key source document for the Board Assurance Framework and is reviewed by the Governance Committee on a quarterly basis.	
<u>Key issues/risks for discussion:</u> Key issues for discussion include: • Have all the risk areas and principle risks been identified? • Are the current controls and assurance systems sufficient? • Is the action planned considered sufficient/acceptable?	

Summary of SMT challenge/discussion:

The Board Assurance Framework was discussed at SMT on 18th November 2015 and further updated .

Internal/External engagement:

Engagement internally and externally has been considered in the context of each areas of risk.



Quality care – for you, with you

BOARD ASSURANCE FRAMEWORK

NOVEMBER 2015

1. Introduction

The Board of the Southern Trust has a responsibility to provide high quality care, which is safe for patients, clients, young people, visitors and staff and which is underpinned by the public service values of accountability, probity and openness.

The Board is responsible for ensuring it has effective systems in place for governance, essential for the achievements of its organisational objectives. The purpose and design of the Board's Assurance Framework is to ensure that the Board can be effective in driving the delivery of its objectives. This document will assist the Board to identify, manage and minimise the principal risks to achieving the objectives.

In the Trust 'Vision Values and Objectives'¹; these are to

Objective 1: Provide safe, high quality care

Objective 2: Maximise independence and choice for our patients and clients

Objective 3: Support people and communities to live healthy lives and improve their health and wellbeing

Objective 4: Be a great place to work, valuing our people

Objective 5: Make the best use of resources

Objective 6: Be a good social partner within our local communities

¹ Southern HSC Trust Visions Values and Objectives, November 2008

The Board Assurance framework is an integral part of the governance arrangements for the Southern Trust and should be read in conjunction with the Trust Delivery Plan, the 3-Year Strategic Plan 2015 -18 – ‘Improving through Change’ and the Integrated Governance Strategy.

The Assurance Framework describes the organisational objectives, identifies principal risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It lays out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

This October 2015 Board Assurance framework presents:

- the strategic risks facing the Trust at 13th November 2015
- the controls currently in place
- the sources of assurance
- where gaps in controls or assurance exist, what actions are being taken to close the gaps.

Updates since the previous version (June 2015) are in blue font for ease of reference

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE

No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report (June 2015)	Status
1.1	Ongoing achievement of Elective Commissioning Plan Standards and Targets	Trust Delivery Plan SHSCT Performance Management Framework Internal and External monitoring Business Case Approvals process	Ministerial/ Commissioner approval Performance Report by HSCB to DHSSPS as part of the Accountability Review process	Monthly exception reporting to Directorates In Year Assurance meetings with Chief Executive Monthly Performance report to SMT and Trust Board Monthly Elective and Unscheduled performance meetings with Health and Social Care Board	Final agreement with Commissioner on extent/ funding for capacity gaps Ongoing change in level of demand for services, including urgent cases, presenting new challenges	The Trust continues to seek investment decisions for recurrent solutions to address remaining capacity gaps In the absence of recurrent funding, the Trust continues to seek level of non-recurrent funding to address gaps Non-recurrent funding made available in November for Independent Sector capacity. The Trust will work to identify what IS capacity can be put in place to increase capacity for Q4 2015/16 in line with HSCB allocation	The level of additional non recurrent funding to address capacity gaps in 2015/16 was not sufficient to meet demand and access times have deteriorated. The Trust has escalated to HSCB requirements for additional capacity above the commissioned level to address key areas of emergent risk	On Corporate Risk Register as high risk in relation to waiting times in excess of Commissioning Plan Standards and Targets across: - Out-Patients; - Diagnostics (including Endoscopy); - In-Patients; and Day Cases (Acute; CYPS; Mental Health; and OPPC areas) - Allied Health Professions 1

							A non recurrent allocation for plain film reporting has been received for Quarter 1&2 and Quarter 3&4 2015/16. This is being utilised for Independent Sector provision As the original IS provider is working to full capacity, a further IS contract has been procured and awarded. Therefore additional capacity is anticipated in Quarter 4. No recurrent funding has been received from the Health and Social Care Board in 2015/16 for the outpatient review backlog	Plain Film x-rays, and outpatient review backlog risk updated to reflect impact and escalating risks associated with unfunded additional capacity

1.1	Ongoing achievement of Commissioning Plan Standards/ Targets in relation to safety, quality and access - HCAI	HCAI Governance system including Bi-monthly HCAI Strategic Forum and monthly HCAI Clinical Forum meetings Outbreak /Incident Management Plan Antimicrobial Management Team to oversee antimicrobial stewardship IPC Audit Programme Environmental Cleanliness Auditing Regional benchmarking for MRSA/MSSA and C.difficile infections	RQIA Reviews and Inspections RQIA Augmented Care Audit Programme Public Health Agency Target Monitoring Reporting Controls Assurance Standards - Infection Control and Environmental Cleanliness Trust Standards and Guidelines Monitoring	Auditing reports to Operational Directors/SMT/ HCAI Strategic Forum/HCAI Clinical Forum HCAI Report to SMT, Governance Committee and Trust Board RQIA Reviews Action Plans to SMT and Governance Committee HCAI Annual Report to Trust Board HCAI Auditing Dashboard HCAI Root Cause Analysis process Performance Report to Trust Board (monthly)		Ongoing measurement of compliance against DHSSPS Communiques Embedding Urinary Catheter project to target E-coli infections across community and acute sites Renewed focus on isolation and screening of transferred patients including planning of negative pressure isolation facilities on CAH and Daisy Hill Hospital sites Engagement with PHA on Regional Surveillance system funding and procurement to recommence Refresh Masterclasses underway for IPC Nurses	Enhanced communication to front line clinical staff via HCAI e-alert Completed Ebola Management Plan Enhanced HCAI RCA information management system developed to further improve meta-analysis of C Difficile cases Re-launch of IV programme in Acute sites to address increasing MRSA/MSSA bacteraemia Joint letter from Medical Director, Executive Director of Nursing and	HCAI on Corporate Risk Register as medium risk

		Manual surveillance systems in place Independent and self-audit programme HCAI Root Cause Analysis process Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI Suite of procedures and guidelines to support the prevention, management and control of CPE				Development of Business Plan to consider Infection Prevention Control (IPC) Nursing Workforce within the Trust Prioritise IPC Nursing workload in collaboration with the Medical Director, Trust IPC Lead	Director of Acute Services issued to staff re Infection Control practice	

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE

No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
1.2	Achievement of statutory duties/functions Care Management processes. Risk includes: Level of Older People & Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed	Performance Management Framework and KPIs in place for teams re targeted reviews	Director of Older People and Primary Care report to Trust Board on compliance with annual reviews Statutory Functions assurance systems/report	Annual Delegation of Statutory Functions report to Trust Board Report to Trust Board includes progress report on completion of annual reviews in Older People and Primary Care until agreed improvements achieved.		The Trust continues to work towards compliance with annual review (12-month) target.	Older People and Primary Care Directorate has undertaken a Domiciliary Care review and has a process in place to implement the recommendations Given improvements achieved on implementing systems and processes for completion of annual reviews in Older People and Primary Care Directorate, report to Trust Board now on a quarterly basis or by exception	On Corporate Risk Register as high risk

	Achievement of statutory duties/functions (cont'd) Robust care management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions	Project Oversight/Weekly Domiciliary Care Accountability Group established Trust Case Management Guidance				Internal Audit of Case Management being planned Restructuring process by Heads of Service in progress within the Disability Division of the Mental Health and Learning Disability Directorate		On Corporate Risk Register as medium risk

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
1.2	Achievement of statutory duties/functions (contd) Compliance with Data Protection Legislation and assurance of good standards of information governance Potential breach of legislation due to loss, unauthorised use, destruction or disclosure of confidential information	Policies, Procedures Guidance available on Sharepoint for all staff Mandatory e-learning training in place for data protection, data quality, records management, IT security Information Governance included in Corporate Mandatory training for all new staff Information Governance Forum Information Governance Framework Senior Information Risk Officer and Information Asset Owners identified	Controls Assurance Standards for Information Management and Information and Communication Technology Information Governance e-learning Modules monitored by Education, Learning, Development – regular global email reminders Information Governance Forum meets quarterly and reports any risks to Governance Committee	Controls Assurance Standards reporting to SMT, Governance and Audit Committees and Trust Board Training update to Trust Board as part of mandatory training uptake Information Governance related incidents, data breaches and KPIs reported to Information Governance Forum. Any risks reported to Governance Committee Information Asset Register reviewed at Information Governance Forum	Privacy Impact Assessment (PIA) required for HRPTS and NI Electronic Care Record (NIECR)	NIECR Information Governance Regional Group aware of the need to complete PIA (correspondence issued in November to SRO) A short internal working group will be established in the Trust to progress PIA on HRPTS in January 2016 Guidance to be issued to staff on PIA via Southern-I in November 2015	Renewal process underway for Data Access Agreement Regional review of GMGR ongoing and Trust participating	

		Specialist Information Governance Team Internal Audit Privacy Impact Assessments Regulatory body in place (Information Commissioners office) Informatics Governance Forum meets bi-monthly to ensure collaborative working in Information Governance and Information Technology	Information Asset Owners training provided Two Officers received training on Data Access requests Regular desktop messages regarding data protection and security Data Access Agreements with all IT suppliers reviewed 2015	Reports on compliance to Senior Information Risk Officer and Information Governance Forum (quarterly via Datix) Data Access Agreement Sharing Register reviewed at Information Governance Forum Reporting to Information Commissioners Office on Data Breaches, Outcome of Reviews and Complaints		Data Access Agreement for HRPTS is being drafted jointly by SHSCT & WHSCT for Regional adoption estimated completion mid 2016 SIRO report to Governance Committee in December 2015		

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE

No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
1.3	Lack of comprehensive systems of assessment and assurance in relation to safety and quality of Trust services Specific risks include:- Lack of compliance with Standards and Guidelines (DHSSPS/HSCB/ other) Lack of agreed indicators/measures of quality to provide assurance across some Trust services Effectiveness of systemic process to review all intelligence from incidents, complaints,	Clinical and Social Care Governance structure and systems Directorate, Division and Professional Governance For a SAI/AI reporting system in place Complaints system Morbidity system	RQIA Reviews Independent Reviews by RQIA, Ombudsman Internal Audits External Audits Mortality reports Professional Governance reports to Trust Board	SMT Governance Committee Patient and Client Experience Committee Professional Director reports to Governance Committee and Trust Board Serious Adverse Incidents/Root Cause Analysis reports to SMT and Governance Committee Accountability Report for Standards and Guidelines to SMT, Governance Committee and DHSSPS Accountability Review meetings	Lack of formal, embedded system of learning Lack of agreed indicators/ measures of quality	Ongoing participation in Regional Patient Safety Forum, including the feedback and benchmarking of performance on indicators via the Health and Social Care Board Monitoring of a range of internationally recognised Patient Safety Initiatives – reported to Governance Committee Work underway to develop more integrated performance corporate dashboard	New I.T. system to capture Standards and Guidelines has not been progressed. The Quality 2020 workstream focusing on Standards & Guidelines has proposed a regional approach to developing an IT system to the Quality 2020 Steering Group.	On Corporate Risk Register as moderate risk

	litigation and user feedback to identify and address service safety and quality issues Effectiveness of process for learning from Adverse Incidents, Complaints and user feedback – lack of formal embedded system of learning			Mortality Reports to Governance Committee and Trust Board Patient Safety Initiative Reports to Governance Committee as part of Medical Director report Annual Quality Report to Trust Board		Clinical and Social Care Governance revisit completed with pilot of new approach of dashboard assurance reports to Governance Committee on 8.12.2015 Q2020 Strategy Regional Workstreams continue to develop and strengthen regional quality indicators for reporting via Trust Quality Report The Trust has commenced the development and implementation of a Quality Improvement Framework to guide a more integrated approach and strengthened assurance processes within the Trust. The role and remit of the Clinical and Social Care Governance Working Body will be reviewed within this work		

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/Controls	Action Planned and Timeframe	Update since last report	Status
1.4	Maintenance and development of Trust estate (facilities, equipment etc.) to support service delivery and improvement and (See 1.5 below)	Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with DHSSPS Capital Resource Limit management process Strategic development plans Minor Works process in place	RQIA Hygiene Inspection Reports Controls Assurance Standard for Buildings, Land and Plant DHSSPS condition of the Estate Review/ Report annually	Reports and Action Plans to SMT, Governance Committee and Trust Board Quarterly Strategic Investment group meetings with DHSSPS (Health Estates Investment Group)	Constraining factor in enabling the works to be carried out is the limited number of Estate Development Officers. Insufficient funding to address backlog maintenance works as identified in Capital Works list	Ongoing prioritisation and bidding process for capital throughout the year Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases continue to be developed for all schemes as per Capital Resource Limit allocation and brought to SMT for approval. A strategic outline case (SOC) for the major redevelopment of CAH has been submitted and work is now being progressed on the main business case for submission in 2015/16.	An extensive replacement programme in relation to the sewage system serving the wards in Craigavon Area Hospital commenced in August 2015 through a carefully co-ordinated and phased programme of ward decants. Works are being carried out to the most critical areas (subject to the availability of decant space v winter pressures). Further works may be necessary after the winter period to complete the programme.	On Corporate Risk Register as high risk

							A review of maintaining existing services (for the next 5 years) has been carried out. This review has identified that funding in the region of £119 million is required to address risk areas including: Critical Telecommunications infrastructure; Infection control and Health & Safety issues in patient areas; Medical Gas infrastructure and ventilation system risks; Structural repairs to DHH. This requirement could be significantly reduced should the replacement of CAH proceed.	

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE								
	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
1.5	High Voltage capacity limit on electrical supply to Craigavon Area Hospital Electrical Supply	Business Continuity Plans for restabilising electrical service in the event of unplanned interruption All future development/ expansion of the estate is to be notified to Estate Services Generator back up Load shedding Monitoring current demand	Ongoing testing of back up systems Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure	Capital development project structures		Site wide installation of High Voltage supply ongoing.	Installation of new Combined Heat and Power plant is completed and G59 approval from NIE (to permit parallel generation) in place. Contract for operation and maintenance of plant being finalised with PALS. This will provide additional source of supply for the site. CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion September 2016	On Corporate Risk Register as medium risk

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
1.6	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	Action Plan in place to address non-conformances External Quality Assurance Internal Quality controls		Progress monitored by SMT and Governance Committee	Lack of Accreditation	Action Plan updated as progress is made	Application for re-accreditation under the new ISO15189 standards made end April 2014 A pre-assessment visit took place on 8 th October 2015 which assessed the Laboratory's state of readiness for a full UKAS 151189 inspection. Full inspection advised for April 2016	On Corporate Risk Register as high risk

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/Control	Action Planned and Timeframe	Update since last report	Status
1.7	Pharmacy Aseptic Suite - Risks include:- The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units	Increased environmental monitoring		Progress on management of risk to SMT via Corporate Risk Register and to Governance Committee	Non-compliance with standards		The queries received in relation to the business case for a new build aseptic suite co-located with the Mandeville Unit have been addressed and the Outline Business Case was submitted to the DHSSPS on 1st July 2015. A letter of Commissioner support from the Health and Social Care Board has also been submitted. The Trust has identified this as its top priority for capital funds.	On Corporate Risk Register as high risk

	Chemotherapy pharmacists' activity is exceeding 100% on a regular basis	Daily report on Chemotherapy Pharmacists activity level in relation to capacity plan developed and implemented					Recent deterioration in the fabric of the building is being addressed through an interim plan involving urgent minor works to the Aseptic Suite	
	The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement						Recruitment process is complete for two Band 7 Pharmacists and they will commence in January 2016.	
							Additional environmental and function testing has been performed on both isolators to identify any sterility failures.	

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance	Action Planned and Timeframe	Update since last report	Status
1.8	Compliance with 22 Controls Assurance Standards	Process for management of self assessment and verification of compliance with Controls Assurance Standards. This includes independent evaluation of evidence.	Self assessment Internal Audit assessment and verification Mid and End Year Accountability Review with DHSSPS	Report to SMT (twice-yearly) Reports to Audit and Governance Committees and Trust Board (annually) Internal Audit verification reports to Audit Committee (annually)		Implementation of action plans ongoing in 2015/16 Self-Assessment process for 2015/16 underway	Implementation programme for 2015/16 agreed by SMT Composite Action Plan in place for those standards where criterion scored <75% in 2014/15	

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
1.9	GP Out of Hours Service – Reduced ability to maintain adequate service provision and patient safety due to vacant GP shifts	Business Continuity Plan and Contingency Plans Medical Managers with medical responsibility for the service Daily monitoring of rotas Escalation process in place for risk management by Director/SMT when required Early Alerts to Health and Social Care Board and Department when medical staffing falls below 50%	KPIs agreed with HSCB	SMT KPIs for service reported to Trust Board via Performance Report Management of risk via Corporate Risk Register to SMT, Governance Committee and Trust Board Internal Audit Report – satisfactory assurance	Sustainable workforce model	Winter Pressures Plan being implemented with enhanced rates and increased capacity Contingency and Escalation Plan currently being implemented	Pharmacy pilot extended as part of Winter Pressure Plans. Evaluation report sent to Health and Social Care Board	On Corporate Risk Register as high risk

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
1.10	Stability of Health Visiting Workforce – Impact on children/families due to reduced ability to deliver services as a result of decreased staffing levels in the service	Control measures in place for when staffing levels reach certain levels within teams Utilisation of bank and additional hours of existing health visiting staff Drop in clinics Rota system in place for allocation of new births and for clinic cover Child protection cases are allocated equitably across the team	Monitoring of service delivery against KPIs	Management of risk via Corporate Risk Register to SMT and Governance Committee	Regional workforce planning for sufficient capacity to deliver service and anticipated shortfall in Post-registration Nursing Education budget to fund training posts	Ongoing monitoring and risk management	Regional recruitment for Health Visitor training resulted in 12 places being commissioned for the programme which commenced in September 2014. It is anticipated that these staff will fill vacancies which may have arisen within this service, as well as potentially covering staff gaps due to long term sick leave and/or maternity leave. There has been no additional funding	On Corporate Risk Register as high risk

							received in order to increase the Funded Staffing Levels within this service. Ten places have been requested for the programme commencing in September 2015 – awaiting DHSSPS funding decisions	

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE							
Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
1.11 Lack of compliance with RQIA standards in relation to medicines management in domiciliary care	- Trust Medicines Management policy - Review of operational procedures - Incident reporting system - Interim procedure on transcribing agreed by Executive Director of Nursing - Trust Medicines Steering Group - Trust representatives on regional group - Themed Domiciliary Care Forum (IS) focused on safe administration of medication	Medicines Management Steering Group meets quarterly and monitors all work streams Incident reporting is collated via Datix/Governance Ongoing work with IS providers to assure best practice guidelines are implemented effectively	Management of risk via Corporate Risk Register to SMT and Governance Committee	Delay in regional progress and feedback regarding issues raised	Following Regional Medication Workshop held by HSCB, a business case is being developed to secure funding to deliver an interim system which includes a specialist medicines assessment and provision of appropriate solutions for service users who are identified as potentially requiring domiciliary care support in the area of medicines management.	Secondment of a registered nurse in the Newry and Mourne area for a pilot for one year dedicated to progressing medicine review re safer systems. A six-month report has been shared on progress/ issues to date Project Nurse is reviewing existing service users in other two localities (Armagh & Dungannon and Craigavon & Banbridge)	On Corporate Risk Register as high risk

					Audit risk assessments for new service users to ensure compliance with guidelines commencing in November 2015		

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE

Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
1.12 Inability to recruit/retain Consultant medical staff for specific specialties • <u>Consultant Medical Staff</u> in Dermatology, Emergency Medicine, Orthodontics, T&O, Haematology, Psychiatry Old Age and Radiology • <u>Staff Grade, Associate Specialist and Specialty Doctors</u> in Anaesthetics, General Surgery, GP Out of Hours, Urology, Dermatology, Emergency Medicine and Paediatrics	• Recruitment campaigns • Use of Locum agencies • Risk Assessment Highlighting controls/action in place • Detailed Action Plan is held within the HROD Directorate		Management of risk via Corporate Risk Register to SMT and Governance Committee		Management of Risk via Risk Assessment Detailed Action Plan for each speciality	The Trust is aware that medical shortages in these specialisms remain at a regional and national level. Medical workforce plans which indicate an increase in medical training in these specialisms are currently being considered by the DHSSPS but difficulties remain due to lack of funding. The Trust continues to explore options including overseas recruitment.	On Corporate Risk Register as high risk

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE							
Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
1.13 Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital	- Trust Senior Oversight Group - Escalation procedures in place to alert senior management of any changes in rota - In-house training programme				- Ongoing recruitment of Consultants and Middle Grade Doctors for Emergency Department - Use of locums - Ongoing review of medical rota to ensure senior doctors on duty until midnight - Daily audit of notes - Opening of observation area from 22.00 – 08.00 for patients who have no definite diagnosis and have not been assessed or discussed with a Registrar - Support provided as required by Paediatric Registrar and Anaesthetic Registrar in the out of hours period.	Resignation of a Consultant effective from 1.2.2016. Action Plans in development to seek to address this.	Added to Corporate Risk Register as high risk on 30.9.2015

					Medical and Surgical Registrar will provide additional support if on duty overnight • Recruitment of senior nursing staff to be on duty 24/7 • Additional ENPs currently being recruited • Associate Medical Director exploring a 16 Consultant model for both Emergency Departments		

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE

Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
1.14 Increasing inability to recruit registered nursing staff	- Ward Sister/Charge Nurse management of available staff on a shift by shift basis - Assistant Director/Head of Service (Operational) oversight regarding availability with possible redeployment of staff to respond to prioritised need - Escalation to Operational Director as required - Open registration for Nurse Bank - Ongoing recruitment campaigns to ensure appropriate waiting lists for all areas of Nursing to ensure an available supply as posts become available	Nursing Workforce Planning Group, chaired by the Assistant Director of Nursing Workforce Development and Training Establishment of Regional Nursing Workforce Planning Group, chaired by Executive Director of Nursing	Management of risk via Corporate Risk Register to SMT and Governance Committee Trust Nursing Workforce Planning Group, chaired by Assistant Director of Nursing Workforce Development and Training, reporting to the Executive Director of Nursing and Director, Human Resources	No increase to pre-registration numbers for NI has been agreed for the next ten years (NI Workforce Plan 2015-2025)	All opportunities to secure permanent staff continue to be progressed Ongoing lobbying with the Chief Nursing Officer to increase pre-registration numbers	Regular recruitment drives ongoing with most recent drive for Adult Nursing including Year 2 and Year 3 students. This resulted in 153 job offers on the day with many of the candidates pre-employment checks undertaken. The most recent drive for Mental Health Nursing is also aimed at including Year 2 and Year 3 students and is ongoing	On Corporate Risk Register as high risk

						Regional Nursing Workforce Planning Group has completed a high level scoping exercise	

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE

	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	
1.15	Ensuring a good patient/client experience	Patient/Client Experience Standards Patient Client Experience Standards Working Group Patient/Client Experience Committee Staff as Service Users 10,000 Voices Complaints process	Patient/Client Experience Committee (quarterly) Patient Client Experience Standards Working Group (monthly)	Performance report to Trust Board. Quarterly reporting to Public Health Agency with remedial action plans Report against Regional Standards to Patient and Client Experience Committee 10,000 Voices Report Staff as Service Users Report to SMT and Governance system	Capacity within Effectiveness and Evaluation for analysis of Patient/Client Experience Standards questionnaires	10,000 Voices surveys continue to provide a mechanism for patients to report on their experience of care received in the Trust. Stories continue to be shared with staff and managers for learning and service improvement.	The 'hello my name is' has been implemented with positive feedback from patients and staff. It has been regionally agreed that the Patient Client Experience Standards and 10,000 Voices initiatives will be merged and a joint action plan will be agreed by the Patient Client Experience Standards Steering Group	

							An “Enhancing the Patient/Client Experience” training programme has been developed and delivered to various staff across the Trust. Ambassadors have also been trained to enable more training to be carried out.	

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE

	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	
1.16	Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016	- NI Revalidation Programme Board - NI Revalidation Working Group - Establishment of Nursing and Midwifery Revalidation Information Management system	NI Revalidation Programme Board (bi-monthly) NI Revalidation Working Group (monthly)	SMT Trust Board via Executive Director of Nursing Report		Monthly reports on the status of nursing and midwifery revalidation will be emailed to nursing/ midwifery managers from 1st November 2015 The Assistant Director Nursing Governance, along with Directorate Champions, are developing tools and proformas to support nurses and midwives in evidencing compliance with the core revalidation elements and to prepare nurses/midwives for their reflective discussion with their NMC colleague.	In October 2015 the NMC agreed its arrangements for the revalidation of nurses and midwives to commence in April 2016 The Trust's Medical Revalidation Team has been extended to support the development and implementation of a Nursing and Midwifery Revalidation Information system which is now live Standard Operating Procedures have been developed to provide timely	On Corporate Risk Register as high risk

							reports to nursing and midwifery managers and heads of service on the status of nursing and midwifery revalidation in their area of responsibility .	

CORPORATE OBJECTIVE 2: MAXIMISING INDEPENDENCE AND CHOICE FOR OUR PATIENTS AND CLIENTS								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance	Action Planned and Timeframe	Update since last report	Status
2.1	Commissioning Plan Standards & Target for Resettlement (Mental Health/Learning Disability)	Southern Area Supporting People Plan Resettlement Group	Regional Resettlement Group HSCB Performance Monitoring	Performance Report to Trust Board		Mental Health continue to plan resettlement with Business cases for Supported Living options. The Trust has submitted a Business Case to Southern Area Supporting People Planning Group for a 10 place Supported Living scheme in Dungannon to meet emerging need.	Mental Health has successfully completed resettlement of the long stay hospital population . There is an ongoing need to secure appropriate supported community accommodation for persons whose discharge from Acute inpatient services is delayed. Learning Disability has resettled	

							all remaining patients in long stay wards in Longstone during 2013/14. As per previous update, one individual in Muckamore Abbey remains to be resettled and has now re-engaged with the process of resettlement and appropriate solutions are being actively sought.	

2.2	Maximising self directed support (SDS) Insufficient SDS Bridging Funding to enable the release of resources for individual budgets whilst ensuring the stability of existing services in the short-term	Performance monitoring In Control project structure Health & Social Care Board Self Directed Support (SDS) Project Initiation document SH&SCT Self Directed Support Implementation Group SH&SCT Self Directed Support Implementation Plan SH&SCT Self Directed Support PPI Action Plan	SH&SCT Director representation on Health & Social Care Board SDS Programme Board SH&SCT Assistant Director representation on Health & Social Care Board SDS Project Team	Indicators of Performance Report to Trust Board (Direct Payments target) Performance reporting to Health & Social Care Board	Clarity on issues linked to ensuring consistency of an SDS approach between Trust areas Lack of clear guidance needed for establishing Trust Costs Ambiguity regarding the process for identifying individual budgets	Key issues from SDS Provider Workshops shared with HSCB requesting guidance on a number of issues, necessary to the progression of SDS	Provider Workshops convened with independent/private and community /voluntary providers	

CORPORATE OBJECTIVE 3: SUPPORTING PEOPLE AND COMMUNITIES TO LIVE HEALTHY LIVES AND IMPROVE THEIR HEALTH AND WELLBEING								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance/ Controls	Action Planned and Timeframe	Update since last report	Status
3.1	Focus on Prevention and Early Intervention – To ensure all Trust activity has an underpinning ethos of prevention and health promotion	Trust Strategy – “Improving through Change” SHSCT Health & Wellbeing Strategy (under review) Health Improvement Action Plans Community Development Action Plan	Accountability Review meetings	Indicators of Performance Report to Trust Board (Health and Wellbeing targets) Reporting at Accountability Review meetings Reporting framework to Health & Social Care Board and Public Health Agency External funding reporting to range of funding bodies		The Trust continues to work with PHA, Councils, NIHE, to develop collaborative approaches to develop Good Neighbourhoods for Ageing Well across Southern Area Work progressing to ensure greater integration of Trust sexual health services per RQIA recommendation The Trust’s Smoke Free Steering group continues to meet regularly to oversee implementation of Smoke Free sites	‘Making Life Better’ - new Public Health Framework has been published and local and Trust implementation structures to be established before March 2016. A mapping of activity against Making Life Better themes was undertaken across the Trust. Annual Reports 2014/15 for Community Development, PPI, Carers, Travellers, Volunteering and Health Improvement completed.	

by March 2016.

Action Plans for
2015/16
developed and
being
implemented.

Quarterly and
end of year
monitoring
reports continue
to be provided
to Public Health
Agency/HSCB
re: health
improvement/
community
development/
PPI action plans.

Trust
participating in
Council
Community
Planning
workshops to
influence health
and wellbeing
priorities and
promote Making
Life Better
Themes

3.2	Development of robust community infrastructure Sustainable funding for maintenance and development of community/voluntary sector providers. Impact of reduced funding streams for the community/voluntary sector from other funding bodies can impact on service delivery in SHSCT area	Annual SHSCT investment plan for community/voluntary sector Trust in Community Project Children & Young People's Strategic Partnership Collaborative working with other government departments e.g Department of Social Development	Regular review meetings. Annual updates to SMT	Quarterly/Annual contract monitoring on agreed Service Level Agreement and service specification. Resources from Health & Social Care Board, Public Health Agency and other funding sources which Trust channel to community/voluntary sector partners is reported annually.		The Trust continues to participate in Council Community Planning meetings in relation to health and wellbeing priorities Contract review process being finalised for SMT approval Active support for community/voluntary sector in sourcing funding to remain sustainable Re-procurement of generic Carers Support underway and being finalised for advertisement November/December 2015	Small grants programme made available annually	

CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance	Action Planned and Timeframe	Update since last report	Status
4.1	A well trained workforce Fully embedded appraisal system Risk that workforce does not have the skills and competency development necessary to deliver high quality service	There are a variety of mechanisms in place to ensure appraisal takes place:- • Medical Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings • Action Plan in place and reviewed quarterly • Staff Attitude	Audit Reports	HR Report to SMT monthly HR Report to Trust Board Medical Director report to Trust Board and Governance Committee	Lack of evidence of compliance All staff to complete PDP form on an annual basis	KSF reports continue to be collated monthly and forwarded to Directors Work is ongoing with individual Directors and Heads of Service to support staff and managers when completing their KSF documentation to increase uptake Work underway to improve Mandatory Training levels	<u>Knowledge and Skills Framework</u> As a result of the Knowledge and Skills (KSF) monitoring system in place, there has been an increase in the extent to which KSF is being implemented within the Trust <u>Consultant/ Medical Appraisal</u> As at 16/11/15, 93% of 300 eligible doctors have completed their 2014 appraisal.	On Corporate Risk Register as moderate risk

		Survey results provide staff view • Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.						

CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance	Action Planned and Timeframe	Update since last report	Status
4.2	Compliance with Controls Assurance Standards Human Resources Health and Safety	Process for management of self assessment of compliance with Controls Assurance Standards	Self assessment against Controls Assurance Standards and action plan Accountability Review with DHSSPS	Report and Action Plans to SMT (bi-annually) Reports to Governance Committee and Trust Board (annually)		Implementation of action plans ongoing in 2015/16 Self-Assessment process for 2015/16 underway	Self-assessment for 2014/15 demonstrated Substantive compliance	

CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance	Action Planned and Timeframe	Update since last report	Status
5.1	Effective systems of financial control Achievement of financial balance in 2015/16	Contingency Plan for in place BCBV project structure Financial Monitoring systems Annual Capital Plan Financial Management Controls Assurance Standards Financial Management	BCBV Project Board BCBV Project Assurance Group Internal Audit Reports External Audit Reports Due Diligence process with HSCB	Finance Report to SMT and Trust Board (monthly) Contingency Plan reported to SMT and Trust Board (monthly) Financial Plan monitored by BCBV Programme Board Final Accounts to Audit Committee and Trust Board (annually) SBA monitoring reports to SMT (bi-monthly) Capital Investment Plan to Trust Board (annually)			As a result of additional Health and Social Care Board allocations and Departmental approval to a number of additional contingency proposals, the Trust would now expect to breakeven in 2015/16	On Corporate Risk Register as medium risk

	Fraud Prevention	SHSCT Fraud Policy and Response Plan Training programme Internal monitoring Involvement in National Fraud Initiative	Audit Committee Internal Audit External Audit Counter Fraud & Probity Services	Reports to Audit Committee				
	Compliance with Financial Management Controls Assurance Standard	Trust process for management of self assessment and verification of compliance with Controls Assurance Standards Internal Audit assessment and verification of level of compliance	Internal Audit verification of self assessment	Reports to Audit Committee Report and Action Plans to SMT Reports to Governance Committee and Trust Board (annually) Internal Audit verification reports to Audit Committee (annually)		Ongoing monitoring of Action Plan		

CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance	Action Planned and Timeframe	Update since last report	Status
5.2	Effective Procurement and Contract Management	Action Plans to address weaknesses identified in Internal Audit reports Contracts Management Establishment Group COPE for significant element of spend	Controls Assurance Standard: Management of Purchasing and Supply Internal Audit External Audit DHSSPS approval for STAs	Progress updates to SMT and Audit Committee Internal Audit reports to Audit Committee Baseline Risk Report on Contract Management provided to Directors	Clarification on scope of Procurement required Lack of compliance with procurement standards associated with COPE capacity No agreed regional way forward for procurement capacity gaps at CoPE level or for Estates/ Social Care which is outside CoPE coverage. Issues continue to be raised	Recommendations of Internal Audit reports continue to be progressed Capacity for new TYC related social care procurement under recruitment E-learning programme for contract management training being updated Proposals brought forward by Trusts on regional basis to address procurement deficit for Estates services to be pursued regionally.	Regional Social Care Procurement Group developing approach for social care procurements New Structures for contract & procurement management being developed. Measured Term Contract (MTC) in place for 2015/16 which mitigates risks to procurement for schemes <£45k	On Corporate Risk Register as medium-risk

					with DHSSPS and Regional Procurement Board	New Regional Task and Finish Group established to determine impact of new EU Directives for Social Care Procurement and provide guidance for social care.	Internal resource diverted to provide procurement support to key Mental Health Directorate projects in 2015/16 enabling change	

CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES								
No	Risk Area and Principle Risks	Key Current Controls	Assurance on Controls	Assurance Reporting	Gaps in Assurance	Action Planned and Timeframe	Update since last report	Status
5.3	HRPTS: Payroll & Travel Payments - potential for inaccurate and/or late payments. Negative media publicity and impact on Trust's reputation as a good employer. Transfer to Payroll Shared Services and maintenance of service delivery	- Customer Forums in place for monitoring the performance of services in Shared Services Centres - Progress updates to Audit Committee 3 weekly performance monitoring meetings between the Trust's Head of Resourcing and Shared Services Centre Head of Recruitment & Selection	SMT			Ongoing communication/ engagement with Managers as regards timely completion of paperwork	The challenge with BSO regarding the timeliness and effectiveness of recruitment processes is now impacting on operational services	



Quality Care - for you, with you

Southern Health and Social Care Trust

Incident Management Procedure

October 2014

Procedure Checklist

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

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1.0 Introduction:

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

1.1 Purpose:

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

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

1.2 Scope of the Procedure:

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

2.0 The Roles and Responsibilities:

2.1 Chief Executive:

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

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

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

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

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

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

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

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

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

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

2.3 Directors:

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

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

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

The Assistant Director / AMDs must also:

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

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

2.5 Head of Service/ Team Manager:

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

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

2.6 Incident Review Team:

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

The Review Teams should also consider and review the following:

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

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

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

2.7 The Directorate CSCG Coordinator:

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

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

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

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

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

2.8 All SHSCT Staff:

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

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

3.1 Incident Identification:

A useful definition of an incident is:

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

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

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

3.1.1 Other Systems for Reporting:

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

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

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

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

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

3.1.3 Immediate Action Checklist Following Identification of an Incident:

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

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

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

3.2 Reporting an Incident:

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

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

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

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

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

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

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

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

4.0 Procedure for Reviewing, Monitoring and Learning from Incidents:

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

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

- Close all incidents following completion of the review process

4.1 Incident Review:

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

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

- 4.1.1 The person reporting the incident should undertake this stage of the assessment, entering it on the IR1 form (DIF1). Based on the actual impact of the incident at the time of occurrence (taking into account psychological as well as physical harm) a judgment is made as to the incident's severity in the range Insignificant to Catastrophic.
- 4.1.2 Incidents assessed as causing actual **major** or **catastrophic** harm at the time of the incident must be given immediate consideration for further in depth analysis.
- 4.1.3 For incidents causing lesser levels of actual harm further questions need to be asked to decide on the level of investigation required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

See Hyperlink:

[http://www.hscboard.hscni.net/publications/Policies/102%20Procedure for the reporting and followup of Serious Adverse Incidents-Oct2013.pdf](http://www.hscboard.hscni.net/publications/Policies/102%20Procedure%20for%20the%20reporting%20and%20followup%20of%20Serious%20Adverse%20Incidents-Oct2013.pdf)

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

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

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

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

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

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

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

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

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

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

(subject to service users consent)

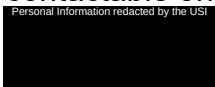
APPENDIX 1:**KEY DEFINITIONS**

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

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

APPENDIX 2:***When and How an Incident Should Also Be Reported To Other Sources***

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

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

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

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

Appendix 3

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

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

Risk Likelihood Scoring Table

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

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

APPENDIX 4:***Guidelines on being open with patients, service users, families and carers when things go wrong or outcomes are unexpected and /or unexplained***

- Any incident involving a service user should be discussed with this individual as soon as is appropriate by a senior member of the service team and preferably the lead professional. If the service user is a child or is unable to give consent due to their physical condition or mental capacity the incident should be discussed with their named next of kin contact. If the service user is able to provide consent and wishes the incident to be discussed with another carer or relative, the service team should facilitate this request.
- Specifically those incidents graded moderate, major and catastrophic should be discussed immediately with the service user and/or their relatives / carers, with consent. Those incidents of an insignificant and minor nature which occur out of hours can be discussed with those required at the most appropriate time within the next 24 hours.
- When discussing an incident with a service user and / or designated relatives / carers, the lead professional should outline the facts of the incident as known, the actual and potential consequences for the service user and how the team will review the incident for future learning. If the service user and/or designated carers / relatives wish to have the outcome of the incident review fed back to them the service team should consider this as good practice and should be conducted with consent of the service user if applicable. These interactions should be documented and attached to the incident report on Datix.
- If an incident meets the criteria for notification as an SAI or internal RCA, (**refer to Section 5**) the service user and / or designated relatives / carers must be informed of this decision before the SAI / RCA review begins. Where possible this should be undertaken by the Lead professional involved in the service user's care. Where this is not possible due to relations being strained or it is judged to be inappropriate the Chair of the SAI /RCA review group supported by the Directorate CSCG Coordinator will undertake this role. This

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

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

APPENDIX 5:***Guidance on Support for Staff following an Incident***

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

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

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

APPENDIX 6:**Major / Catastrophic Incident Checklist**

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

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

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

APPENDIX 7:***Incident Review Guidance***

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

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

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

The above can be expanded to include where appropriate:

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

(b) manage the incident when it occurred?

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

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

APPENDIX 8***Brief Guidance on the Role and Responsibilities of an SAI Review Chairperson***

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

The main responsibilities of the review Chairperson are:

1.0 Prior to the Review

- 1.1 Reviewing all relevant case notes, statements, synopsis of care reports and relevant sections of policies and procedures related to the incident to enable them to lead the initial meeting of the Review Team.
- 1.2 In conjunction with the Governance Coordinator, prepare a draft Terms of Reference for consideration by the Review Team at the initial meeting.

2.0 During the Review

- 2.1 Ensuring that all attendees at the review are introduced to each other and are aware of their role.
- 2.2 Facilitating a process that is conducive to learning and analysis without interference from personal disagreements, criticisms, perceptions or dissatisfaction.
- 2.3 Ensuring that the review is open, fair and participative. That if required appropriate members of the Review Team are delegated to meet members of the service team involved in the incident to obtain clarity on events.

- 2.4 Chairing the Review in a manner which ensures that: all salient facts, a clear chronology of events and interventions, areas of strength/weakness of policy or practice are identified and clear action plans are formulated and agreed.
- 2.5 Ensuring that Review Team members, service teams and patients / clients and /or relatives and carers are kept informed with respect to the review and its progress as required. See **Appendix 4** and **section 5**.

3.0 Following the Review

- 3.1 Liaising with the Governance Coordinator to ensure that a comprehensive report with recommendations / action points and timescales (where relevant) is produced and agreed ensuring that the service team involved in the incident are given an opportunity to check the information they have contributed to the report for factual accuracy. The Chairperson should sign off/approve the report prior to it being sent to the AMD /Assistant Director / Director.
- 3.2 If there are queries / comments raised by the AMD / Assistant Director/ Director following their review of the draft report, the Chair should consider these and reconvene the Review Team if necessary to address same.
- 3.3 Report practices, systems or other issues which the Review Team feel require immediate attention to the relevant Assistant Director, Head of Service and AMD, where appropriate.
- 3.4 If the Chairperson is the nominated contact with the patient/client and or family/ carers, they will be responsible for sharing the facts/ recommendations and action plan with them as outlined in **Appendix 4**.

Meeting:	Governance Committee – 8 th December 2015
Title:	Revisit of Clinical and Social Care Governance Arrangements (CSCG)
Lead Director:	Interim Chief Executive
Corporate Objective:	Safe Effective Care
Purpose:	In April 2015 the Interim Chief Executive requested a revisit of the outcomes of the 2010 Southern Health and Social Care Trust (SHSCT) Review of the CSCG to provide Trust Board, Governance Committee and the Senior Management Team (SMT), with an assurance that these arrangements remain effective and robust in the following areas: • Provide clarity and transparency of function • Drive Quality and Safety • Provide adequate assurances to the SMT, Trust Board, Professional Bodies and the Public, on areas relating to risk, patient safety and non-compliance • Take cognisance of recent external reviews
Summary of Key Areas:	The Report provides an overview of key stakeholder responses to questions set out in the paper entitled – SHSCT Clinical and Social Care Governance Arrangements – Continuous Improvement (attached). The responses focus on the following 3 areas: 1. Information used to provide those interviewed with assurance in areas of risk and patient safety 2. Processes in place to ensure adequate challenge, independent ‘expert’ oversight and scrutiny in respect of the Serious Adverse Incident (SAI) process 3. The effectiveness of SMT Governance as set out in the 2010 Governance Review Actions set out on page 8 were approved for implementation by SMT on 2nd October 2015

Scope of the Review

The scope of the review focused on the strengths and weaknesses of the Trust's CSCG Assurance Framework in the following areas:

- Structure
- Communication flows
- Clarity of roles and functions
- Effective mechanisms in place to review learning across the whole system to inform SMT strategy in respect of patient safety priorities and risk

NB: The scope of this review **did not** include operational Governance arrangements set out in the SHSCT Governance Review 2010.

Structure of the Review

A number of semi-structured interviews were carried out with Directors and Associate Medical Directors, group discussions took place with Professional Governance Leads and Directorate Governance Co-ordinators. In addition, two focus groups were held for Non-Executive Directors.

All of the above, regardless of the format, focused on the questions set out in the paper approved by SMT in May 2015 (attached). The areas of questioning sought views on the **effectiveness** of the following 3 areas:

1. **Information** received by SMT and Governance Committee to inform their decision-making with regard to assurance, risk and patient safety.
2. **Present mechanisms in place** to provide **assurance** of **independent** 'expert' oversight, challenge, scrutiny in respect of learning from SAI incidents.
3. The **effectiveness** of SMT as set out in the 2010 CSCG Review.

External Reviews Considered

Learning from the following external reviews were considered

- Berwick Report
- Francis Report
- Donaldson Report
- Portlaine Hospital

The Key Themes of These Reports Focus on the Following Areas:

- Putting the patient first
- Strong and patient centred healthcare leadership
- Clearly understood fundamental standards and measures of compliance
- Openness, transparency and candour throughout the system
- Accurate, useful and relevant information

All the above Reports stress that good Governance in healthcare is dependent on the integration of **effective Corporate, Clinical and Social Care Governance**. The Reports are clear about the positive role that information plays, encompassing issues such as; highlighting inadequate performance; assurance; accountability; informing the public; and supporting patient choice.

The Reports also recommend the need for Governance structures which support learning across entire systems. The Reports also highlight the risk of 'silo working' and inadequate independent 'expert' challenge, as key barriers to effective Governance arrangements. Each of the Reports refers to the need for effective CSCG audit arrangements as a means of assurance.

Key Themes of Internal Audits

Internal Audit carried out a series of audits which focused on elements of the Trust's CSCG arrangements from 2009 – 2015. Set out below are examples of recommendations:

- The agreement and implementation of an organisational Audit Work Plan (2009)
- The agreement and implementation of a formal Audit Work programme to provide Directors with assurance in respect of compliance with Standards and Guidelines deemed to be implemented (2015)
- The development of the Trust's Standards and Guidelines information system (SG database is held on a excel spread sheet) (2015)
- Strengthening integration of operational/professional Governance (2013)

Themes from Individual Interviews and Focus Groups

Set out below are the key themes identified through individual interviews and focus groups in response to the questions set out in the paper attached.

Area of questioning – *Information you receive to provide assurance in areas of patient safety and risk*

Responses - The organisation is too focused on the DATIX system and the information it generates is quantitative in the main.

Weak in the area of corporate trending – linkages and patterns and consideration should be given to widening the range of information presented both corporately and operationally for assurance purposes with more focus required on:

- Lessons learnt
- Implementing learning
- Evidencing compliance of recommendations out of SAI's and Standards and Guidelines
- Identifying patterns and trends at both an operational and corporate level – More Proactive, Less Reactive
- More 'live data'
- Connectivity of Information across all the elements of CSCG

Area of questioning - Mechanisms in place to provide assurance of independent 'expert' oversight, challenge, and scrutiny in respect of learning from SAI incidents.

The Trust's review of Clinical and Social Care Governance 2010 makes reference to the role of the Executive Directors in assisting the Governance Committee by providing independent assurance to them and the Trust Board. Mechanisms and communication flows are presently in place to support the Executive Directors role in providing independent assurance in respect of learning from SAI's were explored.

Responses - Those interviewed, identified no independent forum /process which provides assurance to the SMT that adequate corporate scrutiny, challenge and '**expert oversight**' in respect to:-

- Application of the learning from SAI's, incidents and complaints across the Directorates
- The identification of SAI's, monitoring arrangements on the quality of SAI reports and the independence of the SAI process - presently led by the Directorates. Therefore, no mechanism is in place for 'expert independent oversight or challenge'
- Connecting the learning /trends of SAI's etc. to areas of organisational risk and improvement

The role of the Assistant Director of Clinical and Social Care Governance (ADCSCG) was also explored by a number of those interviewed:

The CSCG structures implemented in April 2011 introduced a Corporate Co-ordination and overview role within the Chief Executive's Office. The role of the

ADCSCG and the team was to provide a corporate view to integrate all the various strands of CSCG within the Trust.

The Trust identified 3 core components in its CSCG structures:-

1. Corporate co-ordination and overview role (Chief Executive's Office);
2. Operational Directors and their teams; and
3. Professional Executive Directors and their teams

Under these arrangements, resources to support the governance agenda were strengthened in each Directorate with the introduction of the Governance Co-ordinator roles. This re-alignment of resources was targeted at addressing governance issues more closely to patient or client care, as promptly as possible and by those directly involved in service delivery.

Those interviewed were of the opinion that Directorate Governance Arrangements should remain as set out in the Trust's 2010 Governance Review. However, questioned the capacity and capability of the Corporate Co-ordination and an individual overview role (ADCSCG) to deliver the range of information and degree of analysis of organisational intelligence required to present a corporate integrated view of all strands of CSCG to inform SMT decision making.

Area of questioning - The effectiveness of SMT as set out in the 2010 CSCG Review.

Responses - Feedback from interviews and focus groups indicated that a dedicated Governance Agenda should be incorporated into the SMT meeting schedule as set out in the 2010 Review of Governance.

Area of questioning - Has SMT set out and agreed an Organisational Governance Strategy which provides clarity on roles and functions across all Directorates?

Responses - 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.

Conclusion

The purpose of revisiting the outcomes of the 2010 Governance Review was to seek views from a range of senior stakeholders to inform the SMT if present CSCG systems and processes:-

- Provide clarity and transparency of function
- Drive Quality and Safety

- Provide adequate assurances to SMT, Trust Board, Professional Bodies and the Public on areas relating to risk, patient safety and non-compliance
- Take cognisance of recent external reviews

The stakeholders identified areas for improvement in respect to the organisation's ability to produce a range of information which demonstrates connectivity across all elements of patient safety, risk, learning and continuous improvement. It was highlighted in interviews and focus groups that information should be timely, clear, ~~and~~ concise and appropriate to the level of decision making and assurance required e.g. Non-Executive Directors indicated that high level overview is required as opposed to operationally focused information.

The stakeholders also identified there was a need to agree clear measures of improvement and mechanisms to demonstrate compliance. In addition, it was highlighted that clarity is also required in respect of the mechanisms in place for independent challenge and scrutiny in respect to SAI process in identifying areas organisational risk and quality improvement priorities.

Actions:

1. Agree the range of integrated CSCG quality indicators to inform SMT, Governance Committee and Trust Board on matters of patient safety, risk and Quality Improvement.
2. Review of Corporate Governance structures in respect of capability (systems) and capacity (analysis/trending) required for the ADCSCG to provide the type and depth of organisational intelligence/information required to adequately inform the organisations CSCG, Risk, Safety and Quality Improvement priorities.
3. Set out and agree a Clinical and Social Care Audit Plan linked to key safety priorities.
4. Agree on which forum will provide Executive and Non-Operational Directors assurance of independent 'expert' oversight, challenge, and scrutiny in respect of learning from SAI's an opportunity for trends and learning from SAI's to be considered corporately, in respect to risk, patient safety and improvement priorities.
5. A dedicated Governance Agenda will be incorporated into the SMT meeting schedule for 2016.

Governance Re-Visit Action Plan Progress – 26th November 2015

Actions	Progress to date
1. SMT will agree a range of CSCG Quality Indicators	A suite of initial CSCG indicators has been agreed by SMT and incorporated into Governance Committee papers for discussion and views. Work in progress to improve data quality and capabilities of existing information systems. Proposals to SMT regarding future classifications of SAI's and Complaints to develop trending. Liaison with informatics to develop a CSCG electric Dash Board to ensure compatibility with Trust Dash Board work stream
2. Review of Corporate Governance structures in respect of capability (systems) and capacity (analysis/trending)	All Serious Adverse Incidents outcomes from 2011-2015 trended using Donaldson Triggers Proposed complaints categorisation framework tested on all Ombudsman's complaints investigations completed from 2011-2015 Review commenced on systems in place to register and report on Standards and Guidelines
3. Set out and agree a Clinical and Social Care Audit Plan linked to key safety priorities.	Discussions ongoing
4. Agree on which forum will provide Executive and Non-Operational Directors assurance of independent 'expert' oversight, challenge, and scrutiny in respect of learning from SAI's an opportunity for trends and learning from SAI's to be considered corporately, in respect to risk, patient safety and improvement priorities.	Discussions ongoing
5. A dedicated Governance Agenda will be incorporated into the SMT meeting schedule	Incorporated into 2016 schedule



GOVERNANCE COMMITTEE

CONFIDENTIAL AGENDA

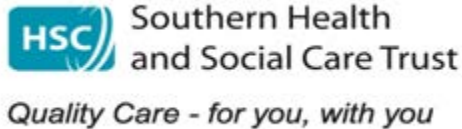
DATE: Tuesday, 12th May 2015

TIME: 9.30 a.m. – 10.15 a.m.

VENUE: Boardroom, Trust Headquarters, Craigavon

AGENDA

1. Minutes of meeting held on 3rd February 2015 Dr Mullan
2. Matters arising from previous meeting Dr Mullan
 - i) Update on Child Protection Practice issue (verbal) Mr Morgan
3. Serious Adverse Incidents/Adverse Incidents
 - i) Summary of SAI recommendations arising from SAI Investigation Reports forwarded to HSCB for the period 1.01.15 – 31.03.15 Directors
4. Non Executive Directors' Children's Home Visits Report Dr Mullan



GOVERNANCE COMMITTEE

Minutes of the confidential section of the Governance Committee held on Tuesday, 12th May 2015, at 9.30 a.m. in the Boardroom, Trust Headquarters

PRESENT:

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

IN ATTENDANCE:

Mrs P Clarke, Interim Chief Executive
Mrs D Burns, Interim Director of Acute Services
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs A Magwood, Acting Director of Performance and Reform
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Mrs M Marshall, Assistant Director, Clinical and Social Care Governance
Mrs A Brennan, Medical Directorate Senior Manager, *(for Dr Simpson)*
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary (Minutes)

APOLOGIES:

Mr K Donaghy, Director of Human Resources and Organisational Development
Dr J Simpson, Medical Director

1. MINUTES OF MEETING HELD ON 3rd FEBRUARY 2015

The Minutes of the meeting held on 3rd February 2015 were agreed as an accurate record and duly signed by the Chairman.

2. MATTERS ARISING

i) Update on Child Protection Practice issue

Mr Morgan provided a verbal update on this matter. He reminded members of the background to the case and stated that the HSCB review report had commended the Trust's internal review and found no systemic issues in terms of how the case was dealt with. The HSCB also concurred with the Trust view that the case did not meet the criteria for a Case Management Review (CMR). Mr Morgan advised that Mrs McAlinden, along with key Trust staff had met with the service user on 18th February 2015 when she was advised that the Trust's position had not changed in that the case did not meet the criteria for a CMR. The service user subsequently wrote to the Trust on 10th March 2015 again requesting a CMR. The Trust has responded reiterating its position and advising the service user to document the issues of practice she would like addressed. A response is awaited.

3. SERIOUS ADVERSE INCIDENTS/ADVERSE INCIDENTS

i) Summary of SAI recommendations arising from SAI Investigation Reports forwarded to the HSCB for the period 1.01.15 – 31.03.15

Mrs Marshall presented the summary report and members noted the change in format since the previous meeting. Members discussed its content and Directors provided responses in relation to their areas of service. Mrs Clarke referred to SAI Personal Information redacted by the USI involving an Personal Information redacted by the USI year old male and asked for an update on recommendations 4 and 5. Mrs McVeigh agreed to provide an update for the next meeting.

Action – Mrs McVeigh

Mrs Rooney sought clarification on the correlation between the summary report and the Incident and Complaints Management Report, and queried why SAI Personal Information
redacted by the USI had not been included in the confidential report in light of the severity of the incident. In response, Mrs McVeigh advised that the process for this particular SAI had commenced, led by OPPC with Acute involvement and following the submission of the Trust Investigation report to the HSCB, subsequent recommendations would come to Governance Committee for consideration. Mrs McVeigh assured members that her Directorate had fully engaged with the family. Mrs Marshall further clarified that the summary report in the confidential section relates to SAI reports which have been completed and forwarded to the HSCB. Mrs Rooney stated that it was important that the report headings were clear.

4. NON EXECUTIVE DIRECTORS' CHILDREN'S HOME VISITS REPORT

Dr Mullan presented the above named report and explained that in light of the sensitive information within the document, it had been included within the confidential section of the meeting. Mrs Mahood acknowledged the pressures facing Trust staff in these facilities and asked about morale across teams. In response, Mr Morgan stated that these teams are very resilient and he felt the strong working relationships within the teams, helps and supports individual members.

Following a discussion on the format and content of the report to Governance Committee, it was agreed that further consideration would be given to what constitutes a key issue. Dr Mullan and Mr Morgan agreed to monitor the report content.

Action – Dr Mullan / Mr Morgan



GOVERNANCE COMMITTEE

CONFIDENTIAL AGENDA

DATE: Tuesday, 8th September 2015

TIME: 9.30 a.m. – 10.00 a.m.

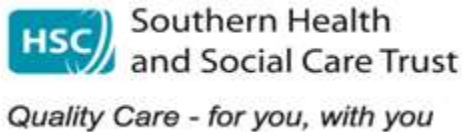
VENUE: Boardroom, Trust Headquarters, Craigavon

AGENDA

1. Minutes of meeting held on 12th May 2015 Dr Mullan

2. Matters arising from previous meeting Dr Mullan

3. Serious Adverse Incidents/Adverse Incidents
 - i) Summary of SAI recommendations arising from SAI Investigation Reports forwarded to HSCB for the period 1.04.15 – 30.06.15 Directors



GOVERNANCE COMMITTEE

Minutes of the confidential section of the Governance Committee held on Tuesday, 8th September 2015, at 9.30 a.m. in the Boardroom, Trust Headquarters

PRESENT:

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

IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs E Gishkori, Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform
Mrs A McVeigh, Director of Older People and Primary Care Services
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Mrs S Judt, Board Assurance Manager (Minutes)
Mrs S McCormick, Committee Secretary

APOLOGIES:

Mrs D Blakely, Non Executive Director
Mrs P Clarke, Interim Chief Executive
Dr R Wright, Medical Director
Dr T Boyce, Director of Pharmacy
Mrs M Marshall, Assistant Director, Clinical and Social Care Governance

1. MINUTES OF MEETING HELD ON 12th MAY 2015

The Minutes of the meeting held on 12th May 2015 were agreed as an accurate record and duly signed by the Chairman.

2. DECLARATION OF INTERESTS

There were no declarations of interest in relation to the agenda items.

3. MATTERS ARISING**i) Update on Child Protection Practice issue**

In response to a question from Dr Mullan, Mr Morgan advised that there has been no response from the service user.

4. SERIOUS ADVERSE INCIDENTS/ADVERSE INCIDENTS**i) Summary of SAI recommendations arising from SAI Investigation Reports forwarded to the HSCB for the period 1.04.15 – 30.06.15**

Members discussed the content of the report and Directors provided responses to questions relating to their area of responsibility. Mrs Mahood, referring to SAI [Personal Information redacted] in particular, commented on the lengthy timescale between the date the SAI occurred (April 2014) and the report being sent to the HSCB (April 2015). Mrs Gishkori acknowledged this and provided assurance as to the thorough process of investigation in place and the time required to complete. Mrs Mahood asked about SAI [Personal Information redacted by the USI] involving a [Personal Information redacted] year old female allergic to penicillin who received a dose of IV penicillin. Mrs Gishkori agreed to look at the detail of this SAI investigation again and provide an update to members.

Mrs Brownlee asked if any learning had been taken forward in relation to SAI [Personal Information redacted by the USI] involving a fall. In response, Mrs McVeigh advised that the full investigation report details the outcomes

and recommendations relating to this SAI and confirmed that learning has been taken forward.

Mrs Mahood asked about collaboration with Nursing Homes and how shared learning is taken forward. In response, Mrs McVeigh assured members that the Trust fully engages with Nursing Homes on compliance issues and outlined a number of processes in place to facilitate shared learning. Members discussed SAI [redacted] involving a [redacted] year old female who had an unwitnessed fall. Mrs McVeigh agreed to provide a progress update on recommendations for the next meeting in December 2015.



**Minutes of a meeting of the Governance Committee held on
Tuesday, 12th May 2015, at 10.15 a.m. in the Boardroom,
Trust Headquarters**

PRESENT:

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

IN ATTENDANCE:

Mrs P Clarke, Interim Chief Executive
Mrs D Burns, Interim Director of Acute Services
Mr P Morgan, Director of Children and Young People's Services/Executive
Director of Social Work
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs A Magwood, Acting Director of Performance and Reform
Mr F Rice, Director of Mental Health and Disability Services/Executive
Director of Nursing
Mrs M Marshall, Assistant Director, Clinical and Social Care Governance
Mrs A Brennan, Medical Directorate Senior Manager (*for Dr Simpson*)
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary (Minutes)

1. WELCOME AND APOLOGIES

Dr Mullan welcomed those present to the meeting. Apologies were recorded from Mr K Donaghy, Director of Human Resources and Organisational Development, Dr J Simpson, Medical Director and Dr T Boyce, Director of Pharmacy.

2. **DECLARATION OF INTERESTS**

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

3. **CHAIRMAN'S BUSINESS**

None.

4. **MINUTES OF MEETING HELD ON 3rd FEBRUARY 2015**

The Minutes of the meeting held on 3rd February 2015 were agreed as an accurate record and duly signed by the Chairman.

5. **MATTERS ARISING FROM PREVIOUS MINUTES**

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

Dr Mullan made reference to a new Bill to reform the Office of the Northern Ireland Ombudsman and suggested that it would be beneficial for the key changes to be circulated to members.

Action – Mrs Marshall

Safer Births and Peri-Natal Report

Mrs Rooney referred to concerns she had raised at the previous Governance committee meeting regarding Caesarean section rates within the Trust. Mrs Burns undertook to address the issues raised by Mrs Rooney in the C-section rate presentation at the next Governance Committee meeting on 8th September 2015.

Action – Mrs Burns

Incidents and Complaints Management Report

Mrs Burns referred to the previous minutes and a query raised by Mrs Mahood regarding a significant number of incidents in the Acute Directorate under the category of delay. Mrs Burns advised that this related to a mixture of issues mainly moving patients out of the Intensive Care Unit (ICU) and delays in beds being available in other wards. There were no issues of patient harm, more system/patient flow issues.

NI Care Leavers

Dr Mullan referred to his challenge at the previous meeting as to why the Southern Trust had the highest percentage of care leavers with no qualifications. Mr Morgan advised that there appears to be a variation across Trusts in terms of how the definition of 'qualifications' is interpreted. Mr Morgan further advised that, as agreed at the previous Governance Committee meeting, he will analyse this issue in more detail and provide an update at the next Trust Board meeting.

Action – Mr Morgan

6. **CORPORATE RISK REGISTER**

Mrs Clarke presented the Corporate Risk Register and stated there are currently 25 risks – 15 high and 10 moderate. She advised that the Corporate Risk Register had been reviewed three times by the Senior Management Team since the last Governance Committee Meeting and by Trust Board on 26th March 2015.

Mrs Mahood made reference to the recent discussion on the Corporate Risk Register at Trust Board and asked about the process for escalation/de-escalation of risks. Mrs Clarke outlined the approach taken to provide assurance that the risks are regularly reviewed and the narrative updated to demonstrate the progress being made. Mrs Clarke also advised that this process will be reviewed in the revisit of Clinical and Social Care Governance. Mrs Clarke highlighted two new risks on the Register, which have the full

risk assessments included. Members discussed the Corporate Risk Register page by page and asked a number of questions to which Directors responded. Discussion focused on key areas of risk around access times. Mrs Clarke advised of a recent letter to the HSCB on this issue which she agreed to share with members.

Action – Mrs Clarke

7. MEDICINES GOVERNANCE REPORT

Members noted the content of the above named report. In the absence of Dr Boyce, it was agreed that any questions/issues raised would be emailed to Dr Boyce following the meeting for response.

Members noted that during the third quarter of 2014/15, 234 medication incidents were reported within the Southern HSC Trust. The average number of reported medication incidents each month was 73, representing a decrease from 84 per month in the previous quarter. During the third quarter of 2014/15, 1 major incident was recorded and following a question from Mrs Rooney, it was agreed that further detail on this incident would be provided at the next meeting.

Action – Dr Boyce

8. CLINICAL AND SOCIAL CARE GOVERNANCE

i) Incidents and Complaints Management Report and Update on Ombudsman Cases 1.1.2015 – 31.3.2015

Mrs Marshall presented the report for the period 1 January 2015 – 31 March 2015. A total of 3089 incidents were reported during this period, an increase of 51 incidents comparable with the same period last year.

Mrs Mahood queried the number of catastrophic incidents for the quarter ending March 2015. In response, Mrs Clarke confirmed that there had been 9 catastrophic incidents for the

period and the figures recorded on page 7, Fig 1.4 were a breakdown of incidents by severity per Directorate. Following a query by Mrs Rooney on Catastrophic incident no. 42174 within the Acute Directorate, it was agreed to provide clarification on the different levels of investigation. Mrs Marshall to provide for the next meeting.

Action – Mrs Marshall

Mrs Rooney referred to the descriptor, 'Lack of suitably trained/skilled staff'. Mr Rice reminded members that this was a regionally agreed term and Mrs Rooney suggested that it may be helpful to include clarification/more information on descriptors going forward.

Action – Mrs Marshall

Complaints were discussed. Mrs Blakely highlighted the percentage of complaints responded to within both 20 and 30 working days to which Mrs Burns spoke about the complexity of some complaints and the pressures on staff to respond within timeframes. Mrs Burns advised of the weekly backstop process in place within Acute which she agreed to bring to the next meeting.

Action – Mrs Burns

Update on Ombudsman Cases

Mrs Marshall spoke to this report which provides a summary of new cases received within the time period 1 January 2015 – 31 March 2015, as well as an update on existing cases. Members noted that 2 cases were closed and 1 case discontinued within the same period.

Dr Mullan referred to a number of cases outstanding from 2012 and asked when these would be closed. Mrs Marshall stated that the cases referred to by Dr Mullan would remain outstanding until the Ombudsman was satisfied the findings of the investigations had been exhausted. Mr Rice stated he was

hopeful a number of outstanding cases within the Mental Health and Disability Directorate would be closed soon.

ii) **Serious Adverse Incidents Report for the period 1.1.2015 – 31.3.2015**

Mrs Marshall presented the summary of SAIs reported during the period 1 January 2015 – 31 March 2015 and those that remain open from 1 April 2009 – 31 March 2015. She reported a total of 34 new notified SAIs during 1 January 2015 – 31 March 2015.

iii) **Guidelines for Directors on the presentation of SAIs at SMT, Governance Committee and Trust Board**

Mrs Marshall spoke to the above named paper. She advised members that the number of Serious Adverse Incident (SAI) notifications the Trust submits to the HSCB has increased, with 154 being forwarded within the past 12 months and explained it was not viable to present all these SAI's individually to SMT, Governance Committee or Trust Board.

In terms of providing adequate assurances in respect of learning from SAIs to improve quality, safety and mitigation of risk, Mrs Marshall explained the purpose of the paper was to advise members of the introduction of a decision-making framework to assist Directors as to which SAI cases should be presented at SMT and Board level.

Members noted the list of criteria detailed within the paper, selected as triggers to identify the presentation of SAI's. A brief discussion ensued. Mrs Rooney requested that a definition of the 3 levels of investigation be included as an appendix to the paper. A further request was made to include the process for screening SAIs. Following a query from Mrs Rooney on one of the criteria, 'Cases resulting in internal disciplinary action', Mr Morgan reflected on the feedback already provided by Directors and asked for clarification as to whether the paper was in its final version or still needed to be refined. Mrs Clarke welcomed the discussion and requested that members forward further

comments on the guidelines to Mrs Marshall no later than Friday 22nd May 2015 and thereafter a final version would be issued to members. Implementation of the framework would commence on 1st June 2015 with evaluation of the effectiveness of the criteria after a 6 month period.

Action – Mrs Marshall

9. PROFESSIONAL GOVERNANCE REPORTS

i) Medical Director Report

Mrs Brennan spoke to the report and updated on medical appraisal and revalidation work-stream for year ending 31 March 2015. She stated that 170 doctors have successfully revalidated to date and the Trust is currently progressing to schedule with planned doctor revalidation. Mrs Rooney asked if the timescale for the completion of all 2014 appraisals by end Summer 2015 was realistic, to which Mrs Brennan provided assurance of the process in place to achieve 100% compliance within this timeframe.

In relation to infection control, Mrs Brennan reported that PfA targets for 2014/15 for C.Difficile within the Trust have been exceeded, with 41 cases reported against a target of 32. However, Mrs Brennan advised that further analysis indicates that the total is 34, taking into account relapsed cases. In relation to MRSA and MSSA, the PfA targets for 2014/15 have also been exceeded in both infections. Further detail is included within the report. Mrs Brennan added that the Trust is in line with the overall NI position for these targets. Mrs Mahood referred to the correlation between the number of C.Difficile cases reported in the paper and the decrease in score for Infection Control, set out in the Controls Assurance Standards Report on Compliance 2014/15 and acknowledged the ongoing work within the Trust on HCAI.

Mrs Brennan advised that the Trust had just received HCAI rates in comparison with its peers and stated that an analysis of the Trust's performance would be brought to the Governance Committee in September.

Action – Dr Simpson

Dr Mullan queried the variance between crash call rates at Craigavon Area Hospital (CAH) and Daisy Hill Hospital (DHH). In response, Mrs Brennan stated that further detail/explanation would be made available for the next meeting in September 2015.

Action – Dr Simpson

Dr Mullan referred to Stroke Collaborative, the detail of which was included on page 21 of the report and raised concern around the timescales for receiving treatment. In response Mrs Clarke assured members that when patients present themselves and are deemed suitable, they receive their first Thrombolysis treatment within 60 minutes, however the figures relating to DHH were for patients who presented out-of-hours, and in the majority of instances were over the timeframe by 20 minutes or less.

Following a query from Mrs Rooney on page 17 pertaining to the completion of medicines reconciliation proforma by pharmacists in the Medical Admissions Unit (MAU), a short discussion ensued. In responding, Mrs Brennan advised that the fall in compliance with 48 hour targets has been discussed by the Acute Governance Committee and a re-audit will take place in December 2015. Mrs Brennan agreed to revisit the narrative included within the report and reflect accordingly.

Action – Mrs Brennan

In concluding discussion, Mrs Clarke commended the Radiology speciality programme review. A final report with the grading A1 Excellent had been received from Northern Ireland Medical and Dental Training Agency (NIMDTA)

10. DRAFT GOVERNANCE STATEMENT

Mrs Clarke presented the draft Governance Statement. Members noted the new control issues in 2014/15 and a number of areas where there was an unacceptable level of assurance from Internal

Audit. Mrs Mahood advised that the draft Governance Statement had also been scrutinised in detail by the Audit Committee. Mrs Judt reminded members the document would come to Trust Board for approval, on 11th June 2015, as part of the final year end accounts.

Mrs Rooney advised that her term of office had been extended until August 2019 and asked if this could be reflected in the document. Mrs Judt agreed to take this forward.

Action – Mrs Judt

11. CONTROLS ASSURANCE STANDARDS – REPORT ON COMPLIANCE 2014/15

Mrs Clarke presented the above-named report. She advised that for 2014/15, the Trust met the Department's requirements and achieved a substantive level of compliance in 22 standards. 11 standards had increased on 2013/14 scores, 3 standards had decreased and 8 remained static. Mrs Mahood confirmed that this report was also reviewed by the Audit Committee. Dr Mullan welcomed the improved position.

12. SH&SCT GOVERNANCE ARRANGEMENTS

Mrs Clarke spoke to the above named paper and provided a brief explanation detailing its purpose. She stated that the revisit of the CSCG arrangements would focus on strengths and weakness of the present arrangements and will assist the Trust in identifying key areas and solutions for improvement. Members were advised that following this process an action plan would be formulated and presented for assurance proposes. Dr Mullan reflected on the timeliness of the document and welcomed the process when an increased emphasis is being placed on good governance arrangements.

Mrs Mahood asked about the timeframe for review, following the scoping exercise. In response, Mrs Clarke advised that following SMT approval an update on progress would be brought to the next Governance Committee meeting in September. Mrs Rooney

suggested that the process would take cognizance of recent external reviews. Mrs Clarke assured members that the scope of this work was broad and encompasses Quality 2020 and the Donaldson Report.

13. **RQIA STATUS UPDATE REPORT**

Mrs Clarke presented the report for the period 1 January 2015 – 31 March 2015 and referred to the updates from the previous quarter. 19 announced/unannounced hygiene inspections have been removed from the report following implementation of all recommendations. Members considered the detail within the report. Mrs Mahood acknowledged the significant progress achieved at Cedar Grove, Oakwood and Woodside facilities and noted that no recommendations had been identified upon inspection.

14. **MORECAMBE BAY REPORT**

Mrs Burns provided a verbal update and stated that the report detailed the findings, conclusions and recommendations of an independent investigation, established to review the management, delivery and outcomes of care provided by the maternity and neonatal services of the University Hospitals of Morecambe Bay NHS Foundation. She advised members that the report had raised 44 recommendations, for the Trust itself and the wider NHS, aimed at ensuring the failings are properly recognized and acted upon. In light of this, Mrs Burns stated, the SHSCT would commence a benchmarking exercise and an update would be brought to the next Governance Committee meeting in September 2015.

Mrs Kelly spoke of a similar investigation carried out at the Midland Regional Hospital, Portlaoise and suggested that it would be beneficial for members to access the findings. She emphasized the importance of the patient voice in providing learning and facilitating ongoing improvement to the overall patient experience.

At this point, Mrs Burns referred to the Workage Project within the Trust and undertook to provide an update at the next Governance Committee meeting in September 2015.

Action – Mrs Burns**15. UPDATE ON AUDIT TEAM ACTIVITY**

Mrs Clarke set in context the above named paper and explained it had evolved from feedback received from both Governance Committee and Non-Executive Directors on the need for richer information on the purpose of clinical audit within the organisation. Mrs Clarke stated that the purpose of the report was to update the Governance Committee on the following areas (i) The Trusts present arrangements for supporting clinical Audit (ii) Mechanisms currently in place to address clinical audit recommendations/action plans and (iii) Ongoing developments. Mrs Marshall explained that the current arrangements focus on clinical audit within the Acute Directorate but further work needs to be undertaken to extend support out to other Directorates including Children & Young People's Services (CYP).

Mrs Mahood asked if there was a clinical audit plan in similar format to that of the Audit Plan reviewed by the Audit Committee. Mrs Marshall advised that the organisations audit work plan would be revisited in the context of the outcomes of the review of Clinical and Social Care Governance and priorities for patient safety emerging from the Integrated Quality Improvement Framework and the Corporate Risk Register. Mrs Mahood welcomed the report and asked if this would now be a standing item for review by the Governance Committee. In response, Mrs Clarke stated that in moving forward with the review of the Trusts present CSCG arrangements, how best to provide assurance to Trust Board on the Clinical Audit process, would be considered.

Mrs Blakely left the meeting at 12.40 p.m.

16. UPDATE ON CARERS ACTION PLAN

Mr Graham, as the designated Board member for carers, introduced the report and highlighted the good progress being made.

Mrs McVeigh presented the report, based on the current Southern Trust Carers Action plan for the period April 2014 – March 2015. She

referred to the challenges around the proposed commissioning plan to raise the Carers Assessment completion target by 10%.

Mrs Rooney referred members to the cash grant scheme and asked about the £40k LCG money. Mrs McVeigh advised of a shift across slippage and explained this was a small amount of money carers can use to purchase tangible items. She referred to the work of the carers reference group and emphasized the important part they play in helping to shape areas for target.

In conclusion Mr Graham highlighted Unmet need, RAG rated Red and stated that Regional guidance was still awaited on this issue.

17. **FREEDOM OF INFORMATION, ENVIRONMENTAL INFORMATION AND SUBJECT ACCESS REQUESTS – SUMMARY REPORT FOR THE PERIOD 1.1.2015 – 31.3.2015**

Mrs Magwood presented the summary report for the period 1 January – 31 March 2015. A total of 80 requests were received and responded to in this period and of these 58 were processed within the 20 day deadline and 22 processed outside of the 20 day deadline. Members noted that the majority of requests were received from the public, businesses and the media. Details of the individual requests for information are included within the report.

Mrs Magwood drew members' attention to additional information on Subject Access Requests included within the report for the first time, for the period 1 January – 31 March 2015. A total of 72 requests were received and responded to in this period and of these 59 responses were processed within the 40 day deadline and 13 processed outside of the 40 day deadline. The majority of Data Protection Act information requests were received from the public, insurance companies and family members.

Members were reminded of the increasing volume of FOI requests and the difficulties facing the Trust to comply with regional targets. Mrs Magood advised that the reducing performance in 2014 regarding FOI response times could be linked to capacity issues across teams. Mrs Mahood asked for reassurance that the Trust has a full team in place to effectively administer all requests. In

responding, Mrs Magwood stated that frontline staff are key in the provision of responses to the majority of requests and assured members that the Trust had effective controls in place to ensure timely responses. Mrs Mahood welcomed the comments and acknowledged the ongoing challenges.

18. **UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE**

Mr Graham, Chair of the Patient and Client Experience Committee provided a verbal update on the recent meeting held on 12th March 2015. He advised regarding a change to the Committee membership and stated that the PPI Panel had increased their membership to four.

Mr Graham advised that Mrs Marshall was formulating a piece of work on forming complaint reporting and added it would be helpful to see more clearly how complaints are reported.

19. **ANY OTHER BUSINESS**

None.

The meeting concluded at 12.55 p.m.



GOVERNANCE COMMITTEE

DATE: Tuesday, 12th May 2015

TIME: 10.15 a.m. – 1.00 p.m.

VENUE: Boardroom, Trust Headquarters, Craigavon

AGENDA

TIME		ITEM	DIRECTOR
10.15 – 10.20 a.m.	1.	Welcome and apologies: <i>Mr K Donaghy, Dr T Boyce</i>	Dr R. Mullan
	2.	Declaration of Interests	Dr R. Mullan
	3.	Chairman's Business	Dr R. Mullan
	4.	Minutes of meeting held on 3rd February 2015 (for approval)	Dr R. Mullan
	5.	Matters Arising from previous minutes	Dr R. Mullan
10.20 – 10.45 a.m.	6.	Corporate Risk Register	Mrs P. Clarke
10.45 – 11.00 a.m.	7.	Medicines Governance Report	Dr T. Boyce
11.00 – 11.20 a.m.	8.	Clinical and Social Care Governance i) Incidents and Complaints Management Report and Update on Ombudsman Cases 1 st January 2015 – 31 st March 2015 ii) Serious Adverse Incidents Report for the period 1 st January 2015 – 31 st March 2015 iii) Guidelines for Directors on the presentation of SAIs at SMT, Governance Committee and Trust Board	Mrs M. Marshall Mrs M. Marshall Mrs M. Marshall

		COFFEE BREAK	
11.30 – 11.40 a.m.	9.	Professional Governance Reports i) Medical Director Report	Dr J. Simpson
11.40 – 11.50 a.m.	10.	Draft Governance Statement	Mrs P. Clarke
11.50 – 12.00 p.m.	11.	Controls Assurance Standards – Report on Compliance 2014/15	Mrs P. Clarke
12.00 – 12.10 p.m.	12.	SH&SCT Governance arrangements	Mrs P. Clarke/ Mrs M. Marshall
12.10 – 12.20 p.m.	13.	RQIA Status Update Report	Directors
12.20 – 12.25 p.m.	14.	Morecombe Bay Report (verbal)	Mrs D. Burns
12.25 – 12.35 p.m.	15.	Update on Audit Team activity	Mrs M. Marshall
12.35 – 12.45 p.m.	16.	Update on Carers Action Plan	Mr E. Graham/ Mrs A. McVeigh
12.45 – 12.55 p.m.	17.	Freedom of Information, Environmental Information and Subject Access Requests – Summary Report for the period 1 January 2015 – 31 March 2015	Mrs A. Magwood
12.55 – 1.00 p.m.	18.	Update from Patient and Client Experience Committee - <i>Verbal</i>	Mr E. Graham
	19.	Any other Business	
<i>The next meeting of the Governance Committee will take place on Tuesday, 8th September 2015 at 9.30 a.m., in the Boardroom, Trust Headquarters.</i>			



**Minutes of a meeting of the Governance Committee held on
Tuesday, 8th September 2015, at 10.15 a.m. in the Boardroom,
Trust Headquarters**

PRESENT:

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

IN ATTENDANCE:

Mrs R Brownlee, Trust Chair
Mr K Donaghy, Director of Human Resources & Organisational Development
Mrs E Gishkori, Director of Acute Services
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs A Magwood, Acting Director of Performance and Reform
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr C Clarke, Clinical Lead for Organ Donation (*Item 15i only*)
Dr M Hogan, Consultant Neonatologist (*Item 10 only*)
Mr D Sim, Consultant Obstetrician/Gynaecologist (*Item 10 only*)
Mr G McCracken, Consultant Obstetrician/Gynaecologist (*Item 10 only*)
Mrs A McVey, Assistant Director, Integrated Maternity, Women's Health & Neonatology (*Item 10 only*)
Ms J Beckett, Workage Project Change Facilitator (*Item 10 only*)
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary (Minutes)

1. **WELCOME AND APOLOGIES**

Dr Mullan welcomed those present to the meeting. Apologies were recorded from Ms D Blakely, Non-Executive Director, Mrs P Clarke, Interim Chief Executive, Dr R Wright, Medical Director, Mrs M Marshall, Assistant Director, Clinical and Social Care Governance and Dr T Boyce, Director of Pharmacy.

2. **DECLARATION OF INTERESTS**

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

3. **CHAIRMAN'S BUSINESS**

None.

4. **MINUTES OF MEETING HELD ON 12th May 2015**

The Minutes of the meeting held on 12th May 2015 were agreed as an accurate record and duly signed by the Chairman.

5. **MATTERS ARISING FROM PREVIOUS MINUTES**

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

Safer Births and Peri-Natal Report

Mrs Rooney pointed out that the areas/issues she had raised with Dr Mullan following the meeting on 12th May 2015 were aligned with the Neonatal Quality Improvement Report 2014 and it was her understanding these would be addressed within the C-section presentation later in the meeting.

6. **CORPORATE RISK REGISTER**

Members considered the Corporate Risk Register (CRR). There are currently 25 risks, 15 high level and 10 moderate level. Members noted a potential new risk 'Inability to recruit into the Medical workforce leaving gaps within the current rotas within Daisy Hill Hospital'. The Trust has in place a range of measures to mitigate the risk and full risk assessment will be brought to SMT when the CRR is next being reviewed.

Members discussed Risk 8, 'Increasing inability to recruit registered nursing staff', due to demand outweighing supply across the Province. Both Mr Rice and Mrs Gishkori alluded to the challenges the Trust faces, in the recruitment and retention of nursing staff. Mr Donaghy outlined a number of actions the Trust has been progressing including a recruitment drive targeting nursing students, as well as a recent advertising campaign. Mrs Brownlee sought assurance that this risk was being escalated through the appropriate channels. In response, Mr Donaghy assured members the issue was being taking forward locally through the Trust Nursing Workforce Planning Group and also via the Regional group, of which Mr Rice is the Chair.

Mrs Rooney referred to Risk 3 and highlighted the 40 permanently placed clients who require to be reviewed and transferred into the Care Home Support Team (CHST) in Craigavon/Banbridge area, from ICT and Memory Teams. In response, Mrs McVeigh stated that the Trust had an assessment process in place and that to her knowledge a number of the 40 clients identified did not require an annual review to be completed, as they were within their first 8 weeks of placement. Mrs McVeigh agreed to provide updated figures for the meeting in December 2015.

Action – Mrs McVeigh

Members noted Risk 19, 'Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements' and the comprehensive work already undertaken by the Trust. Mrs Mahood asked if Trust Board would be updated on this matter through the

Executive Director of Nursing Report. Mr Rice confirmed this would be the case.

Action – Mr Rice

In response to a question from Mrs Rooney on the recruitment of Consultant medical staff within Dermatology, Mr Donaghy advised that an update would be provided in the next CRR to Governance Committee in December 2015.

7. **MEDICINES GOVERNANCE REPORT**

Members noted the content of the Medicines Governance Report. During the final quarter of 2014/15, 222 medication incidents were reported within the Southern HSC Trust. The average number of reported medication incidents each month was 74, representing a decrease from 78 per month in the previous quarter. During the final quarter of 2014/15, 2 major incidents and 1 catastrophic incident were recorded. Members discussed the major incidents associated with prescribing of Penicillin and Codeine to patients with allergies, as well as the Catastrophic incident involving an elderly patient. Various concerns were raised around gaps in the communication and recording of information. Mr Rice and Mrs Gishkori agreed to further investigate these incidents along with Dr Boyce and update members at the meeting in December 2015.

Action – Mr Rice/Mrs Gishkori/Dr Boyce

Mrs Brownlee emphasized the importance of robust training and that learning lessons are taken forward.

ANNUAL REPORT FOR THE ACCOUNTABLE OFFICER RESPONSIBLE FOR CONTROLLED DRUGS

Members welcomed the above named report. For the 12 month period January – December 2014, the Accountable Officer submitted 4 Occurrence Reports to the Northern Ireland Local Intelligence Network (LIN) in line with the legislation. These reports contained 3 concerns, details of which are documented within Appendix A of the report.

8. **CLINICAL AND SOCIAL CARE GOVERNANCE**

i) **Incidents and Complaints Management Report and Update on Ombudsman Cases 1.4.2015 – 30.6.2015**

Members considered the report for the period 1 April 2015 – 30 June 2015. A total of 3266 incidents were reported during this period, a decrease of 58 incidents comparable with the same period last year. For the period ending 30 June 2015, 6 Catastrophic incidents were recorded.

Mrs Magwood referred to the Top 10 Incidents by Directorate and in particular the apparent growth in the number of Internal Absconders. In response, Mr Morgan stated that new criteria had been released on this issue. He referred to the 36 Absconders recorded within the Children and Young Peoples Directorate and explained how these figures are calculated.

Mrs Kelly asked about the uptake on the level of Falls Bundle Training within the Private Nursing Home sector. Mrs McVeigh stated that various initiatives and regional work are ongoing and agreed to provide further information under matters arising for the meeting in December 2015.

Action – Mrs McVeigh

Complaints were discussed. Mrs Brownlee raised the theme, staff attitude and behaviour and spoke of the need for champions to identify areas for improvement. Mrs Brownlee emphasized how important it was that staff were up to date with relevant training and learning was taken forward.

Update on Ombudsman Cases

Members noted the content of the report which provides a summary of new cases received within the time period 1 April 2015 – 30 June 2015, as well as an update on existing cases. Members noted that 4 cases were closed within the same period.

ii) **Serious Adverse Incidents Report for the period 1.4.2015 – 30.6.2015**

Members noted the summary of SAls reported during the period 1 April 2015 – 30 June 2015 and those that remain open from 1 April 2009 – 30 June 2015. A total of 21 new notified SAls were reported during 1 April 2015 – 30 June 2015.

iii) **Revisit of Clinical & Social Care Governance – update on progress**

Discussion on this item was deferred until the next meeting in December 2015.

9. **PROFESSIONAL GOVERNANCE REPORTS**

i) **Report on Compliance of Core and Profession Specific Quality Indicators for Allied Health Professions**

Mr Rice spoke to this report, which presents an update on compliance of Core and Profession Specific Quality Indicators for Allied Health Professions (AHPs). He reminded members that presently compliance is measured against 7 AHP disciplines and pointed out that as part of the Regional AHP Strategy, it will be a requirement that compliance is measured against 12 AHP disciplines. Mr Rice advised members that the Trust is currently in negotiation with the DHSSPSNI and PHA as to how this will be achieved on an incremental basis in the future.

Mrs Brownlee drew attention to Physiotherapy on page 7 of the report and the reduced compliance due to staff vacancies across a range of areas. She emphasized the importance of keeping this under review and referred to the impact on waiting lists. Mrs McVeigh pointed out that the Trust had recently recruited a number of Physiotherapists and stated that improvement in compliance should be evident within the next report. Members noted the 70% compliance within Acute and Community with regards to updated care plans. Mr Rice explained that work in this area was ongoing. A single care plan document, agreed in April

2015 will facilitate improved communication and updating of care packages. Implementation of the care plan is currently being piloted in Armagh/Dungannon locality and is due to be completed in October 2015. Mrs Brownlee asked that AHP Workforce issues along with Compliance issues would be kept under review at Governance Committee/Trust Board.

10. **SHSCT C-SECTION RATES**

Dr Mullan welcomed Dr Hogan, Consultant Neonatologist and Mr Sim, Consultant Obstetrician/Gynaecologist Clinical Director, to the meeting along with Mr McCracken, Consultant Obstetrician, Ms McVey, Assistant Director IMWH and Ms Beckett, Workage Project Change Facilitator.

Dr Hogan began by addressing issues raised by Mrs Rooney following the Governance Committee meeting on 3rd February 2015, in respect of the Neonatal Quality Improvement Report 2014 for CAH. Mrs Rooney welcomed the comprehensive response and recorded her thanks to Dr Hogan for clarifying the points she had raised. She added that in terms of progressing through shared learning it would be worth pursuing the possibility of compiling a joint report with Daisy Hill Hospital in the future.

At this point, Mr Sim presented the SHSCT C-Section rates and compared rates across 4 modes of delivery against regional figures for 2014/15. He acknowledged that in Emergency C-Section births Trust figures remain greater than regional targets but pointed out that progress has been achieved since the prior year 2013/14. Mr Sim advised that Elective C-Section rates are fairly stationary across the Trust and outlined various challenges staff encounter in seeking to educate expectant mothers, in the different safe and effective options available to them. Mr Sim continued by advising that regionally, the Southern Trust is performing well in terms of Perinatal Mortality and Stillbirth rates.

Mr Sim reminded members of the investigation into the Morecambe Bay Foundation Trust Hospital and the subsequent Kirkup Report which highlighted various failings within the dysfunctional maternity unit.

Ms Beckett introduced the Workage project, a 3 year EU-funded project designed to test the proposition that the engagement and retention of staff aged 50+ will be improved by enhancing levels of involvement and participation in the workplace for all employees. She guided members through various methods adopted to engage with this staff group within the Trust and in conclusion outlined a number of positive outcomes to date including; Improving consistency across the Trust Maternity Department, improving communication, shared learning from incidents and enabling all voices to be heard. Mr Rice and Mrs Gishkori commended the project and the commitment shown by Ms Beckett in making it such a success. Mrs Brownlee reiterated the previous comments and suggested that Ms Beckett would give a more detailed presentation on the outcomes of the Workage project at a future Governance Committee meeting. Mrs Gishkori agreed to take this forward.

Action – Mrs Gishkori

Following a question from Mrs Brownlee on medial workforce issues, a brief discussion took place. A number of questions were asked and Mr McCracken and Mrs McVey provided responses. In conclusion, Mrs Brownlee asked how the Trust Board could support staff to meet the challenges they encounter on a daily basis. In responding, Mr Sim spoke of the competing challenges on staff time and the importance of taking time out to share and learn together in a multidisciplinary way. Mr Donaghy assured members that there were opportunities already in place for teams to meet together in this manner, however he acknowledged that “Time out for Teams” needs more embedded focus and this would be further explored at the SMT Away Day planned for October 2015.

Action – Directors

11. RQIA STATUS UPDATE REPORT

Members considered the detail within the report for the period 1 April 2015 – 30 June 2015. Mr Morgan informed members that the final report of the Safeguarding Board Thematic Review, has now been produced and he agreed to report back any learning at a future Trust Board meeting. Mrs Brownlee raised the Failure to Comply notice

issued to Glenview Private Nursing Home. She welcomed the progress to date and the action plan to address outstanding issues. Mrs McVeigh reiterated the previous comments and advised that a new manager had recently taken up post. A further Trust performance management meeting was scheduled for 10th September 2015, when outstanding issues would be reviewed.

12. **HEALTH & SAFETY GOVERNANCE**

i) Annual Health & Safety Governance Report for the period 1.4.2014 – 31.3.2015

Mr Donaghy presented the above named report prepared to provide assurance to the Governance Committee that the Trust is managing its health and safety risks and thereby complying with its statutory responsibilities. Dr Mullan welcomed this comprehensive report.

Mrs Brownlee raised concern at the low numbers of staff particularly within the Functional Support Services Division, who have not completed moving and handling training. She also referred to Infection Prevention and Control (IPC) training and drew members attention to page 55 of the document, which reported a large number of red areas. In response to the previous comments, Mr Donaghy pointed out a steady increase in the number of staff completing moving and handling training since 2013. He acknowledged the low compliance across IPC and spoke of the challenges around releasing staff to complete training within some divisions. Dr Mullan referred to the low number of Trust bank staff having completed IPC training and pointed out the potential risk to the Trust. Mr Donaghy assured members that unless staff have completed the aforementioned training they cannot undertake bank duties. He spoke of the ongoing workforce challenges the Trust encounters and the need to look at ways of identifying areas where training could be revisited.

13. **EMPLOYER/PUBLIC/OCCUPIER LIABILITY REPORT FOR THE PERIOD ENDING 31.3.2015**

Mr Donaghy presented the report which provides a summary of the Employer, Public and Occupier Liability claims against the Southern Health and Social Care Trust for the period 1 April 2014 to 31 March 2015. A total of £510,229 was paid out by the Trust to claimants for the period. Lessons learnt from settled claims indicate that a prompt and thorough investigation carried out as soon as possible after the incident date will assist Trust ability to defend legal action.

14. **FREEDOM OF INFORMATION, ENVIRONMENTAL INFORMATION AND SUBJECT ACCESS REQUESTS – SUMMARY REPORT FOR THE PERIOD 1.4.2015 – 30.6.2015**

Mrs Magwood presented the summary report for the period 1 April – 30 June 2015. A total of 66 requests were received and responded to in this period and of these 52 were processed within the 20 day deadline and 14 processed outside of the 20 day deadline. Members noted that the majority of requests were received from the public, businesses and the media. Details of the individual requests for information are included within the report.

Mrs Magwood drew members' attention to additional information on Subject Access Requests included within the report for the first time, for the period 1 April – 30 June 2015. A total of 78 requests were received and responded to in this period and of these 66 responses were processed within the 40 day deadline and 12 processed outside of the 40 day deadline. The majority of Data Protection Act information requests were received from the public, insurance companies and family members.

15. **REPORTS FOR ASSURANCE**

i) **NI Organ Donation Report**

Dr Clarke presented this performance report produced by the Public Health Agency (PHA), which highlights how the Southern Trust is performing compared with the rest of the UK in terms of organ donation activity. For the period 1 April 2014 – 31 March

2015, the Trust performed above the average UK statistics and recorded 8 deceased solid organ donors, resulting in 19 patients benefitting from transplants.

Members asked a number of questions to which Dr Clarke provided responses.

ii) Standards and Guidelines

For the period 1 November 2014 to 30 April 2015 the Trust received 115 new Standards and Guidelines from the DHSSPSNI or other external agencies. Of these 115 Standards and Guidelines, the Trust has achieved full compliance with 71 (62%). This brings the total number of Standards and Guidelines recorded on the Trust Register to 1265. A short discussion ensued around the volume and complexity involved in the administration of these Standards and Guidelines. Mrs Brownlee suggested focusing on 1 or 2 standards/guidelines and present to Governance Committee/Trust Board to enable more full discussion and understanding, particularly in relation to challenges to implementation. Mrs Magwood undertook to discuss with Dr Wright and Mrs Marshall and to bring forward a process for reporting, ensuring Directorate/cross Directorate representation of case study examples. It was agreed that this process would be brought forward via Senior Management Team (SMT) for approval.

Action – Mrs Magwood/Dr Wright/Mrs Marshall

16. **GOVERNANCE COMMITTEE ANNUAL REPORT**

Dr Mullan presented the Governance Committee Annual Report which relates to the year 2014/15. He stated that its purpose was to report on the work of the Committee for the financial year under review.

Dr Mullan recorded thanks to Mrs Judt for producing this informative report.

17. **UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE**

Mr Graham, Chair of the Patient and Client Experience Committee provided a verbal update on the meeting held on 18th June 2015 and advised that a presentation on the Quality Improvement Framework took place.

18. **PROPOSED MEETING DATES 2016**

The proposed dates for 2016 were approved by those present.

19. **GOVERNANCE COMMITTEE SELF-ASSESSMENT**

Due to time constraints, Mrs Judt advised that she would email the Self-Assessment document to non-executive members following the meeting for completion.

20. **ANY OTHER BUSINESS**

None.

The meeting concluded at 1.30 p.m.

SIGNED: _____

DATED: _____



GOVERNANCE COMMITTEE

DATE: Tuesday, 8th September 2015

TIME: 10.00 a.m. – 1.15 p.m.

VENUE: Boardroom, Trust Headquarters, Craigavon

AGENDA

TIME		ITEM	DIRECTOR
10.15 – 10.25 a.m.	1.	Welcome and apologies: Mrs P Clarke; Dr R Wright; Mrs M Marshall; Dr T Boyce	Dr R. Mullan
	2.	Declaration of Interests	Dr R. Mullan
	3.	Chairman's Business	Dr R. Mullan
	4.	Minutes of meeting held on 12 th May 2015 (<i>for approval</i>)	Dr R. Mullan
	5.	Matters Arising from previous minutes	Dr R. Mullan
10.25 – 10.40 a.m.	6.	Corporate Risk Register	Directors
10.40 – 10.50 a.m.	7.	Medicines Governance Report	Mrs E. Gishkori or nominated rep
		Annual Report from the Accountable Officer Responsible for Controlled Drugs	"
10.50 – 11.05 a.m.	8.	Clinical and Social Care Governance	
		i) Incidents and Complaints Management Report and Update on Ombudsman Cases 1 st April 2015 – 30 th June 2015	Directors
		ii) Serious Adverse Incidents Report for the period 1 st April 2015 – 30 th June 2015	Directors
		iii) Revisit of Clinical & Social Care Governance – update on progress	(for noting only in Chief Executive and AD C&SCG absence)

11.05 – 11.15 a.m.	9.	Professional Governance Reports i) Report on Compliance of Core and Profession Specific Quality Indicators for Allied Health Professions	Mr. F. Rice
		COFFEE BREAK	
11.30 – 11.50 a.m.	10.	SHSCT C-section rates PRESENTATION: to include benchmarking against Morecambe Bay Report and update on Workage project <i>Dr G McCracken and Mr D Sim, Consultants in O&G; Mrs A. McVey, Assistant Director IMWH</i>	Mrs E. Gishkori
11.50 – 12 noon	11.	RQIA Status Update Report	Directors
12.00 – 12.10 p.m.	12.	Health & Safety Governance i) Annual Health & Safety Governance Report for the period 1 April 2014 – 31 March 2015	Mr K. Donaghy
12.10 – 12.20 p.m.	13.	Employer/Public/Occupier Liability Report for the period ending 31 March 2015	Mr K. Donaghy
12.20 – 12.30 p.m.	14.	Freedom of Information, Environmental Information and Subject Access Requests – Summary Report for the period 1 April 2015 – 30 June 2015	Mrs A. Magwood
12.30 – 12.50 p.m.	15.	Reports for Assurance i) NI Organ Donation Report <i>Dr Clarke attending</i> ii) Standards and Guidelines	Mrs E. Gishkori Directors
12.50 – 1.00 p.m.	16.	Governance Committee Annual Report	Dr R. Mullan
1.00 – 1.15 p.m.	17.	Update from Patient and Client Experience Committee – <i>Verbal</i>	Mr E. Graham

	18.	Proposed Meeting Dates 2016	Dr R. Mullan
	19.	Governance Committee Self-Assessment	Dr R. Mullan
	20.	Any other Business	
<i>The next meeting of the Governance Committee will take place on Tuesday, 8th December 2015 at 9.30 a.m., in the Boardroom, Trust Headquarters.</i>			



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

PRESENT:

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

IN ATTENDANCE:

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

1. **WELCOME AND APOLOGIES**

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

2. **DECLARATION OF INTERESTS**

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

3. **CHAIRMAN'S BUSINESS**

None.

4. **MINUTES OF MEETING HELD ON 8TH SEPTEMBER 2015**

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

5. **MATTERS ARISING FROM PREVIOUS MINUTES**

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

6. **CORPORATE RISK REGISTER**

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

In light of the aforementioned new risk, Mrs Mahood asked for assurance regarding recruitment in other key areas. Mr Rice updated in terms of nursing recruitment and advised that the regional piece of work he had been tasked to undertake was now complete and would be presented to the regional advisory committee within the next few days. Mr Morgan advised there were no issues to report under Children and Young People's Services.

Dr Mullan drew member's attention to page 12 and asked about, longest waits, some going back as far as 2011/12. Mrs Magwood acknowledged the high volume and explained that long waiters could be on a list for a number of reasons. She confirmed that all Urology

patients for 2011/12 and 2012/13 have been validated and those waiting from 2011/12 have all been offered an appointment date. Mrs Magwood advised that the Trust has been engaging with GPs in an effort to progress this issue. Mrs Clarke acknowledged this to be a long-standing challenge and stated that practice has changed with regards to the discharge and referral process to seek to avoid long review waits going forward. Additional sessions are being delivered to enable consultants to dedicate time to see these long wait patients.

In response to a point raised by Mrs Rooney in relation to the wording of risk 2, page 12, Mrs Magwood agreed to re-visit the wording used.

7. **MEDICINES GOVERNANCE REPORT**

Members noted the content of the Medicines Governance Report. During the first quarter of 2015/16, 394 medication incidents were reported within the Southern HSC Trust. The average number of reported medication incidents each month was 131 per month, representing an increase from 74 per month in the previous quarter. This spike is due to an educational audit carried out in May 2015, where pharmacists reported every prescribing incident they detected during one week. Dr Boyce welcomed the audit and the learning being taken forward. Following a question from Mrs Mahood, Dr Boyce explained that constraints on pharmacists time do not permit such an audit to be carried out on a weekly basis, but gave assurance that high level auditing processes were in place.

Mrs Rooney asked if medication incidents at ward level were reported and captured. Dr Boyce assured members that medication incidents at ward level are recorded by the clinical member of staff that identifies them and these are recorded onto the datix system using an IR1 form. She went on to explain that on the Acute wards the Governance facilitators or the Heads of Service review each ward's incident reports with the ward manager each month. In addition, the Director of Pharmacy and the Medicines Governance pharmacist review every Trust medication incident each month to look for patterns and trends, which are then fed back through each Directorates Governance system. Dr Wright acknowledged the difficulties around clarifying criteria and stated that direct and immediate feedback is key to moving forward. In conclusion, Mr Rice

emphasized that we need to become more sophisticated in relation to how we extract data from the auditing process.

Dr Boyce left the meeting at 10.45 a.m.

8. **CLINICAL AND SOCIAL CARE GOVERNANCE**

i) **Revisit of Clinical & Social Care Governance – update on progress**

Dr Mullan welcomed Mrs Marshall, to deliver a presentation, updating members on the revisit of Clinical & Social Care Governance within the Southern Trust. She began by reminding members that in April 2015, the Interim Chief Executive requested a revisit of the outcomes of the 2010, SHSCT Review of CSCG, to provide Trust Board with an assurance that these arrangements remain effective and robust and to consider how we can best improve. At the outset, of the process, learning from a number of external reviews was considered. Views from a range of senior stakeholders were also sought to inform the process and a number of areas for improvement were identified. Members noted the Action Plan included within the report, taking recommendations forward.

Mrs Marshall referred to the proposed C&SCG reporting arrangements. She guided members through each of the 4 initial indicators agreed by SMT: SAls, Incidents, Complaints and Standards and Guidelines (S&G) and explained that trends were being classified in relation to complaints and SAI's.

Ms Blakely arrived at this point 11.00 a.m.

Members welcomed the presentation, which they felt was extremely useful alongside the report. In terms of progression, Mr Graham stated that he welcomed the work on trend analysis, something the organisation has not embarked on before. Mrs Clarke reiterated the previous comments and stated that this piece of work would inform the way forward in terms of a corporate approach to how assurance is provided in respect of risk, patient safety and improvement priorities.

Both Mr Rice and Dr Wright referred to the DATIX complaints codes and commended the work undertaken by Mrs Marshall and her team to date, adding that this work would be welcomed by regional colleagues. Concerns were raised regarding the challenges in the area of Standards and Guidelines and in particular, Mrs Rooney noted the quantity of S&Gs brought forward by the DHSSPSNI and the huge amount of work created for staff.

Mrs Kelly asked about the expected timeframe for completion of the review and also queried if a 5 year cycle was too long. In response to the first point, Mrs Marshall reminded members that this is a work in progress and advised that she would envisage being in a position to provide further richness of information within the reports to Governance Committee by the next meeting in February 2016. The new system for the administration of S&Gs should also have commenced by this date. Mrs Clarke responded to Mrs Kelly on the 5 year cycle and stated that she was of the opinion, this should be a rolling process. With good systems and processes in place, this would enable concerns to be raised and taken forward.

Dr Mullan thanked Mrs Marshall for delivering a very informative overview of the review of C&SCG, acknowledging it would take some time to embed into the organisation. In conclusion, Mrs Marshall recorded her thanks to Mr Wallace and the Governance Co-ordinators for their expertise and support throughout the review.

ii) Clinical and Social Care Governance Dashboard

- a) Incidents and Complaints
- b) Ombudsman Cases
- c) Serious Adverse Incidents
- d) Standards and Guidelines

Members considered the content of the proposed report format and were reminded that this format will require further development to incorporate information on how Directorates are

implementing learning from incidents, SAI and complaints through existing work streams/quality improvement activities. Appendix 1, Proposal for classifying Trust Serious Adverse Incidents and Appendix 2, Proposal for classifying Trust Complaints was included for member's information.

iii) **Annual Complaints Report 2014-15**

Mrs Marshall presented an overview of complaints within the Southern Trust for the 2014/15 financial year. The Trust received 1166 formal complaints (by subject) within the period, an increase on the previous year's figures. A further 298 subjects were noted on an enquiry or informal basis. Members welcomed the detail included for information.

9. **PROFESSIONAL GOVERNANCE REPORTS**

i) **Medical Director**

(a) Audit of Documentation for 2013 Appraisal Round

Dr Wright presented a detailed analysis of SHSCT Medical appraisal documentation and feedback questionnaires, received for the 2013 appraisal round and a comparison of 2012 results, along with recommendations for improvement. Members welcomed the detail within the document and the overall improvement recorded between 2012 and 2013 comparisons.

Dr Wright referred to the National Review of Revalidation being taken forward by the General Medical Council (GMC) and stated that new recommendations will evolve from this process. In conclusion Mrs Clarke commended the Trust's appraisal system and advised of a request to present it regionally.

(b) SHSCT Mortality Reports

Dr Wright presented the SHSCT Annual Mortality Review for i) period April 2013 to March 2014 and ii) period July 2013 to

June 2014. He began by pointing out that addendums have been produced by CHKS, relating to the data quality sections of these reports but given the low impact of the new data the Trust and CHKS have agreed there would be no gain by rerunning the reports.

Dr Wright referred to an ongoing regional piece of work and possible changes in future reporting. He advised that the Trust would continue to engage with the DHSSPSNI on this. In terms of performance, Dr Wright commended the Trust's position within the 'CHKS Top UK Hospitals' group. Members welcomed the reports and the progress recorded.

10. **RQIA STATUS UPDATE REPORT**

Members considered the detail within the report for the period 1 July 2015 – 30 September 2015. Mr Morgan referred to the RQIA visit to Neonatal Unit in CAH for the second year's audit. He advised that the Trust were awaiting the final written report, however initial verbal feedback from RQIA Inspectorate team was positive.

11. **CARERS ACTION PLAN UPDATE**

Mr Graham, as the designated Board member for carers introduced the report.

Mrs McClements presented the update, based on the current Southern Trust Carers Action plan for the period April 2015 – March 2016. She began by highlighting Carers Matter and spoke of the pressures being experienced, due to the sickness absence of key staff. Mrs McClements drew member's attention to page 11 of the report, and updated on progress achieved. She spoke of the submission of an IPT for Self-directed support (SDS) and welcomed the £75k funding, agreed recurrently from 2016/17 for carers. Mrs Rooney referred to the cash grant scheme 2014/15 on page 10 of the report and welcomed the £69,343, from which 488 Carers benefitted from Carers grants.

In conclusion Mr Graham thanked Mrs McClements for an informative update and reminded members of the ongoing challenges in providing support to both services users and those who are in the caring role.

12. **SIRO INFORMATION GOVERNANCE REPORT**

Mrs Magwood presented the above named annual report, advising that it provided a summary of the key aspects of the role undertaken by the Senior Information Risk Owner (SIRO).

Mrs Magwood referred to the Northern Ireland Electronic Care Record (NIECR) and the need for clarity around the sharing of information with 3rd parties etc. Mrs Clarke advised that she had corresponded on a number of occasions with Dr Harper, Public Health Authority (PHA), concerning information governance issues. Members noted that a short-life working group, chaired by Dr Harper has been set up to take issues forward. The Trust is also seeking additional legal advice that will inform the working group.

13. **FREEDOM OF INFORMATION, ENVIRONMENTAL INFORMATION AND SUBJECT ACCESS REQUESTS – SUMMARY REPORT FOR THE PERIOD 1.7.2015 – 30.9.2015**

Mrs Magwood presented the summary report for the period 1 July – 30 September 2015. A total of 64 requests were received and responded to in this period and of these 44 were processed within the 20 day deadline and 14 processed outside of the 20 day deadline. Members noted that the majority of requests were received from the public, businesses and the media. Details of the individual requests for information are included within the report.

Mrs Magwood drew members' attention to additional information on Subject Access Requests included within the report for the first time, for the period 1 July – 30 September 2015. A total of 80 requests were received and responded to in this period and of these 68 responses were processed within the 40 day deadline and 12 processed outside of the 40 day deadline. The majority of Data Protection Act information requests were received from the public, insurance companies and family members.

Members acknowledged the continued challenges in dealing with the volume and complexity of these requests.

14. **LEADERSHIP WALKS REPORT**

Members considered the Leadership Walks Report for the period 1 January 2015 – 30 September 2015. A total of 12 leadership walk arounds were undertaken by Board members within the period.

15. **NON-EXECUTIVE DIRECTOR'S VISITS TO CHILDREN'S HOMES REPORT**

Mr Morgan presented the above named report. During the period April 2015 – September 2015, a total of 15 Children's Home visits were undertaken by Board members. Four key themes were identified, details of which are included within Appendix 1 of the paper.

16. **UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE**

Mr Graham, Chair of the Patient and Client Experience Committee provided a verbal update on the meeting held on 3rd December 2015. He referred to the raising PPI panel membership within the Committee and welcomed the good engagement and valuable input they provide. Mr R Dixon, attended the meeting and updated members on the work of the Patient Client Council.

17. **ANY OTHER BUSINESS**

Mr Morgan advised that the Minister for Health, Social Services and Public Safety, will make a statement on 10 December 2015 advising of the outcome of the Child Sexual Exploitation (CSE) SBNI Thematic Review. Mr Morgan assured members that young people under the care of the Trust have been versed and support from staff has been put in place.

Dr Mullan paid tribute to fellow Non-Executive Director colleagues, Mrs Kelly and Mrs Blakely. He recorded thanks to both, for their

commitment and constructive contribution over the past number of years and wished them well for the future.

Personal Information redacted by the USI

The meeting concluded at 12.45 p.m.

SIGNED: _____

DATED: _____



GOVERNANCE COMMITTEE

DATE: Tuesday, 8th December 2015

TIME: 10.00 a.m. – 12.45 p.m.

VENUE: Boardroom, Trust Headquarters, Craigavon

AGENDA

TIME		ITEM	DIRECTOR
10.00 – 10.05 a.m.	1.	Welcome and apologies: Mrs A McVeigh (Mrs M McClements attending)	Dr R. Mullan
	2.	Declaration of Interests	Dr R. Mullan
	3.	Chairman's Business	Dr R. Mullan
	4.	Minutes of meeting held on 8 th September 2015 <i>(for approval)</i>	Dr R. Mullan
	5.	Matters Arising from previous minutes	Dr R. Mullan
10.05 – 10.20 a.m.	6.	Corporate Risk Register	Mrs P. Clarke
10.20 – 10.30 a.m.	7.	Medicines Governance Report	Dr T. Boyce
10.30 – 11.15 a.m.	8.	Clinical and Social Care Governance	
		i) Revisit of Clinical & Social Care Governance – update on progress	Mrs M. Marshall
		ii) Clinical and Social Care Governance Dashboard	Mrs M. Marshall
		a) Incidents and Complaints b) Ombudsman Cases c) Serious Adverse Incidents d) Standards and Guidelines	
		iii) Annual Complaints Report 2014-15	Mrs M. Marshall

11.15 – 11.30 a.m.	9.	Professional Governance Reports i) Medical Director (a) Audit of Documentation for 2013 Appraisal Round (b) SHSCT Mortality Reports	Dr R. Wright
		COFFEE BREAK	
11.45 – 11.50 a.m.	10.	RQIA Status Update Report	Directors
11.50 – 12.00 noon	11.	Carers Action Plan Update	Mrs M. McClements/ Mr E. Graham
12.00 – 12.10 p.m.	12.	SIRO Information Governance Report	Mrs A. Magwood
12.10 – 12.20 p.m.	13.	Freedom of Information, Environmental Information and Subject Access Requests – Summary Report for the period 1 April 2015 – 30 September 2015	Mrs A. Magwood
12.20 – 12.30 p.m.	14.	Leadership Walks Report	Dr R. Mullan
12.30 – 12.40 p.m.	15.	Non-Executive Director's visits to Children's Homes Report	Mr P. Morgan
12.40 – 12.45 p.m.	16.	Update from Patient and Client Experience Committee – <i>Verbal</i>	Mr E. Graham
	17.	Any other Business	
<i>The next meeting of the Governance Committee will take place on Thursday, 4th February 2015 at 9.30 a.m., in the Boardroom, Trust Headquarters.</i>			



**Minutes of a meeting of the Governance Committee held on
Thursday, 4th February 2016, at 9.30 a.m. in the Boardroom,
Trust Headquarters**

PRESENT:

Dr R Mullan, Non Executive Director (Chairman)
Mrs E Mahood, Non Executive Director
Mrs S Rooney, Non Executive Director

IN ATTENDANCE:

Mrs P Clarke, Interim Chief Executive
Mr K Donaghy, Director of Human Resources & Organisational Development
Mrs E Gishkori, Director of Acute Services
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Mrs A McVeigh, Director of Older People and Primary Care Services
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr R Wright, Medical Director
Dr T Boyce, Director of Pharmacy
Mrs M Marshall, Assistant Director, Clinical and Social Care Governance
Mrs L Leeman, Assistant Director Performance and Improvement
Mrs C Campbell, Head of Occupational Health (*Item 8 only*)
Ms F Hughes, Specialist Nurse (*Item 8 only*)
Ms D Johnston, CSCG Co-ordinator, CYP (*Item 8 only*)
Mrs S McCormick, Committee Secretary (Minutes)

1. WELCOME AND APOLOGIES

Dr Mullan welcomed those present to the meeting. Apologies were recorded from Mrs A Magwood, Acting Director of Performance and Reform and Mr E Graham, Non Executive Director.

2. **DECLARATION OF INTERESTS**

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

3. **CHAIRMAN'S BUSINESS**

None.

4. **MINUTES OF MEETING HELD ON 8th SEPTEMBER 2015**

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

5. **MATTERS ARISING FROM PREVIOUS MINUTES**

There were no matters arising from the previous meeting.

6. **CORPORATE RISK REGISTER**

Mrs Clarke presented the Corporate Risk Register (CRR) and stated there are currently 23 risks – 12 high and 11 moderate. Members noted 1 new risk regarding Trust Telecommunication Equipment, added to the CRR since the Committee last reviewed in December 2015. Mrs Clarke referred members to Risk 2, Out-Patient Review and Planned Treatment Backlogs and pointed out an error on page 14 of the document. The actual treatment backlog at 1 January 2016 is 1211 of which the majority, 930 (77%) relates to Endoscopy. Dr Mullan asked about non-recurrent funding for Endoscopy and the 8 months backlog. In responding, Mrs Leeman advised that the current position stands at 11 months for the longest wait and she provided explanation as to the contributing factors. Mrs Clarke clarified for members that the 11 month backlog related to planned treatment, those patients who required review on a regular basis as part of their management plan.

Mrs Mahood raised a number of administrative errors within the report and Mrs Clarke agreed to have these rectified in advance of the next meeting.

Mrs Clarke asked Mr Donaghy to speak to the new risk (No.23) in relation to telecommunication equipment. Mr Donaghy provided a comprehensive overview of the need to replace the current telecommunication system across the Trust. He advised that following November 2017 BT will no longer provide a guaranteed service agreement in the event of a fault which would leave the Trust without internal/external communications for a considerable period, therefore posing a significant risk. Mr Donaghy advised that capital funding of £342K for 2015/16 had already been approved for the provision of a Core Telephony Platform and further funding was required to replace a number of other systems.

Mrs Rooney referred to risk no. 6 and concerns were raised around medication transcribing by nursing staff, in contravention of NMC guidance. Members were assured by Mr Rice and Mrs McVeigh that the Trust continues to escalate this issue at a regional level and locally to seek to navigate a reasonable way through challenging capacity issues to limit the risk and support staff.

A short discussion ensued on nurse staffing levels. Dr Mullan asked about the position with regards International recruitment. Mr Donaghy advised that he had met with a number of shortlisting agencies and spoke of the challenges around language and the restriction in terms of the small number of international nurses that can be recruited at one time. Following a question from Dr Mullan, Mr Rice provided a brief update on targeted recruitment and pathways employed to introduce lower grade staff to the Southern Trust for their Band 5 career.

7. MEDICINES GOVERNANCE REPORT

Dr Boyce presented the Medicines Governance report, which demonstrates that during the second quarter of 2015/16, 304 medication incidents were reported within the Southern HSC Trust. The average number of reported medication incidents each month was 101, representing a decrease from 131 per month in the previous quarter. During the second quarter of 2015/16, there were no major or catastrophic incidents reported via Datix. Members noted the following action resulting from Trust incident monitoring: i) Review of

call allocation procedure for community nursing and ii) Reminder to wards regarding infusion fluid storage and stockholding.

In light of the pressures within the community setting, Mrs Mahood welcomed a review of the call allocation procedure for community nursing. Dr Boyce referred to the challenges associated with the speed of discharge from Acute to Community settings and emphasized the importance of ensuring robust processes are in place. Dr Mullan referred to the update on Oxygen safety in hospitals. Dr Boyce advised that the Trust has excellent bespoke storage for medical gas cylinders in place; however stockholding issues are currently being addressed. Dr Boyce provided some detail for members on the Trust's piped oxygen system, which reduces the wards needs for the higher risk cylinders. In concluding discussion she acknowledged oxygen safety to be a high risk issue but was being managed well. She welcomed the Trust soon to be a Smoke Free Site and pointed out this would help reduce risk and enhance patient safety in relation to the safe use of oxygen.

Annual Report from the Accountable Officer Responsible for Controlled Drugs

Members welcomed the above named report. For the 12 month period January – December 2015, the Accountable Officer submitted 4 Occurrence Reports to the Northern Ireland Local Intelligence Network (LIN) in line with the legislation. These reports contained 3 concerns, details of which are documented within Appendix A of the report. Members noted the detail provided and raised the importance of learning lessons and administering training when necessary.

Dr Boyce left the meeting at 10.20 a.m.

8. CLINICAL AND SOCIAL CARE GOVERNANCE

Incident/Complaints/Patient Safety Report

Mrs Marshall presented the newly formatted report for the period 1 April 2012 – 31 December 2015 and reminded members at the outset that the development of the report was a work in progress. Mrs

Marshall guided members through the detail of the report and pointed out significant areas for consideration.

Mrs Marshall took time to present the Top 5 Incidents reported from 1 April 2012 – 31 December 2015. The highest number of incidents recorded in the Trust fall within the following two categories i) Physical abuse, assault or violence, verbal abuse or disruption and ii) Falls. Directors assured members that the organization is reactive to the information being reported and would envisage a richer more holistic picture evolving over time.

Serious Adverse Incidents (SAI's) were discussed. Since 1 April 2012 – 31 December 2015 the Trust has reported 45,556 such incidents. Presently there are 74 investigations outstanding. Mrs Marshall referred to the mandatory requirement to report all Child Deaths as SAI's and advised that following regional direction, from 1 February 2016 this was no longer a requirement and she would envisage a downward trend in the number of SAIs recorded moving forward. Mrs Marshall highlighted the work undertaken to date with regard to the categorization of SAI's. She explained that the use of this new approach will allow for trend analysis over time and identification of areas for service improvement.

Following a question from Mrs Mahood, Dr Wright welcomed the new evidence based approach to reporting through the Donaldson framework and stated there was a scientific based robustness about this way of reporting. He added that regionally there has been much interest in the work led by Mrs Marshall in this area and the Trust has been asked to present the approach to counterparts across the region.

Complaints were discussed. In the first instance members noted that of the 47 complaints referred to the Ombudsman since April 2011, the Ombudsman has completed an investigation on 17 of the 47 complaints to date. A further 6 complaints were either referred back to the Trust or withdrawn. 24 complaints remain open.

Mrs Marshall spoke to the detail included on complaints management. Activity within the Trust for financial year 2014/15 recorded that there were a total of 1,666 complaints and 4,000

compliments for the period. Mrs Marshall advised that discussions are ongoing at a regional level with regards to complaint subject categorization. Mrs Marshall referred to a piece of work being undertaken within the Child and Young People's Services Directorate (CYP) where complaints are being monitored according to i) Quality of response and (ii) Response times.

Dr Wright was given opportunity to present the Patient Safety element within the report which included regional comparisons for Falls and National Early Warning Scores (NEWS). Members noted that the Director of Acute Services will give a presentation on the Trusts results following participation in a regional audit lead by the HSC Safety Forum on compliance with NEWS recording and monitoring at the meeting in May 2016

At the conclusion of a lengthy discussion, an increased emphasis on trend analysis throughout the document was welcomed, however members felt challenged in interpreting some of the information presented to them and a number of suggestions for improvement were made. Mrs Marshall agreed to take comments on board and review for the next meeting in May 2016.

Action – Mrs Marshall

Dr Wright and Mr Rice commended the work undertaken by Mrs Marshall to date, acknowledging the challenges alluded to in earlier discussion, however they welcomed the fresh direction being taken by the Trust in line with recommendations evolving from the Donaldson Framework.

Mrs Clarke clarified for members that under the revised reporting arrangements the Medical Director would now report to Governance Committee under the umbrella of Incidents/Complaints/Patient Safety Report and continue to report in full to Trust Board.

Managing Violence and Aggression Presentation

Dr Mullan welcomed Mrs Campbell and Ms Hughes to deliver a presentation on the Management of Violence and Aggression (MOVA) within the Southern Trust. Some additional information from

the Crisis Prevention Institute (CPI) was circulated for members' information. Ms Hughes began by referring to the MOVA policy procedure strategies, assuring members that care, welfare, security and safety were central to successful management. Ms Hughes advised that in 2008 the Trust became an approved training centre and she took time to explain various models of training:-

- Therapeutic Crisis Intervention (TCI)
- Management of Actual or Potential Aggression (MAPA)

Other MAPA Training

- Conflict Resolution Training
- Level 2 Personal Safety Training
- E-learning: Basic Personal Safety

Members were assured that training is constantly kept under review and through trend analysis the training is adapted and tailored to the needs of staff. Ms Hughes pointed out that MAPA training is mandatory within the following directorates: i) Mental Health and Learning Disability, ii) Acute and iii) Older People and Primary Care. Members welcomed the increase in staff completing level 3 and 4 MAPA training year on year since 2013 and the recruitment of a new full time MAPA trainer currently underway.

In responding to a number of questions from Dr Mullan, Ms Hughes and Mrs Campbell advised that a consistent training approach is provided to staff working within the Trust in the first instance and is also delivered to the Independent Sector on a case by case basis. There is no cascade training rather all staff are trained on an equal platform.

Dr Mullan welcomed the useful and informative behind the scenes look into MOVA and commended the training as tool that can assist in the prevention of the breakdown of care.

CYP – Complaints Categorisation Pilot Presentation

Mr Morgan began by setting in context the pilot being undertaken within the CYP Directorate around Complaints Categorisation. The pilot involves a look-back exercise at complaints within the Directorate over 2 financial quarters. Mr Morgan welcomed the initiative, and the richer information it would yield from complaints in

terms of improvements in quality and patient experience. He stated that the proposed complaints model offered an enhanced person centered, evidence based approach and the use of taxonomy would allow each complaint to be fully recorded using multiple levels of coding to identify all the emerging key themes.

Mrs Marshall guided members through a detailed presentation. She pointed out the current DATIX complaints codes and spoke about the limitations these present. Mrs Marshall went on to look at the wider classification framework that fits with social care under the proposed complaints categorization and highlighted the benefits of being able to drill down deeper into each complaint using a 3 tiered approach. In concluding the presentation Mrs Marshall advised that the piloting of the proposed complaints model fits into a wider project and she advised that Ms Leyden, SHSCT (along with 4 other social workers from each of the Trusts) are being sponsored by the DHSSPS to complete the IHI Professional Development Improvement Advisor Programme.

Members asked a number of questions about the software used to capture the information. Ms Johnston advised that DATIX is the Trust's primary information recording system but acknowledged that the current software did not extend far enough to encompass the proposed new categorisation. This element was captured using spread sheet software.

Mrs Clarke referred to the Trust's drive for continuous improvement and commended the pilot within CYPS as evidence of this. Dr Wright commended the work to date and added that he would be pleased to see this data set being adapted and rolled out within the medical directorate and nursing. He also spoke of the benefits with regards medical revalidation and how this approach would facilitate richer discussion and learning.

9. **PROFESSIONAL GOVERNANCE REPORTS**

i) Report on Compliance of Core and Profession Specific Quality Indicators for Allied Health Professions

Mr Rice spoke to this report, which presents an update on compliance of Core and Profession Specific Quality Indicators for Allied Health Professions (AHPs). He pointed out that the document was presented in a revised format and had been streamlined at the request of the Senior Management Team (SMT). The new profession specific QI's are more focused on directorate specific safety and improvement work plans, AHP modernization pathways and monitoring requirements arising from the findings of the Internal Review of AHPs'.

Mr Rice referred to Supervision Standards on page 5 of the document and explained that where negative growth was reported, reduced compliance was due to staff turnover and vacancies impacting on maintaining supervision schedules.

Mr Rice updated members on QI number 6, Implementation of the Band Mix/Skill Mix and advised that action plans have been completed and dates scheduled for formal hand over to Operational Directors. Mr Rice concluded by advising that he would envisage implementation to take place around June 2016.

Members welcomed the content of the report and Dr Wright commended the benefits in terms of performance monitoring.

10. **FREEDOM OF INFORMATION, ENVIRONMENTAL INFORMATION AND SUBJECT ACCESS REQUESTS – SUMMARY REPORT FOR THE PERIOD 1 OCTOBER 2015 – 31 DECEMBER 2015**

Dr Mullan welcomed Mrs Leeman to present the summary report for the period 1 October 2015 – 31 December 2015. A total of 53 requests were received and responded to in this period and of these 38 were processed within the 20 day deadline. Members noted that the majority of requests were received from the public, businesses and the media. Details of the individual requests for information are included within the report.

Mrs Leeman drew members' attention to detail on Subject Access Requests included within the report for the period 1 October 2015 – 31 December 2015. A total of 85 requests were received and responded to within the timeframe and of these 65 responses were

processed within the 40 day deadline and 20 requests were processed outside of the 40 day deadline. The majority of Data Protection Act information requests were received from the public, insurance companies and family members.

A brief discussion ensued and members acknowledged the continued challenges in dealing with the volume and complexity of these requests. Mrs Leeman assured members that actions have been put in place to try and improve the Trust's compliance rates as detailed in section 3 of the report. Dr Mullan drew attention to the high level of requests originated within the Acute Directorate. Mrs Clarke spoke about the ongoing workforce pressures and stated that to have 74% of requests responded to within the statutory time and not to have deteriorated further was welcomed.

11. **REVISED TERMS OF REFERENCE**

Members reviewed the Terms of Reference and agreed that no amendments were required at this time.

12. **UPDATE FROM PATIENT AND CLIENT EXPERIENCE COMMITTEE**

This item was deferred until the next meeting.

13. **ANY OTHER BUSINESS**

There was no further business.

The meeting concluded at 12.15 p.m.

SIGNED: _____

DATED: _____



Southern Health
and Social Care Trust

GOVERNANCE COMMITTEE

DATE: Thursday, 4th February 2016

TIME: 9.30 a.m.

VENUE: Boardroom, Trust Headquarters, Craigavon

AGENDA

TIME		ITEM	DIRECTOR
9.30 – 9.45 a.m.	1.	Welcome and apologies: Mrs Magwood (<i>Mrs Leeman attending</i>)	Dr R. Mullan
	2.	Declaration of Interests	Dr R. Mullan
	3.	Chairman's Business	Dr R. Mullan
	4.	Minutes of meeting held on 8 th December 2015 (<i>for approval</i>)	Dr R. Mullan
	5.	Matters Arising from previous minutes	Dr R. Mullan
9.45 – 10.00 a.m.	6.	Corporate Risk Register	Mrs P. Clarke
10.00 – 10.20 a.m.	7.	Medicines Governance Report - Annual Report from the Accountable Officer Responsible for Controlled Drugs	Dr T. Boyce "
10.20 – 10.35 a.m.	8.	Clinical and Social Care Governance • Incident/Complaints/Patient Safety Report	Mrs M. Marshall/ Dr R. Wright
10.35 – 10.55 a.m.		• Managing Violence and Aggression Presentation	Mrs C Campbell/ Ms F Hughes
10.55 – 11.15 a.m.		• CYP - Complaints Categorisation Pilot Presentation	Mrs M. Marshall/ Mrs D. Johnston
		COFFEE BREAK	

11.30 – 11.45 a.m.	9.	Professional Governance Reports i) Report on Compliance of Core and Profession Specific Quality Indicators for Allied Health Professions	Mr F. Rice
11.45 – 11.55 a.m.	10.	Freedom of Information, Environmental Information and Subject Access Requests – Summary Report for the period 1 October 2015 – 31 December 2015	Mrs L. Leeman
11.55 – 12.05 p.m.	11.	Revised Terms of Reference	Dr R. Mullan
12.05 – 12.15 p.m.	12.	Update from Patient and Client Experience Committee – <i>Verbal</i>	Mr E. Graham
	13.	Any other Business	
<i>The next meeting of the Governance Committee will take place on Tuesday, 10th May 2016 at 9.30 a.m., in the Boardroom, Trust Headquarters.</i>			

TRUST BOARD MEETING

DATE: Thursday, 26th March 2015

TIME: 9.30 a.m.

VENUE: Boardroom, Trust HQ, Craigavon

CONFIDENTIAL AGENDA

1. Chair's Business	Mrs R Brownlee
2. Minutes of meeting held on 29 th January 2015	Mrs R Brownlee
3. Matters arising from previous meeting	Mrs R Brownlee
4. Draft Strategic Plan 2015-2018	Mrs P Clarke
5. Corporate Risk Register	Mrs P Clarke
6. Progress Updates	
i) HH/BC	Mr M Crilly
7. SAIs /AIs/Early Alerts	
i) Early Alert - OPPC Directorate	Mrs A McVeigh
8. Update on Management Review	Mr K Donaghy
9. Recommendations of Remuneration Committee	Mrs R Brownlee



**Minutes of a confidential meeting of Trust Board held on
Thursday, 26th March 2015 at 9.30 a.m.
in the Boardroom, Trust Headquarters, Craigavon**

PRESENT:

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

IN ATTENDANCE:

Mrs D Burns, Interim Director of Acute Services
 Mr M Crilly, Acting Director of Mental Health and Disability Services
 Mrs A McVeigh, Director of Older People and Primary Care Services
 Mrs A Magwood, Acting Director of Performance and Reform
 Mrs R Rogers, Head of Communications
 Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES:

Mrs M McAlinden, Chief Executive
 Mr K Donaghy, Director of Human Resources and Organisational
 Development

1. CHAIR'S BUSINESS

The Chair welcomed everyone to the meeting. She particularly welcomed and congratulated Mrs P Clarke on her appointment as Deputy Chief Executive and Mrs A Magwood, on her appointment as Acting Director of Performance and Reform. The Chair stated that she was delighted to advise that Mrs D Blakely and Mrs H Kelly, Non Executive Directors, had their terms extended for a further six months to end September 2015.

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

2. DECLARATION OF INTERESTS

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

3. MINUTES OF MEETING HELD ON 29th JANUARY 2015

The Minutes of the meeting held on 29th January 2015 were agreed as an accurate record and duly signed by the Chair.

4. MATTERS ARISING FROM PREVIOUS MINUTES

i) Meeting with Chair and Chief Executive, HSCB

The Chair advised that, as agreed at the recent Directors' Workshop, Mrs Clarke and herself had met with the Chair and Chief Executive, HSCB. This meeting took place on 11th March 2015 and Mrs Clarke advised that the key issue the Chair and herself raised was the Trust Board's concern about the timing of funding allocations. She stated that Mrs Watts, Chief Executive, HSCB accepted the significant challenges with

annual allocations and agreed to raise this matter as part of the DHSSPS Review of Commissioning.

ii) **Update on Financial Position 2014/15**

Mr McNally reminded members that at month 10, the Trust was reporting a forecasted year-end surplus of £2.6m as a consequence of further income allocations from the HSCB. Following discussions with the HSCB, a decision was then made to retract income in order that the Trust achieves a balanced budget. Mr McNally advised, however, that workforce has not increased to the level anticipated and due to delays in recruitment, the Trust is now forecasting a year end position of £700k surplus. Compounded with this is the difficulty recruiting staff across a number of groups, particularly nursing and AHPs. In response to a query from Dr Mullan, Mr McNally provided assurance that every opportunity for spend was being pursued.

5. DRAFT STRATEGIC PLAN 2015-2018

Mrs Clarke explained that this is a further working draft incorporating the comments and feedback from the Directors' Workshop on 26th February 2015. Mrs Clarke outlined the proposed timeline for engagement and formal approval of the Plan by Trust Board. She proposed that the Plan should come to the Trust Board meeting on 28th May 2015 followed by a 15-week consultation to end September 2015 with final approval at the 22nd October 2015 Trust Board meeting. The Chair emphasised the importance of the Trust clearly communicating the Plan and engaging with people to inform them better. Mrs Clarke acknowledged that further agreement on the communication plan is required and it was agreed to revisit the communication approach/plan at the Directors' Workshop on 30th April 2015. In response to a question from Dr Mullan, Mrs Clarke explained the linkages between the Strategic Plan, the Corporate Plan and the Trust Delivery Plan. The Chair queried the Trust's ability to deliver on the strategic priority in relation to the further development of community dementia services. Mr Rice advised that in setting the direction of travel of Trust services for the next 3 years, the need for resources to fund some proposals will involve

discussions with the commissioner. The Chair stated that it was therefore important that the Trust sets out the difficulties in achieving some of the proposals, identifying those which are outside the Trust's control. Mrs Blakely asked to what extent has the HSCB shared with the Trust the details of opportunities through the ICT initiative being supported and funded by Atlantic Philanthropies to the value of six million euro. Mr Rice advised that he has met with the individuals at the HSCB who are leading on this initiative and is involved in discussions to take forward regionally within dementia services.

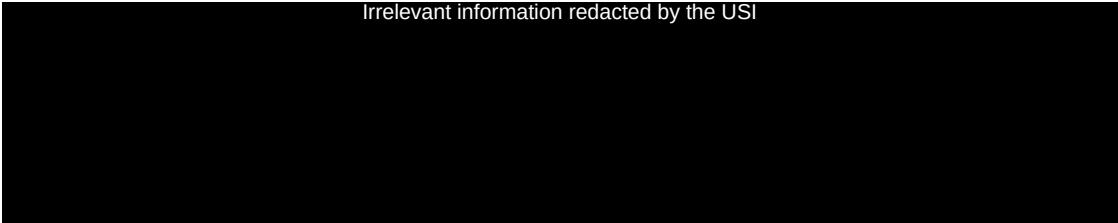
6. CORPORATE RISK REGISTER

The Chair noted that there are currently 24 risks on the Corporate Risk Register – 14 high and 10 moderate and highlighted the importance of actively managing these risks. The introduction timescale for nursing revalidation was discussed and Mr Rice advised that a business case is currently being developed. He provided details of the work underway to achieve the implementation date for revalidation of December 2015. The ability to recruit and retain trained nursing staff across all Operational Directorates was raised and Mrs Clarke advised that a risk assessment is being developed for consideration by SMT. Mrs Burns advised that the risk associated with the laboratory at CAH maintaining its Biochemistry Accreditation status is outside the Trust's control. It was agreed that in the next update of the Corporate Risk Register that the narrative will be updated to provide assurance on progress being made and where issues have been escalated external to the Trust, it is important to note this to ensure clarity of what actions are contingent on.

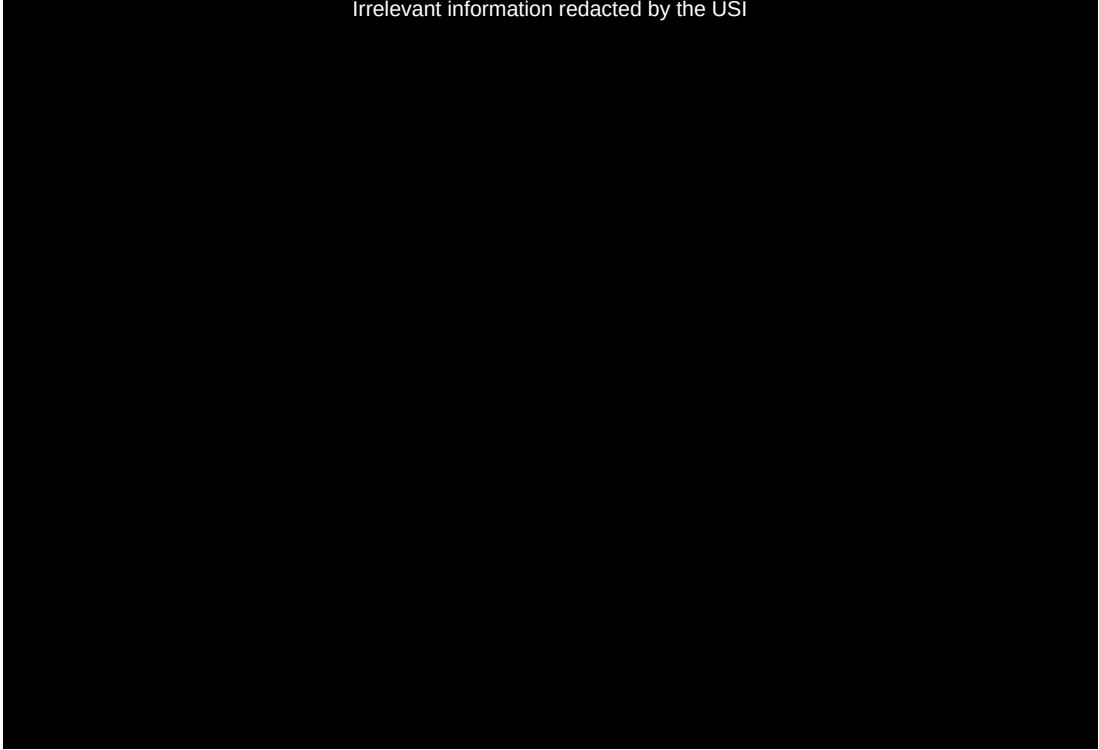
7. PROGRESS UPDATES

i) HH/BC

Irrelevant information redacted by the USI



Irrelevant information redacted by the USI



8. SAls/Als/Early Alerts

Mrs McVeigh informed members of an early alert involving the suspension of a member of staff who admitted to fraudulently claiming for payment of two roles within the Trust in 2010. A disciplinary hearing was held on 13th February 2015 when the decision was taken to dismiss the employee.

The escalation of SAls/Als/Early Alerts to Trust Board was raised and Mrs Clarke stated that it would be helpful to circulate the criteria for the escalation process to members.

9. UPDATE ON MANAGEMENT REVIEW

In the absence of Mr Donaghy, Mrs Clarke spoke to the progress update on the Management Review.

Mr Donaghy subsequently joined the meeting and responded to members questions and provided clarification on the process. Mr Donaghy advised that phase two of the review is about to progress, the outcome of which will be considered by the Project Board on

which Dr Mullan is the NED nomination. Trust Board approval will be sought at the conclusion of the process. Mr Donaghy agreed to provide a written Trust Board report template to members to ensure clarity about the process

Mrs Clarke and Mrs Magwood left the meeting for the next item

10. RECOMMENDATIONS FROM REMUNERATION COMMITTEE

The Chair advised that the Remuneration Committee had met on 4th March 2015 and made recommendations in line with guidance on starting salaries issued by the Permanent Secretary on 30 August 2007 in respect of the Acting Chief Executive and Acting Director of Performance and Reform positions.

11. ANY OTHER BUSINESS

- i) 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.

ii) Stroke Services - Article in Newry Reporter

Mrs Rooney and Dr Mullan both expressed concern at the erroneous reporting and allegations in the Newry Reporter regarding stroke services. Mrs Rogers advised that the Trust has refuted the allegations, but experienced difficulty getting a

statement published. Mrs Clarke agreed to raise with new Chief Executive of Newry Council.

The meeting concluded at 11.15 a.m.

TRUST BOARD MEETING

DATE: Thursday, 28th May 2015

TIME: 9.30 a.m.

VENUE: Boardroom, Trust HQ, Craigavon

CONFIDENTIAL AGENDA

1. Chair's Business	Mrs R Brownlee
2. Minutes of meeting held on 26 th March 2015	Mrs R Brownlee
3. Matters arising from previous meeting	Mrs R Brownlee
4. Progress Updates	
i) HH/BC	Mr F Rice
ii) DHSSPS SAI Lookback Exercise	Mrs P Clarke
5. SAIs /AIs/Early Alerts	
i) RT (<i>verbal</i>)	Ms F Leyden
6. Daisy Hill Hospital overnight cover	Mrs D Burns
7. SHSCT New Banking Contract (<i>verbal</i>)	Mr S McNally
8. Correspondence from Permanent Secretary, DHSSPS	Mrs P Clarke
i) Driving Transformational Change – letter dated 12 th May 2015	
ii) Senior Level Recruitment – letter dated 14 th May 2015	
9. Recommendations of Remuneration Committee	Mrs R Brownlee



**Minutes of a confidential meeting of Trust Board held on
Thursday, 28th May 2015 at 9.30 a.m.
in the Boardroom, Trust Headquarters, Craigavon**

PRESENT:

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

IN ATTENDANCE:

Mrs D Burns, Interim Director of Acute Services
 Mrs A McVeigh, Director of Older People and Primary Care Services
 Mrs A Magwood, Acting Director of Performance and Reform
 Mrs M Mallon (for Mr K Donaghy)
 Ms F Leyden (for Mr P Morgan)
 Mrs R Rogers, Head of Communications
 Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES:

Mr K Donaghy, Director of Human Resources and Organisational
 Development
 Mr P Morgan, Director of Children and Young People's Services/
 Executive Director of Social Work

1. CHAIR'S BUSINESS

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

2. DECLARATION OF INTERESTS

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

3. MINUTES OF MEETING HELD ON 26th MARCH 2015

The Minutes of the meeting held on 26th March 2015 were agreed as an accurate record and duly signed by the Chair.

4. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates.

5. RECOMMENDATIONS FROM REMUNERATION COMMITTEE ON 30TH APRIL 2015

The Chair advised of the Remuneration Committee's recommendation to Trust Board in respect of the starting salary of the new Medical Director.

The Board approved the recommendation of the Remuneration Committee

6. DAISY HILL HOSPITAL OVERNIGHT COVER

Mr B Conway was welcomed to the meeting for a discussion on this item. Mrs Burns circulated a paper which provides an update on concerns in relation to medical cover in Daisy Hill Hospital Emergency Department during the overnight period. This also includes detail on the level of support available from medical and

surgical inhouse teams. Copies of this paper were returned to Mrs Burns at the end of the meeting.

Mrs Burns stated that the medical cover in DHH Emergency Department is no longer sufficient overnight to meet demand and she outlined the actions being taken to manage this. Mrs Clarke has alerted senior colleagues in HSCB, LCG and PHA of the pressures and Trust concerns.

A short discussion ensued in which members asked a number of questions to which Mrs Burns and Mr Conway responded.

Dr R Wright, new Medical Director, arrived at this point (10.20 a.m.)

7. PROGRESS UPDATES

i) HH/BC

Irrelevant information redacted by the USI



Irrelevant information redacted by the USI

ii) **DHSSPS SAI Lookback Exercise**

Members were provided with an update on the Serious Adverse Incidents review by the DHSSPS. Mrs Clarke stated that there is no timeline as yet from the DHSSPS to bring the review to a conclusion.

8. **SAIs/AIs/Early Alerts**

RT

Ms Leyden informed members of a serious adverse incident involving an Personal
information
redacted by the
USI year old female who has made an allegation of inappropriate sexual behaviour by her fostercarer. A PSNI Joint protocol investigation is underway and risk strategy meetings have been held. The father is out of the home. In relation to the other four children in the foster home, the two younger children have been moved with the two older children choosing to remain in the home.

9. **SH&SCT NEW BANKING CONTRACT**

Mr McNally advised of the DHSSPS decision to conduct this on a regional basis. This process has now concluded and the new banking contract has been awarded to Bank of Ireland, subject to Trust Board approval. The terms remain the same as previous contract.

Trust Board approved the awarding of the new banking contract to the Bank of Ireland

10. CORRESPONDENCE FROM PERMANENT SECRETARY, DHSSPS

Mrs Clarke drew members' attention to the following correspondence in their papers:-

i) Driving Transformational Change – letter dated 12th May 2015

This letter includes a proposal to establish a Strategic Leadership Group, chaired by the Permanent Secretary, comprising membership of Chief Executives of the HSCB, PHA, BSO, NIAS, along with a representative of the HSC Trust Chief Executives, to drive transformational change. Mrs Clarke advised that the Trust Chief Executives will decide who their representative will be at their next meeting on 1st June 2015.

ii) Senior Level Recruitment – letter dated 14th May 2015

This letter to Trust Chief Executives asks Trusts not to proceed with any recruitment exercises to fill vacant or new senior positions (at Director or Assistant Director level) without Departmental approval in light of the current need for change and until current reviews are complete. In light of this, Mrs Clarke advised that the Trust has reviewed its scrutiny process. The Chair advised that she had recently written to the Permanent Secretary on the limitations of the current remuneration framework for Senior Executives. Mrs Mahood stated that from a Non Executive Director perspective, it is important that permanent positions are filled and there is stability on the Board.

The meeting concluded at 11.00 a.m.

SIGNED: _____

DATED: _____

TRUST BOARD MEETING

DATE: Thursday, 24th September 2015

TIME: 9.30 a.m.

VENUE: Boardroom, Trust Headquarters

CONFIDENTIAL AGENDA

1. Chair's welcome	Mrs R Brownlee
2. Declaration of Interests	
3. Minutes of meeting held on 27 th August 2015	Mrs R Brownlee
4. Matters arising from previous meeting	Mrs R Brownlee
5. Progress updates:-	
i) Daisy Hill Hospital Overnight Cover - <i>verbal</i>	Mrs E Gishkori/ Dr R Wright
ii) HH/BC (<i>paper to follow</i>)	Mr F Rice
6. SAI Update	
Acute Directorate - <i>verbal</i>	Mrs E Gishkori
7. HCAI	
i) CPE Update - <i>verbal</i>	Dr R Wright
8. Any other Business	

TRUST BOARD MEETING

DATE: Thursday, 11th June 2015

TIME: 9.30 a.m.

VENUE: Boardroom, Ground Floor, Craigavon Area Hospital

CONFIDENTIAL AGENDA

1. Chair's Business Mrs R Brownlee
2. Matters Arising from previous meeting
Progress updates:-
 - i) Daisy Hill Hospital overnight cover Mrs D Burns
 - ii) HH/BC Mr F Rice
 - iii) Child Sexual Exploitation/Marshall Inquiry/
SBNI Thematic Review Mr P Morgan
3. HCAI Peer Group Analysis 2014 Dr J Simpson
4. Any other Business
 - Update from Remuneration Committee Mrs R Brownlee



**Minutes of a confidential meeting of Trust Board held on
Thursday, 11th June 2015 at 9.30 a.m.
in the Boardroom, Trust Headquarters, Craigavon**

PRESENT:

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

IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources and Organisational
 Development
 Mrs D Burns, Interim Director of Acute Services
 Mrs A McVeigh, Director of Older People and Primary Care Services
 Mrs A Magwood, Acting Director of Performance and Reform
 Mr P Toal, Communications Manager
 Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES:

None

1. CHAIR'S BUSINESS

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

2. DECLARATION OF INTERESTS

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

3. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates from Directors.

4. PROGRESS UPDATES

i) Daisy Hill Hospital Emergency Department Overnight Cover

Mrs Clarke circulated a briefing paper which provides an update from the previous meeting on concerns in relation to medical cover in Daisy Hill Hospital Emergency Department during the overnight period, together with the associated level of support available from medical and surgical inhouse teams. Copies of this paper were returned to Mrs Clarke at the end of the discussion.

In terms of immediate and planned action, Mrs Clarke reported that all ED middle grade, consultant and associate specialist staff at Craigavon Area Hospital had been approached confidentially to provide overnight cover at Daisy Hill Hospital via a temporary change to job plan or additional shifts as locums. Unfortunately, there was no agreement to this, primarily due to challenging rotas and the high attendances at Craigavon Area Hospital already. In terms of the Trust's recruitment exercise for permanent middle grade staff, Mrs Clarke advised of four applicants, two for ED and one medical

and one surgical. Of the two for ED, one was not suitable to shortlist and one would not be suitable to commence as middle grade at this point in time and will require a period of training.

Mrs Clarke provided assurance to Trust Board that robust oversight arrangements are in place with a Trust Oversight Group reviewing pressures/level of risk and direct involvement of HSCB and PHA senior staff. DHSSPSNI have also been alerted and kept updated. No further incidents or issues have been brought to her attention since the last update to Trust Board on 28th May 2015.

The Chair asked both Dr Simpson and Mrs Burns if they had anything further to add to Mrs Clarke's update. Dr Simpson stated that whilst it is a difficult and challenging period, progress is being made in exploring all of the options. Mrs Burns stated that the Trust continues to work to bridge the gaps and continues to advertise for locum cover at enhanced rates.

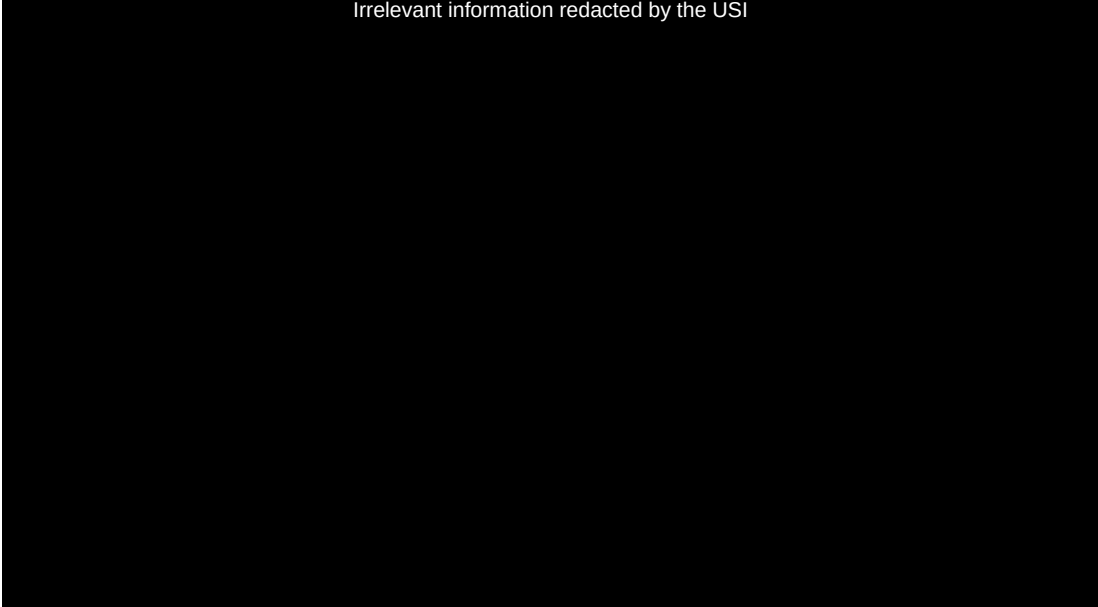
Dr Mullan asked if Consultants are appointed to work Trust wide and queried why some specialties were more at risk than others in terms of cover and why Craigavon staff cannot be made to cover Daisy Hill. Mrs Burns responded by advising that whilst Consultants are appointed on a Trust wide basis, as she had reported at the last Trust Board meeting, this has to be balanced with the fact that recruiting and retaining senior staff in some areas is extremely difficult. She reminded members that for the last recruitment for ED consultants to support the Craigavon rota, there was only one applicant and they did not wish to work in DHH. If this had been pushed, the applicant would have withdrawn weakening the Craigavon cover. Mrs Burns stated that all specialties are asked to provide cross cover if required and all try to do so. She made the point that in Altnagelvin Hospital, Consultants in ED work to 5.00 p.m. whilst in this Trust they work to 10.00 p.m, often staying on beyond this time. The Chair stated that it was important to acknowledge this and stated that the Trust is privileged to have staff who give this commitment. Mrs Burns concurred with the Chair's comments. She went on to say that it was important to

restate that the gap is overnight cover from 10.00 p.m. – 8.00 a.m. with middle grade not consultant cover being the challenge. Mr Donaghy stated that it is important to set this in the regional context in terms of emergency medicine, with the requirement for 40 – 50 new Consultants brought to the attention of the DHSSPS for over a year. Mr Graham commended the work ongoing within the Trust and sought assurance that workforce shortages across all professions are being raised at all levels. Mrs Clarke stated that workforce planning has been a long standing issue and discussions continue with HSCB and PHA.

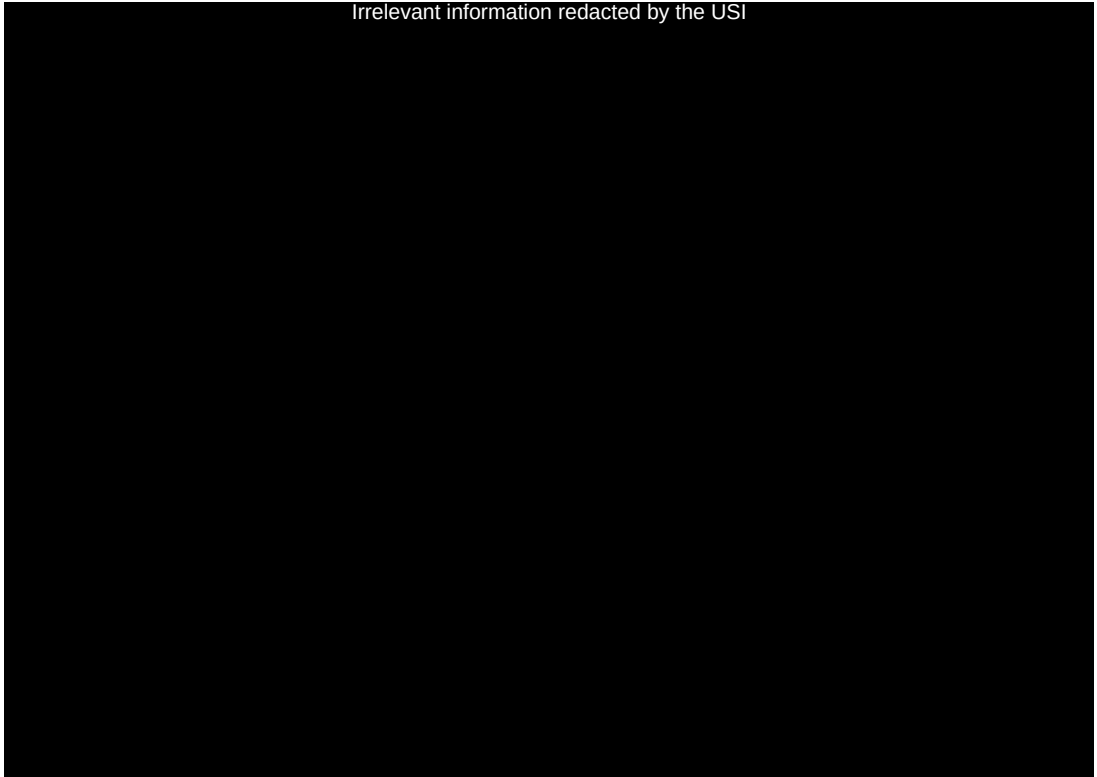
The Chair asked Mrs Clarke about risk mitigation measures going forward into the summer and how Trust Board would be kept informed given that the next Trust Board meeting is not until 24th September 2015. The Chair also referred to the period of transition in respect of the two new Directors. Mrs Clarke advised that daily surveillance is in place and she gave assurance on the systems and processes also in place and that any issues will be managed and reported accordingly. Mrs Burns and Dr Simpson outlined the handover arrangements with their successors. Mrs Clarke advised that Trust Board would be kept updated over coming weeks.

ii) HH/BC

Irrelevant information redacted by the USI



Irrelevant information redacted by the USI



iii) **Child Sexual Exploitation**

Members were provided with an update on the Child Sexual Exploitation and the pending publication of the SBNI Thematic Review Report. Mr Morgan noted that he has provided a number of briefing papers/updates to Trust Board with regard to the Marshall Report and the Thematic Review.

Mr Morgan advised that the Thematic Review Report was discussed by the SBNI on 9th June 2015. Whilst there are areas of improvement identified in the report, there is only one specific recommendation and this relates to a thematic audit of effectiveness in responding to CSE. Mr Morgan stated that the Review Report will be shared with members, once available. Mr Morgan advised that Mrs Jane McKimm is the Trust's representative on the regional media/communication group and that he will be meeting with her to plan an internal communication briefing and how to respond to media queries etc. A short discussion ensued on the impact of social media on young people and the difficulty in managing this. The Chair

spoke of the importance of the Trust engaging with other partners and agencies on young people's health and wellbeing. Mr Morgan and Mrs McVeigh outlined some of the work ongoing within the Trust, as well as the interface work with outside agencies. It was agreed to bring a presentation on this work to a Trust Board meeting in the Autumn.

3. HCAI PEER GROUP ANALYSIS 2014

Dr Simpson spoke to the Public Health Agency MRSA and CDI peer group comparisons for large acute Trusts. Members noted the positive performance of the Trust in comparison to its peers. The MRSA rate per 10,000 admissions for large Acute Trusts in England and NI during January – December 2012 demonstrates the Southern Trust is in the 25th percentile of hospitals in the peer group. CDI rate per 10,000 admissions for large Acute Trusts in England and NI during January – December 2013 demonstrates that the Southern Trust is the best performing hospital in the peer group.

Dr Simpson stated that the PHA has not yet advised Trusts of the HCAI Priorities for Action Targets for 2015/16. However, indications are that these will remain the same as last year.

Dr Simpson reported that during May 2015, the Trust experienced five C Difficile cases. All five cases have been subject to multidisciplinary review and all initial actions from the Multi-Disciplinary Team review have been taken. Root Cause Analysis have been carried out and any key learning will be fed back through the Trust processes.

4. ANY OTHER BUSINESS

i) Remuneration Committee Recommendations

The Chair informed members that the Remuneration Committee had met earlier that morning to discuss the Senior Executive Pay Award, pending the formal issue of the Departmental Circular. The Chair advised of the Remuneration Committee's recommendation to Trust Board that the Chief Executive and Senior Executives are awarded a

performance rating of fully acceptable for performance between 1st April 2013 – 31st March 2014. The Committee also recommended the starting salary of the new Director of Acute Services.

Trust Board approved the recommendations of the Remuneration Committee

ii) E-Coli

Mrs Burns advised that, as a result of routine sampling, E-Coli has been detected in the main kitchen at Craigavon Area Hospital. To date, no patients, staff or members of the public have shown symptoms of being affected by this bacteria. Stringent food safety measures are in place and the Trust is liaising with relevant agencies at this time. A meeting with the PHA, Food Safety Agency and Environmental Health has been arranged for that afternoon when results from recent samples will be known.

SIGNED: _____

DATED: _____

TRUST BOARD MEETING

DATE: Thursday, 27th August 2015

TIME: 9.30 a.m.

VENUE: Boardroom, Trust Headquarters

CONFIDENTIAL AGENDA

1. Chair's welcome Mrs R Brownlee
*Apologies: Mr F Rice; Mrs A McVeigh;
Mr P Morgan*
2. Declaration of Interests
3. Minutes of meetings held on 28th May and
11th June 2015 Mrs R Brownlee
4. Matters arising from previous meeting Mrs R Brownlee
5. Progress updates:-
 - i) Daisy Hill Hospital Overnight Cover Mrs E Gishkori/
Dr R Wright
6. Update on Newry CTCC Mrs P Clarke
7. BCBV Corporate Dashboard Mrs A Magwood
8. Any other Business



**Minutes of a confidential meeting of Trust Board held on
Thursday, 27th August 2015 at 9.30 a.m. in the
Boardroom, Trust Headquarters**

PRESENT:

Mrs R Brownlee, Chair
 Mrs P Clarke, Interim Chief Executive
 Mrs D Blakely, Non Executive Director
 Mr E Graham, Non Executive Director
 Mrs H Kelly, Non Executive Director
 Mrs E Mahood, Non Executive Director
 Dr R Mullan, Non Executive Director
 Mr S McNally, Director of Finance and Procurement
 Mrs S Rooney, Non Executive Director
 Dr R Wright, Medical Director

IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources and Organisational Development
 Mrs E Giskori, Director of Acute Services
 Ms F Leyden, Assistant Director of CYPS (*for Mr Morgan*)
 Mrs A Magwood, Acting Director of Performance and Reform
 Mr B Conway, Assistant Director of Acute Services, Medicine and Unscheduled Care (*Item 5i only*)
 Mrs J McConville, Head of Planning (*Item 6 only*)
 Mr S O'Reilly, Associate Medical Director (*Item 5i only*)
 Mrs R Toner, Assistant Director of Enhanced Services (*for Mrs McVeigh*)
 Mr P Toal, Communications Manager
 Mrs S McCormick, Committee Secretary (Minutes)

APOLOGIES:

Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing, Mrs A McVeigh, Director of Older People and Primary

Care Services, Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work and Mrs S Judt, Board Assurance Manager

1. CHAIR'S WELCOME

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

2. DECLARATION OF INTERESTS

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

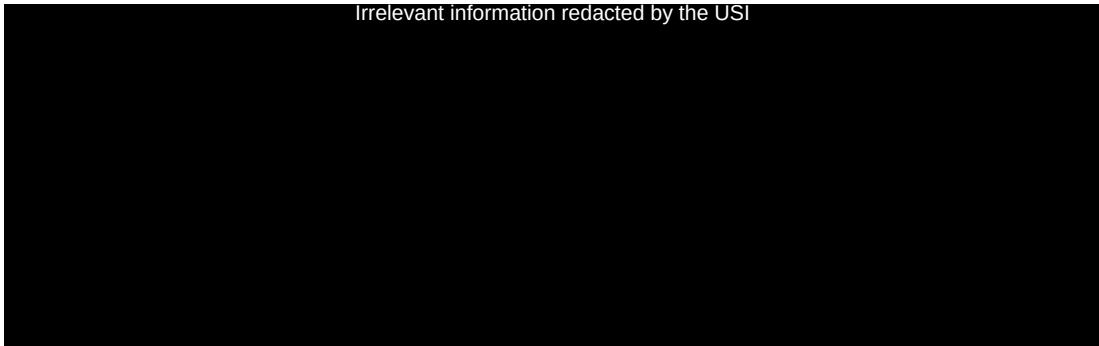
3. MINUTES OF MEETINGS HELD ON 28TH MAY 2015 AND 11TH JUNE 2015

The minutes of meetings held on 28th May 2015 and 11th June 2015 were agreed as an accurate record and duly signed by the Chair.

4. MATTERS ARISING FROM PREVIOUS MINUTES

i) HH/BC

Irrelevant information redacted by the USI



The Chair asked that Items 6 and 7 would be taken at this point on the Agenda

6. UPDATE ON NEWRY CTCC

The Chair welcomed Mrs Janet McConville, Head of Planning for this item. Mrs Clarke introduced the paper and reminded members of the Ministerial direction to progress Newry CTCC as a pathfinder project, through a mechanism known as Third Party Development (3PD), which involves a partnership arrangement with a private sector company. She advised that Trust Board were being asked to provide confirmation that the Appointments Business Case (ABC) fulfils a number of points within the Ministerial direction. Mrs Clarke drew attention to the fact that the ABC excludes a Value For Money (VFM) assessment, due to Trust concerns around some of the technicalities of analysis. She advised that the VFM assessment will be submitted as a separate assessment to DHSSPSNI by KPMG, the external financial advisors appointed by HIB. Mrs Clarke added that DHSSPSNI preference was that Trust Board would have considered the full ABC, but had accepted the Trust position, not to consider or comment on the VFM analysis at this stage, due to concerns as stated above.

The Chair asked Mr McNally, Director of Finance if he had anything further to add. Mr McNally reminded members that the final decision to provide confirmation that the project fulfils the Ministerial Direction and recommend the project for onward DHSSPSNI approval remains with the Trust and not the external advisors. He advised that the methodology used by KPMG was a departure from DFP guidance and he was unable to stand over the conclusions reached in their analysis, hence the decision not to consider or comment on the VFM analysis at this stage.

At this point, Dr Mullan raised a recent article in the local press which named the successful bidder. In response, Mrs McConville clarified the protocol the Trust followed with regard to the 3 bidders who had reached the final stage of the process. Mrs Clarke confirmed that the Trust had provided a response back to the local press following the article, clarifying that a developer had been identified as first placed in the evaluation but had not yet been appointed as a preferred bidder.

Mrs McConville guided members through each of the points the Board is being asked to confirm if the ABC:-

- Is procured in line with EU regulations, Executive and HSC policy
- Draft contract / lease remains “off balance sheet”
- Has LCG support and endorsement
- Has support and endorsement/sign up from GPs

Discussion ensued and members asked a range of questions as follows:- Dr Mullan raised (i) “off balance sheet” treatment, (ii) risk with regards securing revenue, in light of the current political instability and (iii) once operational how will the project be funded. In responding, Mr McNally advised that the final position regarding balance sheet treatment will not be finalised until the lease is signed. He explained that the Trust will record the project as an asset but KPMG felt it would satisfy the conditions necessary for it to score as resource budget at DHSSPS level. In response to Dr Mullan’s second question, Mr McNally stated that the Trust had been given assurance from the HSCB that ringfenced funding will be available for the project. In concluding his response, Mr McNally also advised that once a binding contract was signed the HSC system was obliged to live with the consequences. However, the project could be withdrawn at any stage before this.

Mrs Mahood raised the design/quality of the building and asked for assurance that all practicalities have been considered and the building would be fit for purpose. Mrs McConville assured members that a rigorous procurement process had been followed by CPD colleagues and that Trust representatives had informed the building design brief and were content that the design reflected service needs.. Engagement with a number of specialist advisors has also been ongoing throughout the process. In conclusion, Mrs McConville advised that the preferred bidder will sign off the building as, fit for purpose once the project has been completed. Mrs Kelly asked if staff/users had been involved in the design. Mrs McConville advised that engagement with staff/service users had taken place but this had been restricted due to the process. However service needs had informed the design brief for all final bidders designs. There has also been regular updates on progress given to the community/voluntary sector as well as the local community in Newry

through the issue of press releases to local newspapers. She added that following the appointment of the preferred bidder a larger implementation group would be established to engage with staff and service users similar to what had taken place for other CTCC projects such as Portadown and Banbridge with much more detailed engagement as the process rolls out. Mr Graham asked about the financial risk to the organisation if costs were incurred. Mr McNally advised that the understanding secured with the HSCB was that it would cover all costs associated with the project which were not covered by baseline funding.

Mrs Rooney asked about GP commitment to move to the new CTCC facility and highlighted the 2,830sqm accommodation included within the OBC had been for eight GP Practices. Members were reminded that three of the eight practices had confirmed their commitment in principle to move to the new CTCC facility, with the remaining five confirming that they wished to remain at the Newry Health Village campus. The Chair stated that at this stage in the project the building was designed to include accommodation for three GP practices. A short discussion took place around accommodation if GPs were to come onboard at a later date. Mrs McConville advised this would be outside the Trust's control with discussion taking place between the preferred bidder and the GP.

In conclusion, the Chair asked members to note that full copies of the ABC were available today should any members require to review or have a specific query. The Chair asked if members were content to accept and recommend the project for DHSSPSNI approval.

The Board confirmed acceptance and agreed to recommend the project for DHSSPSNI approval.

Mrs McConville left the meeting at 10.20 a.m.

7. BCBV CORPORATE DASHBOARD

Mrs Magwood presented the paper and explained that following an Internal Audit of Efficiencies and Service Reform in 2014/15, monitoring recommendations included the development of a new corporate dashboard with key service reform areas. Mrs Magwood

explained that the dashboard was two fold and included (a) non-recurrent savings achieved and to be delivered and (b) system reforms related to TYC and quality initiatives. She added that all schemes contribute to the Trust's £13m in recurrent savings for the 2015/2016 financial year. The Chair drew attention to the RAG rated detail included within the dashboard and welcomed the positive position. Mrs Magwood highlighted the single red risk and advised that this was linked to a regional project. She reminded members that the project is part of the aforementioned £13m recurrent savings and has been escalated in the appropriate manner.

Mrs Mahood reminded members that following review by the Audit Committee of the IA Report on Efficiencies and Service Reform in 2014/15, request had been made that the Corporate Dashboard would be presented to Trust Board members and added that the document had been most helpful. Members agreed that the Corporate Dashboard would be reviewed by Trust Board twice yearly going forward.

Action – Mrs Magwood

5. PROGRESS UPDATES:-

i) Daisy Hill Hospital Overnight Cover

The Chair invited Dr Wright to update members on clinical discussions with Associate Medical Directors (AMDs) and Clinical Directors (CDs) at DHH, to potentially secure the DHH ED overnight service. Dr Wright advised that since the last Trust Board meeting, 2 junior doctors along with 1 locum had been recruited on a short term basis but acknowledged this was not an ideal model of cover. He added that concerns had been raised through the GMC survey and also through nursing staff at DHH. Dr Wright spoke of the need to establish stronger middle grade cover but acknowledged that this remains challenging due to increasing national shortages.

The Chair welcomed Mr Conway and Mr O'Reilly to provide an update on progress against the immediate short term action plan.

Mr Conway began by highlighting the Trust objective was to secure senior cover 7 days from 9.00 am – 12 midnight, thus reducing the Out of Hours risk and the provision of consultant cover on the floor from 9.00am – 22.00hrs, Monday to Friday and weekends, 9.00am – 17.00hrs or 14.00hrs – 23.00hrs. He outlined progress on a number of actions but acknowledged continued reliance on significant levels of locums. Mr O'Reilly reported that senior medical cover at middle grade and consultant level remains tenuous and currently can only be viewed as a temporary, short-term position. He advised that the Trust continues to seek to recruit into permanent posts and reported that numerous recent attempts to recruit with enhanced packages have not been successful, adding that at the same time other Trusts are also recruiting with more attractive rotas. Engagement has been ongoing with the Director of Human Resources around how best we can make recruitment to the Trust more attractive at this grade.

Steps to strengthen clinical governance and training were outlined, supported by recent recruitment of a locum consultant. Dr Wright emphasized the importance of a positive working environment for teaching junior doctors and members were advised of an expected visit by NIMDTA and GMC in November 2015.

Members were assured that the Trust has contingency planning arrangements in place in the event that risk cannot be reduced to an acceptable level and consideration has been given to the operational impact of reduced opening hours in DHH Emergency Department. Mr Conway guided members through the impact such sanctions would have on the CAH site. Mr O'Reilly explained that major risk would be increased to medical admissions with predicted annual impact of an additional 16 beds and with CAH already at capacity and in need of additional beds without this DHH flow, this action would be extremely complex and disruptive.

The Chair recognized the extremely challenging position and asked if the HSCB and Minister were kept apprised. Mrs Clarke stated that she meets regularly with the HSCB and PHA and advised that the Permanent Secretary had appointed two officials as point of contact and a further brief would be provided to them following Trust Board discussion today.