

	SAI's SHSCT Position Mrs Marshall outlined the proposed review of SAI Procedures within the Trust. Members agreed that the 2011 procedure needs updated and whilst there are regional constraints that the Trust has to operate within, there are aspects of the process that can be improved and developed linking to evidence based best practice. Members referred to the framework of the review and the high level project structure. Following discussion, Mrs Marshall sought SMT endorsement of the proposal within the timeframe of 6 months. Members were asked to submit nominations to the Project Team to allow this work to proceed. NHS England Document link for information and discussion Members noted the information circulated above. PPI Monitoring Template for PHA – for approval Members noted the PPI Monitoring report which will be tabled at the next Patient & Client Experience Committee. Letter from Dr McBride regarding Donaldson Recommendation 'More Independence should be introduced into complaints processes' Members referred to the letter from Dr Michael McBride regarding the Donaldson Recommendation 10 in terms of more independence being introduced into the Complaints process and noted that it has been agreed that it would be retrospective to reintroduce an additional investigative/independent stage again. Members noted this change in process. Letter regarding changes in the Ombudsman Office Members noted correspondence from the Head of the Civic Service regarding the Public Services Ombudsman.	

	Professional Governance - Response to Professional Assurance Framework for AHP's Mr Rice drew member's attention to the response to Professional Assurance Framework for AHP's and members approved this response for forwarding. Financial Governance - Briefing Paper: Monitoring in Independent Domiciliary Care - Domiciliary Care Audit Members noted the 'limited assurance' regarding the Domiciliary Care Audit Report and the agreement to bring limited assurance reports to SMT. Mrs McVeigh referred members to the areas of risk and advised that there is a rolling programme to address issues. - Access to Healthcare Pilot Evaluation Report Mr McNally referred members to the interim report on the 6 monthly pilot undertaken in conjunction with Counter Fraud. The report focus on outpatients only. Mr McNally advised that it has been agreed with Counter Fraud to do another 6 months and include other areas such as radiology. Members were asked to consider potential areas for inclusion. Information Governance There was no business to discuss.	

	<i>SMT Agenda (3.30-4.15pm)</i>	
1	Notes of SMT Confidential Section 20 January 2016 The notes of the SMT Confidential Section on 20 January 2016 were approved by members.	
2	16/17 Saving Plans – Overview & Clarification Ms O'Neill provided an overview of the current position with respect to the draft financial plans for 2016/17 and areas of potential risk were identified and discussed. It was agreed to revisit this at SMT next week to ensure clarity on actions to be progressed from 1/4/16 by all Directors and to consider any further information to inform the degree of risk in the identified areas. It was noted that where there are risks alternative proposals for contingency measures will require to be identified asap. Mrs McVey referred to the request for an initial risk assessment to be undertaken regarding the winter ward at CAH. A draft had been completed and will be shared before SMT next week however it clearly set out the risks to patient safety if the additional bed capacity was stood down from 1/4/16. The options to redirect suitably experienced nursing staff from other acute services was referenced which equally incurred governance risks particularly relating to elective provision from urgent and red flag patients. Following discussion it was agreed that retention of the winter ward is essential from a patient safety perspective to the end of April in the first instance and that this is an additional cost pressure not factored into the current 2016/17 plan. The level of the pressure is likely to be mitigated to some degree by a current pressure in securing nursing cover at Loane House which may result in the need to temporarily close 1 ward. Mrs McVeigh agreed to consider this risk further and that any slippage in costs could be offset against the winter ward costs for April.	

	It was also agreed to write urgently to HSCB advising that as no response had been received to the previous letter sent by the Trust seeking funding for extension of the winter ward, that this was an additional unavoidable cost pressure going into 2016/17 that the Trust would have to take additional contingency measures to address and seeking their support in identifying acceptable areas of mitigation.	<i>E Gishkori to draft letter as matter of urgency with support from Performance and Finance</i>
3	Capital Update Report Members referred to the Capital Update Report and in particular telephony and the issues surrounding procurement and risk. Following discussion, it was agreed that Alan Metcalfe discuss with BSO/Deloitte in terms of moving forward to procure whilst mitigating the associated risk.	
4	Commissioning Plan Direction Report This item was deferred.	
5	Paediatric Medical Workforce Planning Report 2013-2019 This item was deferred.	
6	Any other business 6.1 Registration – Social Care Workforce Mr Morgan referred to the registration process for the social care workforce, which currently rests with the Director of Human Resources. It was suggested that this area of responsibility is transferred to CYP and Mr Morgan agreed to take this on. Members were also advised that NISCC that decided that registrants are now not required to be Access NI checked and this would mean that the Trust run with a level of risk. Mr Morgan and Mr Donaghy agreed to discuss this and agree the way forward.	



Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 26 November 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
	High level context: 1. Critical to the Trust's performance is achievement of our <u>Service and Budget Agreement (SBA)</u> for core levels of commissioned activity in the first instance. This report reviews performance against the SBA as at the end of September 2015. ➤ Whilst corporately the Month End September performance is showing a greater return to the profiled level of activity expected at this time in the year, some specialty areas are not yet on track to deliver the full volume. 2. This report reviews performance at the end of October 2015 against the <u>Commissioning Plan standards and targets for 2015/2016</u>. ➤ <i>Key areas of risk related to Commissioning Plan standards & targets include:</i> a. <i>Elective Access (Acute outpatient, inpatients, diagnostics; Mental Health and Allied health Professionals)</i> b. <i>Unscheduled care (Emergency Department 4-hour and 12 hour targets; Non-Complex Discharges; Unplanned admissions)</i> c. <i>Health Care Acquired Infection</i> 3. While not formal commissioning plan targets, this report also considers a range of other important related indicators which impact on the Trust's overall performance including: ➤ Reviews and Reporting beyond 'clinically indicated' timescales (Acute & Mental Health Consultant led outpatients; Planned repeat procedures: and plain film and diagnostic reporting)

4. This report also includes a further annex reporting against the regionally defined Indicators of Performance which are reviewed regionally on a 6 monthly basis.

Key issues

(1) Service and Budget Agreement (SBA) – achievement of commissioned levels of activity

The delivery of access times is reliant upon the delivery of agreed levels of commissioned activity, as per the SBA. Whilst corporately the Month End September performance is showing a greater return to the profiled level of activity expected, some specialty areas are not yet on track to deliver the full volume.

The following key actions are in place to address:

- Improvement plans are being implemented in key specialties where performance is not currently in line with profiled activity to ensure these return to profile (i.e. Paediatrics and Cardiology). This is being managed via internal monthly monitoring at Divisional/Directorate level and external monitoring by the HSCB.
- Proposals have been submitted to HSCB to adjust SBA volumes where these do not reflect the current service model (i.e. Trauma & orthopaedics, Urology and a range of general medical specialties)
- The Trust has engaged with HSCB and SLCG to provide mitigating information on specific specialty areas where manpower issues are impacting on SBA performance (Orthopaedic ICATs, General surgery, Diabetology) or lack of demand (Orthodontics, Colposcopy, Community dentistry) is impacting on delivery of set SBA levels.

(2) Commissioning Plan Targets - Elective Access

As previously reported, access times continue to increase particularly for routine patients, and the ability to maintain standards has become increasingly challenging related to:

- Demand exceeding commissioned capacity – regionally an increase in referrals is estimated at 6% year on year;
- Recurrent investment insufficient to address all capacity gaps in elective areas; and
- Limited non-recurrent funding to address capacity gaps resulting in increasing access times in year.

The following key actions are in place:

- Available capacity continues to be prioritised to red flag (cancer) referrals and urgent patients. The Trust is experiencing increasing demand for red flag referrals which has impacted on capacity for routine waits making the access time longer in some areas. There is currently no related increase in confirmed cancer diagnoses resulting from the increase 'red flag' referrals.
- Strict chronological management to ensure routine patients

are treated in turn;

- Measures to minimise lost capacity from those who do not attend or cancel their appointments/procedures on the day;
- Provision of monthly information to General Practitioners to ensure referrers and patients are aware of current and projected waiting times by specialty, and
- Continued focus on the provision of activity in accordance with Service and Budget Agreement (SBA) commissioned volumes

The Trust has formally highlighted a number of emergent risks to the HSCB.

Summary of elective access areas:

- **Diagnostics (CP 16)**– additional non recurrent funding has been provided in year, predominantly to imaging. This will see improved access times at March 16 with all waits anticipated below 18 weeks, and the majority below 13 weeks.

presents with the longest wait for routine diagnostics; whilst additional in-house capacity has been maximised, capacity in the independent sector has been limited and routine waits are projected at 36 weeks by March 16. Capacity continues to be prioritised for red flag, urgent and planned/screening patients.

- **Outpatients (CP 15)**– whilst non-recurrent funding has not been directed to this area to date, the Trust has re-diverted internal resource as available to areas of risk including reviews beyond clinically indicated timescales and urgent waits.
- **Inpatient/ Daycases (CP17)** – non-recurrent funding has not been directed to this area to date in 2015/16. The Trust has re-diverted internal resources as available to areas of risk including patients waiting for planned/screening procedures.
 - o Routine waits beyond 52 weeks present in general surgery, orthopaedics, pain management and urology. It is important also to note that other factors that influence the waiting time include the clinically defined urgency of patients and capacity to treat specific conditions.
- **Mental Health Outpatients (CP22)**– non recurrent funding has not been directed to this area to date and pressures prevail in primary mental health care services (PMHC), psychological therapies and dementia/memory services.
 - o **PMHC** - Additional capacity has been secured in the independent sector to provide low intensity therapies, including facilitated self-help, life coaching, group therapy,

one-to-one counselling and cognitive behavioural therapy (CBT) to reduce the wait for PMHC. It is too early in the life of this contract to determine the full and potentially sustainable impact this capacity might have on demand, however it is already clear that the remaining waiting time breaches in Mental Health are predominantly related to access to CBT practitioners. A number of vacancies in CBT practitioners have recently been filled but it will be some time before this additional capacity will impact on waiting times.

- o **Psychological Therapies** - Workforce challenges continue in psychological therapies with pressures felt both locally and regionally. An internal review of current arrangements is ongoing.
- o **Dementia/services** - are subject to capacity analysis which should be concluded by December 2015 which will provide a baseline of service requirements as part of the implementation of the trusts dementia strategy and provide a platform for future planning.
- **Allied Health Professionals (CP9)** – non recurrent funding has not been provided to this area. Regional review negotiation of capacity is nearing completion and on track for sign off in Q3 as previously reported. The longest routine waits are presenting in Speech & Language therapies and Occupational Therapy.

Note: Following the Ministers statement on Tues 17th November re: c. £43m non-recurrent funding to reduce waiting lists, the DHSSPS and HSCB has indicated this funding is to be targeted to equalise waiting times for individual specialty areas across the region. For the Southern Trust this means additional funding for capacity for pain management, and the visiting service of ophthalmology and for inpatient/ day cases this will be targeted at general surgery, orthopaedics and pain management which will be delivered in the independent sector. Funding may be available for additional in-house capacity for long wait areas if this can be secured.

(3) Commissioning Plan Targets - Unscheduled Care (CP 5,12 & 21)

Emergency Department (ED) performance against the 4-hour and 12-hour standards continues to be challenging locally and regionally.

In October the Trust experienced high level of activity in the latter weeks resulting in high levels of admissions from ED and 8 breaches of the 12-hour standard over 4 days when admissions peaked above 60 per day on the CAH site. Improving performance

and maintaining a safe standard of care remains a priority.

Focus on discharge continues and emphasis on data completeness has shown improvement. A renewed focus on this has reflected a changing position in relation to reported discharge performance which requires to be monitored and validated over the next few months.

Actions to improve unscheduled care include;

- Work with the HSCB to secure and implement investments made in unscheduled care priority areas including for example expanding 7 day radiology and allied health professional services and discharge support to improve patient flow, and ensuring the establishment of minor injuries capacity.
- Internal focus on whole system flow and plans to minimise the impact of winter pressures. This includes for example, ambulatory care models in paediatrics and ED and additional bed capacity where possible.
- Better use of information to link acute and community indicators to provide early indication of pressures and assist pre-active planning/escalation, and
- Expansion of community based services including re-ablement, specialist chronic condition community teams and roll out of the Acute Care at Home model.

(4) Health Care Acquired Infections (HCAI) (CP20)

Detailed information on HCAI and infection prevention and control arrangements is included in the Governance Report.

(5) Reviews and Reporting beyond clinically indicated timescales

There has been a reduction in the volumes of patients waiting for review appointments beyond their clinically indicated timescales in all consultant led areas, which has been sustained over the last three months. The Trust continues to re-direct internal resources, as they become available, to increase capacity to target reviews beyond timescales across a range of specialty areas. Longest consultant outpatient waits continues to present in urology and plans are in place to target capacity to improve this in-year.

As indicated in previous reports to Trust Board, performance against diagnostic reporting turnaround targets is challenging related to recruitment challenges/ vacancies in Consultant manpower which continue to affect Radiology services. The Trust continues to target current capacity to urgent films. Additional capacity for plain film reporting has been established via the independent sector and timescales for reporting are being monitored robustly.

Summary: Other key risks affecting performance remain, and have

	been reported previously, relating to a number of common factors including : • Although the position improved somewhat in 2014/15, recurrent investment has not been secured for all services with a recognised capacity gap; • The ongoing impact of workforce controls related to Trust financial contingency plans; • Particular issues relating to sickness, maternity and other absences in the medical workforce and associated challenges in securing backfill capacity in general and particularly in relation to middle grade medical staff; • Continued pressures on demand in some areas including non-elective demand, urgent and red flag referrals; and • The need to allocate appropriate levels of capacity for service areas not subject to regional standards/targets e.g. Review appointments and planned repeat procedures.
	Senior Management Team Challenge • Review of the reduced performance position and challenge to continue to deliver the agreed SBA levels 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.

15 16 Commissioning Plan Targets & Standards – Snapshot Dashboard – Oct 2015

No.	Target Area	Target	Aug 15	Sept 15	Oct 15	RAG
5.	Unplanned Admissions -reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions	-5%	May +2.4%	June +30.6%	July +18.1% Cum +14.5%	R
6.	Unplanned Admissions - ensure that unplanned admission to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.	TBC	Reporting in development			NA
7.	Carers' assessments - secure a 10% increase in the number of carers' assessments offered.	838 Mar 16	Q4: 14/15 762	Q1: 15/16 745	Q2:15/16 606	R
8.	Direct payments - secure a 10% increase in the number of direct payments across all PoC.	816 Mar 16	720	731	-	A
9.	AHP - no patient will wait longer than 13 weeks from referral to commencement of AHP treatment. (volumes over 13 weeks)	0	2910	3944	3840	R
10.	Hip Fractures - 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. (no. breaches; R:regional ave)	95%	85.3 % (5) 93% R	92.6% (2) 92%-R	96.4% (1) -R	G
11.	Cancer Services - *all urgent breast cancer referrals should be seen within 14 days; (no.breaches; R:regional ave) *at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; *at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.	100%	99.2% (2) 81% R	100% (0) - R	-	G
		98%	99% 96% R	100% - R	-	G
		95%	82.2% 65% R	95.08% - R	-	Y
12.	Unscheduled care -95 % of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hour (R:regional ave; A: attendances) *no patient attending any Emergency Department should wait longer than 12 hours.	95%	82.5% 77% R 13266 A	81.8% 78% R 13200 A	80.18% - R 13190 A	R
		0	0	0	8	Y
14.	Emergency readmissions - secure a 5% reduction in the number of emergency readmissions within 30 days.	Trend (CHKS) reporting performance lower than peer (Trust 5.4 % July 13 – July 15; Peer 6.5%)				
15.	Elective care – outpatients *60% of patients wait no longer than nine weeks for their first outpatient appointment *no patient waits longer than 18 weeks. (volume)	60%	36.5% 31% R	36.1% -	36.4% -	R
		0	12,057	13,216	14,787	R
16.	Elective Care – diagnostics *no patient waits longer than nine weeks for a diagnostic test (volumes) I: imaging, N-I: non imaging *all urgent diagnostic tests are reported on within two days of the test being undertaken.	0	4,075 I 1335 N-I	3,700 I 1207 N-I	3,372 I 1137 N-I	R
		100%	79.6% I 96.1% N-I	78.5% I 97.3- N-I	76.2% I - N-I	R
			88% R	-R	-R	Y
17.	Elective Care – Inpatient/Daycases *65% of inpatients and daycases are treated within 13 weeks and *no patient waits longer than 26 weeks.(volumes)	65%	52.8% 48% R	52.2% -R	54.6% -R	R
		0	1,515	1,520	1,604	R
19.	Stroke Patients - ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis.	13%	May 10.5%	June 23.1%	July 14.7%	G

No.	Target Areas	Target	Aug 15	Sept 15	Oct 15	RAG
20.	Healthcare acquired infections - secure a reduction of 20% in MRSA and <i>Clostridium difficile</i> infections compared to 2014/15.	MRSA 5	0 Cum: 1	0 Cum: 1	0 Cum: 2	G
		CDiff 32	10 Cum 24	4 Cum 28	10 Cum 38	R
21.	Patient discharge – *ensure that 99% of all learning disability (LD) and mental health (MH) discharges take place within 7 days of the patient being assessed as medically fit for discharge, with *no discharge taking more than 28 days; *90% of complex discharges from an acute hospital take place within 48 hours, with *no complex discharge taking more than seven days; and *all non-complex discharges from an acute hospital take place within six hours.	99%	100% LD	100% LD	100% LD	G
			95.5% MH 96% R	93.1% MH	91.7% MH	A
		0	0 LD 2 MH	0 LD 3 MH	0 LD 1 MH	G
						A
		90%	98% 81% R	86.4% - R	92% - R	G
		100%	100%	93.22%	96%	A
22.	Mental Health Services – *no patient waits longer than nine weeks to access child and adolescent mental health services; *nine weeks to access adult mental health services; * nine weeks to access dementia services; and *13 weeks to access psychological therapies	100%	94.7% 95% R	91.7%	91.5%	R
		0	0	0	0	G
		0	19	70	52	A
		0	106	86	93	R
23.	Children in Care – placement change - ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.	0	119	119	129	R
		85%	Annual Reporting			
		90%	Annual Reporting			
		TBC	Reporting in Development			
24.	Children in Care- adoption within 3 years - ensure that a three year time frame for 90% of children who are adopted from care.					
25.	Patient Safety - ensure that the death rate of unplanned weekend admission does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.					
26.	Normative Staffing - implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.	Further detail is available in the Nursing workforce Report.				
27.	Excess bed days - reduce the number of excess bed days for the acute programme of care by 10%.	Trend (CHKS) reporting performance 25% compared to 15.5% HES peer average (July 13 – July 15)				
28.	Cancelled appointments - reduce by 20% the number of hospital cancelled consultant-led outpatient appoints in the acute programme of care which resulted in the patient waiting longer for their appointment. (Volumes & % rate in month)	<4335	642 (4.5%)	803 (4.14%)	N/A	A
29.	Delivering transformation – Safe transfer of £83m from hospital/institutional based care into primary, community and social care services	The Trust contribute to this target by implementing commissioned community based schemes, eg Acute Care at Home/Re-ablement				

Corporate Indicators of Performance (No CP Target)	Aug		Sept		Oct	
Review backlog – Volume of patients waiting beyond clinically indicated timescales	22,968 Acute/CYP/OPPC 1,525 MHD		21,915 Acute/CYP/OPPC 827-MHD		20,627 Acute/CYP/OPPC 665-MHD	
Unallocated cases – number of unallocated child care cases (T:total; >40: volume over 40 days)	152 T 78 >40		36T 6 >40		N/A	
GP OOH - % Urgent calls triaged within 20 mins; % Routine calls triaged within 60 mins	90.38% U 52.37% R		93.9% U 58.31% R		91.46% U 40.68% R	
Service & Budget Agreement Level - % variation in performance against apportioned month end SBA.	NOP -1% ROP -4% Diag +10%	DC +5% IP – 13% Births +1% NEIP +60%	NOP +3% ROP 0% Diag +11%	DC +7% IP – 10% Births +1% NEIP +61%		

PERFORMANCE MANAGEMENT REPORT

COMMISSIONING PLAN STANDARDS/TARGETS FOR 2015/2016

**November 2015 Report for
October 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

CP 5: UNPLANNED ADMISSIONS: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care

By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas. (COPD, Diabetes, Heart Failure, Asthma and Stroke)

Baseline: Increase of 13.5% April – December 14 compared to 2012/13 baseline

TDP Assessment: Unlikely to be achieved/affordable

Comments: Reporting three months in arrears

Reduction in the number of unplanned hospital admissions for people with the identified conditions will depend on arrangements being in place to support service users to manage their condition in a primary/community setting. At the end of March 2015 this target was not achieved with +23.4% against a target of -5%.

The target is profiled based on the actual presentation of conditions in 2013/14, minus 5%. Cumulatively at 31 July 2015 there were 90 more admissions for the target cohort than the same period in the baseline year, which equates to + 20.5% above the target. There was a general increase in non-elective admissions for all patients in the period April – July 15 compared to April – July 13 which makes this target challenging in the face of this increasing trend. Table 5 (a) indicates only Stroke achieved a reduction in July and all other specialties demonstrated an increase in admissions. All specialties have shown an increase in admissions and cumulatively there has been a 14.5% increase in admissions from the baseline year.

It should be noted that unplanned admissions for primary stroke and acute asthma are unlikely to reduce due to clinical best practice. However, a range of initiatives are in place around these and the other condition areas to ensure the necessary supports in place to increase the management of these conditions in a community/primary care environment.

Stroke

- The Trust has focused support in place post stroke for 6-months to seek

Target: 5% reduction (Cumulative Admissions 1917)

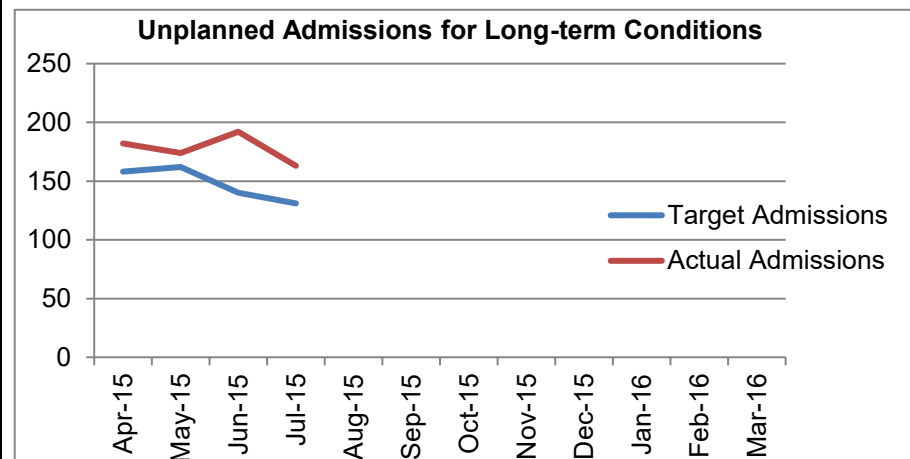


Table 5 (a): Breakdown by Condition

Month of discharge	COPD	Diabetes	Heart failure	Asthma	Stroke
April	+3.8%	+72.7%	-11.8%	+88.9%	+9.3%
May	-20.3%	+33.3%	-2.7%	+85.7%	+24.3%
June	31.5%	116.7%	45.5%	50%	4.3%
July	34.8%	62.5%	5.7%	100%	-11.9%
Cum total (Target -5%)	8.8%	62.5%	6.4%	80.6%	6%

to avoid secondary presentations of stroke;

Heart Failure/COPD/Asthma

- Established arrangements in place for known Heart Failure and COPD patients including self-management plans, good education and awareness provided by Community Team;
- Identification and follow-up of Heart Failure and COPD patients who have been admitted to CAH / DHH;
- Established pulmonary rehabilitation plans and maintenance support programmes in place, particularly focused on 'frequent flier' patients who may have had multiple admissions due to COPD/anxiety issues.
- 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.
- Investment template proposals have been submitted to SLCG for increased diabetic nurse specialist capacity in DHH and in the community.

Further initiatives including development of the Acute Care at Home model & Re-ablement model will continue to support unplanned admissions.

	Monthly Position:												Cum Assess	Trend
	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15		
Target Admissions	146	136	157	155	162	175	159	181	158	162	140	131		
Actual Admissions	173	172	188	200	250	254	233	185	182	174	192	163		
Cumulative Target and Actual	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 158 A 182	T 319 A 356	T459 A548	T590 A711		
Monthly %									+9.6%	+2.4%	+30.6%	+18.1%	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)

Target: To be confirmed

TDP Assessment: Unlikely to be achieved/affordable

Comments: Reporting three months in arrears – New report being established as new definition is significantly different from previous report on IOP B36. (Information report being developed by the Acute Information Team - anticipate will be available for December report).

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.

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		
N/A	N/A	N/A	N/A	N/A									

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.**

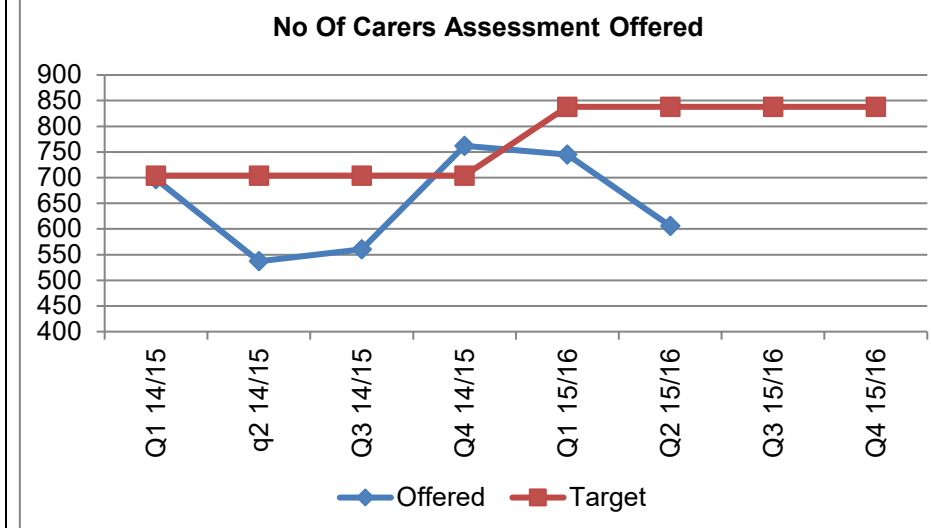
This target is challenging for the Trust. The baseline and target was set based on the volume of carer's assessments undertaken in the Quarter Ending March 15. In this period additional assessments in Physical and Sensory Disability and in Child and Adolescent Mental Health Services resulted in the total 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. Trust performance in Q2 has decreased but this is consistent with performance in this period over the last few years.

Regional performance is not comparable as targets are set on an individual Trust basis however the trend against individual targets demonstrates a cumulative performance of -1% at Quarter 2, with only BHSCT achieving the profiled target for the planned 10% increase.

It is anticipated that the roll out of the community information system will lead to more robust recording of carers assessment offers and funding allocated for Self Directed Support in year will provide an increase in the number of offers.

Actions to Address:

- The Trust has established a 'Carers Reference Group' at which each Directorate is represented by a 'Champion';
- The CYPS Directorate has further established a 'Young Carers Group';
- Promotion of the uptake/offer of carer's assessments will be re-enforced as part of the standard operating processes, and .
- The Carers Action plan for this year include increased focus on ownership of carers and carers assessments.



Quarterly Position:

Trend

	Quarter 2 (Jul to Sept 2014)	Quarter 3 (Oct to Dec 2014)	Quarter 4 (Jan to Mar 2015)	Quarter 1 (Apr to Jun 2015)	Quarter 2 (Jul to Sept 2015)		
Offered	537	560	762 (+58 above target)	745 (-93 below target)	606 (-232 below target)	R	↓

CP 8: DIRECT PAYMENTS: Lead Director – Mr Francis Rice, Director of Mental Health and Disability

By March 2016, secure a 10% increase in the number of direct payments across all programmes of care. (Change in target from 5% to 10%)

Baseline: 695 active and 47 ceased direct payments @ 31 March 15 (742)

TDP Assessment: Partially achievable/ achievable with additional resources

Target: Increase by 10% 816

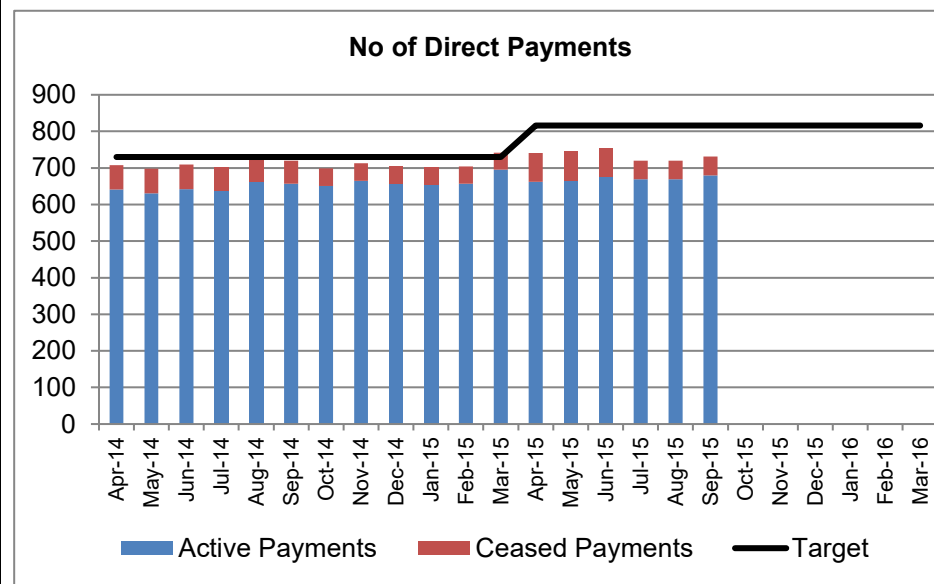
Comments: October update not available

This target is made up of active payments and payments which were previously made and ceased within the quarter. It is of note that the target for the SHSCT (816) is the highest in the region which ranges from 485 in WHSCT Trust to 686 in NHSCT.

Regional performance is not comparable as targets are set on an individual Trust basis however the trend against individual targets demonstrates only two Trusts were on track against their profiled target at the end of Quarter 2 and overall there was a 3% decrease at this point.

Action

- The Trust will continue to promote Direct Payments and to roll out training to staff on the new guidance; and
- The Trust will also continue with the introduction of Self Directed Support payments.



Monthly Position:														Cum Assess	Trend
	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15		
Trust Total	699	713	707	702	704	742	709	712	753	720	720	731	N/A	R	↑

Trust Ceased (Quarterly Only)	48			47			79			51			N/A		
Trust Active (Monthly)	651	665	657	655	657	695	662	665	674	669	669	680	N/A		
Breakdown by Programme of Care:															
	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Cum Assess	Trend
Primary Health & Adult Community	0	0	0	0	0	0	0	0	0	0	0	0	N/A		
Physical & Sensory Disability	173	177	174	173	175	216	174	174	178	176	140	144	N/A		↓
Mental Health	50	52	54	53	56	55	57	56	56	55	56	57	N/A		↔
Learning Disability	264	269	265	270	270	267	271	272	273	272	309	314	N/A		↑
Elderly	164	167	164	169	156	157	160	163	167	166	164	165	N/A		↔

* Children with disabilities included in the Learning Disability category

**Information is only available at the quarterly point for ceased payments therefore performance can only accurately be measured at each quarter end.

Note: Adjustment to Jul-Sep Trust totals due to quarterly update.

CP 9: ALLIED HEALTH PROFESSIONALS: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care

From April 2015, no patient waits longer than 13-weeks for referral to commencement of AHP treatment. (Change in target from 9-weeks to 13-weeks)

Baseline: 1436 >13 weeks @ 31 March 15

TDP Assessment: Unlikely to be achieved/affordable

Standard: 0 waits over 13 weeks

Comments:

The volume of patients waiting in excess of 13-weeks has decreased between September and October, predominantly in Physiotherapy where additional capacity has come on stream. Breakdown of waits by profession can be seen in table 9(a).

September regional performance demonstrates a total of 13,217 patients waiting in excess of 13-weeks, excluding BHSCT. Using May proxy figures for BHSCT this would equate to 17,400 regionally. Volumes range from 276 (SEHSCT) to 5792 (NHSCT). SHSCT accounts for 23% (3931) of the proxy regional total of patients waiting in excess of 13-weeks.

- **Dietetics (Paediatrics)** - has been subject to demography and high levels of demand particularly related to paediatric allergy which makes up almost half of the caseload in this area. Early outcomes from regional demand and capacity exercise indicate agreement on need for additional capacity in paed diabetes; this gap should be signed off in November.
- **Occupational Therapy (Paediatrics)** - has been impacted upon both by manpower issues in 21014/15, which had been partly addressed, and demand related to demography associated with increasing children's population and the high level of children with special needs in SHSCT area. Focused work in OT to ensure no child is waiting beyond the clinically indicated timescale is limiting capacity for new cases in the short term. Ability to source additional temporary staff is challenging, however this continues. Working to confirm a capacity gap in this area is ongoing.
- **Occupational Therapy (Adult)** - Manpower issues in individual

No Waiting in Excess of 13-Weeks from Commencement of Treatment

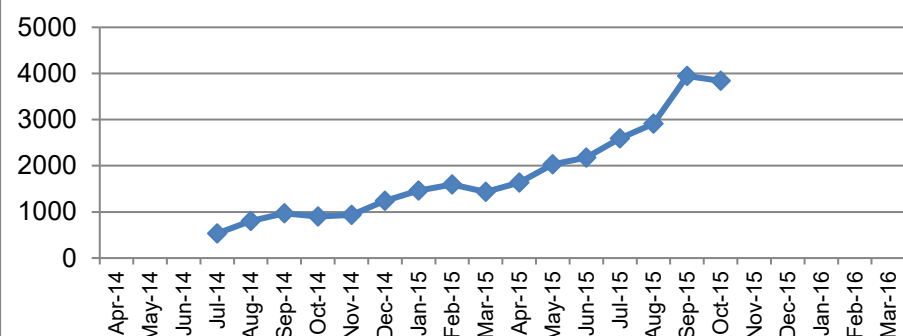


Table 9 (a)

Profession	Access Time (end Oct)	Volume over 13 weeks & increase from Sept	% of total waits within profession
Dietetics	28-weeks	125 (-4)	3.3%
Occupational Therapy	41-weeks	338 (-4)	8.8%
Orthoptics	19-weeks	159 (+0)	4.1%
Physiotherapy	25-weeks	923 (-106)	24%
Podiatry	31-weeks	1399 (+22)	36.4%
Speech & language	42-weeks	896 (+1)	23.3%

integrated care teams have resulted in unequal waits in adult OT services. Recruitment is ongoing but slow and the service continues to managing risks internally by redeploying staff across teams where necessary.

- **Podiatry** - Services have been challenged by manpower issues and have lost considerable new and review capacity over the last 6-8 months; this and a level of demand above capacity has resulted in an access time of 30 weeks at the end of October. Currently long term sick leave continues to impact on capacity. A number of additional temporary posts are in recruitment and should be in place by November. Initial focus will be on continuing to address those reviews which are waiting beyond their clinically indicated timescale. The Trust continues to work with HSCB on the demand and capacity modelling exercise to establish if there is a formal gap between demand and capacity for podiatry.
- **Physiotherapy** - the impact of staff vacancies and lost capacity over the Summer period has resulted in an accrued increase in Physio waits. Some recruitment is in place with remaining posts expected to be in place by December. Early outcomes from regional demand and capacity exercise indicate agreement on need for additional capacity in physiotherapy; this gap should be signed off in November.
- **Speech & Language Therapy (Paediatrics)** – continue to hold the longest access times associated with manpower issues and accrued backlogs from 2014/15 and ongoing demand beyond capacity. Review and treatment blocks remain waiting beyond the clinically indicated timescales. Ongoing challenges associated with ability to recruit temporary posts to address review backlogs. Early outcomes from regional demand and capacity exercise indicate the need for additional capacity in SLT; the level of this is yet to be agreed.

Reviews and treatments beyond their clinically indicated timescale has become an increasing challenge throughout the range of AHP areas. Internal resources have been re-directed, as available, to focus on areas of accrued backlog. Whilst this has led to significant improved and is welcomed challenges remain associated with the ability to attract temporary/additional capacity with the necessary skills. Regional recruitment waiting lists have limited number of candidates available and candidates are less interested in short term temporary work.

Actions to Address:

- Ongoing focus on urgent waits and planned reviews in areas with manpower and demand issues; arrangements have been established for reporting of these patients monthly to increase visibility and action planning;
- Exec Director of AHP/AD CYP have provided input into review of special schools
- Ongoing re-direction of internal resources to areas of backlogged reviews beyond their clinically indicated timescales as posts can be secured;
- 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; and
- Trust has highlighted temporary recruitment challenges to PHA/HSCB and has convened an internal meeting to consider challenges.

	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
>9-weeks	1773	2437	2890	2527	2425	-	-	-	-	-	-	-		
>13 weeks	938	1238	1460	1596	1436	1638	2032	2173	2591	2910	3944	3840	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:

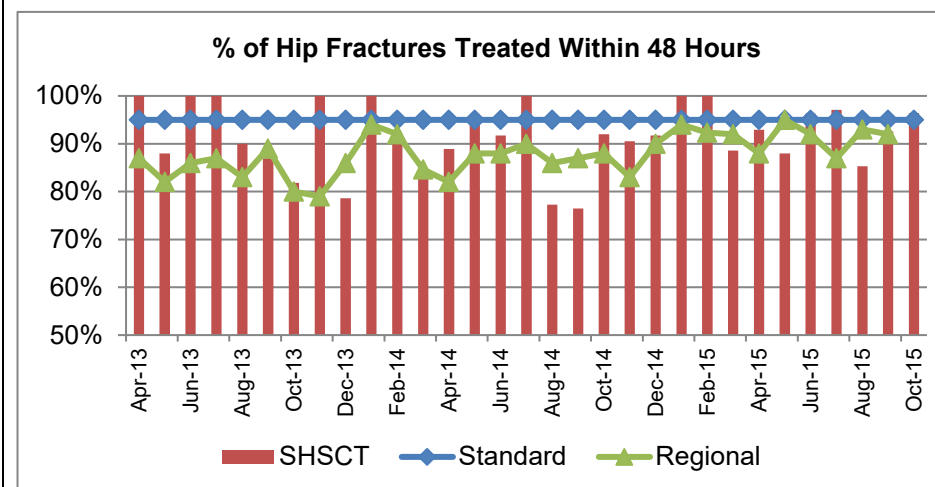
On-going trauma pressures have resulted in the cancellation of elective orthopaedic surgery to facilitate the treatment of the clinically urgent trauma cases. In 2014/2015 there were a total of 106 elective orthopaedic operative cases cancelled/slots lost to facilitate trauma cases. This pressure has continued into 2015/2016 with a total of 89 elective orthopaedic operative cases cancelled up to 13/11/15. The Division predict this trend will continue with 9 additional cases cancelled in November to date associated with heightening winter pressures.

In October there was 1 case not treated within 48 hours. This was associated with higher levels of general trauma, and a range of complex non-neck of femur cases, including compound fractures and multiple trauma cases, which took clinical priority impacting in reduced throughput of neck of femur cases.

The Trusts performance has been comparable with regional performance, which was 92% in September.

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 the trauma list for that day.														
	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
Trust	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)	85.3% (29 out of 34)	92.6% (25 out of 27)	96.4% (27 out of 28)	Y	↑
Regional	83%	90%	94%	92.3%	92%	88%	95%	92%	87%	93%	92%	N/A		

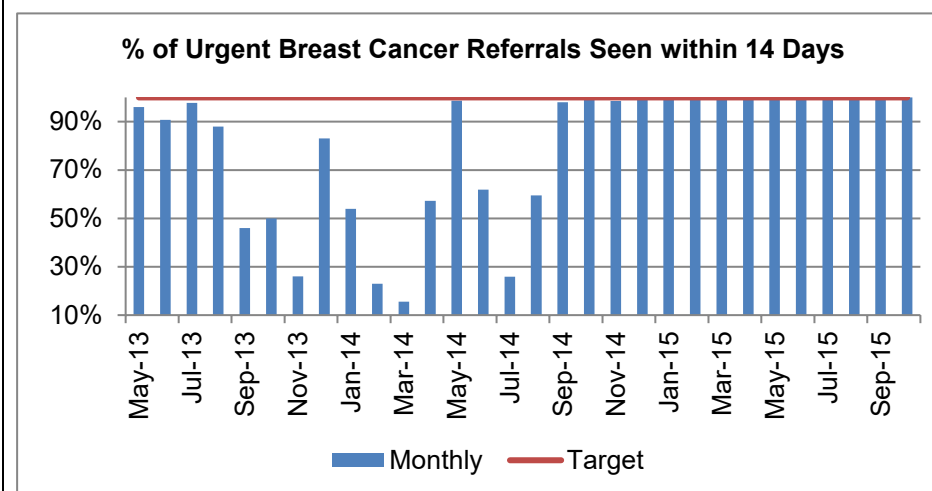
CP11: CANCER CARE SERVICES: Lead Director – Mrs Esther Gishkori, Director of Acute Services**From April 2015, all urgent breast cancer referrals should be seen within 14-days. (No change in target)****Baseline:** 82.7%**TDP Assessment:** Partially achievable/achievable with additional resources**Standard:** 100%**Comments: No update available for October**

Investment has been secured which will increase capacity in this area recurrently. Whilst there are some challenges in securing the specialists skills required plans are in place to implement this capacity in 2016 with an interim non-recurrent solution to ensure additional capacity, which has been in place throughout the year, continues into Q3 and Q4.

It is of note that routine demand, which is outside this target, is 10% higher in the period April – Oct 15 compared to the same period in 2014. This is impacting on routine access time which increased to 14 weeks at the end of October and is predicted to be 15 weeks at the end of December if the trend continues. There is no subsequent increase in confirmed cancers in the same period. This increased demand has been mirrored in other Trusts. Whilst formal reporting is not available for October there were no reported 14 day breaches; early indications however are that breaches will occur in November. The Southern Trust continues to be the joint best performing Trust in the region in relation to this target.

Actions to Address:

- Trust will work to implement the additional resources required to establish this increase capacity recurrently.
- Increasing demand has been highlighted to the HSCB and will be monitored closely to establish if this is a longer term trend.



Monthly Position:												Cum Assess	Trend
Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
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)	100% (282 out of 282)	99.2% (236 out of 238)	100% (248 out of 248)	N/A	G	

CP 11: CANCER CARE SERVICES: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31-days of a decision to treat. (No change in target)

Baseline: 99%

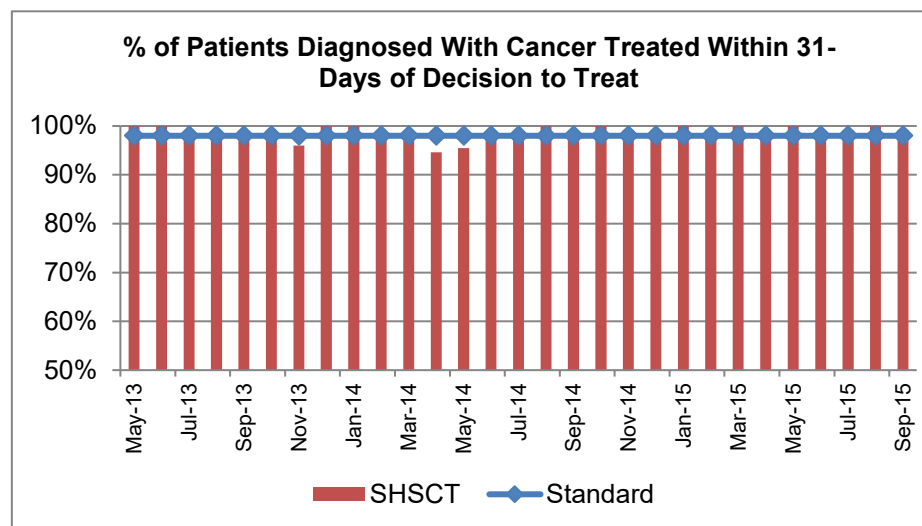
TDP Assessment: Partially achievable/achievable with additional resources

Standard: 98%

Comments: Reporting one month in arrears.

Performance against the 31-day standard is based on completed waits ie. those patients that have had their cancer confirmed and who have received their first definitive treatment. Performance against this target has been consistently high.

September Regional performance demonstrates an average of 96% and a range of performance from 94% (BHSCT) to 100% (SHSCT). The Southern Trust has a performance of 100% in September and is the joint top performing Trust in the region alongside WHSCT.



Monthly Position:												Cum Assess	Trend
Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	June 15	July 15	Aug 15	Sept 15		
99.2%	99.08%	100%	99.18%	100%	98.35%	100%	99.05%	99.15%	100%	99%	100%	G	↑

CP 11: CANCER CARE SERVICES: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2014, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62-days. (No change in target)

Baseline: 85.3%

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 95%

Comments: Reporting two months in arrears.

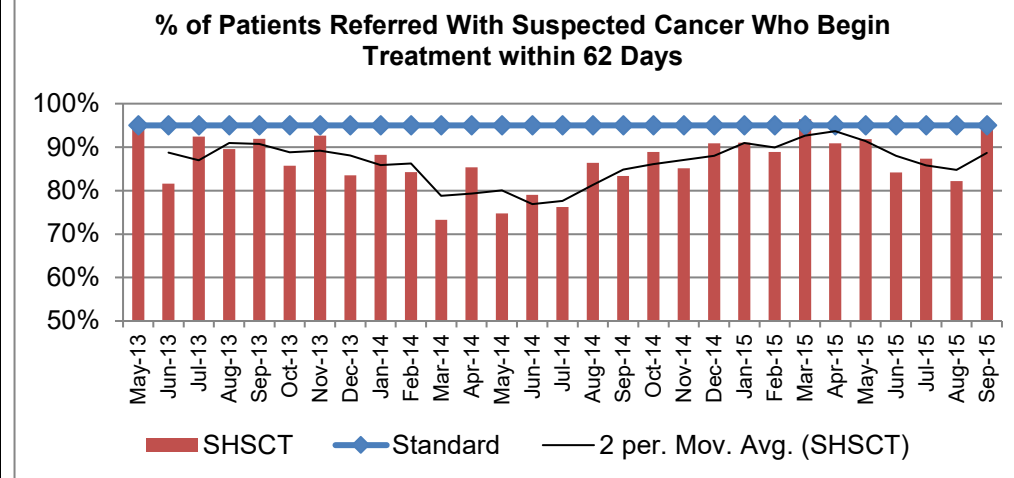
Performance against the 62-day standard is based on completed waits ie. those patients that have had their cancer confirmed and who have received their first definitive treatment.

62-Day: In September there were 6 patients in excess of the 62-day standard.

Performance in June, July, August has been lower due to the impact of summer leave and medical manpower issues in Radiology and Pathology, however this position is improved for September.

Performance in September for Southern Trust (95%) remains above the regional average of 69%. The Southern Trust was the best performing Trust regionally in September and cumulatively to date remains the second best performing Trust in the region (89%) behind Western Trust (90%)

Day-85: There was 1 breach of Day 85 target in September - ENT – thyroid complex. Although not formally validated a further breach is anticipated in October.(upper GI).



Monthly Position:

Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	June 15	July 15	Aug 15	Sept 15	Cum Assess	Trend
88.89%	85.14%	90.91%	90.99%	88.89%	96.43%	90.91%	91.84%	84.21%	87.37%	82.22%	95.08%		

Y

↑

CP 12: UNSCHEDULED CARE: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department. (No change in target)

Baseline: Trust – 83.8%

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 95%

Comments:

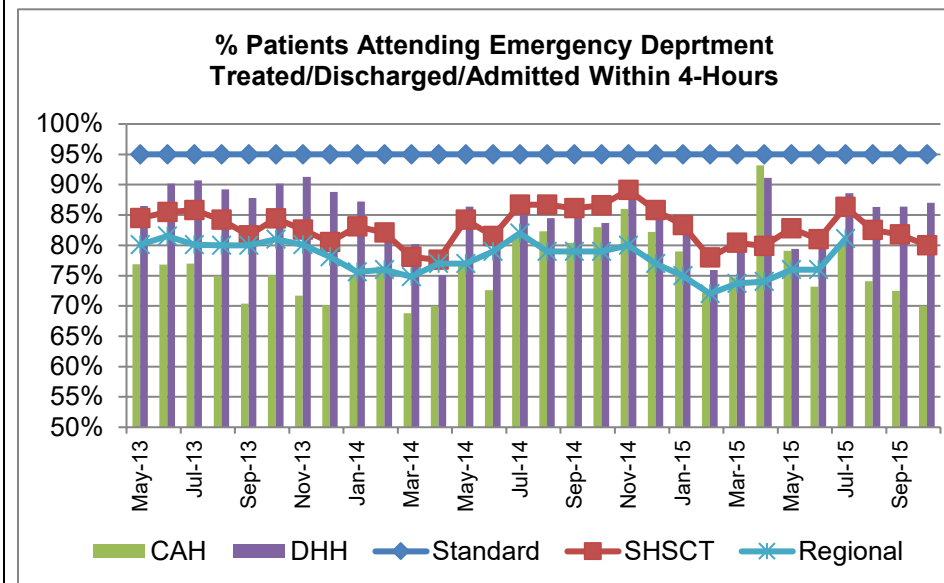
Performance continues to be challenging locally however the Trust was performing (82%) above the regional average (78%) in September and cumulatively is the best performing Trust within the region. Trust is working to minimise the impact on patient flow of Estate works in CAH between September and December which will reduce beds available for admission.

Performance in October against the 4-hour target is decreased. Key analysis of this period indicates

- Emergency Department (ED) attendances at CAH and DHH increase in the month, whilst attendances at MIUs decreased;
- CAH averaged 220 attendances per day with attendances peaking at 297; daily admissions ranged from 43 to 67 and on 6 occasions were over 60; on two occasions admissions were over 60 admissions on two consecutive days which co-incided with 2 clusters of 12- hour breaches (8 patients) over 4 days;
- DHH averaged 136 attendances per day, peaking at 164; daily admissions from ED ranged from 13 – 39 and no 12 hour breaches were sustained in October; Early analysis of discharges indicated a slight reduction in discharge towards the end of October in CAH and in DHH. Further analysis of the impact of this is required.

A number of initiatives have been implemented to improve this position including:

- Sustained management & clinical focus in and out of hours to maintain focus and support staff,
- Renewed focus on key aspects of the 60-minute plan and other key flow indicators,
- Improvement work focused on throughput in the minor stream,
- Daily patient flow processes with the objective of pulling discharges forward and working towards having the hospital settled by 8.00pm.



- Ongoing work with Alamac, assessing performance against the 4 hour standard and highlighting areas for further improvement with particularly interface across the pathway with development of community indicators/alerts; and
- Phased opening of 17 additional medical beds initiated (w/c 16 November) which should assist with flow issues.

Forward Look Actions

- 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. It is anticipated that this will assist in understanding cause and also to assist to know what 'good' looks like, enabling alerts and forecasting;

- The Trust has developed its Unscheduled Care Plan as follows:

Section A

- o 5 key areas for improved flow – including ED Minor Stream and 7 Day working.

Section B

- o Original plans for fast turnover beds in CAH have been revised and plans are being developed for an ambulatory unit which would be co-located to ED. It is anticipated this unit will facilitate prompt senior assessment for those patients that will not require to have an overnight stay;
- o Rollout of Acute Care at Home into the Armagh and Dungannon locality, Both initiatives will have a significant primary care focus and focus on admission avoidance where this is appropriate for the patient's need.

	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
Trust 4-Hour	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)	82.5% (10945 out of 13266)	81.8% (10800 out of 13200)	80.1% (10,567 out of 13,190)	R	↓
Trust 6-Hour	96.7% (11408)	95.7% (11484)	94.1% (11011)	91.9% (10584)	92.9% (10584)	93.2% (12154)	95.5% (12731)	94.07% (13138 out of	96.4% (12553)	94.6% (12549)	94% (12414)	92.7% (12,232)		

	out of 11797)	out of 11994)	out of 11699)	out of 11520)	out of 11520)	out of 13043)	out of 13324)	13966)	out of 13018)	out of 13266)	out of 13200)	out of 13,190)		
CAH 4-Hour	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)	74.1% (4950 out of 6683)	72.5% (4869 out of 6716)	69.6% (4755 out of 6836)	R	↓
CAH 6-Hour	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)	91.3% (6100 out of 6683)	89.9% (6043 out of 6716)	87.7% (5996 out of 6836)		
DHH 4-Hour	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)	86.3% (3708 out of 4296)	86.4% (3492 out of 4044)	86.9% (3591 out of 4132)	R	↔
DHH 6-Hour	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)	96.9% (4162 out of 4296)	97.2% (3932 out of 4044)	97.1% (4014 out of 4132)		
Regional Average	80%	77%	75%	72%	73.7%	74%	76%	76%	81.1%	77%	78%	N/A		

CP 12: UNSCHEDULED CARE: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, no patient attending any Emergency Department should wait longer than 12 hours. (No change in target)

Baseline: 14

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 0

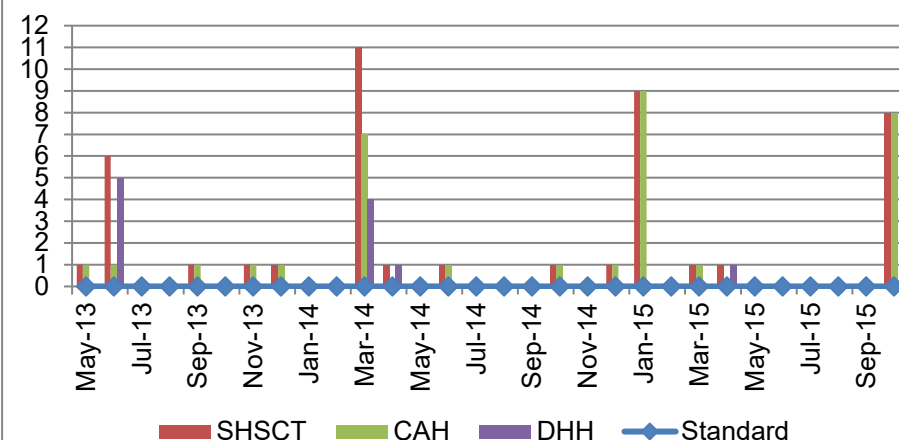
Comments:

There were 8 x 12 hour breaches in October; this is the highest number of breaches since January. This is attributed to a particularly busy period in A&E in the last two weeks of October.

- 6 breaches of the 12 hour standard occurred over two days, on the 19th and 20th October, when admissions from ED peaked at over 60 for two consecutive days.
- 2 further breaches occurred on 27th and 28th October when again admissions were in excess of 60 for two days.

In November, up to 16th, there has been one reported breach. September regional performance (67) demonstrates a reduction in patients waiting greater than 12 hours from August (171) although this was an increase from the July regional position of 44.

Number of Patients Waiting Over 12-Hours in Emergency Department



Note: The volume of 12-hour breaches in April 2013 was 75.

	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
Trust	0	1	9	0	1	1	0	0	0	0	0	8	Y	↓
CAH	0	1	9	0	1	0	0	0	0	0	0	8	Y	↓
DHH	0	0	0	0	0	1	0	0	0	0	0	0	G	↔

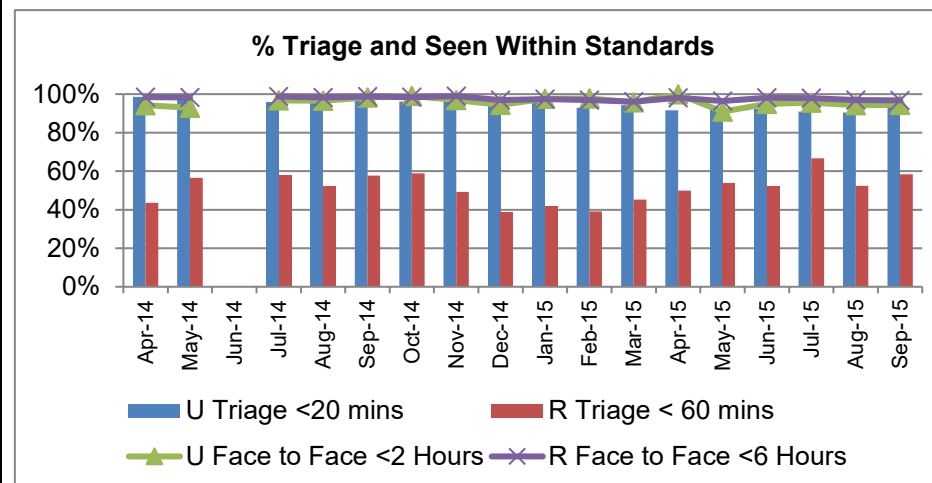
GP OUT OF HOURS: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care**Not a formal CP target - GP Out of Hours Standards are:****Urgent triage (UT)** 90% within 20 minutes**Urgent face to face (UF2F) appointment** 90% within 2-hours**Routine triage (RT)** 90% within 60 minutes**Routine face to face (RF2F) appointment** 90% within 6-hours**Comments:**

In order to reflect the totality of pressures on the 'unscheduled system' information on GP Out of Hours performance has been included. The ability to maintain adequate service provision and standards for triage relate to ongoing challenges presented in filling vacant GP shifts. Efforts to recruit additional GPs and Locum staff have not been successful.

- Urgent Triage - The % of urgent patients triaged within 20 minutes has decreased to 91.46% at end October compared to 93.97% end of September with 14 patients waiting greater than 60 minutes.
- Routine Triage - Trust has shown a large decrease in % of routine patients triaged within 60 minutes at end October 40.68% compared to 58.31% at end September. This equated to 2126 patients not being triaged within 60 minutes of which 16 patients waited 8-9 hours.
- Face to Face – The % of urgent patients seen within two hours has remained fairly static at 95.75% which equates to 19 patients being seen after two hours; this position will continue to be monitored. The % of routine patients seen within 6 hours has also remained fairly static at 96%.

Actions to Address:

- The Trust has 26 nurses to undertake nurse triage, as nurse Triage Advisors. 1 nurse requires competition of training and monitoring;
- 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 March 2016 to provide support in the winter pressure



period. The draft evaluation has been shared for comments and is due to be discussed at November's HSCB Performance and Governance meeting;

- A capacity and demand analysis has been concluded;
- 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 / 4, and
- Proposals to address winter pressures have been prepared.

	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
UT <20 mins	95.95%	96.21%	95.31%	92.91%	94.27%	91.68%	92.57%	92.18%	91.01%	90.38%	93.97%	91.46%	G	↓
No. >20 mins	64	75	92	127	101	129	126	102	117	128	85	144		↓
RT <60 mins	49.28%	38.36%	41.99%	39.09%	45.29%	49.86%	53.6%	52.08%	66.75%	52.37%	58.31%	40.68%	R	↓
No. >60 mins	3296	4498	3839	3577	3341	3047	3079	2432	1791	2554	1966	3171		↓
UF2F <2 hrs	96.89%	94.36%	97.6%	97.74%	95.79%	100%	90.91%	94.87%	95.55%	94.25%	94.5%	95.75%	G	↔
No. >2 hrs	14	26	10	9	15	0	2	13	13	20	18	19		↔
RF2F <6 hrs	98.97%	96.86%	97.38%	96.98%	96.08%	98.15%	96.41%	98.11%	97.99%	96.97%	96.74%	96%	G	↔
No. >6 hrs	34	107	80	78	75	49	109	42	49	69	47	66		↔

CP 14: HOSPITAL RE-ADMISSIONS: Lead Director – Mrs Esther Gishkori, Director of Acute Services**By March 2016, secure a 5% reduction in the number of emergency re-admissions within 30 days. (No change in target)****Baseline:** 13% above target profile**TDP Assessment:** Partially achievable/achievable with additional resources**Target:** 5% reduction**Comments: Reporting three months in arrears.**

Regional performance data for 2014/2015 is not currently available.

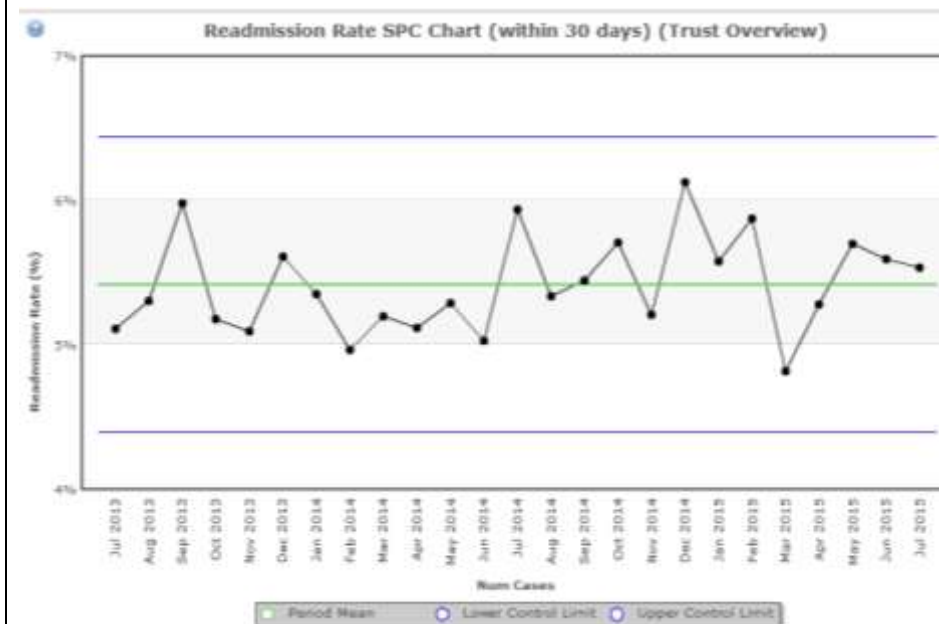
CHKS, the comparative benchmarking system, measures re-admissions against the top hospital peers. Whilst this definition and the comparators are slightly different from those used by HSCB this is a useful guide to performance against our peers and in providing assurance regarding appropriate patient care.

CHKS indicates the Trusts re-admission rate of 5.5% over the last 12 reportable months (July 2014 – June 2015) which is below the Peer average of 6.6% for the same period. Longer term trending on the chart demonstrates the pattern of re-admission over the last two years, which averaged a similar re-admission rate of 5.4% against a peer of 6.5% from July 2013 – July 2015) indicating no specific change in the average position year on year.

In December 2014 the re-admission rate was above the normal variation for the SHSCT, whilst still significantly lower than the peer, analysis has been undertaken to identify specialty areas where the pattern is outside that expected and these areas are being reviewed by Associate Medical Directors to identify any patterns and, or emerging themes and to consider if any further analysis is required.

Actions to Address:

- A detailed analysis of re-admissions, including analysis of the top 10 condition groups, has been undertaken and discussed with clinicians and GP For; 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.



SHSCT Performance Report – November 2015 (for October Performance)

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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 October there were 14,787 patients waiting over 18 weeks including the specialties identified in Table 15 (a). The percentage of patients waiting less than 9-weeks has remained fairly static at 36.4% of patients seen within 9-weeks in October. This is better than the regional performance, where in September the regional average indicated 33% waiting < 9-weeks. Key issues prevail including

- A range of specialty areas where capacity is insufficient to meet demand associated with residual capacity gaps and impacted by a general increase demand ;
- A general increase in red flag demand, which is impacting on the access times for urgent and further reducing the amount of routine capacity that can be provided;
- Financial situation which reduced the level of non-recurrent funding provided in 2014/2015 for additional capacity which resulted in accrued increased access times and provision of no additional funding in 2015/16 for reduction of access times in year;
- A number of specialty areas are currently underperforming against SBA at this stage in the year, which is an established normal variation. The majority will recover in year; exceptions include general surgery, diabetes/endocrinology; orthopaedic ICATs, and urology.

Note: HSCB has indicated (Nov15) that additional funding will be made available for additional capacity in Q4. The level of additional activity that can be undertaken will rely on the ability of independent sector provider to provide capacity in that further additional in-house capacity cannot be undertaken. HSCB will direct funding to areas with long routine waits, and seek to provide an equality of wait for these specialties across the region.

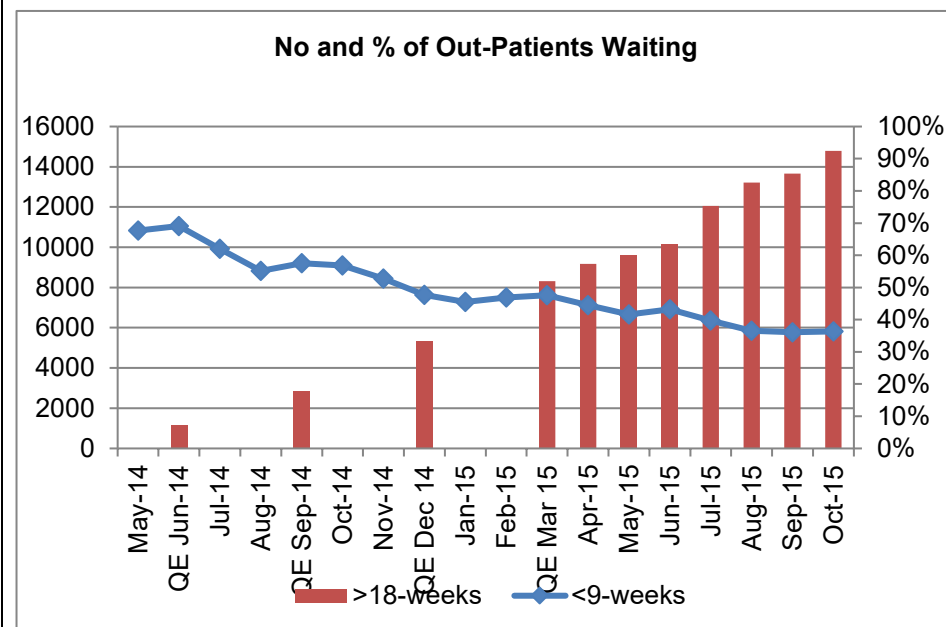
Actions to Address:

Table 15 (a)

Speciality	Access	Volume >18weeks	SBA position as at 30/9/15
Dermatology (Inc ICATS)	25-weeks	84	Underperforming by 2%
Urology (Inc ICATS)	68-weeks	1402	Underperforming by 17%
Ortho-geriatrics	58-weeks	54	Over performing by 5%
Neurology	44-weeks	836	Overperforming by 6%
Orthopaedic (Consultant Led)	56-weeks	662	Underperforming by 16%

- Focus remains on the prioritisation of capacity to red flag and urgent cases;
- Review of performance for routine, urgent and core SBA activity undertaken with bi-weekly & monthly performance meetings. These meetings review and challenge the SBA performance and access delivery and are utilised to agree remedial action required to improve the areas of underperformance;
- Internal recovery plans in place for any areas identified as underperforming against SBA by more than -5% which the normal tolerance for variation;
- Acute, OPIC and CYP Directorates working to implement recommendations from the HSCB audit of outpatient management which will improve chronological management, and
- Information on access times is shared monthly with General Practice to ensure referrers and patients are aware of current access times.
- Procurement activities designed to secure additional capacity in the independent sector have commenced in line with announcement of additional in-year non recurrent funding.

Cardiology (Cons Led & ICATS)	42-weeks	1009	Under performing by 10%
Orthopaedic ICATS	30-weeks	0	Underperforming by 20%
ENT (Cons Led)	38-weeks	2277	Over performing by 5%
General Surgery	34-weeks	1002	Underperforming by 9%
Pain Management	32-weeks	380	Underperforming by 3%
Endocrinology	58-weeks	297	TBC
Diabetology	43-weeks	131	TBC
Rheumatology	55-weeks	588	Underperforming by 5%
Gynaecology	31-weeks	529	Underperforming by 2%
Gastroenterology	45-weeks	584	Over performing by 11%
Haematology	37-weeks	69	Over performing by 18%
Paediatrics	28-weeks	128	Underperforming by 20%

A summary of actual access times for October 2015 is attached in Appendix 2.

Two external (visiting specialties) in excess of 18 weeks:

- Ophthalmology – 4128 patients, longest wait 79-weeks; and
- Paediatric Cardiology – 128 patients, longest wait 68-weeks.

	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
<9-weeks	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)	36.5% (12692)	36.1% (12510)	36.4% (12799)	R	↔
>15-weeks	24.7% (6378)	28% (7477)	32% (8731)	34% (9527)	36% (10847)	-	-	-	-	-	-	-	R	
>18-weeks	QE Dec 14 20.7% (5334)			QE Mar 15 29.2% (8309)			29.5% (9173)	30% (9616)	30.9% (10148)	35.7% (12057)	38% (13216)	42.07% (14787)	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 20,626 patients waiting for review appointments beyond their clinically indicated date at 1 November 2015 the majority of these, 18,313 relate to Acute consultant outpatient services, with approximately 1598 paediatrics and 715 ICATs.

- 44% of those waiting are in excess of 6-months;
- 15% are waiting between 3 – 6 months; and
- 41% are waiting less than 3-months for a review.

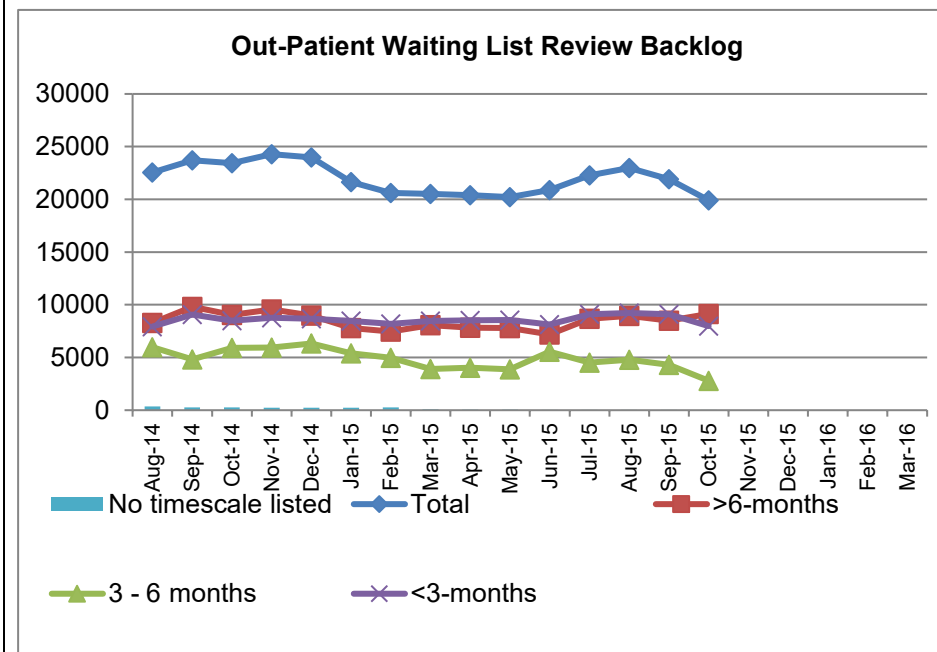
Longest Trust waits are in urology, with 472 patients waiting from 2012/13. All these patients have been validated and a significant proportion will have been made previous offers which were unsuitable for the patient. Capacity has been put in place to address this long waiting cohort over the next few months.

Internal redirected resource will provide capacity to target over 5000 of our longest waits across a range of specialty areas before the end of March which will minimise the volume of patients waiting beyond their clinically indicated timescale for review.

It is of note that there are long waits in the visiting specialty of ophthalmology and Trust provides regular updates on the position to BHSC and SLCG.

Actions to Address:

- Arrangements in place to minimise risk and ensure reviews with high clinical priority take place in accordance with the clinically indicated timescale;
- Trust has sought, via SLCG, engagement with Primary Care to consider potential solutions in the absence of additional funding options to address backlog - not progressed;
- Trust undertook a data and patient validation programme to review patients waiting beyond their clinically indicated date. This was resourced internally by the Trust until March 2015;
- The Trust has highlighted the on-going emergent risk in the clinical pathway from review patients waiting beyond their clinically indicated



timescale to HSCB. HSCB acknowledging the issue but have currently no additional resources available to support this. HSCB have indicated that should additional monies become available they would be happy to consider this, and														
• The Trust in the interim continues to re-direct internal resources to this area as it becomes available or where clinical risk is identified.														
	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
Total	24286	23970	21645	20608	20521	20391	20223	20874	22294	22968	21915	20627		↑
>6-months	9563	8970	7798	7455	8074	7839	7786	7189	8680	8957	8501	9155		
3 – 6 months	5944	6325	5384	4958	3903	4035	3886	5562	4514	4786	4303	3073		
<3-months	8779	8675	8463	8195	8464	8517	8551	8123	9096	9220	9107	8398		
No date listed	238	240	231	258	86	58	53	6	4	5	4	1		

Note: Totals include hospital based reviews including paediatrics, orthopaedic ICATS but excluding mental health which is reported separately.

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**

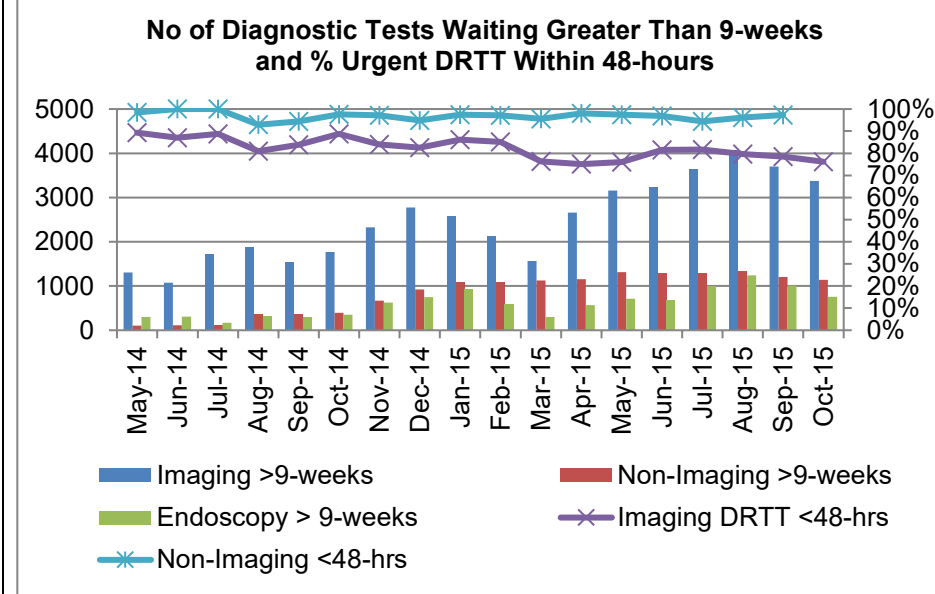
Volumes over 9 weeks have reduced slightly from September with the largest decrease in CT (-71) and Non-Obstetric Ultrasound (-247).

HSCB has confirmed additional non-recurrent funding for additional capacity for CT, non-obstetric ultrasound and plain film reporting in Quarter 3/4 2015/2016. The Trust has secured the additional in-house capacity and is currently tendering to secure further additional capacity from independent sector providers. The Trust has confirmed to HSCB the estimated access time achievable with the level of resource allocated as follows:

- o CT: General 16-weeks,
- o CT: Colonography 9-weeks. Achievement of this position, particularly for CTC, is reliant upon the delivery of additional capacity in the Independent Sector.
- o Non-Obstetric Ultrasound: 13-weeks

Whilst diagnostic imaging continues to perform well against the agreed SBA, capacity is not sufficient to provide for all routine examinations and focus is therefore on in-patients, red flag and urgent patients.

A replacement scanner for the original CT scanner will be commissioned before the end of March 2016 and the Trust is working to secure a mobile solution to provide seamless capacity during the replacement period. SCLG have provided a letter of revenue support for the second CT scanner. The Trust is assessing interim options to improve capacity in 2016/17 whilst



appropriate works and procurement for the 2nd scanner are ongoing.

Current access times are provided in table 16 (a)

Actions to Address:

- o Trust has confirmed the allocation of funding and additional activity it can undertake in Quarter 3/4 to HSCB. Awaiting response from HSCB on additional volumes requested
- o The Trust has submitted an investment proposal for additional CT capacity

Non-Imaging

At the end of October 1243 patients were waiting in excess of 9-weeks; 106 waiting for Urodynamics with the majority, 1137, waiting for cardiac investigations. The Division advise that following a revision of Waiting List codes and consequent review of Business Objects reporting there appears to have been a significant increase in both the number of waiters and access times which will require some validation.

Within Cardiac Investigations echocardiogram examinations, both general (TTE) and Stress (DSE), are in excess of the 9-week access standard. SBA is on track but a capacity gap exists.

HSCB made an allocation for additional capacity for echocardiogram and ambulatory monitoring in Quarter 1/2 2015/2016. Whilst a level of in-house additional capacity was been secured the Trust was unable to secure the total additional capacity offered due to the inability to make temporary appointments to this area. In Q3/4 again a level of additional in-house capacity has been put in place, however this is limited. Division are exploring potential for additional capacity in the independent sector

The Trust has sought to recruit a number of cardiac investigations posts to address current vacancies and prepared for future additional investment, however this has been unsuccessful and options now include pursuing internal training routes.

Actions to Address:

- o An IPT has been submitted for cardiac investigations; formal response awaited from HSCB, and

Table 16(a) –

Modality	Current Access	Volume >9-weeks	SBA position as at 31/9/15
Endoscopy (greater than 13 weeks)	45-weeks	1635 (-8)	Under performing by 4%
Non-Imaging			
Cardiac investigations	31-weeks	1137 (+5)	Over performing < 5%
Neurophysiology	9-weeks	0	Regional service
Sleep Studies	<9-weeks	0	No SBA
Urodynamics (Urology)	TBV ₁	106 (+31)	In OP SBA
Urodynamics (Gynae)	< 9-weeks	0	Under performing < -10%
Imaging			
Plain Film	9-weeks	23 (+13)	Over performing by 17%
CT	18-weeks	269 (-71)	Over performing by 27%
CTC	50-weeks		
Non-Obstetric Ultrasound	23-weeks	1741 (-247)	Over performing by 5%
Dexa	18-weeks	463 (-8)	Over performing by 1%
MRI	19-weeks	806 (+41)	Under performing by 36%
Fluoroscopy	18-weeks	63 (-47)	No SBA
Barium Enema	13-weeks	0 (-10)	No SBA
Gut Transit Studies	9-weeks	1	No SBA
Obstetrics Ultrasound	9-weeks	0	No SBA
Radio Nuclide	9-weeks	4 (-1)	No SBA

Note: 1. Urodynamics (Urology) – following a review of reporting access times need to be validated.

- o The Trust is preparing new recruitment strategies.

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 made an allocation of additional non-recurrent capacity for Q1/2 and Q3/4 2015/2016 and whilst in-house additional capacity has been put in place the Trust has been unable to secure the full capacity required in the Independent Sector..

Trust is projecting an access time of 36 weeks for routine endoscopy at the end of March 2016.

Actions to Address:

- o Trusts continue to focus capacity to red flag, urgent and planned repeat scopes in the first instance;
- o Endoscopy User Group in place who regularly review the access times for red flag, urgent, planned repeat endoscopy and routine scopes and operational issues;
- o The Trust is implementing the agreed investment for endoscopy, and
- o The Trust has re tendered in an attempt to secure further capacity in the Independent sector to improve routine waits.

Reporting Times – No October Position Available

Reporting times for urgent images within 48 hours has decreased to 78% in September. SHSCT performance is at the low end of regional performance with a regional average of 89%.

Consultant manpower issues and vacancies have been further impact in October and affect reporting turnaround as capacity is focused to the most urgent work.

Monitoring is in place to monitor the reporting time for plain films including chest x-rays. HSCB has provided funding for additional plain film reporting

in Q1/2 and Q3/4 2015/16 and an independent sector contract is in place.

Actions

- o A supplementary contract has been put in place with the independent sector to provide further capacity to address reporting pressures and will be operational by end of October and the full volume delivered by December 15.

A summary of actual access times for October is attached in Appendix 2.

	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
Imaging >9-weeks	2326	2772	2583	2130	1566	2660	3155	3233	3628	4075	3700	3372	R	↑
Non-Imaging >9-weeks	672	925	1079	1084	1123	1156	1311	1302	1287	1335	1207	1137	R	↑
Endoscopy >9-weeks	623	752	933	594	302	567	709	686	991	1238	1012	756	R	↑
Imaging DRTT Urgents <48-hrs	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)	79.6% (2388 out of 3000)	78.5% (2640 out of 3363)	76.2% (2792 out of 3664)	R	↓
Non-Imaging DRTT Urgents <48-hrs	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)	96.2% (179 out of 184)	97.3% (179 out of 184)	N/A	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-weeks. (Target change from 80% to 65% <13-weeks)

Baseline: 68.5% <13-weeks and 1162 >26-weeks

TDP Assessment: Partially achievable/achievable with additional resources

Standard: 65% <13-weeks
0 >26-weeks

Comments:

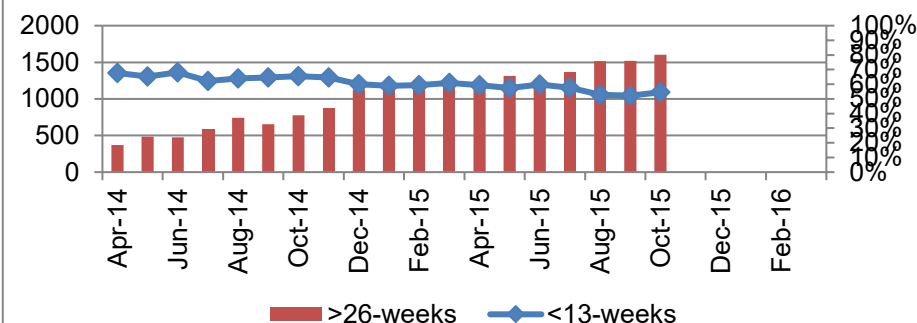
In respect of patients waiting in excess of 26-weeks there is a total of 1776 patients waiting at the end of October which is an improvement from the September position of 1851 patients. This can mainly be attributed to general surgery and gastroenterology. Those specialities waiting over 26 weeks are identified in Table 17 (a).

The percentage of those waiting less than 13-weeks has improved slightly to 54.6% which is below the target of 65% however is comparable with regional performance, where in September an average of 47% of patients waited less than 13-weeks. Issues affecting access time prevail and include

- Impact of decreased level of non-recurrent funding available in 2014/2015 for in-house additionality and independent sector which has resulted in accrued backlogs;
- No non-recurrent funding allocation in 2015/16 which has resulted in ability to reduce accrued backs and seen access times increase where capacity gaps exist;
- The Trust continues to monitor performance against SBA to ensure that this is optimised and that SBA underperformance does not account for growth in access times. Whilst a number of specialty areas are currently underperforming against SBA, plans are in place to recover the majority of areas in-year. Key exceptions include: Orthopaedics and Urology.

Note: HSCB has indicated (Nov15) that additional funding will be made available for additional capacity in Q4. The level of additional activity that can be undertaken will rely on the ability of independent sector provider to provide capacity in that further additional in-house capacity is limited. HSCB will direct funding to areas with long routine waits, and seek to provide an equality of wait for these specialties across the region.

% of Patients Waiting Less Than 13-weeks and No Waiting Greater Than 26-weeks

**Table 17 (a)**

Speciality	Access (Weeks)	Volume >26-weeks	SBA position as at 31/8/15
General Surgery	74-weeks	332 (-123)	Underperforming by 9%
Breast Surgery	51-weeks	24	Underperforming by 2%
Gynaecology	39-weeks	23 (+6)	Underperforming by 4%
Pain	67-weeks	421 (+23)	Over performing by 1%
Urology	115-weeks	350 (+25)	Underperforming by 5%
Orthopaedics	78-weeks	467 (+40)	Underperforming by 8%
Cardiology	47-weeks	67 (+9)	SBA to be agreed
Gastroenterology	13-weeks	81 (-70)	SBA being reviewed

A summary of actual access times for October is attached in Appendix 2.

Actions to Address:

- Internal focus continues on the need to balance the access time for urgent and routine waits within the agreed acceptable levels in each specialty area;
- Review of performance for routine and urgent waits and core SBA activity undertaken with bi-weekly & monthly performance meetings. These meetings review and challenge the SBA performance and access delivery and are utilised to agree remedial action required to improve the areas of underperformance;
- Internal recovery plans in development for any areas identified as underperforming against SBA by more than -5%; and
- Information on access times is shared monthly with General Practice to ensure referrers and patients are aware of current access times.
- Procurement activities designed to secure additional capacity in the independent sector have commenced in line with announcement of additional in-year non recurrent funding.

	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
<13-weeks	64.7% (4132)	60.1% (3904)	58.9% (3829)	59.4% (3872)	60.8% (3867)	59.4% (3839)	57.5% (3835)	59.8% (4061)	57.1% (3920)	52.8% (3559)	52.2% (3511)	54.6% (3707)	R	↑
>26-weeks	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)	22.5% (1515)	22.6% (1520)	23.6% (1604)	R	↓

CP 19: STROKE PATIENTS: Lead Director – Mrs Esther Gishkori, Director of Acute Services

From April 2015, ensure that at least 13% of patients with confirmed Ischaemic Stroke receive Thrombolysis. (Change in target from 12% to 13%)

Baseline: 15% (April – December 2014 – Year-end baseline to be available July 2015)

TDP Assessment: Achievable and Affordable

Target: 13%

Comments: Reporting three months in arrears.

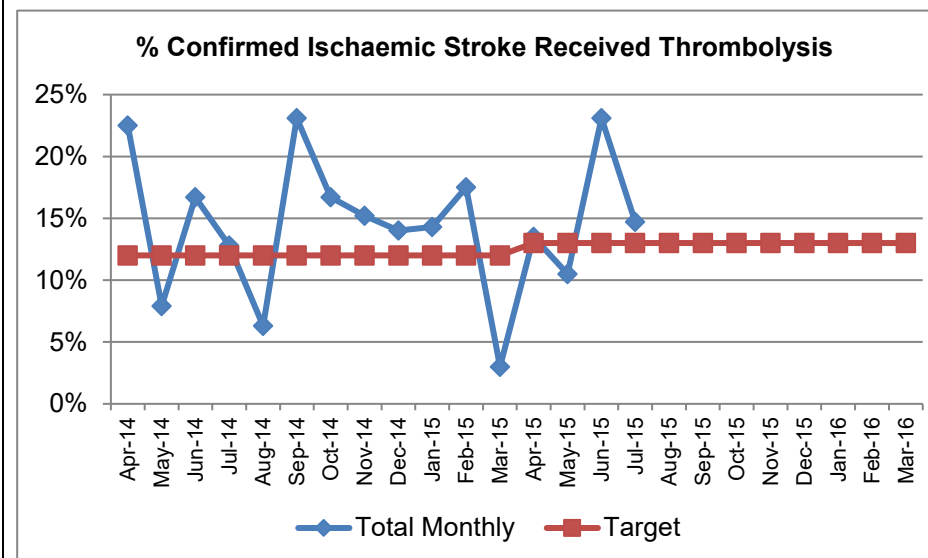
Thrombolysis is a key intervention in the treatment of ischaemic stroke and increasing the number of patients receiving this treatment will allow for significant or complete recovery thereby preventing the need for long term healthcare and enhancing the potential for improved quality of life post stroke.

Performance at 31 March 2015 demonstrated a cumulative performance of 14.1%, which is above the target of 12%. This year to date (April – July 2015) is showing a cumulative performance of 13% which is on target.

Monthly performance against this target is impacted by the variable presentation of strokes, which is affected both seasonally and geographically. It should be noted 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.

Actions to Address:

- A multi-disciplinary group has been established across hospital sites which reviews each case, focusing on performance and identifying any areas for improvement;
- Review of time from scanning to reporting with a view to reducing this ongoing;
- Close monitoring of door to needle time out of hours; and
- Seeking improvement in communication with and feedback to NIAS.



Notes:

- April May 2014 to March 2015 data is based on 12% in line with 2014/2015 Commissioning Plan
- April 2015 onwards is based on 13% in line with 2015/2016 Commissioning Plan – reporting as per technical guidance Deaths and Discharges are used as an approximation of Admissions and figures are presented by month on discharge not month on admission

	Monthly Position:												Cum Assess	Trend
	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015		
Trust	6.3%	23.1%	16.7%	15.2%	14.0%	14.3%	17.5%	3%	13.5%	10.5%	23.1%	14.7%		↑
Trust Admissions * see below	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	A 37 T 5	A 38 T 4	A 39 T 9	A 34 T 5		
Trust Cumulative	-	-	-	-	-	-	-	14.1%	-	-	-	13%	G	
CAH	11.8%	10.5%	9.5%	13%	8.6%	20.7%	15.4%	3.7%	8.7%	15.4%	21.4%	10.7%		↓
CAH Admissions * see below	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	A 23 T 2	A 26 T 4	A 28 T 6	A 28 T 3		
CAH Cumulative	-	-	-	-	-	-	-	10.6%	-	-	-	14.3%		
DHH	0%	57.1%	33.3%	20%	26.7%	0.0%	21.4%	0%	21.4%	0.0%	27.3%	33.3%		↑
DHH Admissions * see below	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	A 14 T 3	A 12 T 0	A 11 T 3	A 6 T 2		
DHH Cumulative	-	-	-	-	-	-	-	22.1%	-	-	-	18.6%		

Key: Stroke: A = Stroke Admissions (14-15) /Deaths or Discharges (15-16) / T = Patients Who Had Thrombolysis Administration

Notes:

- April May 2014 to March 2015 data is based on 12% in line with 2014/2015 Commissioning Plan
- April 2015 onwards is based on 13% in line with 2015/2016 Commissioning Plan – reporting as per technical guidance Deaths and Discharges are used as an approximation of Admissions and figures are presented by month on discharge not month on admission

CP 20: HEALTHCARE ACQUIRED INFECTIONS: Lead Director – Dr Richard Wright, Medical Director**By March 2016, secure a reduction of 20% in MRSA and Clostridium Difficile infections compared to 2014/2015.****Baseline:** MRSA – 9

C Diff – 39

TDP Assessment: Requires further clarification from HSCB/DHSSPS**Target:**

MRSA – 5

C Diff – 32

Comments:**MRSA**

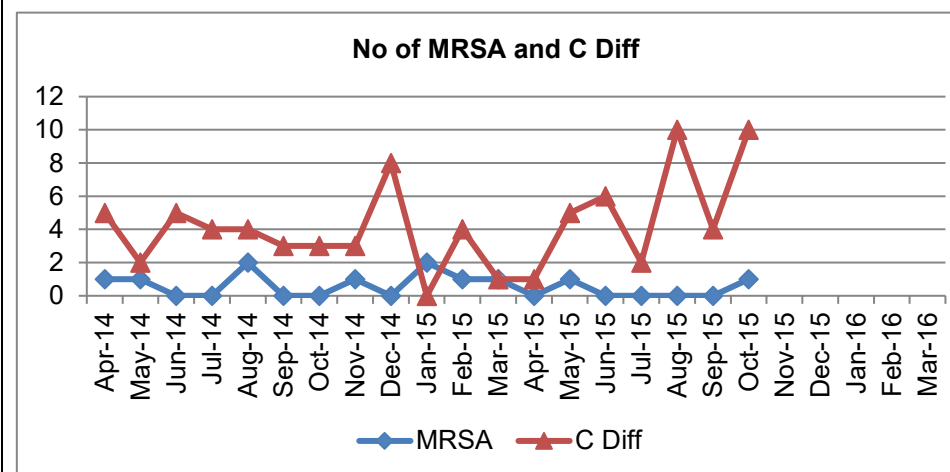
April-September cumulative performance varied across the Region from 1 (SHSCT) to 21 reported cases (BHSCT). SHSCT has had 1 new reported case in October 2015.

C Difficile

April-September cumulative performance varied across the Region from 28 (SHSCT) to 65 reported cases (BHSCT). In August the SHSCT noted a significant increase in the number of cases, 10 and has had a further 4 reported in September and a further 10 in October.

Actions to Address:

- Focus on range of actions to increase accountability and promote shared learning, including root cause analysis, review of trends;
- A re-focus on antibiotic stewardship is in place and Trust is seeking to secure clinical leads to establish this;
- Daily operational review meetings in place between Infection Prevention Control staff and acute bed management staff to review appropriate use of isolation facilities for potentially infectious cases within the Trust;
- A continued focus on monitoring and auditing of adherence to good infection prevention and control standards is in place including regular hand hygiene and environmental self-audit and independent audit;
- Ongoing training and education programmes for all staff involved in patient care including introduction of Aseptic Non-Touch Technique (ANTT) training program into all augmented care areas;
- The Trust has also appointed 3 Public and Patient representatives as members of the HCAI Strategic Forum; and Trust has identified



infection prevention and control as one of its key quality priorities under the new Quality Improvement Framework.															
	Monthly Position:													Cum Assess	Trend
	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	Jun 2015	July 2015	Aug 2015	Sept 2015	Oct 2015		
MRSA Actual	0	1	0	2	1	1	0	1	0	0	0	0	1		↓
MRSA Cum	9 (cumulative for 2014/2015)						0	1	1	1	1	1	2	G	
C Diff Actual	2	3	8	0	4	1	1	5	6	2	10	4	10		↓
C Diff Cum	41 (cumulative for 2014/2015)						1	6	12	14	24	28	38	R	

CP 21: PATIENT DISCHARGE: Lead Director – Mr Francis Rice, Director of Mental Health & Disability

From April 2015, ensure that 99% of all Learning Disability and Mental Health discharges take place within 7-days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28-days. (No change in target)

Baseline: LD – 7-days 74%; 28-days 83%

MH – 7-days 95%; 28days 98%

TDP Assessment: Mental Health – Achievable and affordable
Learning Disability – Partially achievable/
achievable with additional resources

Standard: 99% 7-days
0 > 28-days

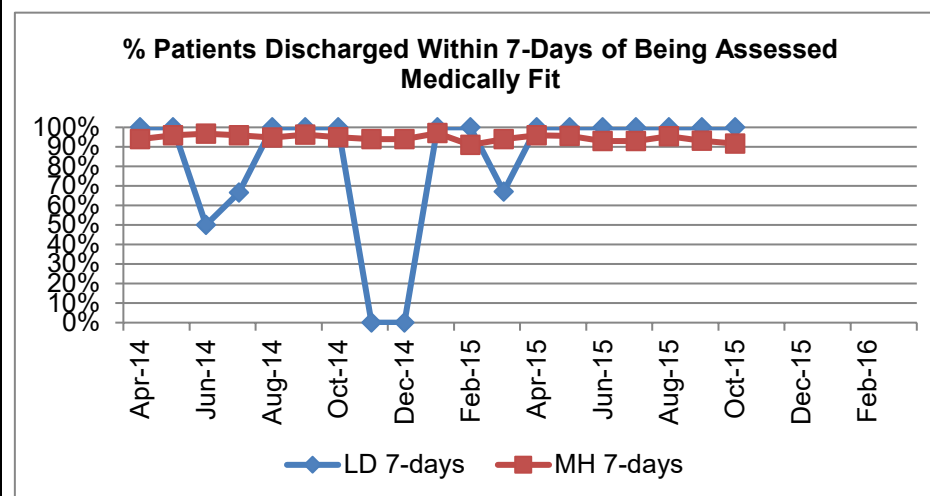
Comments:**Learning Disability**

The relatively low level of patients in this cohort presents challenge in maintaining a 99% target, however in the seven months of this year all patients have been discharged within 7 days of being medically fit for discharge. Regionally in September average rate of 86% achieved.

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 95%; regional average performance for September was 98% ranging from 94% (SHSCT) to 100% (NHSCT).

The number of patients waiting longer than 28 days for discharge in October has reduced to 1 from 3 in September, this patient has been waiting for discharge from a previous month.



	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
LD 7-days	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)	100% (1 out of 1)	100% (0 out of 0)	100% (2 out of 2)	G	↔
LD >28-days	1	1	0	0	1	0 Cum: 0	0 Cum: 0	0 Cum: 0	0 Cum: 0	0 Cum: 0	0 Cum: 0	0 Cum: 0	G	↔
MH 7-days	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)	95.5% (84 out of 88)	93.1% (94 out of 101)	91.7% (100 out of 109)	A	↓
MH >28-days	1	3	2	3	1	0	2	3	3	2	3	1	A	↑

CP 21: PATIENT DISCHARGE: Lead Directors – Mrs Esther Gishkori, Director of Acute Services and Mrs Angela McVeigh, Director of Older People & Primary Care

From April 2015, ensure that 90% of complex discharges from an Acute Hospital take place within 48-hours, with no complex discharge taking more than 7-days; and all non-complex discharges from an Acute Hospital take place within 6-hours. (No change in target)

Baseline: Non-Complex 6-hours – 93%
Complex 48-hours – 98%
All Discharges 7-days – 99.7%

TDP Assessment: Achievable and affordable

Standard: Non-complex 6-hours 100%
Complex 48-hours 90%
All discharges 7-days 100%

Comments:

Delayed Discharge ‘Coding’/Data Completeness

Performance against the delayed discharge standard is based on the discharges that have been had their data completely recorded and not the totality of the discharges. A low level of data completeness had compromised the good performance reported for delayed discharges. There has been a significant improvement in the % of coded delayed discharges in October with a total of 83.7% coded compared with 63% in September.

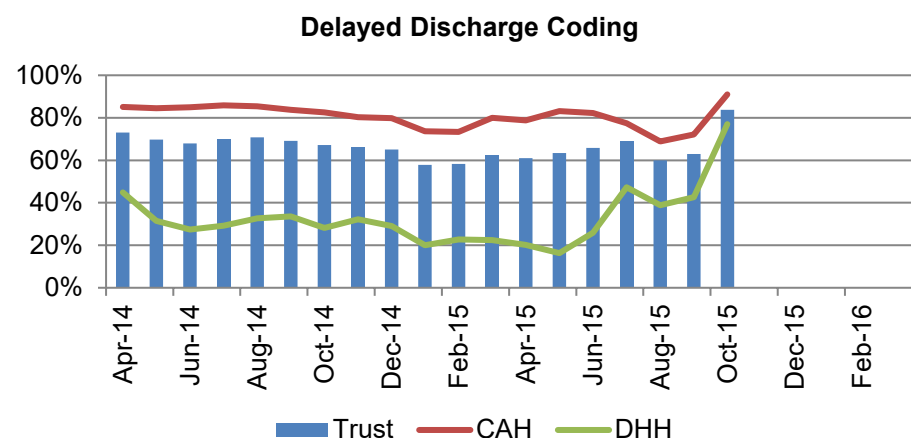
CAH demonstrates a higher level of data completeness than DHH however DHH has seen improvement from an initial low base.

Actions to address:

- Processes for the coding of discharges reviewed across both CAH and DHH;
- Refreshed focus on coding recovery action plan developed by the Acute Services Directorate to effect the improvement required;
- A daily validation is being performed by administrative staff to address the issues with the out of hours period, and
- Refreshed guidance for staff on definition of simple and complex discharges and appropriate codes for selection for each category.

Non-Complex Discharges

Performance against the 6-hour standard remains challenging and is



affected by a number of challenges including operational delays in discharge communication, scripts, transportation and availability of community support arrangements such as re-starting packages of care and delivery of equipment.

Whilst there are ongoing actions the performance against this target has decreased since September with performance for October at 91.5% which is the lowest performance to date. This may be linked to the increased level of simple discharges now coded and the Trust will keep this under review as the coded position is embedded to see if further analysis/ actions required

Actions

- To be added to the agenda of the Timely Discharge Steering Group

Complex Discharges

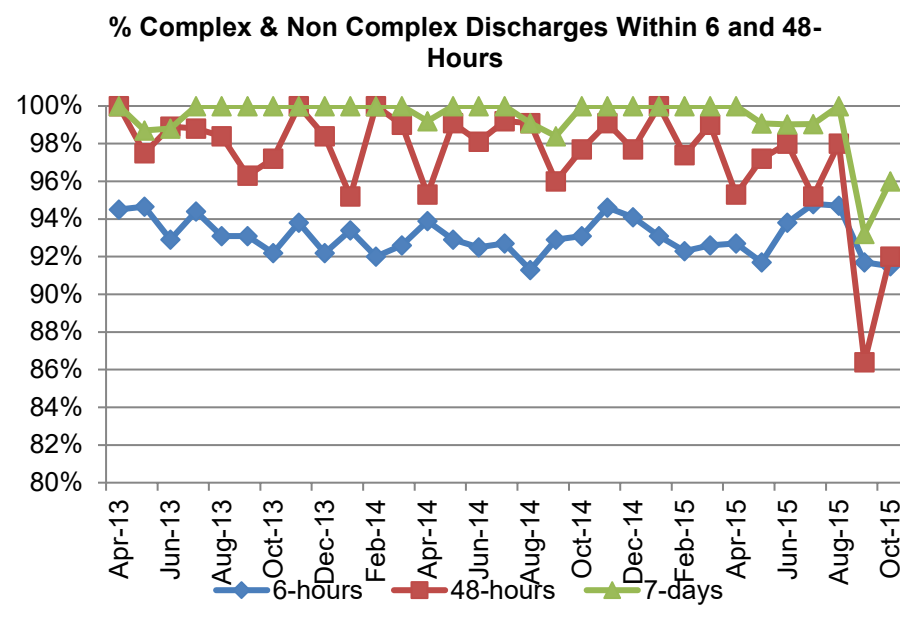
Performance remains variable but continues to perform well against the target. Trust performance is significantly above the regional average of 80%.

There has been a reported reduction in the volume of complex discharges presenting in August & September with the ratio of non-complex to complex reducing significantly. This would appear to be linked to the previous poor coding position. The improved coding positions has seen both the number of non-complex and complex discharges increased.

The Trust will continue working closely with multi-disciplinary teams including mental health services and services in the community as part of a proactive discharge planning process to meet the access standards for complex and non-complex discharges.

Actions to Address:

- 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; • Ongoing interface with NIAS to facilitate early planning/notification re time of discharge and more timely notification of transport requirements; • Review of individual complex discharges that not discharged within 48 hours in place, and • Action plan in place to improve discharge coding and the impact of same.														
	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
% of Coded Delayed Discharges - Trust	66%	65%	58%	58%	62%	61% (1866 out of 3080)	63% (2093 out of 3302)	66% (2201 out of 3338)	69% (2198 out of 3189)	60% (1808 out of 3000)	63% (2057 out of 3243)	83.7% (2783 out of 3195)		↑
% of Coded Delayed Discharges - CAH						79% (1674 out of 2127)	83% (1934 out of 2327)	82% (1950 out of 2371)	77% (1772 out of 2288)	69% (1453 out of 2110)	72% (1645 out of 2278)	91.2% (2074 out of 2272)		↑
% of Coded Delayed Discharges - DHH						20% (192 out of 953)	16% (159 out of 975)	26% (251 out of 967)	47% (426 out of 901)	39% (355 out of 890)	43% (412 out of 965)	76.8% (709 out of 923)		↑
6-hours	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% (1967 out of 2097)	94.8% (1985 out of 2093)	94.7% (1665 out of 1759)	91.7% (1833 out of 1999)	91.5% (2412 out of 2635)	R	↔
48-hours	99.1% (110 out of 111)	97.7% (126 out of 129)	100% (85 out of 85)	97.4% (74 out of 76)	99% (100 out of 101)	95.4% (103 out of 108)	98.2% (111 out of 113)	98% (100 out of 102)	95.2% (100 out of 105)	98% (48 out of 50)	86.4% (51 out of 59)	92% (138 out of 150)	G	↑
7-days	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)	99.05% (104 out of 105)	100% (49 out of 49)	93.2% (55 out of 59)	96% (144 out of 150)	A	↑

CP 22: MENTAL HEALTH SERVICES: Lead Director – Mr Francis Rice, Director of Mental Health & Disability

By April 2015, no patient waits longer than 9-weeks to access Child and Adolescent Mental Health Services; 9-weeks to access Adult Mental Health Services; 9-weeks to access Dementia Services; and 13-weeks to access Psychological Therapies (No change in target, however potential change in definition for CAMHS services to be confirmed).

Baseline: Adult Mental Health – 65 >9-weeks
 CAMHS – 0 >9-weeks
 Dementia Services – 41 >9-weeks
 Psychological Therapies – 54 >13-weeks

TDP Assessment: Adult Mental Health – Partially achievable/achievable with additional resources
 CAMHS – Achievable and affordable
 Dementia Services – Achievable and affordable
 Psychological Therapies – Partially achievable/achievable with additional resources

Standard: Adult Mental Health 9-weeks
 CAMHS 9-weeks
 Dementia Services 9-weeks
 Psychological Therapies 13-weeks

Comments: Data for September not available

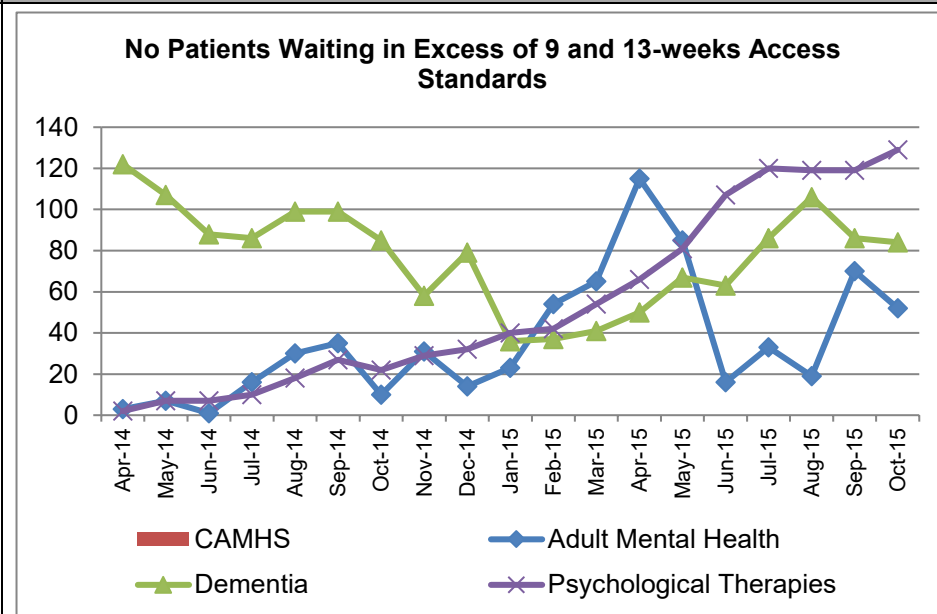
Adult Mental Health Care

The number of patients waiting in excess of 9-weeks has reduced slightly from a September position with the longest waiting patient at 17-weeks. Additional capacity procured in the Independent Sector to address low level referrals has begun and the Service anticipates improved performance in Q3.

September regional performance demonstrates a total of 208 patients waiting in excess of 9 weeks ranging from 0 (NHSCT) to 142 (BHSCT)

Actions to Address:

- o Service have prepared an action plan to mitigate as far as possible the increasing demand including refocus of internal resources & creation of additional capacity and 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 Service

Whilst there are currently no breaches of the 9-week standard within CAMHS the ability to maintain this position is potentially unsustainable. The current longest waiting patient is 6-weeks. September regional performance demonstrates a total of 57 patients waiting in excess of 9-weeks throughout the region.

Memory/Dementia Services

Additional temporary capacity for consultant activity was put in place via re-directed resources in 2014/15, which impacted positively on waits. However this has ceased and the numbers of those waiting in excess of 9-weeks are now continuing to increase again with 93 patients now waiting greater than 9 weeks compared to 86 in September. Medical manpower issues affecting capacity in August/September have now resolved.

Additional IPT investment confirmed for the memory service. Regional demand and capacity exercise ongoing with HSCB as part of implementation of dementia strategy. Early indications indicate capacity gap in SHSCT. This work is anticipated to be completed by December 2015.

Regionally the SHSCT is the only Trust breaching this target.

Actions to Address:

- o Ongoing work to finalise capacity and demand issues in association with HSCB, and
- o Trust will work to implement additional capacity from IPT investment.

Psychological Therapies

New ways of working had been implemented which showed an improved position in terms of access times, but due to vacancies arising in October the Service anticipate waiting times will once again increase to end December while recruitment is underway. Regionally all Trusts are

Specialty	Access Time	Waiters >9 weeks	SBA performance
Adult Mental Health	17 weeks	52	To be agreed
CAMHS	6 weeks	0	To be agreed
Dementia Services	25 weeks	93	To be agreed
Psychological Therapies (waiters >13 weeks)	31 weeks	129	To be agreed

breaching this target

September regional performance demonstrates a total of 1151 patients waiting in excess of 13-weeks ranging from 547 (SEHSCT) to 102 (WHSCT). The SHSCT equates to 11% (129) of the total volume.

Actions to Address:

- o Internal review to consider manpower issues ongoing;
- o Head of Service level performance meetings are held with Mental Health Directorate monthly to review performance against the access standards.

	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
Adult Mental Health	31	14	23	54	65	115	85	16	33	19	70	52	A	↓
CAMHS	0	0	0	0	0	0	0	0	0	0	0	0	G	↔
Dementia	58	79	36	37	41	50	67	63	86	106	86	93	R	↓
Psychological Therapy	29	32	40	42	54	66	81	107	120	119	119	129	R	↓

OUT-PATIENT REVIEWS – Patients waiting beyond their clinically indicated timescales: Lead Director – Mr Francis Rice, Director of Mental Health & Disability (Not a formal target)

Comments:

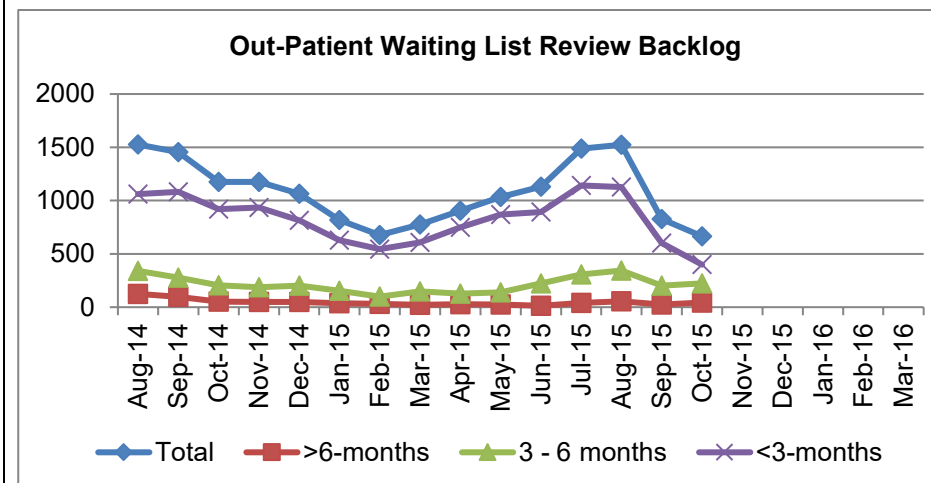
Of the 665 review patients waiting beyond their clinically indicated timescales:

- 6% (42) of these are waiting in excess of 6-months;
- 34% (224) of these are waiting between 3 – 6 months; and
- 60% (399) 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 again in October from 827 in September.

Actions to Address:

- Discussion paper submitted to HSCB and SLCG to highlight ongoing issues (July);
- The Trust has highlighted the on-going emergent risk in the clinical pathway from review patients waiting beyond their clinically indicated timescale to HSCB. HSCB acknowledging the issue but have currently no additional resources available to support this. HSCB have indicated that should additional monies become available they would be happy to consider this, and
- Trust to continue to re-divert resources into this area as this becomes available and an assessment of the level of additional capacity that can be provided is currently ongoing.



	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
Total	1174	1064	819	676	777	904	1034	1131	1488	1525	827	665		↑
>6-months	50	48	36	32	23	28	25	13	39	55	24	42		↓
3 – 6 months	188	202	153	99	147	127	139	224	307	344	202	224		↓
<3-months	936	814	630	545	607	749	870	894	1142	1126	601	399		↑

CP 23: CHILDREN IN CARE: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services

From April 2015, increase the number of children in care for 12 -months or longer with no placement change to 85% (No change in target)

Baseline: To be confirmed

TDP Assessment: Partially achievable/achievable with additional resources

Target: Increase to 85%

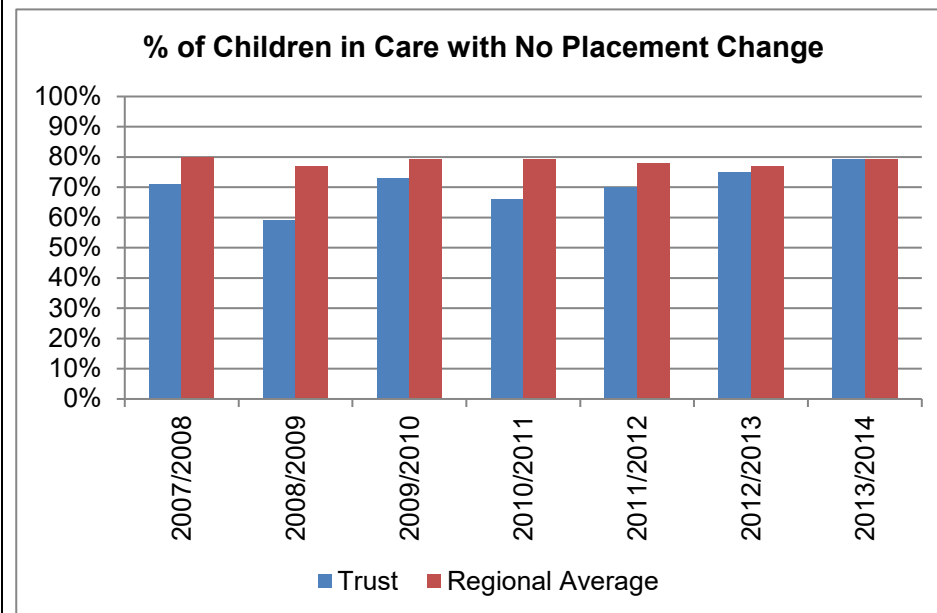
Comment/Actions: 2014/15 not available

2014/2015 performance information is collated during August – September 2015 for the year and will not be available until July 2016 due to the annual reporting cycle associated with this target area.

This area remains an on-going priority in relation to care planning for all children, however, this is 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).



	Monthly Position:							Cum Assess	Trend
	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014		
Trust	71%	59%	73%	66%	70%	75%	79%		↔
Regional Average	80%	77%	79%	79%	78%	77%	79%		↔

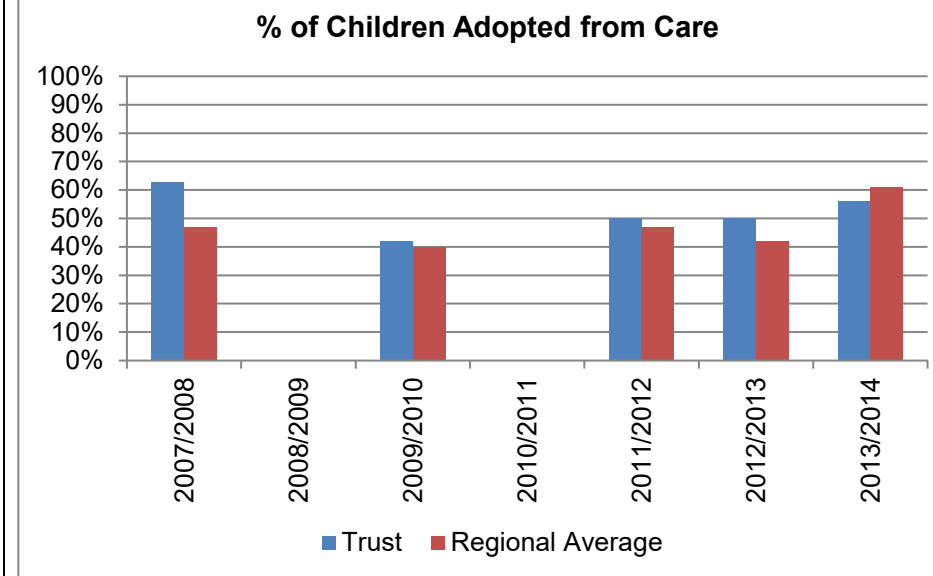
CP 24: CHILDREN IN CARE: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services**By March 2016, ensure a 3-year time frame for 90% of children who are to be adopted from care. (No change in target)****Baseline:** HSCB to source from AD1 return**TDP Assessment:** Achievable and affordable**Standard:** 3-Year timeframe for 90%

Comment/Actions: 2014/15 data not available
 2014/2015 performance information will not be available until December 2015 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).



	Monthly Position:							Cum Assess	Trend
	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%		↔

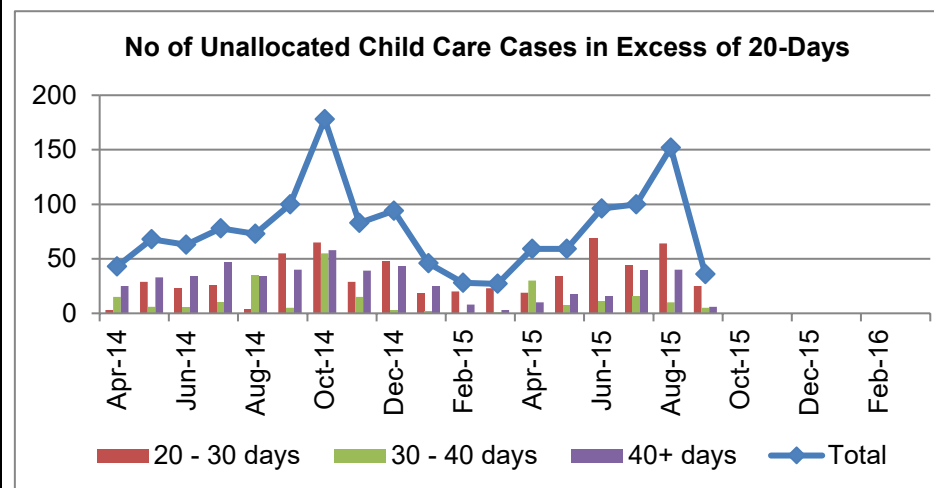
UNALLOCATED CHILD CARE CASES: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services **(Not a formal CP target)**

Comment/Actions: October data not available.

At the end of September there were a total of 36 unallocated child care cases in excess of 20 days, which shows a significant decrease from the position over the Summer period.

69% (25) of these are waiting between 20 and 30 days; and the volumes over 40-days has again considerably decreased to 6 cases.

Further information on the Unallocated Child Care Cases is provided within the Director of CYPS Trust Board Report.



	Monthly Position:												Cum Assess	Trend
	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15		
Total	83	94	46	28	27	59	59	96	100	152	36	N/A		↑
>20 and <30-days	29	48	19	20	23	19	34	69	44	64	25	N/A		↑
>30 and <40-days	15	3	2	0	1	30	7	11	16	10	5	N/A		↑
>40-days	39	43	25	8	3	10	18	16	40	78	6	N/A		↑

CP 25: PATIENT SAFETY: Lead Director(s) – Mrs Esther Gishkori, Director of Acute Services & Dr Richard Wright

From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points. (New target)

Baseline: Clarification waited from HSCB on technical definitions
TDP Assessment: Partially achievable/achievable with additional resources

Standard: To be confirmed by HSCB

Comments: Information report being developed by the Acute Information Team – anticipate will be available for December report.

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 and anticipate that the new report will be available for November.

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). It is important to note that to assess trends in mortality appropriately review over time is required to ensure an adequate volume of cases.

	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	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	Standard: 95%
TDP Assessment: Partially achievable/achievable with additional resources	

Comments:
 The Trust received confirmation of £2 million recurrent funding towards the implementation of normative staffing across medical and surgical wards from HSCB in March 2015, plus an additional non-recurrent £250k towards covering maternity leave. This funding has been allocated across the FSLs of all specified wards in Phase 1. A report detailing compliance with NSR for end September 2015 position has been submitted October 2015.

Further detail is available in the Executive Director of Nursing Report.

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

Comments: Reporting three months in arrears.

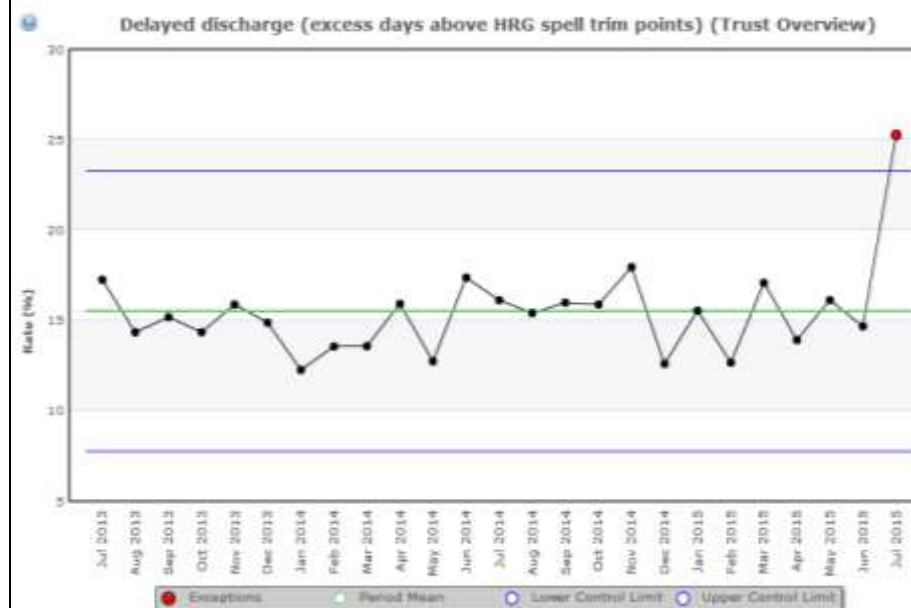
CHKS, the comparative benchmarking system, measures excess beddays against the Top Hospital peers. Whilst this definition and the comparators are different from that used by HSCB as it is based on expected length of stay at condition level calculated for the payment by results (PbR) methodology adopted 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, July 2013 to July 2015 demonstrates the Trust with excess beddays of 25% against the HES Peer Average of 15.5%. Peer benchmarks against the 25th Percentile and 75th Percentile are 16.9% and 12.0% respectively.

The chart opposite demonstrates a timeline analysis of excess beddays at Trust level over the last two years which is largely within normal levels of variation.

Actions

- Analysis being undertaken of the variation in June 2015 to identify if any patterns outside the normal variation or actions necessary



CP 28: CANCELLED APPOINTMENTS: Lead Director – Mrs Esther Gishkori, Director of Acute Services

By March 2016, reduce by 20% the number of hospital cancelled consultant-led out-patient appointments in the Acute Programme of Care which resulted in the patient waiting longer for their appointment. (Change in target from 17% to 20% and area of focus)

Baseline: 5,419 patient cancellations 'put back' (2.7%)

TDP Assessment: Target is partially achievable/achievable with additional resources

Target: Reduce by 20%; Target 4335

Comments: September data not available.

The Trust is awaiting technical guidance from HSCB on how this target will be assessed. However as an interim the Trust will report on work undertaken by a Short Life Working Group at the request of the Health Committee, which analysed the level of cancellations within the Hospital system that had a direct impact on patients.

Cancellations primarily fall into 3 categories:

- Where the appointment is cancelled and 'put back' so the patient waits longer for their appointment;
- Where the appointment is cancelled and 'brought forward' so the patient actually is seen sooner than originally scheduled; and
- Where the appointment time or location is changed which while impacting on the patient does not lead to a longer wait.

Reporting for 2014/2015 year identified 2272 new and 6783 review patients had been cancelled out of 199,850 patients scheduled in the hospital system. As such 4.5% of patients scheduled 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.

Utilising a proxy target of 4335 per year, at month 4, cumulative performance is slightly above the profiled target for the number of appointments cancelled and 'put back' at this stage of the year.

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	July 2015	Aug 2015	Sep 2015		
	New OP	Review OP	Total OP	Total OP	Total OP	Total OP	Total OP	Total OP	Total OP		
Attendances	72,947	126,903	199,850	16534	15128	18070	14530	14220	19366		
Cancellations 'Put back'	1,318 (1.8%)	4,101 (3.2%)	5,419 (2.7%)	418 (2.5%)	347 (2.29%) 765 Cum	466 (2.6%) 1231 Cum.	332 (2.3%) 1563 Cum	380 (2.67%) 1943 Cum	508 (2.62%) 2451 Cum	A	↔
Cancellations 'Brought Forward'	424	1,389	1,823	128 (0.77%)	99 (0.65%)	160 (0.89%)	132 (0.91%)	140 (0.98%)	184 (0.95%)		
Cancellation of Time/ Location	530	1,293	1,813	86 (0.52%)	124 (0.82%)	113 (0.63%)	89 (0.61%)	122 (0.86%)	111 (0.57%)		
Total Cancellations	2272 (3%)	6783 (5.3%)	9055 (4.5%)	632 (3.8%)	570 (3.77%)	739 (4.09%)	553 (3.8%)	642 (4.5%)	803 (4.14%)		

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.

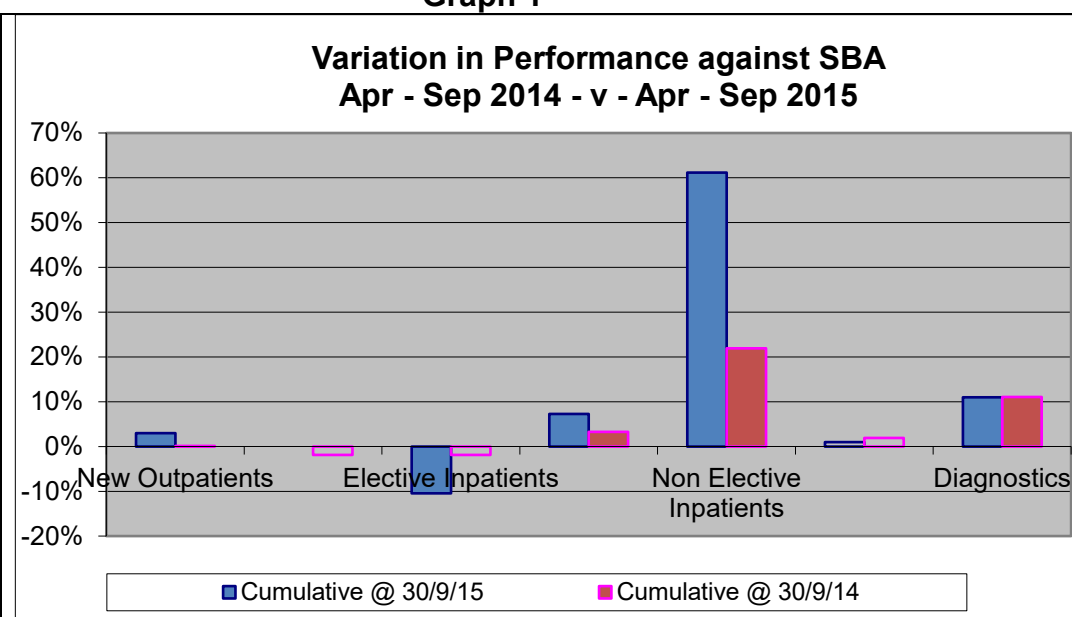
SBA PERFORMANCE SUMMARY FOR TRUST BOARD – MONTH END SEPTEMBER 2015**APPENDIX 1****Total SBA Performance per Activity Type (inclusive of newly agreed in-year uplifts):**

Table 1 below provides a summary of the total performance against elective and non-elective apportioned SBA baselines; this excludes visiting services where the Trust is not responsible for the SBA, a number of areas in Mental Health Directorate where SBAs require to be updated/agreed and activity related to daycentres and bedday contracts. Allied Health Professionals are currently excluded from SBA analysis pending input from HSCB/PHA on new baselines. SBA levels in a small number of areas may differ from regional reporting due to timeline for agreeing volumes.

Table 1 reflects the variation against apportioned SBA volumes as at 30 September 2015. Graph 1 reflects the variation in performance against the apportioned SBA compared to the same period in last year.

Table 1

Activity Type*	Cumulative % Variation against SBA @ 30 September 2015	Cumulative % Variation against SBA @ 30 September 2014
New Out-Patients	+3% (+1135)	+0.1% (+39)
Review Out-Patients	0% (-109)	-1.91% (-1311)
Elective In-Patients	-10.47% (-349)	-1.89% (-59)
Day Cases	+7.29% (+1118)	+3.26% (+487)
Non-Elective In-Patients	+61.18% (+9656)	+21.89% (+3429)
Births	+1% (+40)	+1.89% (+56)
Diagnostics	+11% (+15010)	+11.07% (+15045)
Allied Health Professionals	SBA not yet agreed	

Graph 1

* **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

SBA PERFORMANCE AND ACCESS TIMES – MONTH END OCT 2015 AND PROJECTED MONTH END NOV 2015
OUTPATIENTS
APPENDIX 2

Specialty	SBA Performance – over / under	Known capacity gap	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of October 2015							End of November 2015 position
				End of October 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	Under –16%		9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Breast Family History	Under -5%		9-weeks	9-weeks	-	-	-	-	-	-	13-weeks
Cardiology	Under -10%	Capacity gap	9-weeks	42-weeks	1009	139	458	409	3	0	43-weeks
Cardiology ICATS											
Cardiology – Rapid Access Chest Pain	Over +15%	Capacity Gap	2-weeks	3-weeks	-	-	-	-	-	-	3-weeks
Chemical Pathology	Over +22%	Capacity Gap	9-weeks	15-weeks	-	-	-	-	-	-	14-weeks
Colposcopy	Under -12%		9-weeks	<9-weeks	-	-	-	-	-	-	5-weeks
Community Paediatrics	No SBA	N/A	9-weeks	8-weeks ¹	-	-	-	-	-	-	9-weeks
Dermatology	Under -2%		18-weeks	25-weeks	84	40	44	0	0	0	26-weeks
Dermatology ICATS											
Endocrinology	TBC	Capacity gap	9-weeks	58-weeks	297	26	88	76	61	46	59-weeks
Diabetology	TBC			43-weeks	131	105	77	25	2	0	42-weeks
ENT	Over +5%	Residual Capacity gap	9-weeks	38-weeks	2277	491	1496	290	0	0	51-weeks
ENT ICATS											
Gastro-enterology	Over +11%	Capacity gap	9-weeks	45-weeks	585	97	285	172	31	0	48-weeks

¹ Community Paediatrics figure excluding Education referrals which do not follow the 9-week access standard.

Specialty	SBA Performance – over / under	Known capacity gap	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of October 2015							End of November 2015 position
				End of October 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 +	
General Medicine											
Geriatric Medicine	Over		9-weeks	20-weeks	4	4	-	-	-	-	22-weeks
Ortho Geriatric	Over +5%	Capacity gap	9-weeks	58-weeks	54	5	10	11	12	16	62-weeks
General Surgery	Under –9%	Residual Capacity gap	9-weeks	34-weeks	1002	421	575	6	0	0	38-weeks
Gynaecology	Under -2%	Previous Capacity gap/ accrued backlog	9-weeks	31-weeks	529	273	255	1	0	0	31-weeks
Haematology	Over +18%		9-weeks	37-weeks	69	8	41	20	0	0	39-weeks
Nephrology	Under -1%		9-weeks	<9-weeks	-	-	-	-	-	-	6-weeks
Neurology	Over +6%	Capacity gap	9-weeks	44-weeks	836	111	341	340	44	0	47-weeks
Orthopaedics	Under -16%	Previous Capacity gap/ accrued backlog	13-weeks	56-weeks	662	100	267	205	87	3	60-weeks
Ortho ICATS	Under -20%	Previous Capacity gap/ accrued backlog	9-weeks	30-weeks	623	290	333	0	0	0	28-weeks
Paediatrics	Under -20%		9-weeks	28-weeks	129	43	86	0	0	0	30-weeks

Specialty	SBA Performance – over / under	Known capacity gap	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of October 2015							End of November 2015 position
				End of October 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 +	
Pain Management	Under -3%	Capacity gap	9-weeks	32-weeks	380	98	264	18	0	0	35-weeks
Rheumatology	Under -5%	Capacity gap	18-weeks	55-weeks	588	34	145	179	155	75	54-weeks
Symptomatic Breast Clinic	Over +13%		9-weeks	2-weeks (Red Flag) & 13-weeks (Routine)	-	-	-	-	-	-	2-weeks (Red Flag) & 16-weeks (routine)
Thoracic Medicine	Over +2%	Capacity gap	9-weeks	37-weeks	374	87	230	57	0	0	37-weeks
Urology	Under -17%	Minor Capacity gap	9-weeks	68-weeks	1402	157	355	314	274	302	72-weeks
Urology ICATS											

IN-PATIENTS / DAY CASES

Specialty	SBA Performance – over / under	Known capacity gap	Access Standard or Backstop	Actual Access Time and Volume of Waits (By Time Band) at end of October 2015						End of November 2015 position
				End of October 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	Under -2%	Emergent Capacity gap	26-weeks	51-weeks	24	19	5	0	0	54-weeks
Cardiology	SBA TBA	Capacity gap	13-weeks	47-weeks	67	65	2	0	0	50-weeks
Community Dentistry	Under -15%		13-weeks	<13-weeks	0	0	0	0	0	10-weeks
Dermatology	Over +14%	Capacity Gap	13-weeks	24-weeks	-	-	-	-	-	26-weeks
ENT	Under -7%		13-weeks	22-weeks	-	-	-	-	-	24-weeks
Gastro-enterology (Non Scopes)			13-weeks	29-weeks	2	2	0	0	0	13-weeks
General Surgery	Under -9%	Previous Capacity gap / accrued backlog	26-weeks	74-weeks	332	202	96	34	0	76-weeks
Gynaecology	Under -4%	Previous Capacity gap / accrued backlog	13-weeks	39-weeks IP & 13-weeks DC	23	23	0	0	0	37-weeks IP & 13-weeks DC
Haematology	Over +23%		13-weeks	13-weeks	-	-	-	-	-	13-weeks

Specialty	SBA Performance – over / under	Known capacity gap	Access Standard or Backstop	Actual Access Time and Volume of Waits (By Time Band) at end of October 2015						End of November 2015 position
				End of October 2015 position	Actual Volume of patients waiting in excess of 26-week backstop	Timebands (in weeks)				
						26 - 40	41 - 60	61 - 80	80 +	
Orthopaedics	Under -8%	Residual Capacity gap	26-weeks	78-weeks	467	281	150	36	0	83-weeks
Pain Management	Over +1%	Capacity gap	26-weeks	67-weeks	421	153	216	52	0	71-weeks
Rheumatology	Over +1%		26-weeks	23-weeks	-	-	-	-	-	21-weeks
Urology	Under -5%	No Capacity gap	26-weeks	115-weeks	350	133	89	84	44	118-weeks

DIAGNOSTICS

Specialty	SBA Performance – over / under	Known capacity gap	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of October 2015						End of November 2015 position
					End of October 2015 position	Actual Volume of patients waiting in excess of target	Timebands (in weeks)				
							9 - 13	13 - 21	22 - 26	26 +	
Endoscopy	Under -4%	Capacity Gap	-	9-weeks	Routine 45-weeks	756	287	206	93	170	Routine 49-weeks *18-weeks dependent on IS Urgent 14-weeks
Cardiac Investigations (non Echo)	-		Pacing,ECG, BP, CM, Tapes (28/48 /72 hr), Tilts, Treadmill, DSE,TOE	9-weeks	25-weeks	104	50	43	11	0	24-weeks
Cardiac Invx	Over <+5%	Capacity Gap	Echo		31-weeks	1033	414	545	62	12	30-weeks
Neurophysiology	-				9-weeks	-	-	-	-	-	9-weeks
Sleep Studies	-			9-weeks	7-weeks	-	-	-	-	-	9-weeks
Urodynamics (Urology)	-			9-weeks	TBV	106	15	22	12	57	61-weeks
Urodynamics (Gynae)	Under <-10%			9-weeks	<9-weeks	-	-	-	-	-	<9-weeks
Imaging	Over +17%		Plain Film	9-weeks	9-weeks	23	20	2	0	1	9-weeks
	Over +27%	Capacity Gap	CT		18-weeks	269	211	46	0	12	18-weeks
			CTC		50-weeks						13-weeks
	Over +5%	Capacity Gap	USS		23-weeks	1741	1085	646	9	1	23-weeks
	Over +1%	Capacity Gap	Dexa		18-weeks	463	227	236	0	0	17-weeks
	Under -36%	Capacity Gap	MRI		19-weeks	806	386	419	0	1	20-weeks
	-		Fluoroscopy		18-weeks	63	35	26	2	0	18-weeks
	-		Barium Enema		9-13weeks	0	0	0	-	-	9-weeks

Specialty	SBA Performance – over / under	Known capacity gap	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of October 2015						End of November 2015 position
					End of October 2015 position	Actual Volume of patients waiting in excess of target	Timebands (in weeks)				
							9 - 13	13 - 21	22 - 26	26 +	
	-		Gut Transit Studies		9-weeks	1	-	1	-	-	9-weeks
	-		Obstetrics Ultrasound		9-weeks	-	-	-	-	-	9-weeks
	-		Radio Nuclide		9-weeks	4	1	0	0	3	9-weeks

MENTAL HEALTH AND DISABILITY

Specialty	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of October 2015							End of November 2015 position
			End of October 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	17-weeks	52	42	10	0	0	0	13-weeks
	Memory / Dementia Services		25-weeks	93	42	37	14	0	0	25-weeks
CAMHS	-	9-weeks	8-weeks	-	-	-	-	-	-	9-weeks
Learning Disability	-	9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Psychiatry of Old Age	-	9-weeks	16-weeks	7	6	1	0	-	-	14-weeks
Autism	-	13-weeks	13-weeks	-	-	-	-	-	-	13-weeks
Psychological Therapies	-	13-weeks	32-weeks	129	58	60	11	0	0	32-weeks

ALLIED HEALTH PROFESSIONALS

Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of October 2015				End of November 2015 position
		End of October 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	25-weeks	4	4	0	28-weeks
Dietetics – Paediatrics	13-weeks	28-weeks	121	113	8	32-weeks
Occupational Therapy – Acute	13-weeks	13-weeks	0	0	0	13-weeks
Occupational Therapy – Elderly and Primary Health Care	13-weeks	41-weeks	143	130	13	45-weeks
Occupational Therapy – Paediatric	13-weeks	35-weeks	181	115	66	33-weeks
Occupational Therapy – Physical Disability	13-weeks	17-weeks	14	13	1	14-weeks
Occupational Therapy – Learning Disability	13-weeks	11-weeks	-	-	-	13-weeks
Orthoptics	13-weeks	19-weeks	159	159	0	22-weeks
Physiotherapy – Adult	13-weeks	25-weeks	2039	1126	913	22-weeks
Physiotherapy – Paediatrics	13-weeks	18-weeks	9	9	0	16-weeks
Podiatry – Adult	13-weeks	31-weeks	1399	1309	90	30-weeks
Podiatry – Paediatrics						
Speech & Language Therapy Elderly & Primary Health	13-weeks	13-weeks	0	0	0	13-weeks
Speech & Language Therapy Paediatrics	13-weeks	42-weeks	895	448	447	43-weeks
Speech & Language Therapy Physical Disability	13-weeks	13-weeks	-	-	-	13-weeks
Speech & Language Therapy Learning Disability	13-weeks	9-weeks	0	0	0	13-weeks

Indicator of Performance (IoP) Information

Appendix 3

IoP Reporting 2014/2015 – October update not available

IoP	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015
B18. Variation in death rate for emergency admissions (all diagnoses) comparing patients admitted at the weekend and patients admitted during the week	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%	Weekday 2.3%	Weekday 2.0%	Weekday N/A
	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%	Weekend 3.0%	Weekend 1.3%	Weekend N/A

Note: Amendment to August data

COMMISSIONING PLAN STANDARDS/TARGETS FOR 2014/2015

INDICATORS OF PERFORMANCE

November 2015 for October 2015 Performance

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct
A10. Number of A & E presentations due to deliberate self-harm (self-harm/suicide attempt/ideation)	227	226	204	217	212	187	185	237	211	210	204	N/A
A23. Uptake of seasonal flu vaccine by front-line health and social care workers.	66	42	34	1	0	Vaccination programme not yet commenced – commencing 1 October 2015						1085
A24. Note – Performance reported 1-month in arrears Admissions for Venous Thromboembolism.	Information report being developed by the Acute Information Team (to be available January 2016)											
A25. Level of activity in maternity and child health programme of care including average length of stay.		QE September 2014			QE December 2014			QE March 2015			QE June 2015	
	Obstetrics	Occupancy 64.1% Average Length of Stay 2.4%			Occupancy 61.7% Average Length of Stay 2.3%			Occupancy 68.7% Average Length of Stay 2.2%			N/A until end November 2015	
	Well babies	Occupancy 53.6% Average Length of Stay 1.7%			Occupancy 52.3% Average Length of Stay 1.7%			Occupancy 46.0% Average Length of Stay 1.6%				
	Mid wife	Occupancy 100% Average Length of Stay 1.4%			Occupancy 100% Average Length of Stay 1.7%			Occupancy 100% Average Length of Stay 1.5%				
A26. Percentage of babies born by caesarean section and number of babies born in midwife-led units, either freestanding or alongside.	C-S 30.27%	C-S 30.26%	C-S 37.71%	C-S 31.16%	C-S 30.83%	C-S 34.09%	C-S 34.98%	C-S 30.26%	C-S 33.21%	C-S 31.47%	C-S 32.9%	C-S 32.8%
	MLU 14.7%	MLU 14.5%	MLU 13.8%	MLU 13.7%	MLU 13.7%	MLU 14.7%	MLU 13.2%	MLU 14.5%	MLU 15.5%	MLU 14.6%	MLU 13.5%	MLU 14.1%
A28. Rate of each core contact with the pre-school child health promotion programme offered by health visitors												
	QE March 2015			Number of Children reviewed			Number of children contact undertaken			Percentage rate of contact		
	4 year record review by Health Visitor			7135			1742			24.4%		

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct
A29. Percentage reduction in intervention rates (including caesarean sections) benchmarked against comparable units in UK and Ireland.	April 2014 to April 2015 (CHKS): - Elective C-Section (only): Trust 16.1% Peer 10.9% - Emergency C-Section (only): Trust 16.6% Peer 15%											
B1. Number of red flag cancer referrals	924	887	896	950	1097	1036	961	1203	1084	1014	1181	1263
B2. Percentage of patients triaged at levels 1-5 of the Manchester Triage Scale at Type 1 or 2 emergency departments												
(a) Level 1	0.5%	0.6%	0.6%	0.6%	0.5%	0.6%	0.7%	0.6%	0.5%	0.4%	N/A	N/A
(b) Level 2	18.6%	20.1%	18.6%	19.0%	17.5%	17.7%	18.1%	17.2%	17.6%	18.1%	N/A	N/A
(c) Level 3	45.6%	47.3%	48.4%	45.8%	49.2%	45.1%	46.5%	46.2%	47.8%	45.7%	N/A	N/A
(d) Level 4	32.4%	31%	31.7%	33.8%	32.1%	35.7%	33.8%	35.2%	33.1%	35%	N/A	N/A
(e) Level 5	1.9%	0.3%	0.4%	0.2%	0.2%	0.4%	0.3%	0.2%	0.4%	0.3%	N/A	N/A
B3. Percentage of new and unplanned review attendances at emergency care departments waiting within timebands below before being treated or discharged and admitted												
(a) < 30 minutes	13.7%	11.6%	11.6%	11.0%	10.2%	11.2%	12.2%	11.9%	13.7%	13.3%	13.8%	13.4%
(b) 30 minutes – 1 hour	14.8%	14.0%	14.4%	14.1%	13.8%	15%	14.8%	15.9%	15.7%	14.8%	15.4%	14.7%
(c) 1 – 2 hours	23%	21.2%	20.1%	17.5%	19.2%	19.7%	18.5%	19%	20.1%	18%	19%	18.6%
(d) 2 – 3 hours	20.8%	20.2%	19.4%	17.3%	19.2%	16.7%	19.3%	17.8%	19.9%	18.9%	17.1%	17.7%
(e) 3 – 4 hours	16.8%	18.7%	17.8%	18.1%	18.0%	16.8%	17.9%	16.5%	16.9%	17.6%	16.5%	15.8%
(f) 4 – 6 hours	7.6%	9.9%	10.8%	13.9%	13.8%	13.2%	12.8%	13%	10.1%	12.1%	12.2%	12.6%

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct
(g) 6 – 8 hours	2.2%	3.0%	3.5%	5.2%	4.3%	4.6%	3.4%	4.0%	2.5%	3.8%	3.8%	4.3%
(h) 8 – 10 hours	0.7%	0.8%	1.2%	1.7%	1.1%	1.5%	0.7%	1.3%	0.8%	1%	1.3%	1.7%
(i) 10 – 12 hours	0.4%	0.4%	1.0%	1.2%	0.5%	0.6%	0.4%	0.6%	0.3%	0.6%	0.8%	1.3%
(j) 12 hours or more	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
B7. Percentage of unplanned re-attendances at emergency departments within seven days of original attendance	3.8%	3.5%	4.1%	4.4%	4.2%	3.6%	3.7%	3.8%	3.6%	3.5%	3.2%	N/A
B8. Total time spent in emergency departments including the median, 95 th percentile and single longest time spent by patients in the A&E department, for admitted and non-admitted patients.	Information report being developed by the Acute Information Team – estimated timescale for availability 31 December 2015 (January report)											
B9. Percentage of people who leave the emergency department before their treatment is complete.	2%	2.8%	2.6%	3.2%	3.6%	3.5%	3.1%	3.3%	2.4%	3.1%	N/A	N/A
B10. Time from (i) arrival to initial assessment and (ii) initial assessment to treatment in emergency departments.	Information report being developed by the Acute Information Team – revised timescale for availability 30 January 2016											

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct
B12. Number of GP referrals to consultant-led outpatient services.	6979	6558	7606	7548	8078	7449	7064	8436	7406	6491	7614	7583
B13a. Number of outpatient appointments with procedures within pain management	40	44	42	29	18	41	49	44	24	29	38	35
B13b. Number of outpatient appointments with procedures within gynaecology	1006	981	922	767	839	1141	845	1132	977	1100	1175	1074
B13 c. Number of outpatient appointments with procedures within general surgery	201	206	155	177	147	215	162	149	136	135	160	116
B13 d. Number of outpatient appointments with procedures within dermatology	0	0	0	0	0	0	0	0	0	0	0	0
B14. Number of radiology tests (for discrete list of tests). <i>*Note: Tests undertaken in core SBA sessions</i> <i>BE – Barium Enema</i> <i>CT</i> <i>MRI</i> <i>US – Non-obstetric</i> <i>Plain – Plain Film</i>	BE 43	BE 43	BE 39	BE 25	BE 30	BE 26	BE 39	BE 24	BE 24	BE 15	BE 12	BE N/A
	CT 1748	CT 1710	CT 1872	CT 1889	CT 2653	CT 1758	CT 1687	CT 1891	CT 2158	CT 2097	CT 2218	CT N/A
	MRI 589	MRI 556	MRI 596	MRI 590	MRI 601	MRI 576	MRI 598	MRI 706	MRI 826	MRI 1070	MRI 1233	MRI N/A
	US 3203	US 2865	US 3216	US 2723	US 2892	US 2904	US 2825	US 3192	US 2901	US 2823	US 3084	US N/A
	Plain 15047	Plain 14546	Plain 16000	Plain 15420	Plain 16918	Plain 16597	Plain 15998	Plain 18147	Plain 16224	Plain 15445	Plain 16853	Plain N/A

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
B15. Total number of patients admitted for inpatient treatment in the independent sector	3	3	6	7	2	IP 19 DC 64	IP 4 DC 41	IP 3 DC 20	IP 2 DC 7	IP 1 DC 6	IP 4 DC 191	IP 3 DC 228
B16a. Total number of attendances at consultant-led new outpatient services in the independent sector	0	0	0	0	0	0	0	0	0	0	0	45
B16b. Total number of attendances at consultant-led review outpatient services in the independent sector	80	36	40	30	47	54	46	38	33	10	23	78
B17. Note – Performance reported 3-months in arrears Number of patients admitted with stroke* *As at 1/4/15 per RHSCB technical guidance deaths and discharges are used as an approximation of Admissions and figures are presented by month on discharge.	30	33	50	42	40	33	37	38	39	34		
B18. Variation in death rate for emergency admissions (all diagnoses) comparing patients admitted at the weekend and patients admitted during the week	Weekday 2.0% Weekend 1.5%	Weekday 2.7% Weekend 2.4%	Weekday 3.1% Weekend 2.7%	Weekday 3.5% Weekend 2.9%	Weekday 2.7% Weekend 3.0%	Weekday 2.5% Weekend 2.1%	Weekday 2.3% Weekend 3.7%	Weekday 2.4% Weekend 2.3%	Weekday 2.1% Weekend 1.6%	Weekday 2.3% Weekend 3.0%	Weekday 2.0% Weekend 1.3%	Weekday N/A Weekend N/A

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
B19. Note – Performance reported 3-months in arrears Variation in death rate for emergency admissions comparing patients admitted at the weekend and patients admitted during the week for -												
(i) heart attacks;	100%	0%	18.5%	7.7%	7.7%	14.3%	6.5%					
(ii) heart failure;	10.3%	6.7%	0%	3%	2.9%	15.2%	14.3%					
(iii) stroke and	22.2%	7.7%	18.2%	45%	30%	25%	13.3%					
(iv) aortic aneurysm	0%	75%	100%	100%	0%	-	-					
B21. Percentage of all adult inpatient wards in which the Fall Safe bundle has been implemented.	100% implementation on all applicable wards – all wards have introduced a monthly audit of elements of Fall Safe bundles A and B and report their results via NQI Database											
B22. Number of hearing aids fitted within 13 weeks as a percentage of completed waits.	100%	100%	100%	100%	100%	100%	99% (137 out Of 138)	100%	100%	100%	100%	100%
B23. Percentage of patients waiting over 13 weeks for any wheelchair (basic and specialised).	24%	24%	23%	4%	5%	4%	6%	4%	8%	5%	7%	4%
B24. Percentage of patients who have lifts and ceiling track hoists installed within 16 weeks of the OT assessment and options appraisal.	80% (4 out Of 5)	75% (3 out Of 4)	69% (11 out Of 16)	44% (4 out Of 9)	85% (11 out Of 13)	100%	100%	100%	100%	100%	100%	50% (2 out Of 4)

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
B25. Level of prescribing compliance with the NI Formulary	The Trust has, in agreement with HSCB, undertaken to submit audit data on 2 Chapters of the Formulary once per quarter, for in-patients only. Agreement has been reached Regionally on a programme of chapters and when they are to be undertaken.											
B34. Percentage increase in access to cardiac catheterisation.	Information report to be developed by the Acute Information Team – timescale for availability not defined as Regional interpretation issues – as an interim the number of procedures undertaken is to be used											
Angio (A) PCI (P) Permanent Pacing (PP) Other (O)	Cum. A 684 P 379 PP 57 O 182	Cum. A 789 P 434 PP 60 O 171	Cum. A 904 P 478 PP 66 O 193	Cum. A 1029 P 523 PP 72 O 215	Cum. A 1142 P 580 PP 84 O 236	Cum. A 144 P 44 PP 3 O 97	Cum. A 420 P 101 PP 9 O 310	Cum. A 641 P 150 PP 12 O 479	Cum. A 881 P 199 PP 20 O 662	Cum. A 1106 P 238 PP 24 O 844	Cum. A 1339 P 293 PP 27 O 1019	N/A
B35. Percentage of patients, where clinically appropriate, waiting less than 7 days for in-patient fracture treatment.	98.5% (67out Of 68)	91% (61 out Of 67)	94.6% (53 out Of 56)	96.6% (56 out Of 58)	93.2% (82 out Of 88)	100%	94.7% (75 out Of 79)	86.2% (75 out Of 87)	90.7% (68 out Of 74)	89.2% (66 out Of 70)	92.9% (65 out Of 70)	97.4% (76 out Of 78)
B36. Note – Performance reported 3-months in arrears Number of Emergency admissions for acute conditions which should not usually require hospital admissions.	256	271	290	279	291	Report under development – available in Q4 2015/16						
B37. Number and proportion of emergency admissions and readmissions for people aged 0 – 64 and 65+, (i) with and (ii) without a recorded	Information report under development by the Acute Information Team – not available until Q4 2015/16											

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
long-term condition, in which medicines were considered to have been the primary or contributory factor.												
C3. Note – Performance reported 1-month in arrears. Number of patients benefiting from remote telemonitoring	10	16	19	11	19	11	7	10	12	13	15	4
D1. Number of adults in receipt of day opportunities, by programme of care	Information available annually – For Year 2014/15 as at 31/3/15											
	POC 04 = 0			POC 05 = 0			POC 06 = < 65 392 65+ 10			POC 07 = < 65 56 65+ 0		
D2. Number of people eligible for social care services who are accessing self-directed support through a personal budget	Report under development – estimated timescale will be available Q4 2015/16											
D3. Number of older persons living in supported living facilities	9	9	9	9	9	9	9	9	10	10	N/A	N/A
D4. (i) Number of people with continuing care needs waiting longer than five weeks for an assessment of need to be completed and (ii)	(i) < 5-weeks – 100% (ii) <8-weeks – 100%		(i) < 5-weeks – 100% (ii) <8-weeks – 100%			(i) < 5-weeks – 100% (ii) <8-weeks – 100%			N/A			

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
Number of people with continuing care needs waiting longer than eight weeks, from their assessment of need, for the main components of their care needs to be met												
D5. Number of patients benefiting from the provision of telecare services.	521	499	482	460	437	N/A	N/A	N/A	N/A	N/A	N/A	N/A
F1. Note – Performance reported 3-months in arrears. Elective average pre-operative stay. <i>*Note: Beddays used by elective admissions not on day of surgery – Reported 3-months in arrears</i>	60	72	72	69	38	36	57	52	38			
F2. Average length of stay in acute programme of care.	Elect 2.62 Non- Elect 5.06	Elect 2.4 Non- Elect 4.88	Elect 2.53 Non- Elect 5.29	Elect 2.54 Non- Elect 6.4	Elect 2.6 Non- Elect 5.95	Elect 2.83 Non- Elect 5.66	Elect 2.65 Non- Elect 4.87	Elect 2.87 Non- Elect 5.04	Elect 2.77 Non- Elect 5.07	Elect 2.59 Non- Elect 4.65	Elect 2.54 Non- Elect 4.78	Elect 3.06 Non- Elect 4.93
F3. Note – Performance reported 3-months in arrears. Average length of stay for stroke patients within the acute programme of care. <i>*Note: Reported 3-months in arrears</i>	9.9%	13.5%	8.4%	8.3%	7.7%	10.7%	14.8%	9.5%	6.1%			

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
F4. Note – Performance reported 3-months in arrears. Day surgery rate for each of a basket of 24 elective procedures. <i>*Note: Reported 3-months in arrears</i>	69%	67%	69%	76%	74%	70%	71%	73%	71%			
F5. Percentage of operations cancelled for non-clinical reasons.	1.2%	1.4%	2.1%	1.8%	2.3%	1.4%	0.8%	1.2%	0.8%	1.5%	1.1%	1.4%
F6. Note – Performance reported 3-months in arrears. Percentage of patients admitted electively who have their surgery on the same day as admission.	91.88%	91.34%	92.93%	90.45%	92.75%	94.28%	91.38%	92.26%	93.56%			
F7. Percentage of routine diagnostic tests reported on within 2 weeks of the test being undertaken.	Imag. 97.5% Non-Imag. 99.9%	Imag. 95.8% Non-Imag. 99.8%	Imag. 95.9% Non-Imag. 99.9%	Imag. 96% Non-Imag. 99.5%	Imag. 86.9% Non-Imag. 99.9%	Imag. 82.4% Non-Imag. 98.9%	Imag. 93.8% Non-Imag. 96.9%	Imag. 96% Non-Imag. 97%	Imag. 96.7% Non-Imag. 97%	Imag. 97% Non-Imag. 97%	Imag. 91.9% Non-Imag. 98%	Imag. 95.3% Non-Imag. N/A
F8. Percentage of routine diagnostic tests reported within 4 weeks of the test being undertaken.	Imag. 99.4% Non-Imag. 99.9%	Imag. 99.5% Non-Imag. 99.8%	Imag. 99% Non-Imag. 100%	Imag. 99.4% Non-Imag. 100%	Imag. 97.3% Non-Imag. 100%	Imag. 94.3% Non-Imag. 99.9%	Imag. 97.4% Non-Imag. 98%	Imag. 98.3% Non-Imag. 99.1%	Imag. 99.1% Non-Imag. 99%	Imag. 99.6% Non-Imag. 99.2%	Imag. 98.8% Non-Imag. 99.6%	Imag. 99% Non-Imag. N/A

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
F9. Ratio of new to review outpatient appointments attended <i>*Note: N:R based on actual activity – not scheduled</i>	1 : 2	1 : 2	1 : 2	1 : 2	1 : 1.78	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2	N/A
F10. Rate of New and Review outpatient appointments where the patient did not attend. <i>*Note: Cons-Led OP Only</i>	N 6.3% R 6.9%	N 7.2% R 6.7%	N 6.3% R 7.0%	N 6.2% R 6.2%	N 6.6% R 6.4%	N 6.5% R 6.5%	N 7.0% R 6.6%	N 6.3% R 6.5%	N 7.0% R 6.3%	N 6.3% R 6.3%	N 5.8% R 6.2%	N 5.8% R 6.2%
F11. Rate of New and Review outpatient appointments cancelled by the hospital.	N 5.0% R 7.7%	N 5.3% R 9.6%	N 3.6% R 7.1%	N 4.9% R 7.7%	N 4.0% R 7.7%	N 3.5% R 7.5%	N 3.6% R 6.4%	N 3.1% R 6.8%	N 4.2% R 6.8%	N 4.9% R 9.7%	N 3.3% R 8.0%	N N/A R N/A
F12. Ratio of new to review outpatient appointments cancelled by the hospital	1 : 2.6	1 : 3.4	1 : 3.7	1 : 3.1	1 : 4.2	1 : 3.8	1 : 3.0	1 : 3.7	1 : 2.8	1 : 3.3	1 : 4.2	N/A
F13. Number of 30 day emergency readmissions by days after discharge	Information report to be developed by the Acute Information Team (available in Q4 2015/16)											
F14. Percentage of emergency admissions returning within 7 days and within 8 - 30 days	0-7 days 2.9%			Under development – available in Q4 2015/16								
	8-30 days 5.1%			Under development – available in Q4 2015/16								
F15. Clinical causes of emergency readmissions (as a percentage of all	Information report to be developed by the Acute Information Team (available in Q4 2015/16)											

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
readmissions) for (i) infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF)												
F16. GP Out of Hours Attendance by timeband (i) 12 am to 8.30 am; (ii) 8.30 am to 6pm; and (iii) 6pm to 12 am	Reported in main Trust Board report											
G1. Percentage of all foster care placements that are kinship care placements. <i>*Note: Data reflects kinship foster carers panel and field work approved</i>	37.2%	38.1%	38.1%	38.1%	37.7%	37.6%	37.3%	35.3%	35.6%	37%	N/A	N/A
G2. Number of residential care leavers in education, training and employment. <i>*Note: Data relates to over 19 years care leavers</i>	35	34	37	38	40	39	36	42	41	43	39	N/A
G3. Percentage of care leavers at age 18, 19 and 20 years in education, training and employment.	86%	82%	85%	84%	82%	85%	83%	87%	86%	84%	83%	N/A

IoP	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
G4. Percentage of children with an adoption best-interests decision notified to the Regional Adoption Information system (RAIS) within 4 weeks of the HSC Trust approving the adoption panel's decision that adoption is in the best interest of the child. – <i>Reported 3 months in arrears</i>	QE Dec 14 7		QE Mar 15 1			QE Jun 15 3			QE Sep 15 5			
G6. Length of time for Best Interest Decision to be reached in the adoption process. Reported annually	Q1 2014/15 < 4 weeks			Q2 2014/15 < 4-weeks			Q3 2014/15 < 4-weeks			Q4 2014/15 < 4-weeks		
G7. Number of children and number of times absconding from residential or foster care has been notified to police	Information reported 6 monthly – Oct 2014 – Mar 2015 Number of children: N/A Number of events: N/A						Information reported 6 monthly – Apr – Sep 2015 Number of children: N/A Number of events: N/A					
G9. Number of referrals for ASD (under 18)	16	17	17	22	27	N/A						
G10. Number diagnosed with ASD (under 18)	8	4	7	10	6	N/A						
G11. Number of Adult Protection Referrals received by HSC Trusts	131	90	102	178	118	110	112	153	126	102	120	N/A

Note: Only those IoPs applicable to the Trust have been included in this report.



**Minutes of a confidential meeting of Trust Board held on
Thursday, 29th January 2015 at 9.30 a.m.
in the Boardroom, Trust Headquarters, Craigavon**

PRESENT:

Mrs R Brownlee, Chairman
 Mrs M McAlinden, Chief Executive
 Mr E Graham, 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

IN ATTENDANCE:

Mrs D Burns, Interim Director of Acute Services
 Mrs P Clarke, Director of Performance and Reform
 Mr M Crilly, Acting Director of Mental Health and Disability Services
 Mr K Donaghy, Director of Human Resources and Organisational
 Development
 Mrs A McVeigh, Director of Older People and Primary Care Services
 Mrs R Rogers, Head of Communications
 Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES:

Mrs D Blakely, Non Executive Director
 Mrs H Kelly, Non Executive Director
 Dr J Simpson, Medical Director

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. MINUTES OF MEETING HELD ON 27TH NOVEMBER 2014

The Minutes of the meeting held on 27th November 2014 were taken as read and agreed as an accurate record, subject to the following amendment on page 3:-

Mrs Rooney joined the meeting at 9.40 a.m.

Mr Alexander joined the meeting at 9.50 a.m.

3. MATTERS ARISING FROM PREVIOUS MINUTES

- i) **Corporate Risk Register – letter to Mr J Brogan re Medicines Compliance/Adherence in Community Sector dated 15th December 2014**

At the request of Trust Board, Mrs McAlinden had written to Mr J Brogan to again seek resolution to the significant issues identified and set out in the Corporate Risk Register, and she thanked Mrs McVeigh and Mr Rice for the detail of the letter. Mrs McAlinden advised that to date there has been no response to her letter and she reminded members that in the meantime, the Trust is in breach of RQIA standards and at risk of breaching NMC standards. Mrs Mahood welcomed the letter from an Audit Committee perspective give the limited assurance received in this area and emphasized the importance of maintaining a focus on this important issue.

- ii) **Elective Care – Under-delivery of Core Capacity Volumes – letter to Mrs V Watts, HSCB, dated 15th December 2014**

Mrs McAlinden referred to her letter to Mrs Watts on 15th December 2014 in response to her letter dated 24th November 2014. Mrs McAlinden provided assurance that both Mrs Burns and

Mrs Clarke closely monitor SBA performance and the Trust's letter explains the reasons for the SBA performance, by specialty. Mrs Burns stated that it was important to note that the SBA underperformance was in a small number of specialties only and mainly due to medical workforce issues.

Mrs Mahood expressed her concern at the waiting time for Dermatology. In response, Mrs Burns advised that in order to reduce the clinical risk associated with patients in the out-patient review waiting list, the Trust has approved the diversion of new patient capacity to increase review capacity, allowing the Dermatology team to focus on the review backlog. While this impacts on routine new referrals it ensures follow up for more urgent patients in the review pathway.

At this point, Mrs McAlinden provided the context around the NHSCT Urology service and the recent media coverage. She informed members of Commissioner-led discussions which had taken place at a regional level to agree what the other Urology networks could undertake to address the NHSCT gap. She advised that there was a proposal that the Southern Trust would accept referrals from Cookstown and surrounding area, which Mrs Burns had not accepted and set out the reasons for this. She advised that Mrs Clarke and Mrs Burns had subsequently met with the HSCB and it was agreed that the Trust would provide some limited support, but only on a temporary basis to end of March 2015.

iii) **2014/15 Slippage and alternative spending proposals**

Members discussed the internal movements arising from the mid year review of the overall financial position and the areas where this slippage has been applied. In the context of the projected year end financial position Mr McNally stated that the most recent allocation letter from HSCB confirms additional income of £2.2m, however the late confirmation of this funding has limited the ability to spend given recruitment and procurement lags. Directors agreed that every effort was being made to apply this funding to areas of greatest risk but the opportunities were few given the above limiting factors in spending this before year end.

iv) Update on Donaldson Review

The Chair drew members' attention to the report "The Right Time, The Right Place" prepared by Sir Liam Donaldson and emphasized its significance in terms of findings and recommendations. She advised that the Minister had written to each of the Chairs of the HSC Arms Length Bodies seeking view of staff on the report, specifically the safety and quality aspect, by 30th April 2015. The Chair advised that this matter would be a substantive item on the Directors' Workshop agenda on 26th February 2015.

v) Headway, Newry

Mr Crilly updated members on developments since his previous confidential briefing on this issue. He advised that a final response from Headway UK is awaited. In response to a query from Dr Mullan as to any potential risk to service users, Mr Crilly advised that whilst Headway Newry is providing a good service in the Newry and Mourne area, this was not available to service users in the remainder of the Trust area, and the proposal would be to procure a Trust-wide service.

4. UPDATE ON FINANCIAL POSITION AND CONTINGENCY PLANS

i) Financial Plan 2015/16

Mrs McAlinden reminded members that the Trust's financial plan has been discussed on a number of occasions by Trust Board and is the subject of ongoing negotiations with the HSCB. She stated that the plan remains largely as previously discussed and in her view is robust and, although challenging, should deliver financial balance in 15/16. Members discussed the summary sheet prepared by Mr McNally on the Plan for 2015/16 and noted that the achievement of £6.8m of contingency measures will be a challenge. Mrs McAlinden spoke of risks with the overall financial package for 2015/16 in that there is no funding for waiting list initiatives and the pay settlement remains unclear. Dr Mullan asked if there were any

other emerging issues that may derail the Trust's plan to which Mrs McAlinden advised that the Trust's plan is a subset of the NI financial framework and there were major risks in the other areas of the NI plan. One major risk would be if more savings were required due to under-delivery of other aspects of the NI plan.

At this point Mr Morgan reminded members that in line with Trust plans for recurring savings, the Trust had sought approval from the HSCB for the formal closure of Drumglass which was now temporarily closed for a significant period. He advised that formal confirmation of HSCB approval has now been received. Mr Morgan informed members that, as agreed by the SMT, an EQIA will now be taken forward to comply with and inform any further consultation requirement.

ii) Change or Withdrawal of Services – Revised Guidance on Roles and Responsibilities – letter from Permanent Secretary and HSC Chief Executive dated 27th November 2014

Mrs McAlinden stated that the extant guidance has been revised to strengthen the sections on consultation in relation to temporary closure. She advised that the interpretation of this guidance remains unclear and is the subject of ongoing discussions between DHSSPS, HSCB and Trusts.

iii) Impact of temporary closure of Minor Injuries Unit, Armagh

Mrs Clarke reminded members that the temporary closure of the Armagh Minor Injuries Unit is part of the Trust's contingency measures to achieve financial breakeven by end of March 2015. She referred members to a paper which provides an analysis of the impact of the temporary closure and identifies the proposed way forward. Members discussed the analysis, particularly the evidence that the impact of the temporary closure from 17th November 2014 to date appears to be minimal.

The proposed way forward was discussed in light of the lack of clarity on consultation processes (see above item). Mr Graham expressed his view that the Trust has a good reputation for how it engages with stakeholders and felt this may be damaged if a full consultation was not undertaken in this case. In response, Mrs McAlinden spoke of the Trust's reputation for honesty and credibility and felt that any engagement needed to be proportionate to the options available, suggesting that initial discussions with local Councillors and MLAs to share this information with them and ascertain if there are any concerns from constituents might be a reasonable way forward. She stated that as part of this engagement process, the Trust would be willing to consider a public meeting if members felt this would be helpful. Following discussion, it was agreed that the Trust would write to the Permanent Secretary outlining the proposed way forward for proportionate consultation and then move to commence local stakeholder engagement.

5. CORPORATE RISK REGISTER

Mrs McAlinden drew members' attention to the new risk associated with HH/BC and the accompanying risk assessment. She advised that following review of the Corporate Risk Register by the SMT on 21st January 2015, some potential new risks were discussed, namely the introduction timescale for nursing revalidation and the Trust's capacity to deliver this and the pressures on unscheduled care. The GP Out of Hours Service was discussed and Mrs McAlinden drew members' attention to particular difficulties filling GP shifts recently. She stated that the Trust continues to explore various ways of managing this risk and spoke in particular of a meeting Mrs McVeigh and herself had with Providers working in Dublin who were using a new model supported by technology for home visits. In the absence of progress regionally, Mr Donaghy and Mrs McVeigh are exploring the options for a Trust-led GP recruitment process to increase the capacity for GP Out of Hours medical input.

Mrs Mahood welcomed the inclusion of the risk regarding HH/BC on the Corporate Risk Register and asked for the rationale for including it at this particular time. Mr Crilly advised that after two years in this

process and despite significant engagement between the Trust and the proprietors, there remains concern about ongoing financial irregularities. Mrs McAlinden stated that this risk has been managed at Directorate Risk Register level to date, but with legal processes now starting and the role of Trust Board in terms of decision-making, SMT agreed that it was timely to escalate to the Corporate Risk Register. Mr Crilly undertook to include the rationale into the risk assessment.

6. PROGRESS UPDATES

i) HH/BC

At the outset, the Chair asked that members are provided with a written update on the current situation which Mr Crilly agreed to provide. Mr Crilly advised that the Court Hearing scheduled for 8th December 2014 to discuss the time limits in relation to RQIA bringing a prosecution had been adjourned until 23rd January 2015. At that Court Hearing, the proprietors' legal team alleged a lack of full disclosure of documentation from RQIA. A date for a new Hearing was set for 12th/13th February 2015.

Mr Crilly stated that the offer of meetings with the Home Owners to resolve ongoing concerns continues. Mr Crilly advised that the PSNI investigation has not yet concluded and the NMC investigation continues. The Office of Care and Protection is potentially pursuing civil proceedings on behalf of one client.

Mrs Mahood asked if there had been any progress in terms of correspondence from the Home Owners in relation to invoices regarding transport. Mr Crilly advised that the Trust continues to identify issues of concern regarding transport invoices and he cited an example of same to illustrate the matter.

The Chair noted that the Trust HH/BC steering group continues to meet weekly and asked about the discussion of outstanding issues at these meetings. Mr Crilly advised that a template of outstanding issues is updated weekly at these meetings with 8-

10 issues not yet fully resolved. Dr Mullan asked if the Trust was proportionate in its response to the Home Owner's actions by continuing to suspend admissions to HH/BC. Mrs McAlinden stated that given the ongoing concerns outlined by Mr Crilly, and the parallel actions being taken by other agencies including an active PSNI investigation, RQIA pursuing a prosecution and the NMC investigation, the Trust's rationale for cessation of admissions is considered appropriate by the SMT and this position will remain until such time as issues outstanding are resolved to the Trust's satisfaction.

7 CONSULTATION ON THE FUTURE OF STATUTORY RESIDENTIAL CARE HOMES

Members noted receipt of the following correspondence in their papers:-

- i) Letter from the Permanent Secretary to Mrs V Watts, HSCB, dated 8 January 2015**
- ii) Letter to Trust Chief Executives from Mrs V Watts, HSCB, dated 8 January 2015.**

Mrs McVeigh stated that at the request of the Department, the HSCB has been evaluating Trust proposals on future residential care provision for older people. In light of the outcome of the Dalriada judicial review, the Department has asked for a pause in this process in order to consider whether there are any implications for any future consultation processes in this area. Mrs F McAndrew, HSCB, has issued a letter to each resident within the Statutory Residential Homes, with a copy to their families. Mrs McVeigh indicated that the issue for this Trust to now consider is whether the decision to pause and the associated extended timescale for final decisions on the future of the Trust's SRHs in any way impacted on the Trust Board's previous decision to temporarily suspend new admissions into statutory residential homes.

Mrs Mahood asked if there was any learning from the Dalriada judicial review for the Trust to take on board. Mrs McAlinden stated that she had been advised by the Permanent Secretary that the Department's legal team are currently considering this and the Permanent Secretary will advise Trusts.

The Board agreed to continue to temporarily suspend new admissions into statutory residential homes

8. SAIs UPDATE

Mr Crilly updated members on SAI ID: [Personal Information redacted by the USI] involving a [Personal Information] year old female patient in the Willows Ward. He advised that a joint investigation team between Acute and Mental Health & Learning Disability Directorates is being set up.

9. REVIEW OF ADMINISTRATIVE STRUCTURES WITHIN THE HSC SYSTEM

Mrs McAlinden referred members to correspondence from the Permanent Secretary enclosing Terms of Reference for a review of administrative structures within the HSC system as announced by the Minister on 28th November 2014. Mrs McAlinden advised that Mr K Donaghy is the designated Trust liaison and that this matter is a standing item on the SMT agenda going forward.

10. UPDATE ON MANAGEMENT STRUCTURES REVIEW

Mr Donaghy spoke to the progress update on the Review. He advised that the SMT has agreed the need to allocate time to discuss next steps/areas to progress in light of ongoing corporate risks including the financial environment. Mrs McAlinden made reference to the recruitment for the new Medical Director and the opinion that this post should include some clinical sessions to attract applicants. The Chair welcomed the strategic review by SMT and requested that Trust Board is kept informed of progress.

11. FEEDBACK FROM REMUNERATION COMMITTEE

The Chair updated members on the Remuneration Committee discussion on 5th January 2015. At the request of the Committee, Mr Donaghy had provided the Committee with an update on the progress of the management structures review. At that meeting, members were advised of the interim arrangements for the Chief Executive vacancy and the proposal to appoint a Deputy Chief Executive to take over the Clinical and Social Care Governance Leadership role and to provide a bridge for the period until a replacement for Mrs McAlinden is appointed.

12. HCAI RECORDING ON DEATH CERTIFICATES

Dr Simpson provided data on the number of deaths in the SH&SCT from 1st January 2012 up to 10th December 2014 where HCAI was mentioned and recorded as the underlying cause on the death certification.

13. ANY OTHER BUSINESS

At this point, the Chair advised that it was with regret that she had accepted the resignation of Mrs McAlinden as Chief Executive who will be leaving the Trust in March 2015 to take up the position of Chief Executive with South Devon Healthcare NHS Foundation in England. She stated that Mrs McAlinden's departure will be a massive loss not only for this Trust, but the health and care system in Northern Ireland.

The Chair stated that she was pleased to announce that Mrs Paula Clarke has been appointed as Deputy Chief Executive with effect from 19th January 2015 and will take over as Interim Chief Executive when Mrs McAlinden leaves. The Chair wished both Mrs McAlinden and Mrs Clarke every success in their new roles.

Mrs McAlinden took the opportunity to pay tribute to the Chair, the Trust Board and the Senior Management Team, and

thanked them for their support to her during her tenure as Chief Executive. She reflected her personal support and that of the Senior Management Team to Mrs Clarke's appointment, given her strong commitment to the Trust and the many excellent qualities she will bring to this post.

The meeting concluded at 11.15 a.m.

GOVERNANCE COMMITTEE

**Minutes of the confidential section held on Tuesday,
3rd February 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:

Mrs M McAlinden, Chief Executive
Mrs D Burns, Interim Director of Acute Services
Mrs P Clarke, Director of Performance and Reform
Mr M Crilly, Acting Director of Mental Health and Disability Services
Mr K Donaghy, Director of Human Resources and Organisational Development
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
Dr J Simpson, Medical Director
Mrs M Marshall, Acting Assistant Director, Clinical & Social Care Governance
Mrs S Judt, Board Assurance Manager (Minutes)
Mrs S McLoughlin, Acting Committee Secretary

1. MINUTES OF MEETING HELD ON 9th DECEMBER 2014

The Minutes of the meeting held on 9th December 2014 were agreed as an accurate record and duly signed by the Chairman.

2. MATTERS ARISING**i) Review of Quality of Nursing Care within Gillis Memory Centre – NIPEC Report and SH&SCT Action Plan**

Mr Rice reminded members that following a number of concerns raised through whistleblowing and RQIA reports, the Trust had commissioned NIPEC to complete an independent review of the quality of nursing care in the Gillis Memory Centre. He stated that this was a very comprehensive review and drew members' attention to the report in their papers which identified a number of recommendations. Mr Rice advised that considerable work has been completed in taking forward these recommendations which were incorporated into an action plan, , along with actions already underway in Gillis to modernize and enhance the service. In particular, Mr Rice advised that the culture and practice in the use of restrictive practices has completely changed and there are demonstrable changes in practice which underpin the quality of nursing care.

Mr Rice stated that it was important to note that the RQIA has undertaken a further inspection of the Gillis ward and has commended the work the Trust has taken forward. No other issues were identified.

Members discussed the report and accompanying action plan. Dr Mullan expressed his disappointment at some of the management issues raised in the report. In response, Mrs McAlinden acknowledged the learning for the Trust in terms of the Management of Change Framework as applied to the reconfiguration of services on the St Luke's site. She spoke of the challenge of not making staff redundant and securing them an appropriate redeployment opportunity, but that should not supersede the Trust's commitment to quality care.

Mrs Rooney noted the lengthy timescale between when NIPEC produced its report (early 2014) and the final draft report being brought to the Governance Committee almost one year later.

She also noted the lack of agreed timeframe for the Trust to address the recommendations and stated that the job titles of individuals named in the report would be helpful. Mr Rice stated that demonstrable changes in practice have been made and most recommendations have been completed, however, some are dependent on the Review of Dementia Services.

Mr Crilly drew members' attention to recommendation 9 in relation to nurse staffing levels within the ward and stated that this is an ongoing cost pressure. He advised that in recent discussions with the LCG regarding demography funding, they have indicated that they are not willing to allow mental health funding to be used to fund Dementia pressures recurrently. Mrs Clarke is currently arranging a meeting with the LCG and HSCB to discuss the application of demography funding.

Mrs Mahood asked about progress on the Dementia Strategy to which Mr Rice provided assurance on the work taking place within the Trust with full involvement across Directorates. Mrs McAlinden advised of the proposal under the Trust's Management Review that Dementia services be integrated into a single Directorate, currently the Director of Nursing role.

3. SERIOUS ADVERSE INCIDENTS/ADVERSE INCIDENTS

i) Summary of SAI recommendations arising from SAI Investigation Reports forwarded to the HSCB for the period 1.10.14 – 31.12.14

Members discussed the summary report. In response to a query from Mrs Rooney on timescales, Mrs Marshall stated that the increased number and complexity of SAIs has impacted on timescales due to the time required, particularly the clinical time, to input into the investigations. Mrs McAlinden advised that Mrs V Watts HCSB, has written to her on two occasions regarding a number of SAI reports which are outstanding. She stated that she has responded to advise that the Trust is working as quickly as possible, but this is an under resourced

function in the Trust. The absence of a timescale for the HSCB to close SAls was raised. Mrs Marshall advised of forthcoming changes in criteria for SAls.

Mrs Mahood stated that she found the report difficult to read and made some suggestions for improvement which Mrs Marshall agreed to take on board for the next report.

4. CASE MANAGEMENT REVIEW (CMR)– BABY

Personal Information
redacted by the USI

In Mr Morgan's absence, Mrs McAlinden presented the CMR report for information. She referred to the good work the Trust had undertaken in this case which was recognised and commended by the CMR. Members noted that the Trust had completed an Individual Agency Review (IAR) following Baby death and this too was commended by the CMR. The CMR endorsed the Trust's 3 recommendations in the IAR and made 4 separate recommendations. Mrs McAlinden advised that the Trust's action plan following the IAR has been fully implemented.

Mr Morgan joined the meeting at this point (10.05 a.m.)

Mr Morgan provided further assurance on the summary provided by Mrs McAlinden.

5. CONCERN ABOUT CHILD PROTECTION PRACTICE IN NORTHERN IRELAND

Mr Morgan provided a verbal update on this matter which he had previously reported on to Trust Board. He reminded members that the Trust had undertaken an internal review following a service user's complaint about child protection practice in their specific case. The findings and recommendations of the review were shared with the service user who subsequently wrote to the Minister raising concerns on a regional basis and requesting an independent review. A review was undertaken by the HSCB in June 2014, a copy of which has now been received by the Trust. Mr Morgan advised that the HSCB review report has 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. The service user has

again written to the Minister through her MLA and Mrs McAlinden has since written to her offering some dates to meet. A response is awaited.



LEADERSHIP WALK AROUNDS

***Summary Report for Period
1st January 2015 – 30th September 2015***

Introduction

As part of the ongoing 'Board to Ward' governance assurance process within the Southern Trust, a framework for leadership 'walk arounds' has been developed and implemented since July 2011.

Leadership walk arounds are a direct process of engagement with staff where Board members step outside the Boardroom to see and assess at first hand the experience of patients and the issues of staff. They provide an informal method for Board members to talk with front line staff about issues in the organisation by asking a series of structured questions. Sample questions to ask are provided in a guidance tool and focus on:-

- What works well/doesn't work well
- Challenges faced
- Ideas for improvement
- Commendations/Complaints
- User engagement
- Team meetings/Staffing issues
- Training and Supervision
- Audits
- Incident reporting
- Risks
- Infection prevention and control

A report is completed within 14 days of each visit and shared with the Chair, as well as the person(s) who conducted/assisted in the walk round. Issues identified (if any) are escalated to the Chief Executive who in turn addresses them with the relevant Director. A response to the issues raised is required within a three week timeframe. Assurance is then provided back to the Chair by either explaining the issue or assurance that remedial action has been taken to address concerns. This process also enables Board members to offer appreciation and encouragement where performance is excellent.

Completed reports are held in the Chair's office and summary information will be routinely provided to the Senior Management Team and on a six-monthly basis to the Governance Committee.

The expectation is that the Non Executive Directors complete 3 walk arounds each year in addition to their statutory visits to Children's Homes.

Period January – September 2015

Table 1 provides a summary of the leadership walk arounds undertaken during the period January – September 2015. During this period a total of 12 leadership walk arounds were undertaken.

Table 1: Leadership Walk arounds undertaken during January – September 2015

Date	Name	Visit to
October 2014	Mrs Roberta Brownlee, Chair	Emergency Department, Craigavon Area Hospital (report not included in previous summary report July-Dec 2014)
November 2014	Mrs Roberta Brownlee, Chair	Eating Disorder Service, Lurgan (report not included in previous summary report July-Dec 2014)
April 2015	Dr Raymond Mullan, Non Executive Director	Crozier House, Banbridge
	Mrs Elizabeth Mahood, Non Executive Director	Bronte Ward, Bluestone Unit, Craigavon Area Hospital
May 2015	Mrs Roberta Brownlee, Chair	Rosebrook, Bluestone Unit, Craigavon Area Hospital
	Mrs Siobhan Rooney, Non Executive Director	Outpatients Department, Daisy Hill Hospital
	Mr Edwin Graham, Non Executive Director	Community Equipment Store, Lurgan
	Mrs Hetty Kelly, Non Executive Director	Family Intervention Team, South Tyrone Hospital
	Mrs Hetty Kelly, Non Executive Director	16+ Service, Drumglass Site, Dungannon

Summary Report to Governance Committee: January – September 2015

	Mrs Roberta Brownlee, Chair	Vulnerable Adult Safeguarding
	Mrs Roberta Brownlee, Chair	Ward 2 North (Respiratory), Craigavon Area Hospital
June 2015	Ms Deirdre Blakely, Non Executive Director	Antenatal Outpatients, Daisy Hill Hospital (visit to be rescheduled as unable to complete report template fully)
September 2015	Mrs Roberta Brownlee, Chair	Ward 4 North, Craigavon Area Hospital
	Mrs Roberta Brownlee, Chair	Oakridge Social Education Centre, Dungannon

Issues raised

Please see Appendix 1.



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LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	Emergency Department, Craigavon Area Hospital
Date and time of visit:	30/10/14 at 2.30 pm
Accompanied By:	Sr Sharon Holmes

Key Issues:

- Skill mix of new nurses
- Recent normative staffing requirements WTE/skill mix and retention of staff
- Paediatrics and management of small children to Emergency Department
- Patients coming from Nursing Home and GPs sending via an ambulance not specifically after pm OoH e.g. one patient died within ten minutes of arrival
- Emergency Department environment not fit for purpose only ED in Northern Ireland not to have new build

Director's Response:Skill mix of new nurses

Within ED Department there has been a high number of newly qualified nurses/new starts that have taken up post in the last 2 years. The following initiatives have been implemented to support and train this group of staff so that they are equipped with the necessary skills, competence and confidence to provide safe and effective timely emergency care

- Induction programme
- Preceptorship
- Training programme in place
- 2 clinical sisters on duty from 12 midday – 2300 hours to provide additional support and supervision for the junior staff.

We have just completed a review of the nursing workforce in ED on both sites using the Telford and BEST tool.

Medical Staffing in ED

We are currently reviewing the medical workforce in ED. A regional group has been set up and the purpose of this group is to review the current medical workforce in all ED's and agree the appropriate medical staffing levels/trainee posts for all departments. We have just appointed Mr David Patton as our 8th ED consultant and he will be taking up post in May 2015.

Paediatric Management in the Emergency Department

The paediatric area is no longer in use however; we do allocate children to specific cubicles down one side of the minors area. The layout in ED is not ideal however this will be addressed as part of the new development of ED. We endeavour to ensure that there is a paediatric nurse on duty at all times, however if this is not possible we ensure there is a nurse on duty who has successfully completed their APLS (Advanced Paediatric Life Support). Paediatrics are also referred directly to the ambulatory paediatric unit 2 North.

Patients coming from Nursing Homes and GPs sending via Ambulance

The AMD Mr O'Reilly provides feedback to the medical staff at the GP forum on these cases. With the introduction of the Rapid Response team we are working with primary care to reduce the number of inappropriate patients being transferred from nursing homes to ED for management. We believe our proposal for 10 primary care facing assessment beds will further enhance relationships and patient care.

Emergency Department environment not fit for purpose

There has been ongoing estate work to upgrade the ED. However the Trust is currently planning for a new build for CAH and we are in ongoing discussions with estates, department and external consultants around the requirements for a new Emergency Department.

Flow within the Department/4 hour performance

There is ongoing work to improve the flow within the department and outside for it in the hospital e.g. extension of ambulatory care and a continued focus on the discharging of inpatients before 1pm. We also have a discharge lounge opened from 08:00 – 20:00 where by patients who are to be discharged but are awaiting transport can move to this area.

Regular Supervision

There is supervision set up that is provided by the child protection nurse and the education facilitators.

Lynn Fee, Assistant Director of Nursing: Workforce Development and Training (Francis Rice)

1. “Key issue: Skill mix of new nurses

and

(2a) What would you like to change or see different? Education facilitator dedicated to this area to support Preceptorship etc is required

and

2b what challenges do you face? Newly qualified junior staff so important to have proper skill mix and difficult to maintain training for staff to achieve competencies required”.

Following approval from SMT and TB in 2014 a successful recruitment exercise was undertaken for ED. The majority of staff recruited were new registrants. It was recognised that whilst this success was very much welcomed it did mean that the experience of staff working within the team was less than optimal. The Practice Education Team worked closely with Sr. Holmes to identify new registrants, to allocate them a Preceptor and to ensure they were booked onto the Trust Preceptorship programme which is delivered in partnership with the Clinical Education Centre. The Practice Education Facilitator for ED was asked to provide increased support into this area, which has been achieved, and is ongoing. Twenty staff have now successfully completed the Preceptorship programme, with three remaining to complete (later start dates).

It should be noted that a regional project commissioned by the former Health Minister to advance the Professional Development of the Emergency Care Workforce in NI has commenced. This work-stream aims to develop a career pathway and to explore how learning and development opportunities may be enhanced.

2. Key issue: Recent normative staffing requirements wte/skill mix and retention of staff

and

(2a) What would you like to change or see different? Normative staffing – Audit last week by NIPEC was 67 WTE based on dependency – disappointed outcome – needs reviewed

and

Section 6 Last workforce review before 2002.

An internal review of the nursing workforce in both DHH & CAH ED’s was undertaken and the findings presented to SMT in 2014.

As part of the regional Delivering Care project, a regional review of all ED’s in NI was conducted in October 2014. As a result of this exercise issues with the RCN’s Baseline Emergency Staffing Tool (BEST) have been identified, not least by SHSCT. The ADoN achieved regional agreement that the findings for CAH ED would be withdrawn and not taken under consideration regarding staffing required. This issues identified with this exercise have been communicated to the RCN and an options paper regarding the way forward has been presented to the Delivering Care Steering Group.

3. (1b) What doesn't work well: If Paediatric nurses not on duty then short of this skill.**Hard to recruit Paediatric Nurses to ED**

This issue reflects the current regional challenges regarding recruiting into Emergency Departments. The province is currently beginning to experience a shortage of nursing staff across all fields and this situation is not anticipated to improve as we move into a period of global shortage.

There is a training programme available for Adult nurses working within EDs which is delivered by the Clinical Education Centre, which aims to equip Adult nurses with a level of knowledge and skills to care for children in the emergency department.

The previously referred to regional project to advance the Professional Development of the Emergency Care Workforce in NI will hopefully go some way to attracting staff to work within ED's



LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	Eating Disorder Service, Lurgan
Date and time of visit:	5/11/14 at 11.15 am
Accompanied By:	Dr Heather Mills and Jane Curran

Key Issues:

- Accommodation – what stage in the planning for a better building?
- No Dietician replacement – particular high risk for I/P Wards, patients at risk of re-feeding syndrome, pregnant patients and patients with medical co-morbidity such as diabetes – escalated to Senior Management but due to financial restraints cannot have. However 'Hugo' stated there is .2wte for dietician in budget.
- The need for physician involved in Marsipan project group
- The mainstreaming of the CAWT project

Director's Response:

(Email from Bryce McMurray, Assistant Director of Mental Health Services)

I am pleased that the Chair was able to see at first hand the value of this service and team which has strong links with the inpatient service in Bluestone and has developed a care pathway between community and inpatient services to prevent any ECRs for specialist places in England in recent years.

There is funding available for 0.2 wte dietician and this year's Demography IPT agreed to make this up to 1.0 wte, although my understanding is that this allocation has not been confirmed or allocated by SLCG.

Recruiting to only 0.2wte of a post is notoriously difficult and may be an unnecessary exercise, as I am still hopeful of receiving the additional amount to allow me to recruit to 1.0wte.

The team is currently housed in Trasna House, Lurgan, in which accommodation for all mental health services remains under pressure. I have asked my staff to develop plans on how best to use the additional space provided by the closure of the day services provided in Trasna. As yet there is no definitive plan or cost available and I am aware that there will be a capital cost to change things around and make better use of the space. However, in the current financial climate that could prove difficult. Nonetheless I intend completing and agreeing the accommodation review that will impact on all services in Trasna including the Eating Disorder Team.

ImRoc is an important infrastructure for taking forward Recovery Practice in mental health and as such needs to become inherent in all mental health services. This is perhaps even more relevant for those individuals struggling with an Eating Disorder. While the specialist treatment for eating disorder provided by the team is important, it can be delivered in the context of empowering the individual with the tools and support needed for them to take control of their own Recovery, which is what ImRoc is all about. It is a process of service cultural change which should be viewed as an inherent component in all mental health services. The message is not yet fully embedded in practice and clearly there is still some way to go before this is achieved, especially if staff feel they are being made to go to the ImRoc events. The Division and the Trust has given its commitment to supporting the ImRoc/Recovery initiatives. Being part of the regional network on ImRoc is part of that commitment, hence my decision to continue to support staff to attend.

The training days in Bundoran have been arranged by the CAWT Eating Disorder Project, which I chair. The places are free to the Trust, although CAWT only pay travelling for the Eating Disorder practitioners currently funded through the CAWT project. This is the third year in which the CAWT project has funded this type of Continuous Professional Development and I have supported the Eating Disorder Team to attend on all occasions. Thanks to CAWT our ED Team have enjoyed access to specialist CPD not available to all our services. For this year's round of training, staff will receive the time off to attend, but given the current climate, advised that travel would not be paid. Given the opportunities afforded to staff to attend CAWT training in recent years I did not consider it unreasonable on this occasion that they travel at their own cost. In recent times we have utilised funding from HSCB to support staff attending specialist courses based on the agreement that the Trust would only meet 75% of the cost and travel, which reflects the standard of a few years ago. This requirement has not dimmed the enthusiasm of some individuals to contribute to their own professional development which is also in keeping with registrants taking some responsibility for their own professional development.



LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Dr Raymond J Mullan
Visit To:	Crozier House, Meeting House Road, Banbridge
Date and time of visit:	15 April, 2015
Accompanied By:	Met with Manager, Ms Iris Cromie

Key Issues:

- Rearranging of allocation of bedrooms to ensure that different groups of residents are in the same vicinity could be beneficial to residents' care
- Some staff difficulty in attending staff training outside home.
- Current Female staff changing area to move to adjacent 'smoking' area.

Director's Response:

Thank you Dr. McMullan, I appreciate the very positive comments within your feedback following your visit to Crozier House. I have been updated by the Head of Service on the key issues which your visit raised, and I can report that the following actions have now been put in place:

The manager's proposal to reorganize the design of the home with one wing assigned for permanent residents and one wing assigned for short stay admissions has subsequently been shared and agreed with all residents. Room allocations and transfers of affected residents completed in June. The re-design was evaluated over the summer months and the positive comments returned from residents, relatives and care staff indicate that the re-design has been successful.

Mandatory and good practice staff training is aligned to regulatory and Trust requirements, the manager, ensures that where possible training is provided on-site. All staff have been made aware of their personal responsibility for ensuring that their training remains up to date and when unable to attend training in their own facility dates and locations of similar training are circulated by the manager. E-learning modules are also provided, this is an accessible training model and resources are provided by the manager to support access.

The need for increased spatial environment to accommodate staff changing has been accepted in principle. My Assistant Director has requested an expert opinion on a combination of alternative design factors to take into account 'best use' of all rooms within this designated area. An estimate on cost of redesign and modifications will be provided by the Trust Estates Dept. However, progressing agreed works is not expected to commence until the current SRH consultation process concludes.



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LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Elizabeth Mahood
Visit To:	Bronte Ward – Bluestone Unit Adult Mental Health Unit for 18-64 year olds 18 Beds
Date and time of visit:	16 th April 2015 1.30 pm
Accompanied By:	Sr Elaine McBroom

Key Issues:

- Staffing issues would be the main concern. A number of maternity leave positions on ward.
- Also recruitment process seems long and time consuming for Managers.
- A lot of new systems all at once adding to an already very busy work load for staff.

Director's Response:

The staffing issues were recognised by Senior Managers and have been addressed through recruitment, the use of Bank staff and staff returning from maternity leave. There is on-going workforce planning with a view to increasing overall staffing levels, this includes a Telford review.

Senior managers are aware that they must process recruitment requests speedily and efficiently however Trust Recruitment is managed by BSO who are responsible for the processes.

Whilst it is accepted that new systems take time to embed, staff have been supported with training and additional staffing resources to become competent and confident. Following a pilot in Cloughmore Ward, staff in Bronte, along with staff in all other wards in Bluestone, have been developed to deliver a programme of therapeutic activities ranging from low level Psychological interventions to Recreational Groups. This initiative is being driven forward and supported by the Assistant Director and Head of Acute Mental Health Services.

Bronte staff have embraced ImRoc (Implementing Recovery through Organisational Change) which is reflected in their everyday encounters with patients and Carers. Specialist training courses are being funded for Bronte staff to equip them to manage patients with Personality Disorder and the Challenging behaviours which accompany this diagnosis.

Summary Report to Governance Committee: January – September 2015



Quality Care - for you, with you

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	Rosebrook (Bluestone Unit)
Date and time of visit:	6/5/15 1.30-3.20 pm
Accompanied By:	Sen S/N David Carleton (Sister Kelly on sick leave)

Key Issues:

How could a new unit opened less than a year have had glass panels replaced due to a breakage by a patient. Why was toughened glass of the highest standard (all glass in patient areas) not placed at the commissioning stage by the design and build team?

Director's Response:

Email from Bryce McMurray, Assistant Director of Mental Health Services 7/5/15:

Thank you Roberta for your comments on your recent visit to Rosebrook.

I fully appreciate your concerns and wish to assure you that exhaustive efforts went into the design of Rosebrook with the design team which included Health Estates staff and our own medical and nursing staff along with service users. We drew heavily from our own experience along with that of similar units elsewhere in terms of the safety requirements that needed to be considered at the design stage and included in the fabric of the building.

The glass you referred to was safety glass, considered at the time to be of a robust enough specification to withstand significant force and was supposed to shatter rather than break into large potentially dangerous shards. This incident did cause us all concern and we immediately met with the design team after this incident and worked to replace the glass with a better alternative. It was an unforeseen event and fortunately no one was seriously injured.

My understanding at the time was that the Architect and Health Estates raised this issue with the glass manufacturers.

Patients who are very unwell will from time to time test the fabric of the building in PICU and apart for a few other minor issues the staff feel that the design of the building has made a major contribution to improvements in the environment of care and has helped them considerably in the management of challenging behaviours.



**Southern Health
and Social Care Trust**

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LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Siobhan Rooney,
Visit To:	OPD DHH
Date and time of visit:	2.30pm 14/05/15
Accompanied By:	Sr Marilyn Milligan

Key Issues:

- Manager and staff support is important, Irrelevant information redacted by the USI
[Redacted]
- "Phase 2 – issue of narrow corridors at the back of OPD - mock crash team session has highlighted issue of getting trolley down the narrow corridors
- Perhaps need to review staffing levels in light of 3 site clinics, growing demand, new clinics / specialties not funded and vacant posts reported
- New and Review appointment issues, referrals increased, lists increased, demand increased.
- GP OOH office / reception locked and not used during the day suggestion that this area could be utilised to undertake nurse led activities
- Nurse revalidation sessions - suggested holding more sessions at DHH in order that staff could be released with less travel time and impact on clinics

Director's Response

Sr Mulligan's Line Manager, Martina Corrigan has responsibility for ENT, Urology and 3 Outpatients areas. Apart from Outpatients Martina has no other area of responsibility in Daisy Hill Hospital.

Martina had already organized, through the Surgery and Elective Care Weekly meetings attended by the three Heads of Service with Heather Trouton the Assistant Director, that from the beginning of June she would be in Daisy Hill Hospital on a more regular basis, as within Surgery the team have agreed that there would be a Head of Service on site every Tuesday and the Assistant Director every Thursday and had been agreed that if on either of these days one of her colleagues were not available that she would go there in their place and whilst there would visit OP Department and meet with Marilyn.

However, it should be noted that Martina does speak and communicate with Marilyn on a regular basis, usually at least once per week. As mentioned in the report there is a weekly Surgical Sister's meeting with video-link from CAH to DHH. Currently this is attended by all Surgical Sisters along with the CAH/DHH/Thorndale and Fracture Outpatient Sisters. Martina has requested that Marilyn needs to link in when possible to this forum as this discusses not only Ward issues but current nursing and professional issues and it is an important meeting for Marilyn to attend. Also because all the other OPD sisters attend it is a forum to raise their own issues that can be discussed within the Group. This meeting is chaired by all the Surgical

Heads of Service.

Martina has also agreed that on a bi-monthly basis that she will hold an OPD specific meeting. The first one of these was held on 19 June.

Martina has confirmed that there has been an intensive review undertaken at the beginning of April in respect to Staffing Levels and as with other Trusts throughout the Region we have been looking at how outpatient clinics are supported, for example most clinics just require a Band 2/3 to support them rather than a Band 5. This work has been discussed with all the OPD Sisters over the last number of months. Since the new financial year funding in respect to New Consultant appointments has been transferred into the OPD budgets, we are now in a position to recruit. This information had been shared with Marilyn. However it should be noted that this is the equivalent of two WTE and we have covered this WTE with Bank so that no clinic went unsupported.

We are aware that referrals, lists and demands have increased but this has no impact on the OPD as they cannot see any more patients than agreed on the clinic template. We have bid for additional funding to address the increase in demand and the Review Backlog and if we secure this then we have plans in place to support the consultant clinics to see these patients.

Regarding the issue with Phase 2 – narrow corridors at the back of OPD - mock crash team session has highlighted issue of getting trolley down the narrow corridors – this has been raised with Estates and we will put this on the Risk Register but unfortunately there is nothing that can be done regarding this as it was a refurbishment and the corridors could not be widened.

Re GP OOH office / reception locked and not used during the day suggestion that this area could be utilised to undertake nurse led activities – Martina will liaise with her Community colleagues to see if this is feasible.

Re Nurse revalidation sessions - suggested holding more sessions at DHH in order that staff could be released with less travel time and impact on clinics – Martina will see if this is possible.



LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Edwin Graham
Visit To:	Community Equipment Store
Date and time of visit:	Thu 14 th May 2015 at 3:30pm
Accompanied By:	Karen Black

Key Issues:

The only issue that surfaced was in relation to the difficulty that is created by having multiple different types of the same equipment – e.g. a change in bed type means that the stores have to hold different types of bed rails etc. to fit the different types of beds. There is a perception that changes such as these are made without sufficient consultation with stores.

Director's Response:

At the Community Equipment Project Group, which includes professional reps, there is a focus on the range of different equipment brands stocked. There is also a Community Equipment Oversight Group established. These groups will review the potential to reduce the variance in items further, however there are usually very good reasons for using a range of brands, as different brands meet the unique needs of some of our individual clients.



LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Mrs Hetty Kelly. NED
Visit To:	Family Intervention Team. E Floor. South Tyrone Hospital. Dungannon.
Date and time of visit:	Mon 18th May 2015. 10 am.
Accompanied By:	Bronagh Mc Closkey. Team Manager.

Key Issues:

Camera for monitoring Family Contact not working since beginning of 2014. Requisitioned early 2014. Quotation from Capital Alarms received August 2014. Constant reminders since. Still no camera. Essential for recording observations of contact. Heating needs attention.

Director's Response:

Camera is being installed next week (w/c 29/6/15)

Heating has been addressed, pumps now switch off possible gravity leak. Room in question has no natural light or ventilation. Estates will freshen up paintwork and review lighting (room used for spill over meetings).



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LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Mrs Hetty Kelly NED.
Visit To:	16+ Team. Drumglass. Dungannon.
Date and time of visit:	19th May 2015 11am.
Accompanied By:	Mr Steve Mack. Team Manager

Key Issues:

Increase in Court Work. Team lack experience in Court Work. Training needed.
Problems with the New transfer protocol. R/V due.
Wi Fi needed to enhance Internet access - Wi Fi in adjacent building.

Director's Response:

1. Training is regularly made available to all staff in relation to Court Skills and there is ongoing line management support available in relation to Court Work and associated challenges.
2. Overall the Transfer protocol is working well when all concerned implement it in full. This was reviewed during an inter-division day facilitated by both AD's and Heads of Service on 5th June and the overall consensus was that this worked well. There were a number of minor issues identified which will be reviewed and changed one year post implementation (October 2015) if they remain problematic.
3. Approval for wi-fi has been given a few months ago and must be progressed by the team leader in consultation with the relevant department.



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LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	Vulnerable Adult/Safeguarding, St. Luke's
Date and time of visit:	25/5/15 at 10 am
Accompanied By:	Patricia Trainor; Eilish Colton (Senior Practitioner for Safeguarding); Eamonn Sherry (Adult Safeguarding Manager)

Key Issues:

- Discussed first point of contact-Gateway model and progress to date.
- Regional Safeguarding policy document – template – and its implementation for practice.
- Better and larger office accommodation – present too small
- Length of time for recruitment of posts from approval to actual appointment.

Director's Response:

The Regional Safeguarding Policy and its implications for practice was tabled at SMT. An action plan is being developed.

Discussions are ongoing between a range of teams and Support Service Managers.

Delays in recruiting Band 3 due to difficulties with HRPTS and BSO in Belfast. HR advised of the problems and attempts are ongoing to fill the post.



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LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	2 North, CAH
Date and time of visit:	25/5/15 at 2 pm
Accompanied By:	Sr Maria Hamill

Key Issues:

- Bed Managers don't always listen to who should be moved from MAU to who should be outlyers and then patient returned to 2 North
- Need a full-time Ward Clerk
- More ward support – inadequate at present
- Agency staff – dress code/costs/behaviour

• Band 6 only 1 Band 6 at present would like additional banding

Director's Response:

It has been agreed that Respiratory nurses post ward round liaise with patient flow directly to remove any confusion.

The Division is looking into additionality for all their areas with ward clerks to support the service hopefully this will resolve any issues.

The issue with the agency staff on further investigation was in and around one member of the agency staff and has been dealt with through the agency themselves.

At present we have additionality around senior nursing staff. On further investigation this was solved through shift cover and working around the Rota with the both sisters. They will work opposite to provide a sister on daily. A meeting was held with staff concerned and they are happy with resolution.



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LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	4 North, Craigavon Area Hospital
Date and time of visit:	21/9/15 at 11 am
Accompanied By:	Sister Sheridan

Key Issues:

- Bed flow and communication regarding an empty bed
- At Leadership Walk 2012 – pharmacy an issue, sought a five day week plan. Some 3 years on pharmacy delays still an issue and time commitment to ward remains the same as before – the dispensing a problem.
- Trying to staff a ward that fluctuates with beds opened from 34>28 – changes on a daily basis – difficult to staff. Even if stable for 2/52 at a time could be tried?

Director's Response:

Thank you for your observations and reflection of ward concerns.

- Re bed flow and communication – it is a delicate balance in terms of Emergency Dept pressures between striving to get an emergency patient to a ward area , relieving ED and getting the patient as quickly as possible to a proper bed and checking with the ward re bed availability. 4 North are a very efficient ward and do not require over communication. This has been shared with the bed management team.
- Re Pharmacy, there has been no funding available for full time pharmacy support for 4 North. However we have applied for funding for full integrated medicines management through the 7 day working funding for this year and are confident we will get same by next February.
- Re fluctuating bed situation. We are funded and staffed for 28 beds in 4 North. We are asked each year to formally flex up to 34 beds for winter pressures. Staff are recruited for same from 1st December to end May. This works well, however medical outliers are effectively a year round issue and it is problematic for 4 North outside of the formal winter period to respond to short notice requirements for their additional beds. Bank / agency is always approved but not always supplied. Again the balance of risk remains between leaving patients in ED or transferring patients to a ward bed giving a greater bed to staff ratio. This is risk assessed on a daily basis. Getting staff to permanently flex to 34 is proving difficult at present even with funding.



LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	Oakridge SEC
Date and time of visit:	29/9/15 at 1.50 pm
Accompanied By:	Margaret McShane, Manager and Leanne Cornett, Assistant Manager

Key Issues:

- Bank staff – doesn't work. A big and long process of recruitment for new staff – despite all efforts.
- Challenging the breadth of responsibility as Registered Manager – line management aware of concerns.

Director's Response:

In response to the issue of managerial responsibility of Day Care Manager Band 7 I wish to respond as follows

The span of Day Care Band 7 managers role has been raised in a number of settings over the past 2 years both by managers and RQIA. The management responsibilities for daycare and supported living band 7 managers are more substantial than within other trusts. For some managers the travel between schemes can be quite substantial eg Kilkeel, Crossmaglen etc, which places demands on managers, given RQIA's expectation that they will have a managerial presence within schemes on a weekly basis.

The managerial structure prior to 2008/9 was historically 1 manager on site within each facility in many cases supported by an assistant manager. With internal restructuring within Disability services the assistant managers role has been introduced across daycare settings which has been a support to Day Care Band 7 registered managers. We previously agreed with John Black in RQIA that management support to schemes will include Band 7 and Band 6 managers. Bronagh will be having further discussion with RQIA on the need for more streamlined processes focused on minimising administrative responsibilities for managers eg through registering a number of adjacent schemes as one, thereby reducing the need to prepare separate inspection documentation .

Director's Response:

Issue Raised by Manager (Margaret McShane) with Chair	Response
*Nurse Bank doesn't work well. Management spend a lot of time on the phone to get Bank staff on duty, this brings tensions for the team.	Oakridge is not serviced by the Nurse Bank other than for Pay purposes. This has been the arrangement since before Mary Averall's time. Margaret McShane has more recently asked for a full service but unfortunately we have not agreed to due to resourcing issues. From time to time Nurse Bank have obliged by trying to help out in filling shifts when Oakridge have exhausted their usual sources (own staff) but generally the staff on the Nurse Bank do not wish to accept shifts in this area. Through working with Margaret in May 2015 regarding Recruitment issues, the issue of needing more staff for ad hoc cover was requested. We included such in the advertisement provision for social work students to apply and be 'fast tracked'. There was, however, a limited response to this element of the advertisement.
Issue Raised by Manager (Margaret McShane) with Chair	Response
Faster recruitment of staff	Recruitment to DCSW has been problematic in the past 12 months particularly for the Term Time Cover. Some of this in the past was due to the late requests, shortness of the contracts and general interest. We advertised for SW students as part of the Care and Support Worker role with some limited uptake. Resourcing assisted in the advertisement process, revamping of the packs and review of the assessment process. Unfortunately we are unsure of the timelines thereafter although we are aware that the RSSC were slow in offering posts as the Assistant Director had to push them and my Head of Resourcing had to advise the RSSC on batch texting.

Director's Response:	
Issue Raised by Manager (Margaret McShane) with Chair	Response
Working closely with HR to improve.	Work was undertaken with the Managers as above. In addition when it was clear that the number on the waiting list was more limited than before (particularly men) the new trainee disability support worker was developed. The Assistant Director took a lead and my Head of Resourcing input to the recruitment day which was run on a Saturday with offers made by end of the day together with OH appointments for the following week.
Staff recruitment and nurse cover for enteral feeding	Nurse Bank were asked to provide some cover for this but Nursing Staff on bank were not interested in this work, as it is quite a specialist area of work.
A number of unfilled posts: Day Care Support Workers – 3 vacancies.	I am unable to advise specifically on the number of vacancies as the information is with the RSSC and no recent reports have been received (even when asked).
Agency do not always supply.	It is the nature of the work, duration of bookings and the training requirements which are not attractive.



CORPORATE RISK REGISTER

to Governance Committee on
8th December 2015

INTRODUCTION

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

Each risk on the Register has been linked to the Trust's Corporate Objectives as detailed below:-

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

OVERVIEW OF CORPORATE RISK REVIEW AS AT 30th NOVEMBER 2015

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	10	12		22

New risks identified by SMT or escalated from Directorate Risk Registers	New Risk No.8 Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital.
Risks removed from the Register	• Risk No. 9 Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health’ and retain on MHD Directorate Risk Register. • Risk No.10 Fire Safety – effective management measures are now in place and risk assessments have been substantially progressed. To be managed on Directorate Risk Register • Risk No. 15 Water Safety –effective management measures are now in place and the instances of Legionella detections have been significantly reduced with the installation of the CuAg water treatment system at Craigavon Area Hospital. To be managed on Directorate Risk Register

	• Risk No. 12 The lack of capacity, due to staff shortages within Estate services, to provide and maintain a safe and efficient healthcare environment – Whilst there are still critical vacancies in the Estates structure, their replacement has been approved corporately and resolution rests within Estates.
Merged risks	None
Risks where overall rating has been reduced	Risk No. 12 ‘High Voltage capacity limit on electrical supply to Craigavon Area Hospital’ – downgraded from high to medium risk Risk No.3 ‘Achievement of Statutory Duties/Functions – ‘Level of Residential Home/Nursing Home/Domiciliary Annual Reviews not completed’ – downgraded from high to medium risk Risk No. 6 ‘Medicines Management compliance in Domiciliary Care’ – downgraded from high to medium risk
Risks where overall rating has been increased	None

Summary of Corporate Risks as at November 2015

Risk No.	HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since November 2014
1.	Achievement of Elective Commissioning Plan Standards and Targets	1	HIGH	Unchanged
2.	Out-Patient Reviews and Planned Treatment Backlogs	1	HIGH	Unchanged
7.	Inability to recruit/retain Consultant medical staff for specific specialties	1	HIGH	Unchanged
8.	Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital	1	HIGH	New risk added on 30.9.2015
9.	Inability to Increasing inability to recruit registered nursing staff	1	HIGH	Unchanged
10.	Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
12.	Pharmacy Aseptic Suite, CAH	1	HIGH	Unchanged
14.	Accreditation status of Laboratory, Craigavon Area Hospital	1	HIGH	Unchanged
16.	Implementation of NMC's revised revalidation arrangements for Registered Nurses, Midwives and Specialist Community Public Health Nurses	1	HIGH	Unchanged

20.	GP Out of Hours Service - inability to attract adequate cover for GP shifts	1	HIGH	Unchanged
21.	Health Visiting Service – impact on families due to decreased staffing levels	1	HIGH	Unchanged
22.	Safeguarding of Residents within HH/BC	1	HIGH	Unchanged
Risk No. MODERATE RISKS		* Corporate Objective	Risk Rating	Change to Status Since November 2014
3.	Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	1	MEDIUM	Downgraded from high risk 25.11.2015
4.	Achievement of statutory duties/functions: Robust Case Management processes	1	MEDIUM	Unchanged
5.	Systems of assessment and assurance in relation to quality of Trust services	1	MEDIUM	Unchanged
6.	Medicines Management compliance in domiciliary care	1	MEDIUM	Downgraded from high risk 25.11.2015

11.	High Voltage capacity limit on electrical supply to Craigavon Hospital	1	MEDIUM	Downgraded from high risk 30.9.2015
13.	HCAI	1	MEDIUM	Unchanged
15.	Fully embedded Appraisal system	1	MEDIUM	Unchanged
17.	Financial Balance – risk in 2015/16 that the Trust will not achieve Financial balance in year	4	MEDIUM	Downgraded from high risk 19.11.14
18.	Management and monitoring of procurement and contracts	5	MEDIUM	Unchanged
19.	HRPTS Payroll, Travel Payments and Shared Services Recruitment	5	MEDIUM	Separated out from BSTP risk on 15.10.14

Southern Health & Social Care Trust: Summary of Corporate Risks as at November 2015

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No					Status
1	Achievement of Elective Commissioning Plan Standards and Targets a) Waiting times in excess of Commissioning Plan Standards / Targets across: - Out-Patients; - Diagnostics (including Endoscopy); - In-Patients; and - Day Cases (Acute; CYPS; Mental Health; and OPPC areas) - AHP professions	INTERNAL MONITORING: Fortnightly Operational Performance meetings: - Acute Directorate, and - Children & Young Peoples Services Directorate Monthly Operational Performance meetings: - Mental Health & Disability Directorate Quarterly Operational Performance meetings: - Older Persons and Primary Care Directorate Monthly Operational AHP Performance - Cross- directorate Monthly reporting to Senior Management Team and Trust Board Monthly exception reporting to Operational Directorates In-Year Assurance meetings with Chief Executive.	Access Times a) Focus on Service and Budget Agreement (SBA) remains as first priority within Operational Directorates, where robust SBA volumes exist into 2015/16. Delivery of access times will follow SBA delivery on the priority list. Recurrent capacity gaps prioritised with SLCG, in line with early indication of available recurrent funding in 2015/2016 as: - Symptomatic Breast Clinic and - Haematology. IPT was submitted and formal allocation received for recurrent funding for symptomatic breast services (July 2015) b) Non-recurrent allocation received for Diagnostics (including Endoscopy) in 2015/16 - The totality of diagnostic volumes allocated cannot be secured via in-house capacity alone and challenges have been faced securing Independent Sector capacity - No allocations received for Out-Patients; In-Patients; or Day Cases.	Performance and Reform and Operational Directors	HIGH

		<u>EXTERNAL MONITORING:</u> 7. Monthly Elective and Unscheduled Performance meetings with Health and Social Care Board <u>ACTION PLANNING:</u> 8. Implementation plans in place to reduce access times, where demand remains static, and additional recurrent capacity has been invested/ approved via IPT 9. Periodic plans developed aligned to non-recurrent allocations of available funding for elective access via HSCB 10. Operational plans under development to maintain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times.	- IS Providers have been given permission to undertake the treatment of the paused patients from 2014/15 in Quarter 1 of 2015/16. - SMT permission granted for additionality in April 2015 to continue to address previously identified risk areas that were funded via non-recurrent allocations in 2014/15. Spend from April to be re-couped from 2015/16 non-recurrent allocations. Further non-recurrent funding made available in November for Independent Sector capacity. The Trust will work to identify what Independent Sector capacity can be put in place to increase capacity for Quarter 4 2015/16. c) Key areas of risk identified within the Acute Services Directorate have been partially addressed with non-recurrent funding and part year effect recurrent investments in : - Symptomatic Breast Clinic - CT and - Endoscopy d) Remaining areas of risk highlighted to Health and Social Care Board formally include:- - Haematology (New OP) - Urology (OP Review Backlog) - General Surgery (OP Review Backlog) - Cardiology (OP Review		

	b) Plain film reporting only maintained at current level, which excludes films that have been categorised as IRMER'ised (Ionizing Radiation Medical Exposure Regulations) with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations		Backlog) e. Dermatology (OP Review Backlog) f. Trauma (New OP and IP) The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available or as operationally feasible. Plain Film X Ray e) A non-recurrent allocation for plain film reporting has been received for Quarter 3 & 4 (2015/2016). This non-recurrent funding is being utilised for Independent Sector (IS) provision. • The original IS provider is now working to full capacity with no further options for additional plain film reporting to be undertaken. • With the lack of internal reporting capacity, the Trust is facing further pressure for plain film reporting. • A further IS contract has been procured and awarded (September 2015) and additional capacity is anticipated in Quarter 4. • An operational plan is being developed, in the first instance, to return chest x-ray plain film reporting to within the 28-day standard.		

			f) HSCB has provided recurrent funding for the implementation of plain film reporting by radiographers for ED films. g) HSCB has provided recurrent funding for plain film reporting of the remaining in-patient IRMER'ised patients. h) A training programme is in place to increase the scope of Plain Film reporting that is carried out by Radiographers. AHP Access Times No non-recurrent funding to address access times has been allocated in 2015/16 as the outcome of the PHA demand and capacity exercise remains outstanding No non-recurrent resources from HSCB were provided in 2014/15 either. The Trust has agreed to retain a level of additionality until the end of August 2015. The Trust, In parallel with the PHA/HSCB review, is undertaking a capacity and demand exercise to calculate available capacity within the AHP professions which will inform future capacity gaps and investment priorities. It is anticipated that this work should be completed in Q3 2015/16.		

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
2	Out-Patient Review and Planned Treatment Backlogs Out-Patient Review Waiting List Backlogs in: • Acute; • CYPs; • MHD; and • OPPC Planned Treatment Backlogs: • Acute only On-going risk with a significant volume of patients waiting <i>past their clinically indicated review timescale</i> in Outpatient and AHP services.	Internal and External monitoring controls included as in Corporate Risk 1 above. <u>ACTION PLANNING:</u> • Short-term validation exercise undertaken in Quarter 4 2014/15 within a limited number of Acute Services Directorate specialties • Operational workshop undertaken to review the ability to identify red flag and urgent reviews on the out-patient review waiting list and the processes for monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.	a) Outpatient Backlog At 1 November 2015, there were a total of 20,627 patients waiting in excess of their clinically indicated timescale for review out-patient appointment (Dr-led services only, including Visiting Specialties) as follows: • 44% (9155 people) waiting in excess of 6-months past their clinically indicated timescale; • 15% (3,073) waiting between 3 – 6-months past their clinically indicated timescale; and • 41% (8,398) waiting less than 3-months past their clinically indicated timescale. • The longest waits for Trust services are for Urology and extend back to 2011/12; all patients for 2011/12 and 2012/13 have been validated and those waiting from 2011/12 have all been offered an appointment date. • The longest waits are in the visiting service of Ophthalmology and the Trust is working with the Local Commissioning Group to resolve this. No non-recurrent funding has been received from HSCB in 2015/16 for the out-patient review backlog.		HIGH

			The Acute Services Directorate has identified a number of areas of clinical risk within their review backlog and these were contained within the clinical risk paper to SMT on 29 April 2015. This paper details potential contingency options for discussion and approval in order to minimise the clinical risk associated with this backlog. <u>b) Planned Patient Backlog</u> • As at 2nd November 2015, there are a total of 1,356 patients on the planned treatment backlog. The longest waiting patient dates back to February 2014. • 71% (962) of the planned treatment backlog relates to Endoscopy. The non-recurrent allocation for Endoscopy in Quarter 1 & 2 will only facilitate the maintenance of planned scopes at 8-months past their clinically indicated timescale. Endoscopy, in totality, has been identified as a clinical risk within the clinical risk paper escalated to HSCB in May 15(as referenced in Risk 1 above) and through monthly elective access meetings with HSCB. • In line with JAG accreditation requirements the planned treatment backlog should not exceed 6-months.		

			c) AHP review backlogs AHP backlogs for review are not as readily quantifiable. However, available information indicates significant review backlog volumes within Podiatry; Speech & Language Therapy; Dietetics; and Occupational Therapy. The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available.		
	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
3	Achievement of statutory functions/duties: Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed.	- Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors - Group established to examine operational management of the annual review process - Delegated Statutory Functions Report - Quarterly reporting to Trust Board (from October 2015) - Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services and follow up of action plan	Older People and Primary Care Directorate has undertaken a Domiciliary Care review and has a process in place to implement the recommendations to achieve compliance. Substantial validation is on-going with teams regarding the recording of OPPC reviews as currently two systems are being used. Those clients whose reviews are outstanding are subject to a desktop risk assessment to ensure that the delay in having their review carried out is not detrimental to their care. Care Home Support Team (CHST) The CHST now has responsibility for the majority of clients, with a remaining 8 clients due to transfer on completion of their reviews.	Older People and Primary Care	MEDIUM

			An assurance process is embedded to ensure all residents in a Care Home with a Failure to Comply Notice in place or Vulnerable Adult investigation ongoing has an up to date review in place. Currently there are no Failure to Comply notices in Care Homes in the SHSCT area Adult Safeguarding Team Further targeted vulnerable adults training for those staff in care management and involved in annual reviews. September 2015 Caseload Analysis being led by Social Work Governance Team and supported by the Executive Director of Social Work, has now reported and findings will support changes within teams in respect of how caseloads are allocated and managed.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
4	Achievement of statutory functions/duties: The Trust should have robust case management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Case Management process.	New Trust Case Management Guidance	- Mental Health, Learning/Physical Disability and Older People and Primary Care training completed. - Internal Audit of Case Management being planned. - Restructuring process by Heads of Service is in progress within the Disability Division of the Mental Health & Learning Disability Directorate. - Process to be completed within Mental Health and Learning Disability Directorate by December 2015	Mental Health and Disability/Older People and Primary Care	MEDIUM

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
5	Systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 1. Lack of compliance with Standards and Guidelines (DHSSPS/HSCB/other) 2. Lack of agreed indicators/measures of quality to provide assurance across some Trust services 3. Effectiveness of systemic process to review all intelligence from incidents, complaints, litigation and user feedback to identify and address service safety and quality issues 4. Effectiveness of process for learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	- Standards and Guidelines report on compliance to Governance Committee and DHSSPS Accountability Review meetings - Web-based incident reporting (on Datix) rolled out across the Trust - Clinical and Social Care Governance Review completed and new structures/processes embedded - Governance Committee and Senior Management Team - Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee - Quality Sub Group - Morbidity and Mortality Group - Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information - Review of Specialty Mortality and Morbidity system completed. - Mortality Reports to Governance Committee - Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chair and Chief Executive	- 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. - 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 Framework. The role and remit of the Clinical and Social Care Governance Working Body will be reviewed within this work The revisit of Clinical and Social Care Governance has completed with a pilot of the new approach of dashboard assurance reports to Governance Committee on 8.12.2015	Chief Executive	MEDIUM

		• Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs) • Medical Director Report to Trust Board and Governance Committee includes Quality and Safety Indicators • Serious Adverse Incident/Adverse Incident reporting system in place • Trust Annual Quality Report • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy • Director, Children and Young People's Services, reports to Trust Board and Governance Committee including Roles and Responsibilities on all Looked After Children and Child Protection services • For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora,			

		Professional Governance Fora, Patient and Client Experience Committee for shared learning • Complaints assessed/screened for adverse incident review • Litigation process now embedded to ensure early alert to operational Directors			
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
6	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 in place • Interim procedure on prescribing • Trust Medicines Steering Group • Trust representatives on regional group • Themed Domiciliary Care Forum (IS) focused on safe administration of medication	• Annual Competency based training re medicines management for domiciliary care workers completed for all staff. • A registered nurse has been seconded in the Newry and Mourne area for a pilot of one year since August 2014, dedicated to progressing medicines review and safer systems. A report has been shared on progress / issues to date. This pilot has now been extended to the Armagh and Dungannon areas with core teams supporting the work in Newry/Mourne areas. • As part of this, single patient medication files are being tested across providers to minimise risk of error. • Following a Regional Medication workshop held by the 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	Older People and Primary Care/Mental Health and Disability	MEDIUM

			domiciliary care support in the area of medicines management. - Interim funding is required to allow time to fully evaluate and determine the impact of the assessment process on service delivery in the redesigned Medicines Management Pathway. - Project Nurse to review existing service users in other two localities (Armagh & Dungannon and Craigavon & Banbridge) commencing in November 2015 - Audit risk assessments for new service users to ensure compliance with guidelines commencing November 2015		
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
7	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>SAS Medical Staff</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.	Dermatology: There is a recognised UK shortage of consultant posts in Dermatology and therefore a new model to attract GPs has been introduced. From late November 2014, 4 part-time GPs have started in post so this has proved successful. Two retired consultants were engaged to undertake some WLI clinics however this arrangement ceased at the end of June 2015. An application was submitted to the Royal College of Physicians in 2014 for International Medical Graduates (IMGs) under the Medical Training Initiative (MTI) scheme, but was unsuccessful.	Human Resources & Organisational Development/ Medical Director	HIGH

			One local doctor reached her CCT date in July 2015, so would be eligible to apply for a consultant post in the Trust. An IPT is currently being developed. As no funding currently available, the Trust is considering going at risk to recruit another Consultant Dermatologist T&O: Two consultants have been appointed to T&O during 2015. One commenced in post at the start of January, however the other was not able to take up post until August. In addition 2 Temporary Specialty Doctors have also been appointed. One transferred from a Clinical fellow post within the Southern Trust and the other started on 3 June 2015. One has since left the Trust, however the other has been appointed to a permanent Specialty Doctor post. This means there are now 9 Consultants and 4 Specialty Doctors in T&O. There are plans to advertise for another permanent Consultant, 2 Clinical Fellows and 3 Temporary Specialty Doctors in T&O. Emergency Medicine: A permanent Consultant commenced in Craigavon Area Hospital on 1st May 2015. Two Specialty Doctors were recently interviewed and appointed to ED in DHH, however despite these appointments it still proves very difficult to recruit to Consultant and Specialty Doctor positions within ED The Trust has recently advertised for Consultant and Specialty Doctor posts in DHH. The adverts also featured in the		

			ROI and stated that enhanced rates of pay and a full relocation package would be considered, however these campaigns were unsuccessful. The situation in Daisy Hill Hospital has worsened considerably following the recent resignation of the Lead Consultant and a full time Specialty Doctor. At consultant level, this will leave one Temporary F/T consultant and one permanent P/T consultant. At SAS (middle grade) level there is one Associate Specialist and two Specialty Doctors – all are full time. The Trust regularly raises the requirement for ED locums with all contracted agencies and other known non-contracted agencies. Apart for occasional ad-hoc cover, it has been very difficult to secure any 'longer term' cover. The Trust also embarked on a recruitment campaign for middle grade doctors in ED with M3 Creating Connections. This company undertakes medical recruitment project work with Trusts and Health Boards on behalf of doctors.net.uk. There was only one application received, however the candidate subsequently withdrew. The Trust has also met with 'A Team Recruitment regarding a proposal to recruit medical staff from the EU, however it is expected to take at least 6 months to recruit and train suitably qualified doctors via this route.		

			The Trust has also introduced a Clinical fellowship programme for ED. One appointment has been made – starting in August 2015. Anaesthetics: It is planned to develop a training programme with the aim of “growing our own” specialty doctors. A proposal has been drafted and is currently under consideration by the service. Radiology: There is a recognized gap in Consultant Radiologist numbers and Clinical Radiology has recently been included in the Government approved shortage occupation list. The Trust has successfully appointed a number of Consultant Radiologists over the past few years; however some of these have left to take up other posts. The position remains unstable. In February 2015, the Trust successfully appointed 4 permanent Consultant Radiologists. One person has since withdrawn, however the other 3 took up post in August 2015.		
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	
8	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 - Daily review by Senior Management of night reports and follow up on issues - Daily audit of notes	- 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 - 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		HIGH

			Registrar • Support provided as required by Paediatric Registrar and Anaesthetic Registrar in the out of hours period. 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 • Resignation of a Consultant effective from 1.2.2016. Action plans in development to seek to address this. • Regular updates to Commissioner and DHSSPS		
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
9	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 • E-rostering roll out	• All opportunities to secure permanent staff continue to be progressed • Regular recruitment drives ongoing with the 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 pre-employment checks undertaken. Follow up work is now underway to maintain a relationship with all appointees until their start dates. The most recent drive for MH Nursing is also aimed at including	Acute Director and Medical Director	HIGH

			Year 2 and Year 3 students and is ongoing at the time of this update • Introduction of Rotational Programmes within and across Directorates. • Targeted recruitment of current nursing students for bank Band 3 roles ongoing with a view to introducing them to the Southern Trust for their Band 5 career. • Six staff have secured places on the funded Open University Pre-registration Nursing Programme commencing September 2015. A further ten staff were successful at interview. SHSCT has offered these ten deferred places for the OU PRNP commencing September 2016. • A Trust Nursing Workforce Planning Group has been established to seek to address current and future anticipated challenges regarding the demand for and supply of Registered Nurses across all programmes of care. Consideration is now being given to International Recruitment. • A regional Nursing Workforce Planning Group, chaired by Mr F Rice, Executive Director of Nursing, has now completed a scoping exercise at a high level to collate the statistics on vacant posts compared to Funding Staffing and the numbers of staff unavailable for work due to various types of leave.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
10	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas Specific examples: • Fire Safety Action Plan in place High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below) • Aging High Pressure Hot Water system (HPHW) at Craigavon Area Hospital has now been replaced with new Low Pressure Hot Water system. • £2.9m secured to complete structural works to tower block at South Tyrone Hospital • Completion of Theatre development CAH	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2015/16. Phase 1 of Mechanical Infrastructure complete. • Strategic Outline Case submitted for major redevelopment at CAH site. Work is now being progressed on the main business case for submission in 2015/16. • New negative pressure isolation room at CAH to be completed by November 2015. • Provision of new negative pressure isolation room at DHH awaiting decision on preferred option from Acute Services. Thereafter proposals to be incorporated in Business Case for consideration by SMT/Trust Board.	Director of Human Resources and Organisational Development	HIGH

			The sewage system serving the wards at CAH has reached a critical point with frequent blockages leading to bursts and subsequent contamination of patient and support areas. This presents a serious infection control risk; causes disruption to services; and has been reported in the press potentially damaging service user confidence. An extensive replacement programme commenced in August 2015 through a carefully co-ordinated and phased programme of ward decants. Works will be carried out to the most critical areas over the next few months (subject to the availability of decant space v winter pressures). Further works may be necessary after the winter period to complete the programme. 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.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
11	High Voltage capacity limit on electrical supply to Craigavon Area Hospital - Identified under Maintaining Existing Services scheme - Possible limit to expansion of service provision on the Craigavon Area Hospital site - Increased electrical demand on existing limited supply may exceed capability of supply	- All future development/ expansion of the estates is to be notified to Estate Services - Generator backup - Load shedding - Monitoring current demand - Business Continuity Plans for restabilising electrical service in the event of unplanned interruption - Peak Lopping installed and completed following agreement with Northern Ireland Electricity - Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed.	- Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. - Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure - Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the risk. - 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. At this point, this risk will be re-assessed and may reduce to moderate risk. - CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion September 2016	Human Resources & Organisational Development	MEDIUM

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
12	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified several issues: - The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). - Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding)	- Increased environmental monitoring to check for failures of sterility in the unit - Expiry dates of all products prepared has been reduced to a maximum of 24 hours. - A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented - Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved	- 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 OBC was submitted to the Department on 1.7. 2015. A letter of Commissioner Support received from the HSCB has been submitted. The Trust has identified this as its top priority for capital funding. Recent deterioration in the fabric of the building is being addressed through an interim plan involving urgent minor works to the aseptic suite. - The Capita Model for chemotherapy/cytotoxic dispensing was applied to the current workload in the unit. This identified a staffing deficit of 3.6wte pharmacists. Using the capacity plan as a model the unit is short 2 pharmacists for the current workload. HSCB agreed to fund	Director of Acute Services	HIGH

	The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	the 2 additional band 7 pharmacists required. The IPT was received in May 2015 and the recruitment process is complete. The pharmacists will start in January 2016. complete		
	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
13	HCAI - Risk to achievement of Priorities for Action target identified - Risk to patient safety - Lack of automated HCAI surveillance system linked to Trust laboratory system - Lack of appropriate isolation facilities (including negative pressure facilities) within the Trust hospital network - Emerging infections (CPE/VHF/ebola) - HCAI outbreaks in tertiary services (BHSCT)	- Comprehensive isolation policy in place and strictly adhered to - On-going mandatory and tailored IPC training - Manual surveillance systems in place. Independent and self-audit programme - Comprehensive governance structure in place, including bi-monthly HCAI Strategic Forum and monthly HCAI Clinical Forum meetings - Outbreak /incident management plan in place - Establishment of antimicrobial management team to oversee antimicrobial stewardship - HCAI Root Cause Analysis process in place - Compliance monitoring against key DHSSPS standards and	- On-going measurement of compliance against DHSSPS Communiqués - Ongoing self and independent audit using the RQIA Augmented Care Audit tools. - Learning outcomes from RCAs being shared with senior and junior medical staff. - Engagement meeting with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases - Embedding Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters across community and acute sites. - Engagement with PHA on Regional Surveillance system funding and procurement to recommence	Medical Director	MEDIUM

	Increasing emergence of CPE infections	guidelines relating to HCAI	- Enhancement communication to front line clinical staff via HCAI e-Alert - Suite of procedures and guidelines to support the prevention, management and control of CPE. - Completed Ebola Management Plan - CPE Outbreak/Incident Management - Enhanced HCAI RCA information management system and system developed to further improve meta-analysis of C Difficile cases - Renewed focus on isolation and screening of transferred patients, including planning of negative pressure isolation facilities on CAH site - Joint letter from Medical Director, Executive Director of Nursing and Director of Acute Services issued to staff re Infection Control practice - Re-launch of IV Programme in Acute sites to address increasing MRSA/MSSA bacteraemia - Development of a Business Plan to consider Infection Prevention Control (IPC) Nursing Workforce within the Trust		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
14	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	- Action Plan in place to address non-conformances - External Quality Assurance and Internal Quality controls	- The Trust has submitted its application for re-accreditation and is awaiting a new date. A pre-assessment visit is planned for 8th October 2015. This visit will assess the Laboratory's state of readiness for a full UKAS 151189 inspection. - Action Plan updated as progress is made. - Full inspection advised for April 2016		HIGH

CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
15	Fully embedded appraisal system – lack of evidence of compliance	There are a variety of mechanisms in place to ensure appraisal takes place:- • Medical Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings • Action Plan in place and reviewed quarterly • Staff Attitude Survey results provide staff view • Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.	<u>Consultant / Medical Appraisal</u> As at 16/11/15, 93% of 300 eligible doctors have completed their 2014 appraisal. <u>Knowledge and Skills Framework</u> A KSF steering group continues to meet quarterly. Work is ongoing with individual Directors and Heads of Services to support staff and managers when completing their KSF Documentation, and therefore to increase uptake within each Directorate KSF reports continue to be collated monthly and forwarded to Directors. Regular reports regarding uptake levels across the Trust continue to be presented to SMT PDP's are now being recorded on HRPTS as a qualification. As a result of all of the above, there has been an increase in the extent to which KSF is being implemented across the Trust. Work underway to improve mandatory training levels within the Trust	Medical Director Director of HR and Organisational Development	MEDIUM

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
16	Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016	- NI Revalidation Programme Board, attended by the Executive Director of Nursing, meets bi-monthly - NI Revalidation Working Group attended by the Trust's Assistant Director Nursing Governance, meets monthly - In October 2015 the NMC has 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 implementation and progression of Nursing and Midwifery revalidation which is due to commence in April 2016. Extensive work has been undertaken to establish a Nursing and Midwifery Revalidation information management system which holds all (3,023) Trust NMC registrants' PIN, Annual Fee Expiry and Revalidation dates. This information management system is now live and will provide assurance to the Executive Director of Nursing, SMT and Trust Board in relation to the progression of Nursing and Midwifery revalidation. Monthly revalidation reports will be issued to individual nursing / midwifery managers to support local arrangements on the timely revalidation of nurses and midwives for whom they have responsibility. Standard Operating Procedures have been developed to provide timely reports to nursing and midwifery managers and heads of service. Assistant Director Nursing Governance, 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 professional development discussion with their NMC colleague. Assistant Director Nursing Governance has linked with the AD Nursing Workforce Development and Training and Clinical Education Centre to scope out planned support programmes.	Executive Director of Nursing	HIGH

CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
17	Achievement of financial balance in 2015/16	- Contingency Plan for 2015/16 in place - Best Care Best Value (BCBV) Project structure - Financial monitoring systems in place - Monthly report to SMT and Trust Board	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.	Finance and Procurement/ All	MEDIUM
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
18	Management and monitoring of procurement and contracts – not compliant with best practice guidance	- Contracts management improvement group established and key actions formed - New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided . - Training on Contract Management with focus on responsibilities of Contract Owners rolled-out with follow up sessions also delivered	GENERAL - Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee - Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing	Director of Performance and Reform/ Director of Finance and Procurement/ All Directors	MEDIUM

			(Central monitoring ceased in October 2013) • Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Capacity sought via IPT for social care procurement of key projects including (Learning disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. Alternative options being considered to progress these procurements. • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited • New Structures for contract & procurement management being developed as part of Management Review ESTATES • Proposed models brought forward by PALS and Trusts on regional basis to address procurement deficit for Estates services agreed by Directors of Finance. Regional Steering and Working Groups established. Recruitment of PALS team underway.		

			Recruitment of Trust Team being taken forward under newly appointed Head of Service. • Measured Term Contract (MTC) in place for 2015/16 which mitigates risks to procurement for schemes <£45k • Estates Works Management Improvement Action Plan (incorporating all IA recommendations) established and 95% implemented during 14/15. Internal Audit undertook a follow-up audit (reported March 2015) and verified that the majority of recommendations had been either partially or fully implemented. Further IA work to be undertaken third quarter of 2015/16. • Two replacement Estates Officers appointed and volume of works being undertaken balanced against resources to facilitate compliance. SOCIAL CARE PROCUREMENT • Regional Procurement Board via Social Care Procurement Group have agreed approach to social care procurement. Internal plan to be developed to secure necessary resources, skill and capacity to take forward a limited number of social care procurements		

			• Capacity sought via HSCB transitional funding in 2014/15 for social care procurement of key projects including (Learning Disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. • Internal resource diverted to provide procurement support to key mental health directorate projects in 2014/15 enabling change. This capacity has been extended into 2015/16. • Further capacity established in October 2015 to support domiciliary care procurement from redirected internal resources. • Impact of 2015 Public Contract Regulations on social care procurement assessed and key actions agreed to scope demand and capacity requirements		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
19	Payroll & Travel - HRPTS System & Shared Services - 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 - Recruitment – considerable delays currently being experienced in the recruitment of posts which is impacting on operational services	- Customer Forums are in place for monitoring the performance of services in Shared Services Centres - Progress updates to Audit Committee - Regular meetings with BSO - Escalation procedure in place by Trust's Head of Resourcing - Weekly monitoring	- Ongoing communication/engagement with Managers as regards timely completion of paperwork - Weekly, Fortnightly and Monthly staff transferred to the Payroll Shared Service Centre. - Additional resources identified to support BSO in the delivery of services	Finance Director	MEDIUM

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
20	GP Out of Hours Service – Reduced ability to maintain adequate service provision and patient safety due to vacant GP shifts	- Recruitment process for vacant posts - Business Continuity Plan - Medical Managers with medical responsibility for the service - Call Centre Co-ordinator - Call Manager system - Late availability payment - Flexibility re shift patterns offered - Daily monitoring of rotas and appropriate contingency plans deployed based on resources available	- Regular updates to HSCB/Integrated Care Department regarding vacant shifts. Escalation to HSCB when GP cover is significantly reduced. - When clinical cover reduced to less than 50% or 1 red eye doctor, early alert sent to HSCB by 3.00 p.m. - A weekly email of vacant shifts is being sent on a Monday to all clinicians. Daily text messages and phone calls to GPs and Nurses in attempts to cover shifts. - Small team of nurses in GP Out of Hours Service working extra hours, where possible to assist in covering gaps - IPT submitted to appoint 50 Nurse Triage staff. Trust proceeded at risk to commence the recruitment process. Interviews have been completed. Nurse Advisors – 25 are competent and able to work. A further 9 have received telephone triage training and are being shadowed to be deemed competent - As and when bank Nurse Practitioners have been recruited and are working within the service. - Recruitment of 8A service improvement role to the end of April 2015 to review the service model. Report will be presented by end July 2015. - Review of workload of clinicians ongoing by Clinical Lead	Older People and Primary Care	HIGH

			• KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB • Working with Integrated Care Dept to address capacity issues and use of locum GPs. Locum agencies had been contacted and no doctors available. • Working with other OoH providers to secure additional capacity • Twice daily operational meetings to review cover and actions required. • Pharmacy pilot has been extended to end of March 2016 using winter pressures money and covering hours 10.00 a.m. – 8.00 p.m. • Winter pressures plan is being implemented, with enhanced rates and increased capacity • Locally Enhanced Service (LES) implemented on 7th November 2015 until end of March 2016 • Contingency and escalation plan agreed and now being implemented		
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
21	Health Visiting Service – 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 include step down i.e. universal contacts to non-vulnerable families have been reduced; • Utilisation of bank (limited supply) and additional hours of existing health visiting staff; • Drop in clinics available to ensure rapid access to HV if parent worried or concerned	• The Health Visiting workforce position demonstrates that Staff in Post equate to the Funded Staffing Levels. The reality is that there are 16.54 wte unavailable to deliver the service (due to planned and unplanned absence), which equates to 20% of this workforce not available at a given time. This demonstrates a worsening position	Executive Director of Nursing/ Director of C&YPS	HIGH

		about an infant / child; • Rota system is in place to equitably allocate clinic cover, new births, movement in visits and new safeguarding cases; • Team managers to notify HoS and Named Nurse for Safeguarding Children if they are unable to allocate a child protection case. • Provision of universal contacts is being monitored across service/teams on a quarterly basis through IoP report and this information is sent to Director/DHSSPS/HSCB/PHA	from that of May 2015 when 14% of the HV workforce was unavailable. This staffing deficit means that all 7 Health Visiting Teams are in step down: • There are currently 8 permanent vacancies, 7 maternity leaves and 8 staff on long-term sick leave. • Due to the regional shortage of Health Visitors, the amount of temporary staff the SH&SCT is able to secure through the bank is insufficient to meet the deficit. • Eleven Health Visiting students are currently completing their management placements which releases some of the Practice Teachers time to work into some of the vacant caseloads. • In communications with the HSCB and PHA regarding the Health Visiting workforce, assurance has been given that SHSCT are proactively processing vacancies in order to appoint staff as soon as possible. SHSCT has also articulated the need for additional funding to meet the particular needs of the population within this area. • Sixty-one Health Visiting places were approved regionally for 14/15 and SHSCT is facilitating 11 students. These students will finish in September 2015. 5 of the permanent vacancies have been		

			offered and accepted by the students, with e-requisitions in progress for the remaining vacancies. We continue to await additional investment agreed with the PHA. This situation is exacerbated by the reduced capacity of the Family Nurse Partnership team (detailed on the CYP Directorate Risk Register).		
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
22	Safeguarding of residents within HH/BC - Historical and ongoing risk to residents of potential financial abuse.	- Review of Residents within the Care Management process. Residents' reviews are held more frequently if required. - Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out of 5 moved - Liaison with the residents, relatives/families where appropriate. - Weekly Trust meetings to review status & regular updates provided to Trust Board / SMT. - Regular updates from Trust HHBC group provided to DHSS/HSCB/RQIA/Other Trusts	- Ongoing liaison with the residents, relatives/families where appropriate. - Suspension of new admissions/respite beds remains in place. Current controls to remain as agreed by SMT and Trust Board. - Public Prosecution Service has determined no prosecution of the Home Owners regarding one client - RQIA is currently pursuing a prosecution of the Home Owners under Article 42 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. - Formal Court Order regarding disclosure received by Trust. Information requested was provided to DLS for	Mental Health & Disability	HIGH

		• Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel. • Regular advice/support/direction by Trust Legal Advisers • Contract Review Meetings with HHBC and quarterly operational meetings with HHBC as part of the contract compliance process. • Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives. • Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff. • Trust addresses any identified concerns/queries raised by DHSSPSNI/RQIA. • Adult Safeguarding Process. Remaining residents have care and protection plans which have been put in place and updated as required. • Contacts with RQIA • Trust "Procedure for Responding to RQIA Alerts & Other Performance Management issues within Social Care Contracts".	presentation to the Court on 16.9.2015. • Scoping exercise has been completed should alternative placements be required and will be revisited • Update Report to Trust Board on 26th November 2015		

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



JOB DESCRIPTION

JOB TITLE	Board Assurance Manager
BAND	Band 7
DIRECTORATE	Chairman and Chief Executive's Office
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Chairman
ACCOUNTABLE TO	Chairman

JOB SUMMARY:

The postholder will manage and be responsible for the organisation and effective and efficient servicing of Trust Board and its Committees, liaising with the Chief Executive and Chairman to ensure planned approaches to issues requiring the consideration of the Board. The postholder will play a lead role in the administration of governance and risk issues at Corporate level which includes ensuring the appropriate completion of Controls Assurance Standards to support the embedding of organisation wide risk management.

KEY DUTIES / RESPONSIBILITIES

1. Analyse all relevant information and propose an agenda to Trust Board and its Standing Committees. Working closely with the Chairman, Chief Executive, Trust Directors and Non-Executive Directors.
2. Work proactively with the Chairman and Chief Executive to secure a planned approach to matters of Board interest and issues requiring Board and SMT action.
3. Supervise logistics of the organisation of meetings ensuring board members are provided with all relevant information and ensuring papers are issued within exact timescales.
4. Supervise the taking and approval of minutes taking appropriate follow up action and ensuring tasks with action are followed up and reported at subsequent meetings. Ensuring that information is channelled to and from Committees and to from individuals involved in Board and executive business.
5. Attend Trust Board meetings and take accurate and concise formal minutes which are published to a wide audience.

6. Monitor the rhythm and pattern of meetings to ensure Trust objectives and development of the organisation and delivery of key objectives are met. Develop a schedule of reporting to Trust Board to enable the Board to meet its legal and statutory requirements and clinical, social care, quality and financial objectives within set timescales.
7. Review Terms of Reference of Committees of the Board and ensure that these are up-to-date in relation to best practice and revisions approved by relevant Committee and the Board.
8. Ensuring annual reviews of Committees are undertaken.
9. Ensure Standing Orders are updated as required and advice provided to the Chairman on processes as contained within the Standing Orders.
10. Ensure the regular provision of information for the Trust website in accordance with the Trust's Publication Scheme.
11. Ensure the Trust operates in accordance with agreed standards of integrated governance, to ethical standards appropriate to a public service organisation.
12. Initiate correspondence and other action at the request of the Chairman and Committee Chairs arising from the Board or its Standing Committees.
13. Line manage Committee Secretary in Chair/Chief Executive's office to deliver all responsibilities. Allocate and supervise workload.
14. Line manage Administrative Assistant (Band 3) in Chair/Chief Executive's office to deliver all responsibilities. Allocate and supervise workload.
15. Co-ordinate Trust wide process for management, monitoring and reporting Controls Assurance standards to assist the organisation to improve its governance and risk management procedures.
16. Co-ordinate risk information and present Board Assurance Framework to SMT and Board of Directors on bi-annual basis.
17. Co-ordinate risk information and present Corporate Risk Register to SMT on a monthly basis and Governance Committee on a quarterly basis.
18. Supervise the development and maintenance of database for Gifts and Hospitality register Trust wide. Provide quarterly report to SMT.
19. Supervise the process of Declaration of Interests and Declaration of Hospitality of Board members. Ensuring up to date register available in the Chief Executive's office.
20. Co-ordinate documentation to ensure the regular provision of information to the DHSSPS.

21. Development and co-ordination of Board Development programme. Responsible for taking forward identified actions within Board Development Plan.
22. Review of Board meetings on an ongoing basis (through facilitation of questionnaire) and analysis of same

GENERAL MANAGEMENT RESPONSIBILITIES

- 1 Review the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.
- 2 Ensure that the review of performance identified in 1 above is performed for all levels of staff for which he/she has management authority.
- 3 Maintain staff relationships and morale amongst the staff reporting to him/her.
- 4 Review the organisation plan and establish the level of service for which he/she is responsible to ensure that it is consistent with achieving objectives and recommends change where appropriate.
- 5 Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.
- 6 Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- 7 Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour

4. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
5. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
6. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.
8. This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.
9. It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.



Notes of SMT Meeting held on
Wednesday 18 March 2015
@ 2pm in the Boardroom, Trust Headquarters

Present: Kieran Donaghy (Chair)
Paul Morgan
Stephen McNally
Miceal Crilly
Dr Simpson
Brian Beattie (for Angela McVeigh)
Simon Gibson (for Debbie Burns)
Charlene Stoops (for Paula Clarke)
Ruth Rogers
Elaine Wright (Notes)

Apologies: Paula Clarke
Francis Rice
Angela McVeigh
Debbie Burns
Aldrina Magwood

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Paula Clarke, Francis Rice, Angela McVeigh, Debbie Burns and Aldrina Magwood.	
2	NOTES FROM THE PREVIOUS MEETING The notes from the previous meeting will be approved at next week's SMT.	<i>25 March 2015</i>
3	CHIEF EXECUTIVE BUSINESS 1.1 Approval of Trust Board Papers Strategic Issues: Business Cases over £300k	

	- Operational Performance Performance Report Finance Report Financial Plan 2015/16 Human Resources Report - Patient/Client Safety and Quality of Care Director of Social Work Report Unallocated Childcare Cases Annual Care Management Reviews Medical Director Report HCAI Update Update on AHP Internal Review - Revised Standing Financial Instructions - SHSCT Three Year Strategic Plan 2015-2018 – <u>CONFIDENTIAL SECTION</u> Members considered the above reports for the forthcoming Trust Board Meeting and discussed the key challenges and discussion points within the papers, as appropriate. Mrs Judt will update/progress papers for Trust Board on 26 March 2015.	<i>Approved</i>
4	MATTERS ARISING 4.1 Donaldson Facilitated Workshops – Packs Mrs Rogers updated members on progress of the packs to be issued to staff in advance of the facilitated workshops. The content of the packs will include: - Summary of recommendations from the Donaldson Report - Staff survey - Presentations given at the event on 6 March 2015 - Dates of Trust Workshops Members agreed to cascade the information through Directorates in the usual manner.	<i>All – cascade through Directorates</i>
5	STRATEGIC PLANNING There was no specific business to discuss.	

6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plan Members noted that the Finance Paper has been submitted to DHSSPS and will be retrospectively tabled at Trust Board on 26 March 2015. Elaine Wright agreed to circulate again to SMT.	<i>Trust Board 26 March 2015</i> <i>E Wright to circulate</i>
7	PERFORMANCE UPDATE 7.1 Performance Report There was no further performance report.	
8	INNOVATION/CONTINUOUS IMPROVEMENT 8.1 Review of Winter Pressures Response/Learning for Improvement Work progresses to the timeframes identified in the Action Plan and this will be tabled at a forthcoming SMT Meeting.	<i>SMT 25 March 2015</i>
9	GOVERNANCE ISSUES There were no specific Governance Issues to discuss.	
10	INFECTION CONTROL UPDATE 10.1 HCAI Update/Briefing Dr Simpson updated members on the current infection control position within the Trust. 10.2 HCAI Update – PFA Targets Dr Simpson updated members on the performance targets noting reference to C Diff cases.	
11	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 11.1 IPT Business Cases for approval There were no IPT Business Cases for approval this week.	

12	WORKFORCE ISSUES 12.1 Improving performance in Statutory Health and Safety Risk Assessment – framework paper Mr Donaghy referred members to the above framework paper for information.	
13	COMMUNICATIONS & PUBLIC AFFAIRS Mrs Rogers informed members of current issues in the media and the Trusts response/position regarding same.	
14	DHSSPS CIRCULARS/CORRESPONDENCE There were no circulars to note.	
15	ANY OTHER BUSINESS 15.1 Rapid Response Roll Out Mr Beattie advised that the Rapid Response Roll Out would be tabled at next week's SMT meeting. 15.2 Community Care Risk Assessment The Community Care Risk Assessment will be finalised and tabled at a forthcoming SMT meeting. 15.3 Pension Reforms – Information Seminars Mr Donaghy advised that a number of Pension Reform Information Sessions have been arranged and information will be issued to staff shortly. Members noted that a session will be held prior to SMT next week running from 1.30pm – 2.45pm. 15.4 Adult Safeguarding Policy Mr Morgan referred to the Draft Adult Safeguarding Policy Paper and following discussion he summarised the key challenges/discussion points as follows: • Have we the capacity to respond • Could impact on investigation Work • Training needs are significant	<i>SMT 25 March 2015</i> <i>SMT 25 March 2015 @ 1.30pm</i>

	• DAPOs restricted to 1st Line Managers • More work coming over to Operational Teams • ASW/Adult Safeguarding Leads already struggling with workloads. 15.5 Management Review Mr Donaghy advised that he will bring the final outcome of the Management Review to Trust Board on 26 March 2015 for final sign off.	<i>Trust Board 26 March 2015</i>
16	DATE OF NEXT MEETING Wednesday 25 March 2015	



Revised: 8 June 2015

**Notes of SMT Meeting held on
Wednesday 27 May 2015
@ 2pm in the Boardroom, Trust Headquarters**

Present: Paula Clarke
Francis Rice
Miceal Crilly
Angela McVeigh
Stephen McNally
Debbie Burns
Dr Simpson
Dr Wright (in attendance)
Jenny Johnston (for Kieran Donaghy)
Charlene Stoops (for Aldrina Magwood)
Jane McKimm
Mrs Karyn Patterson (for item 12.2)
Elaine Wright (Notes)

Apologies: Paul Morgan
Kieran Donaghy
Aldrina Magwood

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Paul Morgan, Kieran Donaghy & Aldrina Magwood.	
2	NOTES FROM THE PREVIOUS MEETING The notes from the previous meeting held on 20 May 2015 will be tabled for approval at the next meeting.	<i>SMT 3 June 2015</i>

3	CHIEF EXECUTIVE BUSINESS 3.1 Confidential Item for Trust Board The Chief Executive advised members of an issue requiring discussion at Confidential Trust Board tomorrow. 3.2 Physio Workout Day – 12 June 2015 The Chief Executive referred to a forthcoming Physio Workout Day event due to be held on 12 June 2015 in CAH. A number of other events have been organized throughout the Trust. Members were encouraged to attend where possible and support this initiative. Members agreed that information should go out globally in the Trust.	<i>Members to encourage attendance</i> <i>To be issued globally</i>
4	MATTERS ARISING 4.1 Smoke Free Sites: Operational Groups Further to discussion at previous meetings, nominations are now being sought from Directorates for a number of Operational Groups. The Chief Executive's Office will issue this information following SMT.	<i>E Wright to issue</i>
5	STRATEGIC PLANNING Ms Stoops advised that the draft Trust Corporate Plan will be tabled at SMT on 3 June 2015 and on the agenda for Trust Board on 11 June 2015. Members were asked to submit comments by Friday 29 May 2015.	<i>All comments by 29 May 15</i>
6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plans Mr McNally advised that the Finance Report would be tabled at Trust Board on 28 May 2015.	<i>Trust Board 28 May 2015</i>
7	PERFORMANCE UPDATE There was no additional report to make.	

	The Performance Report is being tabled at Trust Board on 28 May 2015.	<i>Trust Board 28 May 2015</i>
8	INNOVATION/CONTINUOUS IMPROVEMENT There was no specific business to discuss.	
9	GOVERNANCE ISSUES There were no Governance Issues to raise.	
10	INFECTION CONTROL UPDATE 10.1 HCAI Update/Briefing Dr Simpson updated members on the current infection control position within the Trust. 10.2 HCAI Update – PFA Targets Dr Simpson updated members on the performance targets noting reference to C Diff cases and the 5 cases in May which are being progressed to RCA. 10.3 Infection Control Issue Dr Simpson advised that investigations were still ongoing. A further update would be given when the investigations are concluded. PHA are involved in this process.	
11	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 11.1 Cases for approval: There were no cases for approval this week.	
12	WORKFORCE ISSUES 12.1 Revised Corporate Scrutiny Process Mrs Johnston confirmed discussions at last week's meeting that all posts at level 8a and above will come through SMT Scrutiny. Members confirmed this agreement.	

	12.2 Nursing Staffing Levels Mrs Karyn Patterson attended the meeting to discuss Nurse Staffing Levels within the Trust. Mrs Patterson advised that planning had commenced and outlined a summary of the waiting list information for Band 5 Nurse posts as at 26 May 2015. A recruitment campaign for band 5 nurses commenced in October 2014 which created a list of approximately 139 people. There are 37 remaining on this list. A further campaign was commenced in April 2015 which resulted in 207 applicants, however 43 applicants never responded to invitations to interview, reducing this applicant pool to 164. The current waiting list for LD was created in February 2015 with just 10 successful at interview. To date there have been no offers from this list. The current waiting list for MH Nurses was created in February 2015 with 29 successful at interview. To date there have been 8 offers from this list with 21 remaining on the list. Children's Nurse Band 5 has been done as a regional waiting list, with recruitment campaigns commencing back in September 2014 with two further campaigns since then. Currently there are only 5 on the waiting lists expressing interest in posts in the Southern Trust area. Members noted the current situation on the ongoing work to progress this recruitment and gave approval for offer of posts up to agreed levels. 12.3 PDP Summary, April 2013 – April 2015 Mrs Johnston referred members to the PDP Summary Report and members were asked to continue to encourage PDP meeting within Directorates and teams. Mrs Johnston offered assistance for HR to help Directorates to progress this work and member's welcomed this approach.	<i>Members to encourage uptake</i> <i>HR to work alongside Director</i>

13	COMMUNICATIONS & PUBLIC AFFAIRS Mrs McKimm informed members of current issues in the media and the Trusts response/position regarding same.	
14	SELF DIRECTED SUPPORT: UPDATE Mr Rice referred to the paper regarding SDS and provided an update to members. Following discussions of the potential options regarding implementation, members agreed to register with HSCB as a cost pressure and await implementation until further clarity is received.	<i>Mr Rice to progress</i>
15	DHSSPS CIRCULARS/CORRESPONDENCE There were no circulars to note.	
16	ANY OTHER BUSINESS 16.1 Letter to Mrs Watts re Capacity The Chief Executive advised that her office will follow up the response to the recent letter issued on 18 May 2015.	<i>E Wright to action</i>
17	DATE OF NEXT MEETING Wednesday 3 June 2015 and will be a Strategic SMT	



**Notes of SMT Meeting held on
Wednesday 16 September 2015
@ 2pm in the Boardroom, Trust Headquarters**

Present: Kieran Donaghy (Chair)
Francis Rice
Stephen McNally
Aldrina Magwood
Angela McVeigh
Paul Morgan
Esther Gishkori
Dr Richard Wright
Elaine Wright (Notes)

Apologies: Paula Clarke

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Mrs Clarke.	
2	NOTES FROM THE PREVIOUS MEETING The notes from the previous meeting held on 26 August and 2 September were approved.	<i>Approved</i>
3	CHIEF EXECUTIVE BUSINESS 3.1 Approval of Trust Board Papers: 24 Sept 15 Mrs Sandra Judt attended the meeting to consider and approve the suite of papers for the forthcoming Trust Board Meeting on 24 September 2015. 3.2 Annual Quality Report This item was deferred to next week's SMT meeting.	<i>SMT 23 September 15</i>

4	MATTERS ARISING There were no matters arising.	
5	STRATEGIC PLANNING Members referred to the email correspondence from Gill Smith, DHSSPS regarding Trusts Consultation Processes and the need to place in Confidential Section of Trust Board. Members noted that the Trust is currently seeking advise on the guidance suggested. Members noted receipt of the Capital Priorities letter and the requirement to respond by 16 October 2015. Mr McNally and Mrs Magwood will progress in conjunction with Directors.	
6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plans Mr McNally advised that there was no further update from that given at the last meeting. Members noted correspondence from Bill Pauley, DHSSPS regarding Newry CTCC and the associated costs with the Centre. Mr McNally and Mrs Magwood are jointly preparing the Trust response.	Mr McNally/ Mrs Magwood to prepare response
7	PERFORMANCE UPDATE 7.1 Performance Update The Trust Performance Report was included in item 3.1 above.	
8	INNOVATION/CONTINUOUS IMPROVEMENT There was no specific business to discuss.	
9	GOVERNANCE ISSUES 9.1 Matters Arising/Actions Requirement from Governance Committee Meeting on 8 September 2015	

	Members referred to the action plan of requirements from the Governance Committee Meeting held on 8 September 2015. Directors undertook to follow up on actions as noted. 9.2 Medical SUMDE Accountability Report – Templates & Guidance 2014-2015 Dr Wright referred members to the SUMDE Accountability Report and noted the content.	<i>All to progress as required</i>
10	INFECTION CONTROL UPDATE 10.1 HCAI Update/Briefing Dr Wright informed members of the current infection control figures for the month of September. Members noted the increased focus on leadership and improvement, which will be monitored and reported on. 10.2 HCAI Update – PFA Targets There was no separate report.	
11	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 11.1 Report: Summary of IPTs to be funded 2015/16 - District Nursing: Extension of Service & Weekend Discharge - Community Care: Additional Dom Care Hours & Nursing Home Beds - Acute Care at Home: Phase 2 extension of service - Access to AHP & Pharmacy at CAH ED and Short Stay Wards 7 days per week Members considered the Summary Report of IPT's and in particular the 4 IPT's noted above. Following consideration, approval was given to submit as outlined.	<i>Approved</i>
12	WORKFORCE ISSUES 12.1 Proposal for Temporary Pharmacist Support for the Antimicrobial Stewardship Team Members referred to the briefing paper regarding the Proposal for Temporary Pharmacist support for the	

	antimicrobial stewardship team. The proposal outlines the need to recruit 2 temporary pharmacists for 5 months to work with the current team at a cost of £27,125. This would be on a non-recurrent basis. Following consideration of the proposal, members granted approval to proceed to appoint as outlined. 12.2 Senior Level Appointments, letter from Heather Stevens, Director of Workforce Policy, DHSSPS dated 16 September 2015 Mr Donaghy referred to correspondence regarding Senior Level Appointments and agreed to share with members. 12.3 Flu Campaign Members noted that the Flu Campaign will be launched shortly.	<i>Approved</i>
13	COMMUNICATIONS & PUBLIC AFFAIRS Members were aware of current issues in the media and the Trusts response/position regarding same. Mrs McKimm advised that the Visiting Campaign will be re-launched.	
14	DHSSPS CIRCULARS/CORRESPONDENCE 14.1 Revenue Business Case Test Drilling 2014-15, letter from Peter Toogood dated 10 September 2015 Members noted receipt of the Revenue Business Case Test Drilling letter from Peter Toogood.	
15	ANY OTHER BUSINESS 15.1 Medico Legal Posts Dr Wright agreed to table a proposal for the appointment of Medico Legal posts at the next SMT meeting. 15.2 RQIA Questionnaire – Review of Quality Improvement Systems & Processes	<i>SMT 23 September 2015</i>

	Mrs Magwood advised that the RQIA questionnaire regarding the Review of Quality Improvement Systems & Processes was currently being finalised and will be submitted to RQIA on Friday. Members were asked to advise of any comments by return. 15.3 Privacy Advisory Committee training for Personal Data Guardians Dr Wright confirmed he would be attending the above training which is planned for Wednesday 23 September 2015.	<i>Due for submission 18 Sept 2015</i>
16	DATE OF NEXT MEETING Wednesday 23 September 2015	



**Notes of SMT Meeting held on
Wednesday 21 October 2015
@ 2pm in the Boardroom, Trust Headquarters**

Present: Paula Clarke
Kieran Donaghy
Stephen McNally
Aldrina Magwood
Paul Morgan
Esther Gishkori
Dr Richard Wright
Angela McVeigh
Bryce McMurray (for Francis Rice)
Vivienne Toal (for items 9.2 and 15.1)
Elaine Wright (Notes)

Apologies: Francis Rice

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Mr Rice.	
2	NOTES FROM THE PREVIOUS MEETING The notes from the previous meeting held on 14 October were approved by members.	<i>Approved</i>
3	CHIEF EXECUTIVE BUSINESS 3.1 Health Committee Representation, 4 November 2015 The Chief Executive advised that further clarification on attendance is being sought via the Department. The Trust will await the Department's determination.	

	3.2 CAWT – Interreg V Process & Summary Members noted the CAWT Interreg V papers outlining process and summary, which are complex and work in progress. The timelines for applications are 16 November 2015. The Chief Executive acknowledged the considerable amount of work which has gone into this to date and the members confirmed their support for the proposals as they currently stand. 3.3 Chief Executive Meeting, Update 12 October 2015 The Chief Executive drew member's attention to the update from the recent Chief Executive's Meeting and noted actions. 3.4 SMT Action Plan (final) Mr Donaghy referred to the final SMT Action Plan tabled for approval and sign off. Members undertook to progress outstanding actions/timescales and bring to Directorate SMTs accordingly.	A//
4	MATTERS ARISING Members noted the matters arising from the previous meeting and actions taken to date.	
5	STRATEGIC PLANNING 5.1 Contingency Plan for General Surgery Cover Mrs Gishkori drew member's attention to the gap in General Surgery Cover at CAH and DHH and shared a briefing paper outlining the proposed contingency plan for covering general surgery at Middle Grade level. The gap is due to only 3 out of the 4 NIMDTA Registrar training post being filled for this year and the inability of the Trust to recruit to a funded Specialty Doctor post. A 6 person rota with 4 doctors is currently in operation. This situation has now been exacerbated by sick leave and there is currently now 3 middle grade staff. Mrs Gishkori outlined the actions already taken to date to fill the remaining gap and detailed the steps to be taken	

	in the event that an outstanding Out of Hours Shift cannot be covered. Discussion took place regarding this position and it was agreed to draw up a protocol outlining the mechanisms, triggers and communications pathway.	<i>Mrs Gishkori</i>
6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plans Mr McNally distributed the financial report for period ending 30 September 2015. Members noted the detail contained and Mr McNally clarified the requirements for going forward. 6.2 Audit Committee, 15 October 2015 The Chief Executive highlighted the process for feedback to Audit Committee on 'limited assurance' Audit Reports. Members noted the need to attend an Audit Committee when requested to feedback on reports as they arise. 6.3 Approach to Financial Planning for 2016/17 – letter from Mr R Pengelly dated 14 October 2015 Members noted the correspondence from Mr R Pengelly dated 14 October 2015 regarding 'Approach to Financial Planning for 2016/17'. Members noted the content of the letter and the actions outlined. Mr McNally agreed to refer to previous plans and work with Directors on the areas of spend as outlined. Mr McNally to progress the actions required.	<i>15/16 position for further discussion at BCBV on 27 October 15</i> <i>All</i> <i>Mr McNally to progress</i>
7	PERFORMANCE UPDATE 7.1 Performance Update Members noted the recent pressures on the system resulting in 12 hour breaches over the last number of days and the actions being taken.	

8	INNOVATION/CONTINUOUS IMPROVEMENT The Chief Executive asked that thanks are passed on to the staff involved in the Quality Event. Everyone agreed it was a very successful event and echoed the Chief Executive's sentiments.	
9	GOVERNANCE ISSUES 9.1 RQIA Programme of Acute Hospital Inspections, letter from Mr G Houston dated 16 October 2015 The Chief Executive referred members to the recent correspondence from RQIA regarding the Programme of Acute Hospital Inspections. Mrs Gishkori undertook to take forward. 9.2 RQIA Review of the Operation of HSC Whistleblowing Arrangements, letter from G Houston dated 8 October 2015 – Presentation by Vivienne Toal Members referred to correspondence from RQIA regarding the Review of Operational of HSC Whistleblowing Arrangements and noted that Mrs Vivienne Toal will be the Trust Lead. Mrs Toal attended the meeting to present to members the findings from the recent Staff Survey into Whistleblowing: Raising Concerns which took place in April 2015. The report provides details on the findings and outlines recommendations for the Trust to consider in order to address the issues highlighted. A summary of the findings and employer actions recommended in the Francis Report – 'Freedom to Speak Up' published in February 2015 are also included. Members raised various issues in terms of complexity of certain issues, the importance of 'talking' to staff, recognising at an 'early stage' if for example there is a gap where training could be identified as the tool, the need for protection of the person and culture issues	<i>Mrs Gishkori</i>

	across the Trust. Members agreed the importance of providing feedback to staff. In order to move forward it was agreed to progress with a number of immediate actions whilst continuing to review key messages and themes. Mrs Toal undertook to condense the recommendations into 'immediate actions', use this as a basis for communicating back to staff and bring back to SMT prior to Governance Committee. It was agreed to present this information to the Trust Governance Committee in December 2015 or to confidential Trust Board in November, and sign off the action plan. 9.3 Confidential SAI Members noted the Confidential briefing which will be tabled at Trust Board on 22 October 2015.	
10	INFECTION CONTROL UPDATE 10.1 HCAI Update/Briefing Dr Wright advised members on the current HCAI position within the Trust. He stated that there has been an increase in the number of c-diff cases both within the Trust and the region. He undertook to provide a detailed briefing to Trust Board. Members were encouraged by the increase in uptake of audit compliance from previous weeks. Dr Wright will continue to monitor the situation and report to SMT accordingly. 10.2 HCAI Update – PFA Targets There was no separate report. 10.3 Winter Flu Vaccination Action Plan 2015 Mr Donaghy referred members to the documentation regarding the forthcoming flu vaccination programme, which includes a letter to be shared Trust wide, an action plan and poster campaign.	<i>Dr Wright to continue to monitor</i>

	Members agreed to the approach outlined and undertook to promote within Directorates.	All																								
11	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 11.1 IPT's/Business Cases for approval - POC 6 LD Transition & Community Team Pressures - £354,500 - POC 7 PD (High Cost Cases & Programme Pressures) £152,000 - POC5 – Demographics 2015/16 - Business Care for DHH Lighting & CCTV Members considered the above IPT's and following discussion approval was given to proceed. Mr Donaghy drew member's attention to a number of large revenue schemes which had been given previous SMT approval and since work has commenced, it is realised that there is a variation from business case funded values. These included: <table><tr><td>Work scheme description</td><td>Initial approved funding as per business case</td><td>Pre tender estimates/costs</td><td>Diff</td></tr><tr><td>Roof repairs DHH</td><td>£295K</td><td>£430K</td><td>+£135K</td></tr><tr><td>Pharmacy store and infection control works CAH</td><td>£170K</td><td>£130K</td><td>-£40K</td></tr><tr><td>CAH roof repairs</td><td>£315K</td><td>£405K</td><td>+£90K</td></tr><tr><td>DHH resurfacing of main car park and associated lighting and CCTV</td><td>£180K</td><td>£300K</td><td>+£120K</td></tr><tr><td>2 North Isolation Room</td><td>£300K</td><td>£365K</td><td>+£65K</td></tr></table> Following consideration, members approved in principal subject to clarifying a number of issues.	Work scheme description	Initial approved funding as per business case	Pre tender estimates/costs	Diff	Roof repairs DHH	£295K	£430K	+£135K	Pharmacy store and infection control works CAH	£170K	£130K	-£40K	CAH roof repairs	£315K	£405K	+£90K	DHH resurfacing of main car park and associated lighting and CCTV	£180K	£300K	+£120K	2 North Isolation Room	£300K	£365K	+£65K	Approved Approved in principal
Work scheme description	Initial approved funding as per business case	Pre tender estimates/costs	Diff																							
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DHH resurfacing of main car park and associated lighting and CCTV	£180K	£300K	+£120K																							
2 North Isolation Room	£300K	£365K	+£65K																							

[illegible]

17	DATE OF NEXT MEETING Wednesday 28 October 2015	



CORPORATE RISK REGISTER

to Governance Committee
on 4th February 2016

INTRODUCTION

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

Each risk on the Register has been linked to the Trust's Corporate Objectives as detailed below:-

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

OVERVIEW OF CORPORATE RISK REVIEW AS AT JANUARY 2016

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	11	12		23

New risks identified by SMT or escalated from Directorate Risk Registers	New Risk No.8 Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital. New Risk No.23 Risk of loss of life and/or serious harm to patient(s), significant interruption to service(s) and limited or no telecommunication within the major hospital sites due to foreseeable unserviceable obsolete telecommunication equipment.
Risks removed from the Register	• Risk No. 9 Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health' and retain on MHD Directorate Risk Register. • Risk No.10 Fire Safety – effective management measures are now in place and risk assessments have been substantially progressed. To be managed on Directorate Risk Register

	• Risk No. 15 Water Safety –effective management measures are now in place and the instances of Legionella detections have been significantly reduced with the installation of the CuAg water treatment system at Craigavon Area Hospital. To be managed on Directorate Risk Register • Risk No. 12 The lack of capacity, due to staff shortages within Estate services, to provide and maintain a safe and efficient healthcare environment – Whilst there are still critical vacancies in the Estates structure, their replacement has been approved corporately and resolution rests within Estates.
Merged risks	None
Risks where overall rating has been reduced	Risk No. 12 'High Voltage capacity limit on electrical supply to Craigavon Area Hospital' – downgraded from high to medium risk Risk No.3 'Achievement of Statutory Duties/Functions – 'Level of Residential Home/Nursing Home/Domiciliary Annual Reviews not completed' – downgraded from high to medium risk Risk No. 6 'Medicines Management compliance in Domiciliary Care' – downgraded from high to medium risk
Risks where overall rating has been increased	None

Summary of Corporate Risks as at January 2016

Risk No.	HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since November 2014
1.	Achievement of Elective Commissioning Plan Standards and Targets	1	HIGH	Unchanged
2.	Out-Patient Reviews and Planned Treatment Backlogs	1	HIGH	Unchanged
7.	Inability to recruit/retain Consultant medical staff for specific specialties	1	HIGH	Unchanged
8.	Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital	1	HIGH	New risk added on 30.9.2015
9.	Increasing inability to recruit registered nursing staff	1	HIGH	Unchanged
10.	Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
12.	Pharmacy Aseptic Suite, CAH	1	HIGH	Unchanged
14.	Accreditation status of Laboratory, Craigavon Area Hospital	1	HIGH	Unchanged
16.	Implementation of NMC's revised revalidation arrangements for Registered Nurses, Midwives and Specialist Community Public Health Nurses	1	HIGH	Unchanged

20.	GP Out of Hours Service - inability to attract adequate cover for GP shifts	1	HIGH	Unchanged
21.	Health Visiting Service – impact on families due to decreased staffing levels	1	HIGH	Unchanged
22.	Safeguarding of Residents within HH/BC	1	HIGH	Unchanged
Risk No. MODERATE RISKS		* Corporate Objective	Risk Rating	Change to Status Since November 2014
3.	Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	1	MEDIUM	Downgraded from high risk 25.11.2015
4.	Achievement of statutory duties/functions: Robust Case Management processes	1	MEDIUM	Unchanged
5.	Systems of assessment and assurance in relation to quality of Trust services	1	MEDIUM	Unchanged

6.	Medicines Management compliance in domiciliary care	1	MEDIUM	Downgraded from high risk 25.11.2015
11.	High Voltage capacity limit on electrical supply to Craigavon Hospital	1	MEDIUM	Downgraded from high risk 30.9.2015
13.	HCAI	1	MEDIUM	Unchanged
15.	Fully embedded Appraisal system	1	MEDIUM	Unchanged
17.	Financial Balance – risk in 2015/16 that the Trust will not achieve Financial balance in year	4	MEDIUM	Downgraded from high risk 19.11.14
18.	Management and monitoring of procurement and contracts	5	MEDIUM	Unchanged
19.	HRPTS Payroll, Travel Payments and Shared Services Recruitment	5	MEDIUM	Separated out from BSTP risk on 15.10.14
23.	Risk of loss of life and/or serious harm to patient(s), significant interruption to service(s) and limited or no telecommunication within the major hospital sites due to foreseeable unserviceable obsolete telecommunication equipment.	1	MEDIUM	New risk added on 27.01.2016

Southern Health & Social Care Trust: Summary of Corporate Risks as at January 2016

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No					Status
1	Achievement of Elective Commissioning Plan Standards and Targets a) Waiting times in excess of Commissioning Plan Standards / Targets across: • Out-Patients; • Diagnostics (including Endoscopy); • In-Patients; and • Day Cases (Acute; CYPS; Mental Health; and OPPC areas) • AHP professions	<u>INTERNAL MONITORING:</u> Fortnightly Operational Performance meetings: • Acute Directorate, and • Children & Young Peoples Services Directorate Monthly Operational Performance meetings: • Mental Health & Disability Directorate Quarterly Operational Performance meetings: • Older Persons and Primary Care Directorate Monthly Operational AHP Performance - Cross- directorate Monthly reporting to Senior Management Team and Trust Board Monthly exception reporting to Operational Directorates In-Year Assurance meetings with Chief Executive.	<u>Access Times</u> a) Focus on Service and Budget Agreement (SBA) remains as first priority within Operational Directorates, where robust SBA volumes exist into 2015/16. Delivery of access times will follow SBA delivery on the priority list. Recurrent capacity gaps prioritised with SLCC, in line with early indication of available recurrent funding in 2015/2016 as: - Symptomatic Breast Clinic and - Haematology. IPT was submitted and formal allocation received for recurrent funding for symptomatic breast services (July 2015) b) Non-recurrent allocation received for Diagnostics (including Endoscopy) in 2015/16 • The totality of diagnostic volumes allocated cannot be secured via in-house capacity alone and challenges have been faced securing Independent Sector capacity • IS Providers have been given permission to undertake the treatment of the paused patients	Performance and Reform and Operational Directors	HIGH

		<u>EXTERNAL MONITORING:</u> 7. Monthly Elective and Unscheduled Performance meetings with Health and Social Care Board <u>ACTION PLANNING:</u> 8. Implementation plans in place to reduce access times, where demand remains static, and additional recurrent capacity has been invested/ approved via IPT 9. Periodic plans developed aligned to non-recurrent allocations of available funding for elective access via HSCB 10. Operational plans under development to maintain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times.	from 2014/15 in Quarter 1 of 2015/16. - SMT permission granted for additionality in April 2015 to continue to address previously identified risk areas that were funded via non-recurrent allocations in 2014/15. Spend from April to be re-couped from 2015/16 non-recurrent allocations. - Further non-recurrent funding for Independent sector capacity was made available in November for specific regionally agreed speciality areas for OP/IP/DC. In response, the Trust has established additional capacity in Q4 2015/16 for pain management, general surgery and orthopaedics. c) Key areas of risk identified within the Acute Services Directorate have been partially addressed with non-recurrent funding and part year effect recurrent investments in : - Symptomatic Breast Clinic - CT and - Endoscopy d) Remaining areas of risk highlighted to Health and Social Care Board formally include:- a. Haematology (New OP) b. Urology (OP Review Backlog)		

	b) Plain film reporting only maintained at current level, which excludes films that have been categorised as IRMER'ised (Ionizing Radiation Medical Exposure Regulations) with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations		c. General Surgery (OP Review Backlog) d. Cardiology (OP Review Backlog) e. Dermatology (OP Review Backlog) f. Trauma (New OP and IP) The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available or as operationally feasible. Plain Film X Ray e) A non-recurrent allocation for plain film reporting has been received for Quarter 3 & 4 (2015/2016). This non-recurrent funding is being utilised for Independent Sector (IS) provision. • The original IS provider is now working to full capacity with no further options for additional plain film reporting to be undertaken. • With the lack of internal reporting capacity, the Trust is facing further pressure for plain film reporting. • A further IS contract has been procured and awarded (September 2015) and additional capacity is anticipated in Quarter 4. • An operational plan is being developed, in the first instance, to		

			return chest x-ray plain film reporting to within the 28-day standard. f) HSCB has provided recurrent funding for the implementation of plain film reporting by radiographers for ED films. g) HSCB has provided recurrent funding for plain film reporting of the remaining in-patient IRMER'ised patients. h) A training programme is in place to increase the scope of Plain Film reporting that is carried out by Radiographers. i) The Trust is preparing an IPT for recurrent investment in additional reporting radiography staff to increase capacity. The lead in time for training could see implementation of this investment when agreed over the next 4 years. AHP Access Times No non-recurrent funding to address access times has been allocated in 2015/16. The Trust has agreed to retain a level of additionality until the end of August 2015. Internal resources continue to be directed as available to increase AHP		

			capacity, particularly for review activity however, the ability to access staff on short term contracts remains challenging. The outcome of the PHA/HSCB demand and capacity exercise is concluding with areas of investment for 2016-17 identified, pending formal allocation.		
	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
2	Out-Patient Review and Planned Treatment Backlogs Out-Patient Review Waiting List Backlogs in: - Acute; - CYPS; - MHD; and - OPPC Planned Treatment Backlogs: - Acute only On-going risk with a significant volume of patients waiting <i>past their clinically indicated review timescale</i> in Outpatient and AHP services.	Internal and External monitoring controls included as in Corporate Risk 1 above. <u>ACTION PLANNING:</u> - Short-term validation exercise undertaken in Quarter 4 2014/15 within a limited number of Acute Services Directorate specialties - Operational workshop undertaken to review the ability to identify red flag and urgent reviews on the out-patient review waiting list and the processes for monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.	a) Outpatient Backlog The Acute Services Directorate has identified a number of areas of clinical risk within their review backlog and these were contained within the clinical risk paper to SMT on 29 April 2015. This paper details potential contingency options for discussion and approval in order to minimise the clinical risk associated with this backlog. At 1 January 2016, there were a total of 18,065 patients waiting in excess of their clinically indicated timescale for review out-patient appointment (Dr-led services only, including Visiting Specialties) as follows: 41% (7407 people) waiting in excess of 6-months past their clinically indicated timescale; 18% (3251) waiting between 3 – 6-months past their clinically indicated timescale; and 41% (7407) waiting less than 3-		HIGH

			months past their clinically indicated timescale. • The longest waits for Trust services are for Urology and extend back to 2012/13 all patients for 2012/13 have been validated and those waiting from 2012/13 have all been offered an appointment date. • The longest waits are in the visiting service of Ophthalmology which is provided by the Belfast Trust. The Local Commissioning Group is working with the Trust to resolve this. Note: No non-recurrent funding has been received from HSCB in 2015/16 for the out-patient review backlog. Internal resource continues to be directed to increase capacity for consultant review activity as this becomes available. <u>b) Planned Patient Backlog</u> • As at 31st December 2015, there are a total of 1211 patients on the planned treatment backlog. The longest waiting patient dates back to February 2015. • 52% (1326) of the planned treatment backlog relates to Endoscopy.		

			• The non-recurrent allocation for Endoscopy in Quarter 1 & 2 will only facilitate the maintenance of planned scopes at 8-months past their clinically indicated timescale. Endoscopy, in totality, has been identified as a clinical risk within the clinical risk paper escalated to HSCB in May 15(as referenced in Risk 1 above) and through monthly elective access meetings with HSCB. • Further non recurrent funding allocated by HSCB in Quarter 3 and 4 for additional capacity. In-house activity has been maximised however limited capacity in the Independent Sector has reduced the level of capacity that can be secured. • In line with JAG accreditation requirements the planned treatment backlog should not exceed 6-months. c) AHP review backlogs • AHP backlogs for review are not as readily quantifiable. However, available information indicates significant review backlog volumes within Podiatry; Speech & Language Therapy; Dietetics; and Occupational Therapy. • The Trust will continue to re-direct		

			internally resources to areas of greatest risk as funding becomes available, however, ability to access staff on short term contracts remains challenging.		
	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
3	Achievement of statutory functions/duties: Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed.	- Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors - Group established to examine operational management of the annual review process - Delegated Statutory Functions Report - Quarterly reporting to Trust Board (from October 2015) - Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services and follow up of action plan	Older People and Primary Care Directorate have undertaken a Domiciliary Care review and have a process in place to implement the recommendations to achieve compliance. At the June 2015 Delegated Statutory Functions meeting with the HSCB, it was recognised that SHSCT compliance was among the best in the region. Compliance with Review Target as at 30-12-2015 - Overall % within 12 months for commissioned packages is 78.5% - Overall % within 12 months for Domiciliary Care Packages is 71% - Overall % within 12 months for Nursing Home Packages is 94.3% - Overall % within 12 months for Residential Home Packages is 93% Please note that Banbridge ICT were	Older People and Primary Care	MEDIUM

			unable to provide update for OPPC reviews in December 2015 as PARIS validation due for completion by Week Ending 22 January 2016. Those clients whose reviews are outstanding are subject to a desktop risk assessment to ensure that the delay in having their review carried out is not detrimental to their care. Adult Safeguarding Team Further targeted vulnerable adults training for those staff in care management and involved in annual reviews. Care Home Support Team (CHST) The CHST now has responsibility for all permanently placed clients. All reviews are completed in a timely way with 96% compliance and the remainder planned. An assurance process is embedded to ensure all residents in a Care Home with a Failure to Comply Notice in place or Vulnerable Adult investigation ongoing has an up to date review in place.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
4	Achievement of statutory functions/duties: The Trust should have robust case management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Case Management process.	New Trust Case Management Guidance	- Mental Health, Learning/Physical Disability and Older People and Primary Care training completed. - Internal Audit of Case Management completed. Draft report being considered. - Restructuring process by Heads of Service completed within the Disability Division of the Mental Health & Learning Disability Directorate. - Process has been completed within Mental Health and Learning Disability Directorate and will be by March 2016 in OPPC.	Mental Health and Disability/Older People and Primary Care	MEDIUM

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
5	Systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 1. Lack of compliance with Standards and Guidelines (DHSSPS/HSCB/other) 2. Lack of agreed indicators/measures of quality to provide assurance across some Trust services 3. Effectiveness of systemic process to review all intelligence from incidents, complaints, litigation and user feedback to identify and address service safety and quality issues 4. Effectiveness of process for learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	- Standards and Guidelines report on compliance to Governance Committee and DHSSPS Accountability Review meetings - Web-based incident reporting (on Datix) rolled out across the Trust - Clinical and Social Care Governance Review completed and new structures/processes embedded - Governance Committee and Senior Management Team - Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee - Quality Sub Group - Morbidity and Mortality Group - Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information - Review of Specialty Mortality and Morbidity system completed. - Mortality Reports to Governance Committee - Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback	- 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. - 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 Framework. The role and remit of the Clinical and Social Care Governance Working Body will be reviewed within this work - The revisit of Clinical and Social Care Governance has completed with a pilot of the new approach of dashboard assurance reports to Governance Committee on 8.12.2015 This risk will be fully reassessed and presented at SMT Governance on 2nd March 2016 as agreed at SMT Governance 27th January 2016.	Chief Executive	MEDIUM

		to Chair and Chief Executive • Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs) • Medical Director Report to Trust Board and Governance Committee includes Quality and Safety Indicators • Serious Adverse Incident/Adverse Incident reporting system in place • Trust Annual Quality Report • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy • Director, Children and Young People's Services, reports to Trust Board and Governance Committee including Roles and Responsibilities on all Looked After Children and Child Protection services • For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team,			

		Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning • Complaints assessed/screened for adverse incident review • Litigation process now embedded to ensure early alert to operational Directors			
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
6	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 in place • Interim procedure on transcribing developed. • Trust Medicines Steering Group • Trust representatives on regional group • Themed Domiciliary Care Forum (IS) focused on safe administration of medication	• Annual Competency based training re medicines management for domiciliary care workers completed for all staff from September to December 2015. • A registered nurse has been seconded to carry out medicines review and safer systems. Completed in Newry/Mourne area. Now commenced in Armagh and Dungannon area. Core teams support the ongoing work in Newry/Mourne areas to prevent regression of project work to date. • A rolling audit will be carried out in N&M area as part of an exit strategy. • The Transcribing procedures have been revised (October 2015) and now include specific guidance for community nurses completing MIS for DCWs. • A Transcribing E learning training programme is available. All	Older People and Primary Care/Mental Health and Disability	MEDIUM

			community nurses who will be required to transcribe to complete this by 01 April 2016. • Risk assessment revised November 2015. • Audit risk assessments for new service users to ensure compliance with guidelines commenced November 2015. • Further training / awareness sessions planned for key workers completing medication assessments. • Single patient medication files are being tested across providers to minimise risk of error. • A regional business case is being developed by HSCB 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. Statutory domiciliary care agencies recently inspected by RQIA – no requirements identified. Ongoing capacity issues in community nursing teams affecting timely provision of detailed care plans, medication instruction sheets, adherence to procedures etc. There are a range of processes in place for identification and management of		

			medication risks identified in Trust domiciliary care services which are not available in independent sector providers except through notified incidents.		
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
7	Inability to recruit/retain Consultant medical staff for specific specialties - Consultant Medical Staff in Dermatology, Emergency Medicine, and Radiology - SAS Medical Staff 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.	Dermatology: There is a recognised UK shortage of consultant posts in Dermatology and therefore a new model to attract GPs has been introduced. From late November 2014, 4 part-time GPs have started in post so this has proved successful. Two retired consultants were engaged to undertake some WLI clinics and this is continuing until end March 2016. There has also been an increase in expanding nurse led clinics. However there is still a requirement for a new (3rd) consultant post which will be difficult to fill. Part of the difficulty is that trainees do not rotate through our hospital as part of their training so local trainees are more likely to take up posts in Belfast where they are familiar. It has now been agreed that one registrar will rotate through Craigavon on a Thursday which may help somewhat. Emergency Medicine: A permanent Consultant commenced in Craigavon Area Hospital on 1st May 2015. Two Specialty Doctors were recently interviewed and appointed to ED in DHH, however despite these	Human Resources & Organisational Development/ Medical Director	HIGH

			appointments it still proves very difficult to recruit to Consultant and Specialty Doctor positions within ED The situation in Daisy Hill Hospital has worsened considerably following the recent resignation of the Lead Consultant and a full time Specialty Doctor. At consultant level, this will leave one Temporary F/T consultant and one permanent P/T consultant. At SAS (middle grade) level there is one Associate Specialist and two Specialty Doctors – all are full time. The Trust has recently advertised for 5 consultants in Emergency Medicine (4 new posts and one replacement). A display advert was compiled and will be advertised as a full page in the BMJ, geo targeting UK, ROI and Western Europe. Also BMJ Banner, Irish Medical Times, NHS Jobs website and Facebook. Closing date 02.02.16. The Trust regularly raises the requirement for ED locums with all contracted agencies and other known non-contracted agencies. Apart for occasional ad-hoc cover, it has been very difficult to secure any 'longer term' cover. The Trust also embarked on a recruitment campaign for middle grade doctors in ED with M3 Creating Connections. This company undertakes medical recruitment project work with Trusts and Health Boards on behalf of		

			doctors.net.uk. There was only one application received, however the candidate subsequently withdrew. The Trust has also met with 'A Team Recruitment regarding a proposal to recruit medical staff at SHO level from the EU, however it is expected to take at least 6 months to recruit and train suitably qualified doctors via this route. The Trust has also introduced a Clinical fellowship programme for ED. One appointment has been made and this doctor took up post in August 2015. Anaesthetics: It is planned to develop a training programme with the aim of "growing our own" specialty doctors. A proposal has been drafted and is currently under consideration by the service. Radiology: There is a recognised gap in Consultant Radiologist numbers and Clinical Radiology has recently been included in the Government approved shortage occupation list. The Trust has successfully appointed a number of Consultant Radiologists over the past few years; however some of these have left to take up other posts. The position remains unstable. In February 2015, the Trust successfully appointed 4 permanent Consultant Radiologists. One person has since withdrawn, however the other 3 took up post in August 2015.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	
8	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 • Daily review by Senior Management of night reports and follow up on issues • Daily audit of notes	• 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 • 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. 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 • Action re medical recruitment covered under detail of risk 7 above • Regular updates to Commissioner and DHSSPS		HIGH

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
9	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 - Open Recruitment for Adult Band 5 Nurses with interviews scheduled every 2 weeks - E-rostering roll out	- All opportunities to secure permanent staff continue to be progressed - Open Recruitment implemented from 21/12/15 with interviews scheduled every two weeks to ensure ongoing progression of applications received - Regular recruitment days planned alongside ongoing recruitment. An open advertisement with the most recent drive for Adult Nursing including Year 2 and Year 3 students which resulted in 153 job offers on the day with many of the pre-employment checks undertaken. Follow up work is continuing to maintain a relationship with all appointees until their start dates. The most recent drive for MH Nursing is also aimed at including Year 2 and Year 3 students. - Introduction of Rotational Programmes within and across Directorates. - Targeted recruitment of current nursing students for bank Band 3 roles ongoing with a view to introducing them to the Southern Trust for their Band 5 career. - Discussions continue with DHSSPSNI to increase the number of places available on the OU PRNP commencing September 2016. SHSCT has also utilised funding from DHSSPSNI in-year to support	Executive Director of Nursing; Director of HR; Operational Directors	HIGH

			thirty-two staff to commence the module K101 in February 2016. • A Trust Nursing Workforce Planning Group has been established to seek to address current and future anticipated challenges regarding the demand for and supply of Registered Nurses across all programmes of care. Consideration is now being given to International Recruitment. • A regional Nursing Workforce Planning Group, chaired by Mr F Rice, Executive Director of Nursing, has now completed a scoping exercise at a high level to collate the statistics on vacant posts compared to Funding Staffing and the numbers of staff unavailable for work due to various types of leave. The report of this group was presented to CNO at CNMAC in December 2015 with 12 key recommendations. 7 of these recommendations relate to recruitment approaches including international recruitment. The Trust has now agreed with other Trusts that two senior Southern Trust staff, take a lead role in progressing international recruitment across the region as well as reviewing the model for recruitment to consider further streamlining of approaches to maximise on the available pool		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
10	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	- Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department - Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk - Strategic development plans in place for major projects and business cases submitted for highest risk areas Specific examples: - Fire Safety Action Plan in place and continuing to progress. - High Voltage capacity limit on supply to Craigavon Area Hospital Identified and remedial project underway. - Aging High Pressure Hot Water system (HPHW) at Craigavon Area Hospital has now been replaced with new Low Pressure Hot Water system. - Structural works to tower block at South Tyrone Hospital complete. - Completion of Theatre development CAH - New negative pressure isolation room at CAH complete.	- On-going prioritisation and bidding process for capital in place - Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment - Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available - Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2015/16/17. Phase 1 of Mechanical Infrastructure complete. - Strategic Outline Case submitted for major redevelopment at CAH site. Work is now being progressed on the main business case for submission in 2015/16. - Provision of new negative pressure isolation room at DHH awaiting decision on preferred option from Acute Services. Thereafter proposals to be incorporated in Business Case for consideration by SMT/Trust Board.	Director of Human Resources and Organisational Development	HIGH

			The sewage system serving the wards at CAH has reached a critical point with frequent blockages leading to bursts and subsequent contamination of patient and support areas. This presents a serious infection control risk; causes disruption to services; and has been reported in the press potentially damaging service user confidence. An extensive replacement programme commenced in August 2015 through a carefully co-ordinated and phased programme of ward decants and is progressing well with works 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. 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.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
11	High Voltage capacity limit on electrical supply to Craigavon Area Hospital - Identified under Maintaining Existing Services scheme - Possible limit to expansion of service provision on the Craigavon Area Hospital site - Increased electrical demand on existing limited supply may exceed capability of supply	- All future development/ expansion of the estates is to be notified to Estate Services - Generator backup - Load shedding - Monitoring current demand - Business Continuity Plans for restabilising electrical service in the event of unplanned interruption - Peak Lopping installed and completed following agreement with Northern Ireland Electricity - Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed. - Installation of new Combined Heat and Power plant is complete and G59 approval from NIE (to permit parallel generation) is in place. This will provide increased resilience through an additional source of supply for the site.	- Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. - Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure - Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the risk. - CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion September 2016	Human Resources & Organisational Development	MEDIUM

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
12	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified several issues: - The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). - Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding)	- Increased environmental monitoring to check for failures of sterility in the unit - Expiry dates of all products prepared has been reduced to a maximum of 24 hours. - A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented - Additional activity will not be accepted by the aseptic unit until the staffing issue	- 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 OBC was submitted to the Department on 1.7. 2015. A letter of Commissioner Support received from the HSCB has been submitted. The Trust has identified this as its top priority for capital funding. - Recent deterioration in the fabric of the building is being addressed through an interim plan involving urgent minor works to the aseptic suite. - The Capita Model for chemotherapy/cytotoxic dispensing was applied to the current workload in the unit. This identified a staffing deficit of 3.6wte pharmacists. Using the capacity plan as a model the unit is short 2 pharmacists for the current	Director of Acute Services	HIGH

	The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	is resolved Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	workload. HSCB agreed to fund the 2 additional band 7 pharmacists required. The IPT was received in May 2015 and the recruitment process is complete. The pharmacists will be in post by the end of February 2016. Complete		
	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
13	HCAI - Risk to achievement of Priorities for Action target identified - Risk to patient safety - Lack of automated HCAI surveillance system linked to Trust laboratory system - Lack of appropriate isolation facilities (including negative pressure facilities) within the Trust hospital network - Emerging infections (CPE/VHF/ebola)	- Comprehensive isolation policy in place and strictly adhered to - On-going mandatory and tailored IPC training - Manual surveillance systems in place. Independent and self-audit programme - Comprehensive governance structure in place, including bi-monthly HCAI Strategic Forum and monthly HCAI Clinical Forum meetings - Craigavon pressure isolation room now complete - Outbreak /incident management plan in place - Establishment of antimicrobial	- On-going measurement of compliance against DHSSPS Communiqués - Ongoing self and independent audit using the RQIA Augmented Care Audit tools. - Learning outcomes from RCAs being shared with senior and junior medical staff. - Engagement meeting with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases - Embedding Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters across community and acute sites.	Medical Director	MEDIUM

	• HCAI outbreaks in tertiary services (BHSCT) • Increasing emergence of CPE infections	management team to oversee antimicrobial stewardship • HCAI Root Cause Analysis process in place • Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI	• Engagement with PHA on Regional Surveillance system funding and procurement to recommence • Enhancement communication to front line clinical staff via HCAI e-Alert • Suite of procedures and guidelines to support the prevention, management and control of CPE. • Completed Ebola Management Plan • CPE Outbreak/Incident Management in line with regional CPE toolkit • Enhanced HCAI RCA information management system and system developed to further improve meta-analysis of C Difficile cases • Joint letter from Medical Director, Executive Director of Nursing and Director of Acute Services issued to staff re Infection Control practice • Re-launch of IV Programme in Acute sites to address increasing MRSA/MSSA bacteraemia • Development of a Business Plan to consider Infection Prevention Control (IPC) Nursing Workforce within the Trust • Electronic C Diff database now developed to develop learning from trends • New early warning criteria developed to identify potential outbreaks earlier • Development of Clinical Antibiotic Stewardship champions to implement new Antibiotic Stewardship Policy		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
14	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	- Action Plan in place to address non-conformances - External Quality Assurance and Internal Quality controls	- The Trust has submitted its application for re-accreditation and is awaiting a new date. A pre-assessment visit took place on 8th October 2015. - Action Plan updated as progress is made. - Full inspection advised for April 2016	Director of Acute	HIGH
CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
15	Fully embedded appraisal system – lack of evidence of compliance	There are a variety of mechanisms in place to ensure appraisal takes place:- - Medical Appraisal - Professional Supervision - Knowledge and Skills Framework (KSF) policy and monitoring system in place - KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings - Action Plan in place and reviewed quarterly - Staff Attitude Survey results	<u>Consultant / Medical Appraisal</u> As at 16/11/15, 93% of 300 eligible doctors have completed their 2014 appraisal. <u>Knowledge and Skills Framework</u> A KSF steering group continues to meet quarterly. Work is ongoing with individual Directors and Heads of Services to support staff and managers when completing their KSF Documentation, and therefore to increase uptake within each Directorate KSF reports continue to be collated monthly and forwarded to Directors. Regular reports regarding uptake levels across the Trust	Medical Director Director of HR and Organisational Development	MEDIUM

		- provide staff view - Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.	continue to be presented to SMT PDP's are now being recorded on HRPTS as a qualification. As a result of all of the above, there has been an increase in the extent to which KSF is being implemented across the Trust. Work underway to improve mandatory training levels within the Trust In May 2015 39% of staff completed their PDP. In November 2015 47% of staff completed their PDP.		
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
16	Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016	- NI Revalidation Programme Board, attended by the Executive Director of Nursing, meets bi-monthly - NI Revalidation Working Group attended by the Trust's Assistant Director Nursing Governance, meets monthly - In October 2015 the NMC has 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 implementation and progression of Nursing and Midwifery revalidation which is due to commence in April 2016. Extensive work has been undertaken to establish a Nursing and Midwifery Revalidation information management system which holds all (3,023) Trust NMC registrants' PIN, Annual Fee Expiry and Revalidation dates. This information management system is now live and will provide assurance to the Executive Director of Nursing, SMT and Trust Board in relation to the progression of Nursing and Midwifery revalidation. Monthly revalidation reports will be issued to individual nursing / midwifery managers to support local arrangements on the timely revalidation of nurses and midwives for whom they have responsibility. Standard Operating Procedures have been developed to	Executive Director of Nursing	HIGH

			provide timely reports to nursing and midwifery managers and heads of service. Assistant Director Nursing Governance, 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 professional development discussion with their NMC colleague. Assistant Director Nursing Governance has linked with the AD Nursing Workforce Development and Training and Clinical Education Centre to scope out planned support programmes.		
CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
17	Achievement of financial balance in 2015/16	- Contingency Plan for 2015/16 in place - Best Care Best Value (BCBV) Project structure - Financial monitoring systems in place - Monthly report to SMT and Trust Board	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 not expect to breakeven in 2015/16.	Finance and Procurement/ All	MEDIUM

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
18	Management and monitoring of procurement and contracts – not compliant with best practice guidance	- Contracts management improvement group established and key actions formed - New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided . - Training on Contract Management with focus on responsibilities of Contract Owners rolled-out with follow up sessions also delivered	GENERAL - Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee - Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing (Central monitoring ceased in October 2013) - Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. - Capacity sought via IPT for social care procurement of key projects including (Learning disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. Alternative options being considered to progress these procurements. - Trust has responded to draft recommendations of J. Allen Review of Procurement. Final	Director of Finance and Procurement Director of HROD	MEDIUM

			recommendations of Procurement Policy awaited • New Structures for contract & procurement management being developed as part of Management Review ESTATES • Proposed models brought forward by PALS and Trusts on regional basis to address procurement deficit for Estates services agreed by Directors of Finance. Regional Steering and Working Groups established. Recruitment of PALS team underway. Recruitment of Trust Team being taken forward under newly appointed Head of Service. • Measured Term Contract (MTC) in place for 2015/16 which mitigates risks to procurement for schemes <£45k • Estates Works Management Improvement Action Plan (incorporating all IA recommendations) established and 95% implemented during 14/15. Internal Audit undertook a follow-up audit (reported March 2015) and verified that the majority of recommendations had been either partially or fully implemented. Further IA work to be undertaken fourth		

			quarter of 2015/16. - Two replacement Estates Officers appointed to Estate Development team and volume of works being undertaken balanced against resources to facilitate compliance. SOCIAL CARE PROCUREMENT - Regional Procurement Board via Social Care Procurement Group have agreed approach to social care procurement. Internal plan to be developed to secure necessary resources, skill and capacity to take forward a limited number of social care procurements - Capacity sought via HSCB transitional funding in 2014/15 for social care procurement of key projects including (Learning Disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. - Internal resource diverted to provide procurement support to key mental health directorate projects in 2014/15	Director of Performance and Reform; All Directors	

			enabling change. This capacity has been extended into 2015/16. • Further capacity established in October 2015 to support domiciliary care procurement from redirected internal resources. • Impact of 2015 Public Contract Regulations on social care procurement assessed and key actions agreed to scope demand and capacity requirements		
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
19	Payroll & Travel - HRPTS System & Shared Services • Payroll & Travel Payments - potential for inaccurate and/or late payments. Negative media publicity and impact on Trust's reputation as a good employer.	• Customer Forums are in place for monitoring the performance of services in Shared Services Centres • Progress updates to Audit Committee	• Ongoing communication/engagement with Managers as regards timely completion of paperwork • Weekly, Fortnightly and Monthly staff transferred to the Payroll Shared Service Centre.	Finance Director	MEDIUM

	• Transfer to Payroll Shared Services and maintenance of service delivery • Recruitment – considerable delays currently being experienced in the recruitment of posts which is impacting on operational services	• Regular meetings with BSO • Escalation procedure in place by Trust's Head of Resourcing Director of HROD also now meeting with Assistant Director of SSC to escalate concerns and seek engagement for a solutions focused approach. • Weekly monitoring of contract indicators raised with HOS for Issues Log (Reporting unavailable to facilitate actual monitoring of KPI's)	• Additional resources identified to support BSO in the delivery of services. The Trust has appointed a Recruitment Liaison officer on a temporary basis for a trial period. This officer reports directly to the Head of Resourcing and is charged with the responsibility of supporting the Recruitment SSC in high volume recruitment areas to provide advice and guidance on progressing pre-employment checks in a timely manner. • Face-to-face meetings being progressed with Directorate HOS teams to provide further guidance and support on managing recruitment activity including advice on escalation arrangements and what the Trust can do to ensure there are no delays caused by Trust actions. • Reporting information still unavailable but requested and highlighted with SSC as a key component to allow monitoring of KPI's.	Director of HROD	

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
20	GP Out of Hours Service – Reduced ability to maintain adequate service provision and patient safety due to vacant GP shifts	- Recruitment process for vacant posts - Business Continuity Plan - Medical Managers with medical responsibility for the service - Call Centre Co-ordinator - Call Manager system - Late availability payment - Flexibility re shift patterns offered - Daily monitoring of rotas and appropriate contingency plans deployed based on resources available	- The Trust has escalated risk to HSCB and DHSSPS, and has had recent joint meetings. - There is a range of actions in place to attract GPs to work in the service. - Ongoing recruitment - Implementation of winter pressure plan to include additional shifts. - The process of over-seas GP recruitment began in December 2015 - HSCB and Trust initiatives to support cost of increased GP indemnity payments. - The HSCB has requested Dalriada Urgent Care to carry out a peer review and report – by end of January 2016. - Early alerts are issued when rate of GP uptake of shifts are less than 50% or when there is less than 2 GP's on duty in the period 12 midnight to 8 am. - Twice daily operational meetings to review medical cover and contingency actions implemented. - Dalriada is providing nurse triage from 8 pm to 8 am daily since December 2015. - Triage and Nurse Practitioners are working within GP Out of Hours Service to assist in covering gaps. - Capacity and demand work is being undertaken by Planning and reform. This commenced in	Older People and Primary Care	HIGH

			December 2015. Review of workload of clinicians ongoing by Clinical Lead. - KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB. - Locally Enhanced Service pilot commissioned by the Health and Social Care Board commenced in November until March 2016 to provide additional medical cover on Saturdays and Sundays. Working with other OOH providers to secure additional capacity. - The Pharmacy Pilot commenced on 28.2.2015 with 8 Pharmacists recruited to provide cover from 11 am – 4 pm Saturday and Sunday and Bank Holidays. Pharmacists have also provided additional cover outside these hours to increase capacity. An evaluation been completed and submitted to HSCB. The pharmacy service will continue until end of March 2016, with additional 5 hours on a Saturday and Sunday as part of the winter pressures plan. - Internal review via independent GP underway to report by end March 2016		
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
21	Health Visiting Service – Impact on children/families due to reduced ability to deliver services as a result of decreased staffing levels in	- Control measures in place include step down i.e. universal contacts to non-vulnerable families have been reduced; - Utilisation of bank (limited	The Health Visiting workforce position demonstrates that Staff in Post equate to the Funded Staffing Levels inclusive of the investment funding of 8.4wte Band 6 health	Executive Director of Nursing/ Director of C&YPS	HIGH

	the service	supply) and additional hours of existing health visiting staff; • Drop in clinics available to ensure rapid access to HV if parent worried or concerned about an infant / child; • Rota system is in place to equitably allocate clinic cover, new births, movement in visits and new safeguarding cases; • Team managers to notify HoS and Named Nurse for Safeguarding Children if they are unable to allocate a child protection case. • Provision of universal contacts is being monitored across service/teams on a quarterly basis through IoP report and this information is sent to Director/DHSSPS/HSCB/PHA	visitor posts received in September 2015. The additional funding allowed all 11 health visiting students who completed training in September 2015 to secure permanent posts. This has led to some improvement with 10.22 wte unavailable to deliver the service (due to current permanent vacancies and planned and unplanned absence), which equates to 12% deficit in the health visiting workforce. This demonstrates an improved position from that of September 2015 when 20% of the HV workforce was unavailable. This staffing deficit means that 5 of the 7 Health Visiting Teams are in step down: • There are currently 6 permanent vacancies, 3 maternity leaves and 4 staff on long-term sick leave. • Due to the regional shortage of Health Visitors, the amount of temporary staff the SH&SCT is able to secure through the bank is insufficient to meet the deficit. • Ten Health Visiting students are currently training in the Trust but won't complete until September 2016. The internal waiting list has been exhausted and the external waiting list is significantly reduced to HV working in other Trusts who want specific localities. It is unlikely that all our permanent		

			vacancies will be filled until the next cohort of students qualifies in September 2016. • In communications with the HSCB and PHA regarding the Health Visiting workforce, assurance has been given that SHSCT are proactively processing vacancies in order to appoint staff as soon as possible. • The Trust is progressing on first regional Ecat caseload weighting in February 2016 and this will inform regional normative staffing initiative for health visiting which is been led by the Trust Nursing Workforce Leads and the PHA. • This situation is exacerbated by the reduced capacity of the Family Nurse Partnership team (detailed on the CYP Directorate Risk Register).		
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
22	Safeguarding of residents within HH/BC - Historical and ongoing risk to residents of potential financial abuse.	• Review of Residents within the Care Management process. Residents' reviews are held more frequently if required. • Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out of 5	• Ongoing liaison with the residents, relatives/families where appropriate. • Suspension of new admissions/respite beds remains in place. Current controls to remain as agreed by SMT and Trust Board and QA by independent "critical friend" review (January 2016) • Public Prosecution Service has	Mental Health & Disability	HIGH

		moved • Liaison with the residents, relatives/families where appropriate. • Weekly Trust meetings to review status & regular updates provided to Trust Board / SMT. • Regular updates from Trust HHBC group provided to DHSS/HSCB/RQIA/Other Trusts • Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel. • Regular advice/support/direction by Trust Legal Advisers • Contract Review Meetings with HHBC and quarterly operational meetings with HHBC as part of the contract compliance process. • Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives. • Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff. • Trust addresses any	determined no prosecution of the Home Owners regarding one client • 13.01.16 – RQIA have advised the Trust that their prosecution case against HHBC is now concluded as the Judge granted an application by the defence counsel to stay the proceedings. RQIA also advised that their intention to initiate formal enforcement with HHBC will not proceed. Scoping exercise has been completed and should alternative placements be required will be revisited • Update Report to Trust Board on 28th January 2016 provides further details.		

		identified concerns/queries raised by DHSSPSNI/RQIA. • Adult Safeguarding Process. Remaining residents have care and protection plans which have been put in place and updated as required. • Contacts with RQIA • Trust "Procedure for Responding to RQIA Alerts & Other Performance Management issues within Social Care Contracts". • Ongoing processes with OCP / RQIA / NMC / HSCB re SAI, Disclosure & Barring Service (DBS) • Trust assumed responsibility for mobility monies which are now held in PPP accounts and payment is only made on receipt of verified invoices. • New Trust Case Management Guidance and Training Programme completed.			
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
23	Risk of loss of life and/or serious harm to patient(s), significant interruption to	Hardware: • The Trust have entered into a	• SMT approved Capital Funding of £342,000 (2015/16) for the provision of a Core Telephony	Director of HROD; Director of Acute	MEDIUM

	service(s) and limited or no telecommunication within the major hospital sites due to foreseeable unserviceable obsolete telecommunication equipment	comprehensive contract (VDCP) with BT to manage the existing network and support the structured replacement of individual legacy systems. The existing Siemens DX switches, which serve telecoms users for approximately 60% of the trust, reach end of supported life in November 2017. At present, in the event of a failure, BT VDCP through Siemens guarantee a repair within 4/8 hours depending on service level agreement. After November 2017 BT will no longer provide a guaranteed service agreement and it will be "best endeavours" i.e. only if parts can be sourced (used stock of whatever) etc. they'll try and fix it, if the fault is software related there is unlikely to be a fix. A fault will leave the trust without internal/external communications for a considerable period. These phone systems are well beyond their expected life and desperately need to be replaced.	Platform to provide the centralised telephony foundation and continuity for the existing Avaya Telephony infrastructure deployment. Planned completion end March 2016. - Requirement for additional funding to replace 5 systems on core DX sites including St Lukes, Tower Hill, Craigavon Hospital and Daisy Hill Hospital. [5 systems c£450k each] - Requirement for additional funding to replace 4 systems serving Medium and Small sites (62). [4 systems c£425k each]	Services	

		System Support: Increased risk of in-cohesive maintenance, system support, due to gaps in out-of-hours provision of cover.			

CONFIDENTIAL – TIMELINE/KEY ISSUES AND ACTIONS RE SUSTAINABILITY CHALLENGES AT DHH ED

DATE/EVENT	KEY ISSUES RAISED	ACTIONS
13/4	Request by DoA to meet Cx to discuss escalating concerns with medical staffing cover in OOHs period at DHH	Meeting arranged urgently
15/4 meeting attended by Interim CX; DoA;MD;DR O'Reilly AMD; B Conway AD;	Summary of main issues discussed including current medical staffing pressures; increasing challenges with recruitment and retention and specifically in securing locum cover at appropriate level of experience in OOHs period; changing context re increasing attendances/admissions; governance concerns	Agreed to - Urgently consider potential recruitment options and meet with DHOD on return to explore potential to secure cover via enhanced offers - Reconvene in 1 week
17/4	Cx email to DoC HSCB to arrange meeting asap to discuss issues	Meeting arranged for 28/4
22/4 meeting attended by Interim CX; DoA; MD; Dr O'Reilly AMD; B Conway AD; DHROD; M Clegg HR Med workforce	Main issues reviewed and options/opportunities for immediate actions considered.	Agreed to - develop clear summary of issues and action plan to ensure visibility, shared clarity and support timely decision making - Alert HSCB/PHA/DHSS as precautionary measure given potential of leaks/queries arising
24/4 Cx alert to Cx HSCB and Deputy PS DHSSPS and MD alert to DPH PHA	Brief meeting PC with VW and D McN to advise of issues, actions underway to seek to mitigate MD call to CH	Confirmed process for ongoing engagement with HSCB DoC and PHA
28/4 Videoconference meeting with DS HSCB, D Corrigan PHA; DHROD; Cx; BC; SO'R; MD; M Clegg	Main issues reviewed and options/opportunities for immediate and medium term/more sustainable actions considered	Agreed to - Document issues leading to current position identifying specifically what has changed to “escalate” concerns - Complete action plan including all actions taken/planned - Clarify planned management/ governance process for oversight and decision making (to be weekly Trust Strategic Oversight Group or more urgently if required and fortnightly meeting with HSCB/PHA)

1/5 AMD meeting	Dr O'Reilly AMD raised issues with AMD forum as governance risk (<i>insert form notes of meeting</i>)	
6/5 weekly SOG (Dr Corrigan PHA attended as observer)	Review of detailed action plan with updates on progress or lack of and reasons with further suggestions made	Agreed to - Convene urgent meeting with DHH CDs and lead ED consultant to discuss action plan, additional solutions, secure shared understanding of options if actions not successful - Ensure all discussions to date are documented and going forward



Notes of SMT Meeting held on
Wednesday 1 July 2015
@ 2pm in the Boardroom, Trust Headquarters

Present: Paula Clarke
Angela McVeigh
Stephen McNally
Paul Morgan
Debbie Burns
Dr Richard Wright
Kieran Donaghy
Francis Rice
Aldrina Magwood
Jane McKimm
Elaine Wright (Notes)

Apologies: Dr Simpson

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Dr John Simpson.	
2	NOTES FROM THE PREVIOUS MEETING The notes from the previous meeting held on 17 & 24 June 2015 were approved.	<i>Approved</i>
3	CHIEF EXECUTIVE BUSINESS 3.1 Draft Trust Board Agenda's 27 August 2015 and 24 September 2015 Members considered the draft agenda's for the August and September Trust Board which were in the early stages of drafting. Discussion took place regarding the timing of particular items. Revised agenda's will be considered again nearer the time.	

	3.2 Departmental Strategic Leadership Group – list of priorities The Chief Executive referred to the recent Strategic Leadership Group Meeting and the actions/discussions from the meeting.	
4	MATTERS ARISING There were no matters arising.	
5	STRATEGIC PLANNING 5.1 Strategic Plan – Communications and Engagement Plan Members noted the Communications & Engagement timeline for the Strategic Plan and approved the approach. The Strategic Plan will be tabled at the October Trust Board Meeting. 5.2 Future of Commissioning of Vascular Services for NI – letter from Dean Sullivan dated 14 April 2015 – Trust response to consultation The Trusts response to the Future of Commissioning of Vascular Services for NI will be tabled at next week's SMT Meeting for approval to submit by the closing date of 10 July 2015.	<i>October Trust Board Mtg</i> <i>SMT 8 July 2015</i>
6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plans Mr McNally advised that there was nothing further to report following full discussion at the last meeting. Mrs McVeigh referred members to the Community Equipment and the demand on the budget. The principle of shared responsibility for the budget across OPPC, MHD and CYP was agreed with further work to take place to identify full funding sources.	
7	PERFORMANCE UPDATE There were no specific performance issues to address.	

8	INNOVATION/CONTINUOUS IMPROVEMENT There was no specific business to discuss.	
9	GOVERNANCE ISSUES 9.1 Addressing Service delivery issues within Independent Sector Domiciliary Care Mrs McVeigh referred to the paper addressing service delivery issues within Independent Sector Domiciliary Care, which clearly sets out the issues and proposed changes. Following discussion, members agreed with the approach outlined and Mrs McVeigh advised that further communication will be fed back to Providers regarding the way forward and processes to enable same. An implementation plan will be developed to progress the agreed changes.	<i>Mrs McVeigh to progress</i>
10	INFECTION CONTROL UPDATE 10.1 HCAI Update/Briefing Dr Simpson updated members on the current infection control position within the Trust. 10.2 HCAI Update – PFA Targets Dr Simpson updated members on the performance targets. 10.3 Infection Control Issue Members were informed that the reporting on the recent infection control issued was now complete. Dr Wright advised that next year’s Infection Control targets had been received and shared same with members.	
11	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 11.1 Cases for approval: - Home Oxygen Therapy IPT The above IPT was deferred to the next meeting.	<i>SMT 8 July 2015</i>

	- SUSE Programme Partnership Bid Mrs McVeigh referred members to the SUSE Programme Partnership Bid. She advised members that the Trust is now being asked to commit funding to this bid. Following discussion, Mrs McVeigh agreed to find out what the position is in other Trusts, and if it is a full or partial commitment and the impact of this decision.	<i>Mrs McVeigh to progress</i>
12	WORKFORCE ISSUES There were no specific issues.	
13	COMMUNICATIONS & PUBLIC AFFAIRS Mrs McKimm informed members of current issues in the media and the Trusts response/position regarding same.	
14	DHSSPS CIRCULARS/CORRESPONDENCE There were no circulars to note.	
15	ANY OTHER BUSINESS 15.1 Procedure for Scanning & Disposing of Documents Mr Rice referred members to the procedure for scanning and disposing of documents and sought member's approval to begin the process with the lower risk services. Members agreed. 15.2 HH/BC Mr Rice advised members on the current position regarding the process and members were assured that all processes and appropriate challenges were in order. 15.3 Adult Safeguarding Investigation Mrs McVeigh referred to an Adult Safeguarding Investigation and advised members on the position to date and remains ongoing.	<i>Approved</i>
16	DATE OF NEXT MEETING Wednesday 8 July 2015	

17	CONFIDENTIAL DISCUSSION Mr Seamus O'Reilly attended the meeting and gave an overview of the ED situation in Daisy Hill Hospital and outlined the current position. Members agreed that the Trust need to mitigate the risk out of hours and stabilise the service in hours. The delivery of safe high quality ED services is the priority, where the Trust have the appropriate range of staff to manage the increasing number and complexity of patients who are now attending the hospital. Dr Wright informed members that himself and Mr O'Reilly had met Clinical Leads from DHH and will be considering proposals from them within the next 2 weeks. The Chief Executive advised the way forward in terms of contingency planning and negotiations with the HSCB and DHSSPS.	



Notes of SMT Meeting held on
Wednesday 22 July 2015
@ 2pm in the Boardroom, Trust Headquarters

Present: Paula Clarke
Angela McVeigh
Paul Morgan
Esther Gishkori
Dr Richard Wright
Helen Walker (for Kieran Donaghy)
Stephen McNally
Francis Rice
Sandra Waddell (for Aldrina Magwood)
Elaine Wright (Notes)

Apologies: Kieran Donaghy
Aldrina Magwood
Debbie Burns

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Aldrina Magwood, Kieran Donaghy and Debbie Burns.	
2	NOTES FROM THE PREVIOUS MEETING The notes from the previous meeting held on 8 July 2015 were approved.	<i>Approved</i>
3	CHIEF EXECUTIVE BUSINESS 3.1 Visit by Permanent Secretary, 30 September 2014 The Chief Executive advised that the Permanent Secretary has accepted an invitation to visit the Trust and a date of Wednesday 30 September 2015 has been agreed for the visit. She advised that this will be an	

	opportunity to have informal discussions with staff and asked members to begin to think about what services we would profile. Further discussion to agree itinerary will take place at SMT on 26 August 2015. 3.2 Strategic Leadership Group Meeting: 20 July 2015 The Chief Executive advised that a meeting of the Strategic Leadership Group had taken place on 20 July 2015 and the Chief Executive representative was Dr Tony Stevens. A note of the meeting will be shared with members in due course. 3.3 Stability in the Independent Sector Discussion took place regarding the importance of maintaining this as a risk on the CRR.	<i>SMT 26 August 2015</i>
4	MATTERS ARISING 4.1 Newry CTCC Further to discussion at the last meeting, Mr McNally advised that he had provided an evaluation and was currently completing a detailed analysis which will reflect the wording agreed. This would be finalised and submitted by the end of the week.	<i>Mr McNally To progress</i>
5	STRATEGIC PLANNING 5.1 DDH ED Update Members noted that an update on DHH ED will be given at the next SMT Meeting.	<i>SMT 29 July 2015</i>
6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plans Mr McNally updated members on the Month 3 financial position and discussion took place on the detail. The Minor Works lists had been prioritised by members and was being progressed by Finance. Members were reminded to submit any detail to Ms Helen O'Neill.	

7	PERFORMANCE UPDATE Members considered the June 2015 Performance Report and Mrs Waddell drew attention to specific key areas. Members were asked to provide any comments to Lynn Lappin by close of play Thursday 23 July 2015.	<i>All Thursday 23 July 2015</i>
8	INNOVATION/CONTINUOUS IMPROVEMENT There was no specific business to discuss.	
9	GOVERNANCE ISSUES 9.1 Preceptorship Annual Report, April 2014-March 2015 Mr Rice referred to the Preceptorship Annual Report which was tabled for member's information. He advised that this was a positive report of the review of the preceptorship process.	
10	INFECTION CONTROL UPDATE 10.1 HCAI Update/Briefing Dr Wright updated members on the current infection control position within the Trust. 10.2 HCAI Update – PFA Targets Dr Wright updated members on the performance targets. Dr Wright discussed infection control issues within the Trust and plans to progress work in this area. He agreed to keep members informed regarding plans to provide a focus on specific areas for improvement. With regard to ebola training, Dr Wright advised that this remains ongoing. Mrs McVeigh asked that GP OOH are engaged in the training programme.	
11	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 11.1 Cases for approval: - Endobronchial Ultrasound Service (EBUS) at CAH Members considered the above business case and following discussion, approval was given.	<i>Approved</i>

12	WORKFORCE ISSUES Members noted the shortage of trainees in general surgery and the work being undertaken to address/mitigate the impact from 1 August 2015.	
13	COMMUNICATIONS & PUBLIC AFFAIRS Members were aware of current issues in the media and the Trusts response/position regarding same.	
14	DHSSPS CIRCULARS/CORRESPONDENCE 14.1 Consultation on Proposals to Extend Age Discrimination Legislation from 3 July 2015- 8 October 2015 Mrs Walker referred members to the correspondence regarding proposals to extend Age Discrimination Legislation and the requirement for the Trust to feedback into the consultation process. The Chief Executive asked that the Trusts Equality Unit take forward this piece of work and Mrs Walker agreed to follow up with Mrs Lynda Gordon. 14.2 Test Drilling Report – Use of External Consultants 2013-14 The above correspondence was tabled for member's information/noting.	
15	ANY OTHER BUSINESS 15.1 Making Life Better (MLB) Template Mrs McVeigh referred members to the MLB template which was populated on behalf of SMT and asked members to consider the information and advise by Friday 24 July 2015 in order that the template can be submitted.	<i>All Submission due 24 July 2015</i>
16	DATE OF NEXT MEETING Wednesday 29 July 2015	



Notes of SMT Meeting held on
Wednesday 5 August 2015
@ 2.00 pm in the Boardroom, Trust Headquarters

Present: Paula Clarke
Dr Wright
Stephen McNally
Aldrina Magwood
Kieran Donaghy
Ronan Carroll (for Debbie Burns)
Angela McVeigh
Paul Morgan
Francis Rice
Jane McKimm
Jennifer Comac (Notes)

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Mrs Debbie Burns.	
2	NOTES OF PREVIOUS MEETING The notes of the previous meeting held on 29 July 2015 were approved by members.	
3	CHIEF EXECUTIVE BUSINESS 3.1 Trust Chief Executive's Forum update The Chief Executive briefed members on the key issues discussed. She highlighted the medical workforce planning reports and advised that Dr G Rankin agreed that all reports will be shared. The Chief Executive advised members that she would follow-up with Dr Rankin.	

	In relation to the Pathology Review, Mr Carroll advised that a local meeting has been arranged for 7th September 2015. The Chief Executive concluded by advising that the Trust Chief Executives are meeting with Valerie Watts at 5 pm today to discuss the Strategic Leadership Group priorities.	
4	MATTERS ARISING There were no matters arising from the previous meeting.	
5	STRATEGIC PLANNING 5.1 DHH ED Update See under Confidential Note.	
6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plan Mr Donaghy advised members on the sewerage works required in Craigavon Area Hospital and added that while Estates can progress these works, there are problems surrounding the decant of wards during the works. Members discussed and Mr Donaghy agreed to arrange a meeting with Mr Morgan, Mrs McVeigh and a member of Planning to try and identify a solution.	<i>Mr Donaghy</i>
7	PERFORMANCE UPDATE No escalated issues were raised.	
8	INNOVATION/CONTINUOUS IMPROVEMENT There was nothing further to update at this meeting.	

9	GOVERNANCE ISSUES 9.1 Proposal for full cover of Clinical Pharmacists maternity leave Members discussed the above proposal in detail. Mr Carroll advised that this is in place for CT Radiographers with posts being agreed by exception when there is a risk associated. Members agreed to approve by exception and review again at the end of March 2016. 9.2 Supported Living risk assessment Clanmil – AD and CB areas Mrs McVeigh briefed members and advised that business case approval has been secured from Supporting People for an 18 unit scheme in CB area and a second similar scheme in AD area. Mrs McVeigh advised that following a recent meeting with Clanmil they have advised that no sites have been identified to date that are both affordable and suitable for older people. They also advised that 18 unit schemes on their own are not economically viable and would require to be built on the same site as social housing to make the scheme economically viable for Clanmil. Following discussion it was agreed that a number of key areas required clarification with Clanmill. This included: • Evidence of the need for 18+ units to be economically viable • Evidence that Clanmill have sought to identify and progress areas with social housing need to align with the existing case. Mrs McVeigh agreed to follow-up with Planning support.	

	Mrs McVeigh advised members that this issue will go onto the Directorate risk register. 9.3 Standards and Guidelines Accountability Report Members approved the above report.	<i>Mrs McVeigh</i>
10	INFECTION CONTROL UPDATE Dr Wright advised members that there was one new C.Diff case at the start of August. He also updated members on the CPE issue. 10.3 IPC Independent Audit and Administration Team Briefing Paper Members discussed the above and Dr Wright agreed to look at other options and bring back to SMT.	<i>Dr Wright</i>
11	CAPITAL PRIORITIES/REVENUE BUSINESS CASES There was nothing further to update at this meeting.	
12	WORKFORCE ISSUES There was nothing further to update at this meeting.	
13	COMMUNICATIONS AND PUBLIC AFFAIRS Mrs McKimm informed members about Freedom Talk Radio who have been ringing staff across the Trust in relation to a patient in the Bluestone Unit. Mrs McKimm advised that this Radio station have been recording conversations with staff and posting them on YouTube. Mrs McKimm also thanked members for their support and assistance due to staff shortages within the Communications team.	
14	DHSSPS CIRCULARS/CORRESPONDENCE	

	There was no specific correspondence to raise.	
15	ANY OTHER BUSINESS Mrs McVeigh advised members of the current difficulties in relation to covering GP OOH. She added that the Trust has agreed when there is only one GP on duty an early alert will be issued to HSCB and DHSSPS. The Chief Executive advised there have been discussions with the Emergency Department regarding escalation when the Trust knows there is going to be a problem. Mr Morgan updated members on the thematic review of the Child Sexual Exploitation Report advising that no date has been given for release of the report and that the Chair of the SBNI has called an extraordinary meeting in August.	

16	DATE OF NEXT MEETING The next SMT Meeting will be held on Wednesday 12 August 2015 at 2pm in the Boardroom, Trust HQ.	
	STRATEGIC SMT	
1	Winter Pressures Action Plan The Winter Pressures Action Plan to ensure learning from last winter is applied this year was reviewed. Members updated on progress against each issue. Mr Donaghy referred to the potential need for 60 nurses regarding winter pressures. Mr Rice advised there continues to be high turnover of Acute nurses. The Chief Executive asked Mr Donaghy to liaise with Acute Services and bring a proposal back to SMT.	<i>Mr Donaghy / Acute Services</i>

17	CONFIDENTIAL DISCUSSION DHH ED Update The Chief Executive advised that Dr O'Reilly is on leave and that further discussions with Clinical Directors at DHH have presented additional potential to strengthen senior oversight/cover in the overnight period as part of a package of measures. This is to be further tested with Dr O'Reilly and AMD's and has indicative support from the Commissioner. This was discussed and accepted as a potential option to pursue. A more detailed plan will be brought to SMT next week.	



Notes of SMT Meeting held on
Wednesday 12 August 2015
@ 2.00 pm in the Boardroom, Trust Headquarters

Present: Paula Clarke
Aldrina Magwood
Kieran Donaghy
Heather Trouton (for Debbie Burns)
Angela McVeigh
Paul Morgan
Francis Rice
Jane McKimm
Jennifer Comac (Notes)

NICON MEMBER ENGAGEMENT	
The Chief Executive welcomed Ms Heather Moorehead (Director, Northern Ireland Confederation for Health and Social Services) to the meeting. Ms Moorehead advised members that the Northern Ireland Confederation (NICON) had agreed to take the opportunity over the summer to engage with members, primarily to seek input around drafting the 2016 election briefing priorities, but also to use the opportunity to have a slightly wider discussion to seek to maximise the value of NICON for member bodies. Ms Moorehead noted members' comments in relation to the 2016 election briefing and agreed to incorporate these into the briefing. Ms Moorehead also highlighted the NICON 2016 Conference and the work of the NHS Confederation. The Chief Executive thanked Ms Moorehead for coming to speak to members.	

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Mrs Debbie Burns; Dr Richard Wright and Mr Stephen McNally.	

2	NOTES OF PREVIOUS MEETING The notes of the previous meeting held on 5 August 2015 were approved by members.	
3	CHIEF EXECUTIVE BUSINESS The Chief Executive had no specific issues to raise.	
4	MATTERS ARISING 4.1 Winter Pressures – Letter from Valerie Watts dated 10th August 2015 The Chief Executive spoke to the above and advised members that the Board are looking for assurances from the Trust in relation to planning for winter 2015/16. Members discussed and the Chief Executive advised that she had asked Mrs Magwood to draft a response. The Chief Executive also asked each of the Operational Directors to ensure they are progressing plans for winter 2015/16, building in lessons learned from last winter as recently reviewed at SMT. It was agreed that all plans will be considered at corporate level at an SMT at the end of September.	<i>Mrs Magwood</i> <i>Operational Directors</i>
5	STRATEGIC PLANNING 5.1 DHH ED Update See under Confidential Note.	
6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plan The Chief Executive noted Mr McNally's apologies and advised there was no update in his absence.	

	6.2 Demography Funding Update Mrs Magwood circulated the demography funding update to members and advised that she had just received approx 20 IPTs from SLCG for CYPS and MH Directorates. Mrs Magwood added that she will send the update electronically to members. The Chief Executive asked members to implement as soon as possible. Ms Trouton advised that Mr D Sullivan, HSCB had advised that Trauma Pressures should be taken out of Demography money. The Chief Executive said this would not be an appropriate use of recurrent demography funds and that clarification is needed if this intention is for in-year slippage only. Ms Trouton said she would forward the email to the Chief Executive and Mrs Magwood for follow up with commissioner.	<i>Ms H Trouton/Mrs A Magwood</i>
7	PERFORMANCE UPDATE No escalated issues were raised.	
8	INNOVATION/CONTINUOUS IMPROVEMENT There was nothing further to update at this meeting.	
9	GOVERNANCE ISSUES 9.1 Update on Governance Revisit Mrs Marshall updated members on initial themes and findings and highlighted the context of the Governance Revisit which was to provide assurance that the outcomes of the 2010 review of CSCG remain effective and robust. The Chief Executive advised that as part of the Governance Revisit it would be timely to look at the operational governance structures and asked Mrs Marshall to consider this within the final recommendations.	<i>Mrs Marshall</i>

	Mr Rice indicated he felt there was a lack of consistency across Directorates and also a need for greater learning across Directorates. He added that reports focus more on quantitative rather than qualitative data. Mr Donaghy said that sources of information to corporate governance are relying heavily on Directorates and Datix – need more independence. The Chief Executive asked Mrs Marshall to look at what information we have and how that information is collated together and also the independence function. All members agreed that the process needs to be simplified rather than over-complicating. Ms Trouton advised that within the Acute Directorate they look at complaints, IR1's etc within their team to seek to make linkages on key issues and ensure these are dealt with. Mr Morgan raised an issue in relation to SAI's and advised that the DRO are raising questions outside of what the SAI requests. Mrs Marshall suggested it was timely to review the SAI process. The Chief Executive asked Mrs Marshall to incorporate member's comments and bring back the final draft report including options for how to implement recommendations to SMT by 2/10. Mrs Marshall advised that she would share with members in advance.	<i>Mrs Marshall</i> <i>Mrs Marshall</i>
10	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 10.1 Family Group Conference Proposal for pilot project Mr Morgan briefed members on the above proposal. Following discussion members agreed in principal with the proposal.	

	The Chief Executive asked Mr Morgan to discuss cost implications with Mr McNally. Mr Morgan added that he would ask Maureen Devlin, Head of Service, to link in with Mrs McVeigh and Mr Rice initially.	<i>Mr Morgan</i>
11	WORKFORCE ISSUES 11.1 Resourcing Report – July Mr Donaghy briefed members and advised he should have month 3/4 figures next week. He added that Mr McNally advised he should have Month 4 finance figures also for next week. 11.2 IMWH Workforce Report Mr Rice spoke to the above and introduced Anne McVey and Lynn Fee who briefed members on the review of Midwifery staff Integrated Maternity and Women’s Health Division. The Chief Executive thanked Ms McVey and Ms Fee for their very comprehensive presentation.	
12	SECTION 75 PROGRESS REPORT Mr Donaghy briefed members and advised that the briefing paper will go to Trust Board. Members approved the above report and the Chief Executive asked Mr Donaghy to pass on SMT thanks to Ms Lynda Gordon and her team for the huge amount of work which was involved in compiling this very informative report.	<i>Mr Donaghy</i>
13	COMMUNICATIONS AND PUBLIC AFFAIRS Mrs McKimm updated on key issues in media currently including Crossmaglen health care cover.	
14	DHSSPS CIRCULARS/CORRESPONDENCE 14.1 HSC(F) 43-2015 – External Consultancy PPE Dissemination of Lessons Learned Members noted the above circular.	

15	ANY OTHER BUSINESS Mr Donaghy advised on Scrutiny Posts. Mrs Magwood tabled the Positive Assurance Template for HSCB issued NICE Guidelines. It was agreed that this update is incorporated in the standards and guidelines reports to SMT and Governance Committee and therefore as long as cleared by the relevant Director, they do not require SMT approval when updates sought by HSCB.	
16	DATE OF NEXT MEETING The next SMT Meeting will be held on Wednesday 19 August 2015 at 2pm in the Boardroom, Trust HQ.	

17	CONFIDENTIAL DISCUSSION DHH ED Update The Chief Executive tabled the immediate/short-term action plan to address pressures with medical staffing cover in the Emergency Department in Daisy Hill Hospital. Members discussed in detail and the Chief Executive advised that Mr S O'Reilly was in agreement with progressing the plan and keeping under review. She added that Dr Wright had discussed the plan at the Associate Medical Directors on Friday who also supported this approach and that she will be updating DHH Clinical Directors in Dr Wrights absence. The Chief Executive concluded by asking members if they were willing to support the plan and members advised they were. She advised that the plan will be tabled at confidential section of Trust Board on 27th August to seek Trust Board approval with Mr O'Reilly to be in attendance.	<i>Chief Executive</i>



**Notes of SMT Meeting held on
Wednesday 23 September 2015
@ 2pm in the Boardroom, Trust Headquarters**

Present: Paula Clarke
Kieran Donaghy
Francis Rice
Stephen McNally
Aldrina Magwood
Angela McVeigh
Paul Morgan
Esther Gishkori
Dr Richard Wright
Jane McKimm
Elaine Wright (Notes)

Jeremy Griffith – ALAMAC

Mr Jeremy Griffith from ALAMAC attended SMT to update members on the ongoing work within the Trust.

He outlined the findings to date, highlighting those areas which the Trust can 'get better at' and those areas which are working well and continue to. He noted that much work had taken place in terms of system wide approach and the workings of the system dashboard on a daily basis.

Mr Griffith outlined the delivery objectives for the next 6 month period, launching in October 2015.

Discussion took place regarding packages of care and the challenges faced in terms of availability of GP OOH and the various constraints placed on the system to deliver.

Mr Griffith agreed to share his presentation with members and to contact relevant Directors to arrange a system-wide, scenario based workshop to test out the winter plans and identify ongoing learning/gaps. This is to happen by end of October 2015.

The Chief Executive thanked Mr Griffith's for his attendance and presentation to SMT.

ITEM	NOTE	ACTION
1	APOLOGIES There were no apologies.	
2	NOTES FROM THE PREVIOUS MEETING The notes from the previous meeting held on 16 September were approved.	<i>Approved</i>
3	CHIEF EXECUTIVE BUSINESS 3.1 Process for missing patient alert The Chief Executive referred to the need for clear processes when a patient goes missing within the Trust. She stressed the importance of having an internal alert mechanism and Mrs McKimm agreed to take forward with Directors and devise a simple flow chart for implementation. 3.2 Strategic Leadership Group, 25 August 2015 – Update The Chief Executive referred to the recent Strategic Leadership Group Meetings and members noted the correspondence from the meeting held on 25 August 2015. 3.3 Visit by Permanent Secretary 30 September 2015 Members noted the proposed agenda for the forthcoming visit to the Trust by the Permanent Secretary on 30 September 2015. Members discussed the timing for the day and Mrs McKimm to take forward proposed suggestions and re-issue itinerary.	<i>Mrs McKimm to progress</i> <i>Mrs McKimm to update and reissue</i>

4	MATTERS ARISING 4.1 Correspondence from Bill Pauley re Newry CTCC Mrs Magwood confirmed that correspondence had been flowing between the Trust and the DHSSPS regarding Newry CTCC. Mrs Magwood will follow up on position. 4.2 Consultation Process Members noted that following advice from DHSSPS regarding the process for consultation, the Trust has now received legal advice on the matter and discussion will take place, as originally planned, in the open section of Trust Board, at its meeting in October.	<i>Mrs Magwood</i> <i>October Trust Board</i>
5	STRATEGIC PLANNING 5.1 SMT 1-2 October 2015 Members noted the draft agenda for the forthcoming SMT Away Days. Members were asked to provide comments to Mr Donaghy by Monday 28 September 2015.	<i>Mr Donaghy</i>
6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plans Mr McNally referred to the financial report previously issued which will be discussed at Trust Board on 24 September 2015. 6.2 Fostering & Adoption Payments 2015-16 Mr Morgan referred members to the Fostering & Adoption Payments 2015-16 Audit Report which was tabled at SMT due to the 'limited assurance' given. Mr Morgan confirmed that recommendations have been accepted and work was progressing to take forward, within the specified timelines.	<i>Mr Morgan progressing</i>
7	PERFORMANCE UPDATE 7.1 Performance Update There was no update to be given.	

8	INNOVATION/CONTINUOUS IMPROVEMENT There was no specific business to discuss.	
9	GOVERNANCE ISSUES 9.1 Annual Quality Report Mrs Magwood referred members to the draft Annual Quality Report tabled for review/consideration. Feedback to be provided in order for a further update to be presented at SMT on 30 September. The final Annual Quality Report will be tabled at the October Trust Board. 9.2 Controls Assurance Standards: Performance in 2014-15 & Reporting Requirements for 2015-16 – letter from Karen Jeffrey, DHSSPS dated 14 September 2015 The Chief Executive referred members to the CAS correspondence which outlines the normal process adopted and the areas subject to Internal Audit. Members noted. 9.3 SAI Mr Morgan informed members that a review was now being escalated as an SAI. He agreed to alert PHA and to update at Trust Board on 24 September 2015.	<i>SMT 30 Sept 2015</i>
10	INFECTION CONTROL UPDATE 10.1 HCAI Update/Briefing Dr Wright updated on current HCAI figures which are showing an improvement upon last months. He advised that jointly signed correspondence had been issued from all Operational Directors and himself promoting the continued support for HCAI procedures within the Trust. 10.2 HCAI Update – PFA Targets There was no separate report.	
11	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 11.1 IPT's for approval - St Luke's Hospital Rear Car Park Replacement	

	- Mullinuire Roof Works - Lurgan Hospital Works – Roof Repairs Summary IPT Report including approval for: - Health Visiting - Home Oxygen and Diabetes Members noted and considered the above documentation and supporting cases. Following discussion, members approved as outlined.	<i>Approved</i>
12	WORKFORCE ISSUES 12.1 Medico Legal Posts Dr Wright undertook to provide a briefing to members for the next SMT meeting.	<i>SMT 30 Sept 2015</i>
13	COMMUNICATIONS & PUBLIC AFFAIRS Members were aware of current issues in the media and the Trusts response/position regarding same. Mrs McKimm advised on the following: - The recent adjournment debate at DHH and advised that both the Hansard report and Trust statement have been shared with members - Nolan Show Query – to confirm that the Trust cannot comment on individual cases but confirm that all appropriate policies and procedures had been followed - Slieve Roe Parades – noted forthcoming planned parades	
14	DHSSPS CIRCULARS/CORRESPONDENCE There were no circulars to note.	
15	ANY OTHER BUSINESS There was no additional business to discuss.	
16	DATE OF NEXT MEETING Wednesday 30 September 2015	



**Notes of SMT Meeting held on
Wednesday 30 September 2015
@ 2pm in the Boardroom, Trust Headquarters**

Present: Paula Clarke
Kieran Donaghy
Francis Rice
Stephen McNally
Aldrina Magwood
Angela McVeigh
Paul Morgan
Esther Gishkori
Dr Richard Wright
Sandra Judt (item 9.3)
Elaine Wright (Notes)

ITEM	NOTE	ACTION
1	APOLOGIES There were no apologies.	
2	NOTES FROM THE PREVIOUS MEETING The notes from the previous meeting held on 23 September will be tabled at the next meeting.	<i>SMT 7 October 2015</i>
3	CHIEF EXECUTIVE BUSINESS 3.1 TPB Meeting, 25 September 2015 Members referred to the briefing issued regarding the recent TPB Meeting at the BCBV Meeting on 29 September 2015. 3.2 Visit by Permanent Secretary, 30 Sept 2015 The Chief Executive referred to the visit by Mr Richard Pengelly and expressed her thanks to all involved in what was a very successful visit.	

	She advised that Mr Pengelly expressed an interest to visit the Newry Site and that this will be arranged.	
4	MATTERS ARISING There were no matters arising.	
5	STRATEGIC PLANNING 5.1 SMT 1-2 October 2015 The itinerary for the forthcoming SMT Away Days was finalised by members. 5.2 Winter Pressures Action Plan Members referred to the current version of the corporate Winter Pressures Action Plan. Members discussed the details at length and each operational Director provided a verbal report on their individual actions and plans. OPPC - Flexing of beds in South Tyrone & Lurgan Hospital - Negotiation of number of beds per ward - Recruitment of specialist doctor - Issues re Nursing Home placements at weekends ACUTE - Recruitment of staff into post - Opening of winter ward on 1 November (17 beds) - CDU – move from 6 beds to 8 on 1 December - 7 day working - Patient flow co-ordinator from 6pm-midnight, DHH MH&D - Liaison Psychiatry - Memory Liaison – points of referral CYP - Paediatrics: revising scheduling of Community Nurse roles and establishment of Community Nursing Paediatric Team - Review of Paediatric on call system - Establishment of working group re Primary Care	

	- Extending Ambulatory on CAH site Mrs Magwood undertook to follow up actions arising from last week's presentation given by ALAMAC. Winter Pressures will be tabled at SMT end October/Early November and any emergent risks to be escalated as required.	<i>Mrs Magwood to progress</i> <i>SMT end Oct/ Early Nov</i>
6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plans Mr McNally advised that there was no change in the financial position reported to Trust Board on 25 September 2015. Mr McNally referred to the recent FSPB Meeting and updated members on discussions.	
7	PERFORMANCE UPDATE 7.1 Performance Update There was no further update from the report given to Trust Board on 25 September 2015.	
8	INNOVATION/CONTINUOUS IMPROVEMENT There was no specific business to discuss.	
9	GOVERNANCE ISSUES 9.1 Annual Quality Report Mrs Magwood reminded members to submit any comments to the draft QIP which was tabled at last week's SMT meeting. 9.2 RQIA Web Portal Mr Morgan advised members on the proposal by RQIA to develop a new Web Portal for the purposes of registration and quality improvement. Following discussion, members agreed to write to Maurice Atkinson, RQIA to invite him to a future SMT to	<i>All – comments to Mrs Magwood</i> <i>Mr Morgan to</i>

	share RQIA plans on the Web Portal. Mr Morgan undertook to draft letter. 9.3 Corporate Risk Register, September 2015 Mrs Judt attended the meeting to consider the Corporate Risk Register. Discussion took place regarding potential new risks and those which could be de-escalated to Directorate Risk Registers. Mrs Judt undertook to make the necessary changes and share an update with members. Mrs Gishkori to table DHH risk assessment next week.	<i>draft letter of invite</i> <i>Mrs Judt to progress changes</i> <i>Mrs Gishkori SMT 7 Oct 15</i>
10	INFECTION CONTROL UPDATE 10.1 HCAI Update/Briefing Dr Wright informed members of the current infection control figures for the month of September. Members noted the improvement in C-Diff figures for the month of September and again Dr Wright stressed the importance of continuing to promote policies and procedures with staff. Members noted that the Trust is actively pursuing and implementing the Stewardship Programme. 10.2 HCAI Update – PFA Targets There was no separate report.	
11	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 11.1 IPT's/Business Cases for approval - Replacement of Staff Call System at CAH - Proposed relocation of Ground Floor Coffee Bar at CAH Members considered the above IPT's and following discussion approval was given to proceed. - Summary of IPTs (Revenue) 15/16 for approval • Teenage Pregnancy/ Sexual Health - £93,983 • BME Alcohol & Drug Co-ordination Service/CADSS - £9,835 • Programmes to Improve Health & Wellbeing of Looked After Children - £15,000 • Special Diets in Schools Pilot Project - £1,640 • Dietetic Training on Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes - £2000 • Cook It! & Weigh to Health Programmes - £106,964	<i>Approved</i>

	• Accident Prevention - £27,130 • Fit 4 U Programme - £50,384 • AHP and Looked after Children – Community Paediatrics - £287,138 • Children with Complex Healthcare needs - £710,543 • Mrs Magwood referred members to the Summary IPT Report which included the above cases. Members approved in principal with the agreement that Mrs Magwood would circulate the individual cases for further discussion and final approval at the next meeting. 11.2 Capital Priorities Review Members referred to the Capital Priorities Review correspondence from DHSSPS and agreed to further discuss at next week's SMT meeting. The list of priorities will be issued to all members.	<i>Approved in principle. Will be shared with members in advance of next meeting on 7 Oct 15</i> <i>SMT 7 Oct 15</i>
12	WORKFORCE ISSUES 13.1 Medico Legal Posts Dr Wright asked that this item is removed from SMT agenda. 13.2 Mentoring Scheme for Medical Staff Dr Wright referred members to the Mentoring Scheme for Medical Staff which he explained is for all new and existing members of staff. Members noted and supported the paper. 13.3 Regional Percentage Absence Comparison Mr Donaghy referred to the Regional Percentage Absence Comparison report. He advised that this report was being confidentially shared with SMT members only.	
13	EXTENSION OF FLOATING SUPPORT SERVICE PROPOSAL Mrs McVeigh referred members to the Floating Support Scheme which is now in the 3rd roll out stage. She confirmed that funding comes from the Supporting People Fund.	

14	COMMUNICATIONS & PUBLIC AFFAIRS Members were aware of current issues in the media and the Trusts response/position regarding same.	
15	DHSSPS CIRCULARS/CORRESPONDENCE There were no circulars to note.	
16	ANY OTHER BUSINESS There was no further business.	
17	DATE OF NEXT MEETING Wednesday 7 October 2015	



Official Report (Hansard)

Tuesday 22 September 2015
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Assembly Members

Agnew, Steven (North Down)	McCallister, John (South Down)
Allen, Andy (East Belfast)	McCann, Fra (West Belfast)
Allister, Jim (North Antrim)	McCann, Ms Jennifer (West Belfast)
Anderson, Sydney (Upper Bann)	McCarthy, Kieran (Strangford)
Attwood, Alex (West Belfast)	McCartney, Raymond (Foyle)
Beggs, Roy (East Antrim)	McCausland, Nelson (North Belfast)
Bell, Jonathan (Strangford)	McCorley, Ms Rosaleen (West Belfast)
Boylan, Cathal (Newry and Armagh)	McCrea, Basil (Lagan Valley)
Boyle, Ms Michaela (West Tyrone)	McCrea, Ian (Mid Ulster)
Bradley, Dominic (Newry and Armagh)	McElduff, Barry (West Tyrone)
Bradley, Ms Paula (North Belfast)	McGahan, Ms Bronwyn (Fermanagh and South Tyrone)
Buchanan, Thomas (West Tyrone)	McGimpsey, Michael (South Belfast)
Byrne, Joe (West Tyrone)	McGlone, Patsy (Mid Ulster)
Cameron, Mrs Pam (South Antrim)	McGuinness, Martin (Mid Ulster)
Campbell, Gregory (East Londonderry)	McIlveen, David (North Antrim)
Clarke, Trevor (South Antrim)	McIlveen, Miss Michelle (Strangford)
Cochrane, Mrs Judith (East Belfast)	McKay, Daithí (North Antrim)
Cochrane-Watson, Adrian (South Antrim)	McKevitt, Mrs Karen (South Down)
Craig, Jonathan (Lagan Valley)	McKinney, Fearghal (South Belfast)
Cree, Leslie (North Down)	McLaughlin, Ms Maeve (Foyle)
Dallat, John (East Londonderry)	McLaughlin, Mitchel (Speaker)
Dickson, Stewart (East Antrim)	McMullan, Oliver (East Antrim)
Dobson, Mrs Jo-Anne (Upper Bann)	McNarry, David (Strangford)
Douglas, Sammy (East Belfast)	McQuillan, Adrian (East Londonderry)
Dunne, Gordon (North Down)	Maginness, Alban (North Belfast)
Durkan, Mark (Foyle)	Maskey, Alex (West Belfast)
Easton, Alex (North Down)	Middleton, Gary (Foyle)
Eastwood, Colum (Foyle)	Milne, Ian (Mid Ulster)
Farry, Stephen (North Down)	Morrow, The Lord (Fermanagh and South Tyrone)
Fearon, Ms Megan (Newry and Armagh)	Moutray, Stephen (Upper Bann)
Flanagan, Phil (Fermanagh and South Tyrone)	Murphy, Conor (Newry and Armagh)
Ford, David (South Antrim)	Nesbitt, Mike (Strangford)
Foster, Mrs Arlene (Fermanagh and South Tyrone)	Newton, Robin (East Belfast)
Frew, Paul (North Antrim)	Ní Chuilín, Ms Carál (North Belfast)
Gardiner, Samuel (Upper Bann)	Ó hOisín, Cathal (East Londonderry)
Girvan, Paul (South Antrim)	Ó Muilleoir, Máirtín (South Belfast)
Givan, Paul (Lagan Valley)	O'Dowd, John (Upper Bann)
Hale, Mrs Brenda (Lagan Valley)	O'Neill, Mrs Michelle (Mid Ulster)
Hamilton, Simon (Strangford)	Overend, Mrs Sandra (Mid Ulster)
Hanna, Ms Claire (South Belfast)	Poots, Edwin (Lagan Valley)
Hazzard, Chris (South Down)	Ramsey, Pat (Foyle)
Hilditch, David (East Antrim)	Robinson, George (East Londonderry)
Humphrey, William (North Belfast)	Robinson, Peter (East Belfast)
Hussey, Ross (West Tyrone)	Rogers, Seán (South Down)
Irwin, William (Newry and Armagh)	Ross, Alastair (East Antrim)
Kelly, Mrs Dolores (Upper Bann)	Ruane, Ms Caitriona (South Down)
Kelly, Gerry (North Belfast)	Sheehan, Pat (West Belfast)
Kennedy, Danny (Newry and Armagh)	Somerville, Neil (Fermanagh and South Tyrone)
Lo, Ms Anna (South Belfast)	Spratt, Jimmy (South Belfast)
Lunn, Trevor (Lagan Valley)	Storey, Mervyn (North Antrim)
Lynch, Seán (Fermanagh and South Tyrone)	Sugden, Ms Claire (East Londonderry)
Lyons, Gordon (East Antrim)	Swann, Robin (North Antrim)
Lyttle, Chris (East Belfast)	Weir, Peter (North Down)
McAleer, Declan (West Tyrone)	Wells, Jim (South Down)

Northern Ireland Assembly

Tuesday 22 September 2015

The Assembly met at 10.30 am (Mr Speaker in the Chair).

Members observed two minutes' silence.

Assembly Business

Ministerial Resignation: Miss McIlveen

Mr Speaker: Before we proceed to today's business, I have an announcement to make. I wish to advise the House that the Minister for Regional Development, Miss Michelle McIlveen, resigned her office on 21 September 2015. *[Interruption.]* Order.

Standing Order 44(3) provides for a seven-day period during which the party that held the office can nominate a member of its party to replace them and take up that office. That period will expire at the end of Sunday 27 September 2015. I am satisfied that the requirements of Standing Orders have been met. Let us move on.

Mr Allister: On a point of order, Mr Speaker. Can the House be advised whether these 10-minute Ministers are being remunerated and whether, by the recycling of their resignations every seven days, they are maintaining their continuity of service for pension purposes?

Mr Speaker: Those are not matters for the Speaker, as you will know, and they are certainly not matters on which I would have information. I have noted some of the media comments from the people concerned, who have indicated that they are not accepting their salaries. The questions that you raise are not for my office.

Ms Fearon: On a point of order, Mr Speaker. I apologise for missing a question to the Acting First Minister yesterday. I will ensure that it will not happen again.

Mr Speaker: I am not sure that you should be smiling when you are making an apology, but I accept your apology.

Executive Committee Business

Pension Schemes Bill: Consideration Stage

Mr Speaker: The Consideration Stage of the Pension Schemes Bill is listed in the name of the Minister for Social Development. As that ministerial office is vacant, the item of business cannot be moved.

Private Members' Business

Assembly and Executive Reform (Assembly Opposition) Bill: First Stage

Mr McCallister: I beg to introduce the Assembly and Executive Reform (Assembly Opposition) Bill [NIA62/11-16], which is a Bill to provide for the formation of an Assembly Opposition; to provide for the passing of an Assembly and Executive Reform Motion; to reform the Assembly and the Executive; and to provide that all Northern Ireland Departments are a single legal entity.

Bill passed First Stage and ordered to be printed.

Mr Speaker: I am sure that you are very glad to hear that, John.

Syrian Humanitarian Crisis

Mr Speaker: Before we proceed, can I confirm that Ms Anna Lo will propose the following motion? Thank you. The Business Committee has agreed to allow up to one hour and 30 minutes for this debate. The proposer of the motion will have 10 minutes to propose and 10 minutes to make a winding-up speech. All other contributors will have five minutes.

Ms Lo: I beg to move

That this Assembly expresses its despair at the ongoing international humanitarian crisis in Syria; notes the tragic deaths of refugees fleeing to Europe seeking sanctuary and the terrible conditions endured by those refugees in transport to Europe and in refugee camps upon arrival; believes that EU nations have a moral obligation to assist people seeking refuge from war and persecution; further notes the Prime Minister's eventual decision to accept 20,000 refugees; further believes that the UK Government and some other EU Governments have not acted in line with their humanitarian obligations; and calls on the Executive to ensure provisions are in place for Northern Ireland to welcome refugees from Syria.

It has been more than three years since human rights groups confirmed the Syrian Government's use of cluster bombs in an attack that killed innocent people, many of whom were children. So far, 220,000 people have died and four million have been displaced, but it took the image of one dead child lying on the shores that his parents hoped would offer them safety to remind us of our common humanity and the need for action. There seems to be some confusion regarding whether a person is a refugee or an immigrant. Economic migrants are different from refugees fleeing conflict, and we must not conflate the two terms. We cannot let the politics of immigration stop us helping those fleeing violence and persecution.

We are experiencing great political uncertainty at a time when we find it hard to agree on many things. This motion is surely something on which we can all unite. The compassion of Northern Irish people never ceases to amaze me. We have seen rallies, appeals and petitions and even people offering to open up their homes to those in need. In a radio interview three weeks ago, I mentioned that the Alliance Party offices were taking collections for refugees in Calais. To be honest, for a few days it was difficult to move between desks in our premises with all the donations that were received. This is the best of Northern Ireland, and I would like to pay tribute to our generous people whose response has been truly heart-warming.

The UK Government have undoubtedly been generous in aid terms, with 0·7% of our GDP rightly spent on international development. However, we are here today to discuss the adequacy of the overall approach. Since 2011, the UK has granted humanitarian protection to almost 5,000 Syrians through normal asylum procedures. The Prime Minister recently

announced that the UK would accept 20,000 Syrian refugees over five years, but 4,000 refugees a year is not enough.

If Northern Ireland takes only 3% of that pro rata, that is 120 refugees per year. When you compare that with the 800,000 welcomed into Germany or the 24,000 into France, you see that it is clear that we could be doing more. Even Brazil, which is halfway across the world, has taken in 2,000 Syrian refugees.

The crisis is now. We do not know what the situation will be in a few years' time. We should be doing all we can now. I welcome the deputy First Minister's proposal that Northern Ireland could accommodate 2,000 refugees. The public will is there; they want us to help.

We have a moral responsibility to help refugees, and Britain has a proud history of doing just that. At the end of the Vietnam War, Britain took in 19,000 Vietnamese, the so-called boat people, who were fleeing violence and persecution. In fact, I volunteered with the Red Cross then to help Vietnamese families to settle in Craigavon. They not only integrated extremely well but were entrepreneurial in setting up businesses and seeking employment. The Syrian refugees have much to offer our society. There are doctors, engineers and other professionals in those refugee camps who are seeking a better life. Let them seek it here.

However, good sentiments are not enough. We need a plan to ensure that provisions are in place for us to welcome the refugees. That is OFMDFM's responsibility, and I understand that the Department is looking at various ways to help us to play our part and work with the Home Office and other Departments.

The Refugee and Asylum Forum has produced a five-point list of necessary measures to ensure the smooth process of integration for newly arrived refugees. The first is a call for a refugee integration strategy. We are the only region in the UK without a strategy, which is pertinent, given that integration continues to be something of a difficulty in our society.

The Strategic Migration Partnership produced a paper in 2013 outlining what the strategy would look like. A key point was that actions taken by Departments and agencies could not be done in isolation. For the meaningful integration of refugees, the approach must be collaborative. I would like clarification from OFMDFM regarding whether it is seeking to introduce a refugee integration strategy and what interim measures

it is planning to take to facilitate integration in the absence of a strategy.

Mr Lyttle: I thank the Member for giving way. The Member will be aware that, on 9 September, as Deputy Chair of the Committee for the Office of the First Minister and deputy First Minister, I requested that officials seek an update from OFMDFM on the contact it had with the Home Office and, indeed, on the refugee integration strategy. Would she agree that the people of Northern Ireland deserve a fuller and more formal statement from OFMDFM on these matters as a matter of urgency?

Ms Lo: Absolutely; I totally agree and thank the Member for mentioning it.

The Refugee and Asylum Forum calls for a long-term commitment to welcome refugees, which is important. Our support should last beyond the news cycle and should include the provision of free English classes and housing. The final request is that the Executive work with those in our excellent support sector, some of whom, I am delighted to say, are with us today in our Public Gallery. Those organisations are already on the ground supporting refugees and asylum seekers, and their expertise will be valuable.

One cause for concern is that OFMDFM's track record in delivering is not always the best. Over the years, a number of organisations and Churches have had to step in to provide support to refugees and asylum seekers in the absence of government support. For example, when OFMDFM announced the introduction of the crisis fund to help the most vulnerable in 2014, it took a year until it was put in place. A small amount of money can make an enormous difference to these people, particularly to destitute asylum seekers who are often left in limbo with very few options and have difficulty accessing services. It is paramount that we ensure that our services are prepared for the refugees whom we will be welcoming. I ask that OFMDFM ensures that generous offers made by the public can be turned into practical assistance, and I look forward to hearing, in the near future, from the Department on the progress made in coordinating our efforts.

10.45 am

The scale of this problem is huge, and there are no quick solutions. However, it is clear that there is a very great need for a coordinated European response. This is not just about taking in refugees but is about dealing with the

root causes in conflict areas and tackling the criminal gangs that are preying on vulnerable refugees.

As Members will be aware, I have a particular interest in ending modern slavery, and the unspeakable horrors that refugees face at the hands of traffickers must be dealt with. I welcome the Home Secretary's recent joint declaration with France for new law enforcement collaboration and intelligence sharing. One of the most harrowing stories to emerge is of the 52 people who died in the airless hull of a boat. Those who survived that journey did so only because they could afford to pay to come up on deck to breathe. We cannot allow that to happen again. We must work together.

No one chooses to be a refugee. A person who risks everything, even life itself, in search of a tolerable existence is a person whom we must help. I urge you to support the motion.

Ms Ruane: Go raibh maith agat, a Cheann Comhairle. I thank Anna Lo and her party for bringing forward the motion. I absolutely agree with Ms Anna Lo that no one chooses to be refugee. None of us in the House would choose to be a refugee and leave our homes and our families and bring our children with us for many thousands of miles.

Let us look at the global trends report from 2014. These figures are outdated at this stage. In the world, 59 million people are being forcibly displaced by persecution, conflict, generalised violence and human rights violations. We have 19.5 million refugees and 38.2 million internally displaced persons and asylum seekers.

To put the debate in context, which countries are the top hosts of the refugees? I can tell you that they are not in Europe. They are as follows: Turkey, Pakistan, Lebanon, Iran and Ethiopia. The developing world hosts 86% of the world's refugees. For example, of the four million Syrian refugees, 1.2 million are in Lebanon; that is one fifth of the entire population of Lebanon. Six per cent have sought asylum in Europe. It is paltry and tiny, yet look at how the European Governments, with a few exceptions, are dealing with this.

Look at how many people have died coming to our shores. Look at how many people are on rafts and boats that are so dangerous for them and are coming from Libya to Italy on the Mediterranean Sea. It is a risky, dangerous journey, and they are fleeing from a war that was not of their making. Men, women and children are leaving their homes because of

policies made thousands of miles away in England, the United States, Europe, China and Russia, the bigger superpowers. They are fleeing because of a global crisis, because of deep injustice and because of repression.

The crisis needs a global response. It needs a human-rights-based response. It is not good enough for Europe to say that it will not play its role. It is not good enough for countries like Hungary to build fences to keep people out, a bit like Israel does.

We need a twofold approach. We need conflict resolution. The superpowers need to be challenged. They are the ones who have caused the conflict. As Ms Lo said, we need to look at the root causes of conflict. We need to challenge the superpowers and the arms manufacturers. We also need to provide sanctuary for refugees. Citizens across Europe are ensuring that their voices are heard. We have seen them on this island, in Dublin, Belfast, Newry, Fermanagh and Derry — all over Ireland. Their voices are saying that refugees are welcome — tá fáilte romhaibh — to this island. We know what it is like to flee in the coffin ships and the boats. We know what it is like to arrive in a country with nothing but the clothes on our backs. That is what our ancestors did. We need to open up our doors, and our Governments in Ireland and Europe need to follow the citizens. As usual, the citizens are leading from the front.

I put on record and pay tribute to what Martin McGuinness and the deputy First Minister's office are doing. As the proposer of the motion will know, they are meeting NGOs, community-based forums and representatives from councils across the North. Officials from OFMDFM are also involved in a joined-up approach to support refugees who come here. John O'Dowd — I welcome the fact that the Minister is in the House — has tasked his officials with making preparations for children and education. I also pay tribute to the Department of Education, which has been leading from the front. Indeed, during my time, we brought forward the English as an additional language report and Every School a Good School, and extra resources were given to schools for every ethnic minority child that they had so that they could put in place special programmes.

Mr Speaker: The Member's time is almost up.

Ms Ruane: That will continue. Sinn Féin supports the five key actions that have been developed by the Refugee and Asylum Forum

and endorsed by the 16 organisations. We very much welcome the work that they are doing and look forward to ongoing partnership working.

Ms Hanna: I commend the Members for tabling the motion. It is vital that the Assembly continues to give voice to the solidarity, the very clear solidarity, of people here with the millions who are fleeing conflict in Syria and elsewhere. It is also appropriate that we look at the practical support that we can offer.

Members have outlined some of the context of the crisis that has seen several hundred thousand people dead in Syria, half of that country's population displaced and 12 million people, including over five million children, in need of humanitarian assistance. All the indicators are that those numbers will only get worse.

It is vital to preserve the integrity of the word "refugee". Since 2011, life expectancy in Syria has decreased by 13 years, and the country has seen a reversal of all the progress that was made on the millennium development goals, including the numbers of children attending school having halved and a dramatic increase in acute malnutrition among children. The suggestion that people who are crossing the sea in boats, spending days in the back of fridges or literally walking across countries with their children on their shoulders are doing so for a change of scenery or a new job is unconscionable and should not be given the time of day.

All of us in the Chamber and across Europe have been very moved by the images of refugees making those desperate journeys to Europe. As the Member pointed out, we should remember that only a tiny fraction of the numbers are making their way to and arriving in Europe. The vast majority are displaced in Syria, and around four million are in Turkey, Lebanon, Jordan and other nearby countries. The work that has been done by aid agencies such as Concern, Oxfam, Trócaire and Christian Aid, representatives of some of which are with us today, will literally mean the difference between life and death for people at the very sharp end of the conflict. I know that those organisations are being generously supported by people here.

The UK and Irish Governments have provided substantial financial aid to support the humanitarian needs of the people in those camps in and near Syria. That should continue and be increased, but the EU also has a moral obligation to increase the safe, legal routes into

Europe for people who are literally fleeing the total destruction of their countries.

The theory that search and rescue is a pull factor should not be entertained. Search and rescue needs to be increased. We are going into the winter months, when those desperate and dangerous journeys are going to become even more perilous, and that support should be enhanced. If we cannot do that, I think that the European Union will have lost sight of what it was intended to do.

We should also remember, as other Members have pointed out, that most of the people who have made their way to Europe are skilled, educated workers who have a lot to offer here, as have previous economic migrants. They will bring substantial benefits to our economy and our community.

The motion also calls on us:

"to ensure provisions are in place ... to welcome refugees from Syria."

That is, of course, a reserved matter, but it is clear that there are gaps in ensuring the humane treatment of existing refugees and asylum seekers, as well as that of those who will hopefully come from Syria. It is not enough for us to get into an auction about how many we are going to take without ensuring that the response is planned and properly funded. I welcome the guidance given by the Refugee and Asylum Forum on how we can better do that, and our party endorses those proposals.

The key priority is, of course, a refugee integration strategy, as is in place elsewhere. It seems shameful that, at precisely the time that asylum seekers and refugees should be assisted with getting on with their new life here, they are instead having to navigate complex bureaucratic and legal systems to get what they are entitled to. I understand that each new arriver is having to reinvent the wheel in accessing legal support, education and healthcare. Vital organisations such as the Law Centre, Homeplus and the Northern Ireland Community of Refugees and Asylum Seekers (NICRAS) are providing that support, but a strategy developed by those providing it would make the journey a lot easier. I understand that the racial equality strategy was receptive to it, but, like another load of documents, it has not made its way out of the OFMDFM bunker. Now would be the appropriate time for it to do so, ideally with a central coordinating group — such as the Law Centre — that would allow us to monitor the numbers. That would mean that

statistics were not muddled by those seeking to undermine the integration of refugees.

Mr Speaker: The Member's time is up.

Ms Hanna: Mr Speaker, an open humanitarian response to the crisis is our moral obligation, and it is the will of the people here. We support the motion.

Mr Speaker: This is the first debate in which the Assembly will hear from Mr Andy Allen, so I remind the House that it is the convention that a maiden speech be made without interruption.

Mr Allen: I am honoured to be in the House as a representative of East Belfast, where I was born and bred. First, I pay tribute to Michael Copeland, who, I know at first hand, worked tirelessly and passionately for the people of the constituency. I thank Michael for all his help and assistance in the past and wish him well on what I hope will be a road to recovery. He was totally committed to his role as a public representative who sought to give a voice to people who often felt marginalised, and I promise that I shall do my best to ensure that I continue down that path. I am especially keen to tackle the educational underachievement that has affected too many young people from the east; to tackle housing stress; and to play my part in attracting jobs and investment to an area that was once Northern Ireland's economic powerhouse but is now in need of help to restore its fortunes and to give its people a sense of purpose. I am up for that challenge.

It gives me no pleasure to speak on this motion. On 2 September 2015, the world was shaken by the horrifying images of young Alan Kurdi's lifeless body washed up on a Turkish beach. There is no doubting the enormity of the humanitarian crisis that has emerged from the chaos in the Middle East and north Africa. The Syrian civil war has been raging for four and a half years and has claimed the lives of 200,000 people. As a result of the twin evils of the barbaric Islamic State and the brutality of the Assad regime, each day there are fewer safe places in Syria and, indeed, the region in which it lies. The EU has struggled to cope, and Governments in the Balkans in particular have been forced to make policy on the hoof as border crossings are opened and closed, almost on a whim, as states become overwhelmed.

11.00 am

I do, however, draw a distinction between genuine refugees, who are fleeing persecution

and violence, and who have made their way to Europe in search of a place of safety, and economic migrants, who are simply seeking access to Europe in a search for a better life. We, in Northern Ireland, are not responsible for immigration policy or the granting of asylum, so we must work closely with the UK Government to play our part in alleviating suffering. Our natural sympathy and desire to help fellow human beings in their desperate plight need to be matched by an appreciation of the practicalities of the situation.

The Law Society highlighted a number of key actions that it would like to see delivered for those refugees who are accommodated in Northern Ireland, including a refugee integration strategy and free accredited English language classes for all refugees. I believe that these actions, in particular, are vital if we are to allow those refugees who wish to settle in Northern Ireland the opportunity to fully integrate into society. The Law Society also calls for a commitment to partnership working. I do not believe that this should be restricted to dealing with refugees who arrive in Northern Ireland. This Assembly should develop partnership working between all Departments and agencies as a matter of course. It is not enough to say that we will ensure that those entering Northern Ireland as refugees will receive the best possible support through healthcare, housing and education. That is something this Assembly and Executive should already be committed to delivering for every person in Northern Ireland.

The Ulster Unionist Party fully supports the steps taken by the UK Government, including the spending of £900 million from their foreign aid budget on helping some of the four million refugees who have fled Syria since the war began. The vast majority are in refugee camps in neighbouring Turkey, Lebanon and Jordan, and the need for humanitarian aid is constant.

In the longer term, political solutions are a much more effective response to the migrant crisis than opening up another country's borders. Syrian refugees accepted into Europe or the West are a small part of the total need. There are four million Syrian refugees living in bordering countries and another 78 million displaced Syrians living in Government-controlled areas in Syria. Permitting more Syrians to immigrate addresses a symptom but not the root cause. The majority of Syrian refugees do not want to emigrate to Europe or elsewhere. We must work to address the causes of the flight of people from Syria, namely the brutal conflict in the region fuelled by the terrorism of Islamic State. Only then will

the people of that region who are currently displaced be able to return home and rebuild their and their families' lives in their own country. Maybe we should pay heed to the words of a young Syrian boy trying to reach Europe. He said:

"Stop the war in Syria, and we will not want to go to Europe."

Some Members: Hear, hear.

Ms Fearon: Go raibh maith agat, a Cheann Comhairle. Like the previous Member who spoke, I welcome the opportunity to speak in this debate. However, we would all rather that such a discussion was not necessary. We would all rather that there was no such suffering in the world, but the heartbreaking images of the pain and suffering of refugees fleeing Syria have brought home to millions the need for urgent humanitarian action. It is worth noting at the outset that, while Syrian is to the fore of people's thoughts regarding this crisis, there are also people fleeing Palestine, Libya, Eritrea, Afghanistan and Iraq, to name a few. The conflicts in these places are mostly caused or worsened by Western action, so there is also an onus and responsibility on Governments to address these humanitarian issues.

I pay tribute to my friend and colleague Martina Anderson MEP for the amazing work that she has been doing on this issue. She is visiting a refugee camp in Jordan, having visited one in Italy. Her overwhelming passion for this issue is clear to be seen, and there are many more like her. Speaking from Jordan this week, she said:

"These refugees face the choice of dying in the conflict in Syria, drowning in the Mediterranean or starving in refugee camps."

As the motion states, that is the dire situation faced.

The response to the shocking pictures of the body of three-year old Alan Kurdi washed ashore has shown the depth of feeling on this issue. In fact, once again, citizens have proven to be way ahead of the British and Irish Governments by offering to do what they can, as Ms Lo stated earlier, even opening up their own homes. We have not only an international obligation to act but a human one. Alan Kurdi should have been playing on a beach, not washed up on one; but it should not have taken such a picture to wake many up to the reality

that these are our brothers and sisters, our fellow human beings.

Do Governments respond with humanity across Europe? No. Instead, they increase coercive measures to keep people out to reinforce "fortress Europe". Thirty thousand men, women and children have drowned in the Mediterranean Sea in a desperate attempt to flee wars and persecution over the last number of years.

The media and certain Governments have a lot to answer for. They have dehumanised refugees and provoked racism and xenophobia throughout Europe, and they need to take responsibility for their actions.

Ms McCorley: Go raibh maith agat, agus gabhaim buíochas leis an bhall as an urlár a fhágáil fúm. I thank the Member for giving way. Does she agree that we need to stop refugees being destitute and that we can do this by ensuring that there are as few administrative delays as possible so that they are not left without money? Does she also agree that we need a proper strategy for dealing with refugees so that there are plans to coordinate support services in areas such as education, hate crime, jobs and integration?

Mr Speaker: The Member has an extra minute.

Ms Fearon: I thank the Member for making that important point. It is important that we offer whatever practical help we can to refugees.

Europe has a responsibility to help these people. This is very much a crisis of European creation. Member states encouraged, started or participated in the wars that these people are fleeing from, but European policy allows member states to shake off their responsibilities. Europe must step up and commit to meaningful action on relocation and resettlement, which will provide a fresh start for many. We need a radical shift of migration and asylum policies across Europe. Indeed, the European Union Charter of Fundamental Rights states that all have the right to dignity, which includes life, and freedoms, which include liberty, prohibition of all discrimination and, crucially, asylum.

Closer to home, the Irish and British Governments must do more to tackle this humanitarian disaster. The response of the Irish and British Governments should match the scale of the crisis and the generosity of our people, which has, once again, been overwhelming. We can be proud of the

response in all our local areas. In my area, solidarity collections and vigils have been held across Newry and south Armagh. I hope that we can find a resolution to this crisis that puts people before politics. One thing that we can all agree on is that the Executive should do everything in their power to help. A humanitarian crisis of this scale must be met with humanity.

I want to finish, perhaps in an unorthodox manner, with an extract from a poem about this crisis called 'Home'. It is very powerful and brings home the reality that these people are facing:

*"you only leave home
when home won't let you stay.*

*no one leaves home unless home chases
you
fire under feet
hot blood in your belly
it's not something you ever thought of doing
until the blade burnt threats into
your neck
and even then you carried the anthem under
your breath
.....
you have to understand,
that no one puts their children in a boat
unless the water is safer than the land".*

Mr Eastwood: Mr Speaker, last night, you, along with our colleague John Dallat, organised and hosted an event about the Great Famine. I commend you for doing that. It is a major event in our history, one that we should never forget. We should not forget it because, in the immediate aftermath of the Great Famine, one million people died. One million people travelled to other parts of the world, many of whom died on coffin ships. Even if they did reach places like America, they received a very hostile reception in a lot of cases. Many others went on and did very well, and, in subsequent generations, their families ended up in very prominent positions in places like Washington DC. We, on the other hand, many years later, have not learned the lesson that we need open and welcoming countries for people who are in deep and real crisis. If America, for example, had been closed to Irish refugees — refugees is what they were — what would have happened to all those people? People were dying in the ocean, and now, in 2015, people are dying in the ocean. It is not good enough.

One of the founding values of the European Union was the protection of human dignity. I am not so sure that the scenes around the borders of Hungary are living up to that

founding value. Sanctions need to be placed on EU countries that do not live up to those values because it is a stain on the reputation of the European Union that, instead of opening our arms to people who are fleeing brutal conflict, we close the doors and fire tear gas at them.

I do not think that that is something that we can be proud of at all; it is something that we should be very ashamed of. All of us, as European citizens, need to respond to that. I know that in this city, my city and places all around the North, we have had demonstrations, with people saying that refugees are welcome in their homes. That is an illustration of the character of the people of this place. Even though we all have great difficulties here — there are 4,000 on the waiting list for houses in Derry — people in Derry are still saying, "Come here. We will look after you. We will open our arms to you." They understand the difficulties that people are going through.

When we had a Matter of the Day on this issue a couple of weeks ago, I was criticised for making a political speech. People told me that it is not about politics and that it is only about a humanitarian crisis. However, these people are not fleeing an earthquake. They are fleeing a manmade crisis, whether it is the evil of Assad's regime, the evil of ISIS or the stupidity of Western Governments and their interventions in places like Iraq. We helped to create this crisis. We need to help to solve the problem as it stands.

About five minute before I rose to speak on that day, the First Minister, if that is what he still is, made a comment that the Executive would not be meeting. I know that a lot of these issues are reserved, but we in these institutions have a responsibility, in whatever way we need to and have to, to meet as an Executive, to act in whatever way we need to act, and to allow the Executive to make those decisions. However, they cannot take those decisions if they do not even meet as an Executive. The people are calling on the politicians up here, whatever our other difficulties, to act on this issue and to be to the forefront of showing the compassion that is required to meet these refugees with open arms and to ensure that, if they do get this far, they are not living in the destitute conditions that some of our recent refugees are living in at the minute.

This is a political issue. There are many major geopolitical implications to all these things, but right now we have an Executive that are not meeting. We have responsibilities. Our responsibilities are not as large as the UK

Government's, the Irish Government's or anybody else's, but we have responsibilities and we cannot meet those responsibilities unless this Executive meet. I encourage the First Minister to change his attitude.

Mr Allister: I begin by congratulating Mr Allen on his maiden speech. Some of those who spoke subsequent to him have obviously forgotten the tradition of congratulating a person on their maiden speech. I do that genuinely. I wish him well, and I look forward to his further contributions.

One would have to be utterly heartless not to be struck and very moved by the sheer devastation that we have seen in Syria. It is a country that has been bombed to a pulp by the various factions, and it is no surprise that, in consequence of that, there is a migration of refugees. We should approach their plight with considerable sympathy, and not just sympathy but by stretching ourselves in terms of material and other support. This is such an emotive subject that, if you dare to ask questions that in other circumstances would be objective and reasonable, you run the risk of being vilified for daring to raise those subjects and being painted as someone who is, in fact, heartless. However, with the spectacle that we are witnessing across Europe, there are questions that have to be asked: are all those whom we see on our screens truly refugees? There seems to be a great preponderance of young men, which perhaps speaks more of economic migration. I think that we need to distinguish the necessity for our humanitarian response from a genuine refugee situation, which, in international law, is met in the country where the refugee first arrives.

11.15 am

Mr Agnew: Will the Member give way?

Mr Allister: Yes.

Mr Agnew: Is the Member prepared to accept that, in the filtering process to try to separate the deserving from the non-deserving, as he perhaps see it, we could contribute to human suffering, whereby more people will die, rather than simply having a more humanitarian approach and giving people the benefit of the doubt in the first instance?

Mr Speaker: The Member has an extra minute, of course.

Mr Allister: Thank you.

I take the point, but you, and Europe as a whole, cannot give carte blanche. Given all the risks that come to Europe's security, with the possibility of some of those under the cloak of the crowd of refugees being jihadists who come to destroy, not to build, their lives or anyone else's, I think that Europe has to be careful and to approach this thing sensibly.

What I see is a great thrust of people who are determined that they are getting to Germany. That is fine. People may have that aspiration, but is that the first priority of a refugee or is safety the first priority of a refugee? I think that one has to be careful about some of those matters.

I also think the motion is a little unfair to the United Kingdom Government, because it berates the Government for not acting in line with their humanitarian obligations. The United Kingdom Government in the last four years have contributed more than any other European state in humanitarian aid — £920 million. In fact, and I think that this is a point worth making, that is considerably more than many of the neighbouring Arab states in the Middle East, which have contributed paltry amounts in comparison with their wealth. If you take the United Arab Emirates, you see that it has one of the highest GDPs in the world. The United Kingdom has contributed three times what the United Arab Emirates has contributed and almost three times what Saudi Arabia has contributed. So, I think that there is an obligation on the adjacent Arab states that has not been fully and adequately met.

I think that, before we berate our own Government about these matters, we need to recognise the scale of the contribution they have made, which is now approaching and soon to surpass £1 billion. The motion derides that, with no criticism of other countries in Europe. If we take the example of some of the major countries in Europe, such as France, we see that it has contributed £70 million in humanitarian aid, as opposed to the £1 billion of the United Kingdom. So, I reject the notion that the United Kingdom has not lived up to that responsibility.

What is our responsibility in that context? Our responsibility is to take our share of whatever the United Kingdom properly admits as a refugee quota. That is our obligation as a devolved part of the United Kingdom, and I am sure that we will meet it handsomely. However, it is not for the Assembly, which does not have control over these matters, to set artificial aspirations or to say that we will do things that we know we cannot do. Our obligation is to live

within the responsibilities that our nation meets and for our nation to meet its responsibilities. In that way, we approach the thing properly.

Mr Agnew: I echo the comments of Mr Allister in welcoming Mr Allen and congratulating him on his maiden speech.

I think the first thing that everybody has asked in this humanitarian crisis is this: "What can I do?" It is time for the Assembly and these institutions to ask this question: "What can we do?" The public have stepped up. It has been pointed out that people have offered their spare rooms and their homes. They have offered to help, but what they have not seen is public services step in to facilitate the support that they wish to give.

Towards the end of last week, I visited the Northern Ireland Calais Refugee Solidarity group in north Down. It is running out of space to take donations, so the public is stepping up. The group needs the statutory services to do what they can to facilitate the goodwill that is there among our electorate and ensure that those who wish to help can give real help to those who are in a time of need.

The Law Centre has launched its SAFER campaign, calling for a big Northern Ireland welcome for refugees, and it has outlined some practical steps that the Assembly can take. It will need a coordinated response, which will require the Executive to meet and for us to get past our current difficulties and give a real focus to the situation. The SAFER campaign asks us to stop destitution and ensure that refugees, when they come to our shores, have support to ensure that their basic needs are met. It also calls on us to ask the experts. There are those who are expert in the situation faced by refugees and asylum seekers. For example, NICRAS has come out in the media and said: "We have been doing this work for years and we have the expertise, but we need the additional support." Greater numbers are going to come in, and NICRAS will need that support to carry on its excellent work.

The SAFER campaign calls for financial help, which does not have to be direct subsidy which, I know, is almost a bogeyman that is created. It is said that these people come here for the £45 per week or whatever it might be that they can access on benefits. I know that I would not risk my life for that, and I am sure that the people travelling in the boats do not risk their lives in the hope of the great boon of our benefits system. It is about putting support systems in place to ensure that, when we take in refugees with open arms, as our public has demanded, we do so to offer them a better opportunity.

The campaign calls for the provision of English classes, to ensure particularly that children entering education have the best hope and an equal opportunity to realise their potential. It calls for a refugee strategy. This is not something new. Refugees have been coming to Northern Ireland, and the support mechanisms probably have not been sufficient. That is being highlighted now through the attention being brought by the current humanitarian crisis which has been created.

The final ask of the Law Centre's campaign is to end the big injustice. That is the assumption, almost, of guilt by those who seek refuge in the UK as a whole. Until we can process people, we lock them up. Innocent people, including children and families, are held in detention centres. In the past, we have deported people, who have made their lives here and become a part of our community, by coming into their homes in the middle of the night. We should have a humanitarian response to a humanitarian crisis. We should follow the lead of those citizens who have stepped up and said: "I want to help." This Assembly should help.

Mr McNarry: I, too, welcome Andy Allen's contribution in his maiden speech. I also welcome it because I noted the criticism of the EU countries in the debate. I welcome that criticism because it is likely to impact on our exiting the EU in next year's referendum.

In this debate, we enter the realms of a definition. We have been here before with definitions, and here we have the definition of the word "migrant". That is why this motion is highly commendable.

It is an expression of heartfelt human sympathy that, I believe, the House can rise to and unanimously support. How can we feel anything but the deepest humanitarian sympathy for genuine refugees caught up in an appalling war situation, in what, for them, is a no-choice situation? It is a situation characterised by the most appalling levels of violence and brutality that has been visited on ordinary, innocent civilians.

Who would not try to do their best for their families, especially for their children, when deprived of a future by warring savages, who are destroying Syria's past, present and future? It is said that the grass is always greener for those who see, for example, a minimum wage in our country that is nine times the amount they could expect to earn in their own country, and who would fault them? On the other hand,

in this debate the question has to be who can afford them?

We must follow the lead of Her Majesty's Government in taking 20,000 genuine refugees over the next four years. Of the 20,000 that the United Kingdom is taking, how many will be allocated to Northern Ireland? Where in Northern Ireland will the planned reception centres be located? Decisions on that will enable the proper level of forward planning. I see an absence of forward planning at this crucial moment, but that is so important in a refugee emergency situation. It is vital that all of those given refugee status are properly assessed so that they know where they stand, and that they are properly catered for and looked after. In that regard, I believe, as I said before, that many Arab countries, particularly rich countries like Saudi Arabia, should do far more to help refugees from Syria. I also believe that the United States — now that, at long last, it came forward yesterday and said that it will take refugees next year and the following year — should be explicit about the numbers that it will take.

My own party leader, Nigel Farage, has drawn attention to the particular plight of Christian refugees from Syria, who stand in the greatest danger from those ISIS fanatics. For Christians, there are no safe camps that they can enter. That is something that a country like ours, with our Christian heritage, should be especially sensitive to.

I remind the House that the mass migration of whole populations from North Africa and the Middle East is a long-term problem. It has been driven by water, by poverty and now by war. It is going to need a great deal more thought and strategy than the simple but well-meaning humanitarian response that we all share and that the motion rightly calls for. In that regard, I invite Members to attend a talk given by UKIP's immigration spokesperson, Steve Woolfe, in the Skainos Centre on the Newtownards Road on 2 October, where those major issues will be addressed.

Mr Hazzard: I thank the Member for giving way. You talk about party colleagues. Recently, your South Down party colleague made some quite despicable comments about the Syrian refugee crisis. Will you take the opportunity today to distance yourself from those comments? Go raibh maith agat.

Mr Speaker: The Member has an extra minute.

Mr McNarry: Thank you. I have to be precise and tell the Member that I do not have a party colleague in South Down.

As I was saying, it has to be about public perceptions based on accurate facts and proper information. Regrettably, too often misinformation, rumour and gossip have led to action based on ignorance. We have seen it on our streets. We have seen it particularly in Belfast. In that regard, neither this House nor anyone who is active in politics can afford to avoid the issue of resentment. It is something that we, too, will have to deal with appropriately and properly. There is a problem with immigration: the criminals who visit us on the back of it; the benefit tourists; and so on. However, for genuine refugees, the motion has my support.

11.30 am

Mr McAleer: Go raibh maith agat, a Cheann Comhairle. I regret not being in the Chamber earlier to hear the maiden speech of Andrew Allen.

Mr Speaker: Will you pull the microphone a little bit closer, for the benefit of Hansard?

Mr McAleer: Sorry. I regret not being in for his maiden speech, but he is very welcome.

We will all have been taken by the plight of the Syrian refugees. In local communities, not just in my district but throughout the North and throughout the country, we have seen a huge outpouring of grief from ordinary people who want to do something to help resolve the situation.

I spoke recently to my colleague Martina Anderson MEP. She made the point that, in the small strip of the Mediterranean between Italy and Libya, 30,000 people have drowned in the past 10 years. She said that it is like a floating graveyard. It took the images of the two young children, Galib Kurdi and Alan Kurdi, aged five and three, who were fleeing Syria and had their young bodies wash up on a beach, to make people realise the extent of the plight that those people face. I am the parent of a three-year-old child and that image struck me very sorely. I think that most people connected that image to their own family.

Martina has just come back from visiting a refugee camp in Jordan where there are 80,000 people crammed in together with very little water, no food and very little hope. Unfortunately, most of them have only three

choices: they can either die in the conflict; they can drown in a dinghy in the Mediterranean; or they can starve in a refugee camp. This is the huge humanitarian crisis of our time, and I think that it is important that we take a collaborative approach to dealing with it. Yesterday, I raised the issue with acting First Minister Foster during OFMDFM Question Time, and I was glad to note that a collaborative approach is being planned between the Executive and the British Home Office.

I take the opportunity to commend the huge amount of support and solidarity that I have witnessed, not just in my political role but in my community role, coming from ordinary people throughout the country who want to do something. I pay tribute to Ramona House in Omagh, which has become a focal point for aid for refugees. That work is being headed up by a team of volunteers. Martina Anderson is there today, meeting those volunteers to commend their good work and to brief them on the situation. Although I have cited Omagh, I am conscious that that is happening throughout the country. People in the community are taking the initiative, and that is resulting in a huge level of volunteer effort. I commend them today, because that gives me heart.

It is important to look at all options: at EU level; here in the Executive and the Assembly; and at a community level. All options must be explored in order to resolve this major humanitarian crisis of our time.

(Mr Deputy Speaker [Mr Dallat] in the Chair)

Mr Ó Muilleoir: Go raibh maith agat, a LeasCheann Comhairle. Ba mhaith liom mo leithscéal a ghabháil leat; bhí mé ag cruinniú ar maidin. I apologise, as I was at a meeting of the economy Committee earlier and missed the start of the debate.

I want to make three quick points to echo some of the sentiments that we have heard today and to give Members some background on the work that has gone on to date to help refugees through the crisis and on the work that some of the great volunteer groups in Belfast have been involved in.

It was in December last year that Rev Bill Shaw approached the Executive and asked that we take in some Syrian refugees under the vulnerable persons relocation scheme. At that time, shamefully, the London Government had taken in only a few hundred people, despite the requests from the United Nations refugee agency that they take in many tens of thousands. Through working with Rev Bill

Shaw, I have got to meet some exemplary organisations in the city of Belfast. I have heard them speaking in recent days, asking us to respond with big hearts and to give a generous welcome to the refugees who will be coming in.

I want to mention three of those, because the work that they do reflects back to the points that Mr Agnew made about the need for a coherent strategy and consistent help for those who work with asylum seekers and refugees. Mornington is an organisation on the Ormeau Road that runs a food bank and many other community outreach activities. In recent months, it has been pressing society to respond to this global crisis, as it does day and daily. Last week, for example, on Friday morning when it held its food bank, it could not close because people continued to come. Many of those they help are asylum seekers.

I also want to commend our young friend Jasper in Tearfund and the work that he did and it did in visiting refugee camps in the Lebanon during the summer, raising £50,000 from young people here involved in the faith community and bringing that money to help the refugee crisis. Finally, the third group is the Presbyterian international meeting point on the Lisburn Road. Again, it shows us how we should respond to our brothers and sisters who are in peril and in refugee camps. Every day, they welcome in and educate them — I heard Mr Agnew talk about English classes. They build and try to create a welcoming environment for asylum seekers, to try to get them permanent status, and, when they get that, to try to make sure that they play a full part in our society.

I therefore commend the request and the five points put forward by the Law Society. We should and must unite around those. It is essential that we echo and mirror the response that we have seen from the community. All sides, all parties — even the one party that is not here today — all communities and all sectors of our community want to see refugees being given a welcome that is true to our values as a welcoming people and that reflects the welcome that we have received, whether Scots-Irish, Ulster-Scots or Irish people, when we have travelled the globe.

Ba mhaith liom focal a rá faoinár gcomradaithe in Albain, a bhí chun tosaigh san obair seo. I will finish by mentioning our friends in the Scottish Parliament and Scottish Government, who have always been a bit ahead of the curve on this. They first put it up to Mr Cameron when he refused to respond to the United Nations Refugee Agency's appeal for help.

They managed to get together a scheme to bring in hundreds under the vulnerable persons relocation scheme, via London, late last year and early this year. They have set up a task force, led by Minister Humza Yousaf, to look at the practical ways in which they will welcome, integrate and look after the refugees when they arrive. We can learn from that, and, if we are united in this, which I think that we are — despite maybe some discordant voices — as a society and community, let us get this done immediately. Let us put fire under the feet of Mr Cameron. We want to get people released from the terrible conditions and danger that they are in, and welcomed into this society so that they can start to rebuild their lives.

Mr Dickson: I start by thanking every Member who has contributed to the debate. I particularly thank Andy Allen and congratulate him on his maiden speech. He and others have made some challenging points in regard to all of this.

I do not intend to repeat the words that have been well said by individuals around the Chamber. Rather, after thanking all those who have spoken, I would like, first of all, to reference my colleague Anna Lo and to congratulate her for proposing the motion, which, as many will have heard in the speeches here today, is about one of the greatest humanitarian crises that Europe and the world has seen in the post-war era. Therefore, it is vital that she has brought that discussion to the House.

As we have heard, the world is experiencing a humanitarian disaster on a massive scale. For many, that was not truly brought home — others have made reference to this — until we saw the distressing and deeply sad images of that three-year-old child washed up on a beach in Turkey. Born in 2012, Aylan Kurdi never knew peace. By the time of his birth, the Syrian war had already begun. His parents sought to change that and to secure a stable life, free from the fear of oppression and death. They sought to reach other members of their family in a prosperous, free and stable Canada. Tragically, as we all know, Aylan and his brother and mother did not make it to Canada. Their story, as we know, is not unique. Since the beginning of the year, thousands have died making similar attempts to reach safety and freedom on the peripheries of Europe. The photographs, however, have focused minds on the injustice and suffering being felt, and they reinforce the fact that, behind the statistics, there are thousands upon thousands of individual human stories. It is incumbent on us, as citizens of the world, to respond to such

disasters in a compassionate but also meaningful way. I believe that those words have been stated by every Member in their contributions today.

In the past few weeks, people right across Northern Ireland — I pay tribute to people in east Antrim — have demonstrated such compassion by collecting items and funds for people in Calais and further afield in the Balkans and Italy. However, local voluntary action is not enough. The numbers are so large and the challenges so enormous that it takes —

Mr McKinney: I thank the Member for giving way. I apologise that I was not in for the earlier contributions to the debate. Does the Member accept that Ireland, North and South, knows intimately the pain of emigration? At its height, Ireland's population was close to 9 million. We have significantly less than that now, so we have space.

Mr Dickson: I agree with the Member. It is important — indeed, it is vital — that we have a coordinated intergovernmental approach to dealing with these issues. It is for that reason that, yesterday, I wrote to the Home Secretary, urging the UK Government to rapidly reconsider their position of accepting only 20,000 refugees over the course of the next five years. That, quite simply, is a paltry figure, especially at a time when Germany's Interior Ministry says that it expects to receive more than 800,000 asylum applications by the end of this year.

Furthermore, to ensure that resettlement is as trauma-free as possible, we need rapid Government action to make effective social and financial provision for refugees who will come to the United Kingdom. Of course we need a solution to the problems, the fighting, the wars and the terror gangs that rule Syria at this point in time. I firmly believe that those who are currently refugees, given a stable country, will wish to return there as soon as possible. It is important that we have a strategy that includes refugee integration, assisting people in their new lives if this is where they choose to be and our Government permit them entry, and, to ensure that they do not become isolated, English language classes for those who do not speak English. OFMDFM and the Home Office must act now to prepare such a plan and ensure that the best possible welcome is extended to refugees when they arrive.

Ultimately, this is not only a United Kingdom, German, Greek or European problem; this is a world crisis. Gulf states must certainly step up their support to their neighbours in the region. The fabulously wealthy nations of Saudi Arabia,

Kuwait, the UAE and Qatar have merely stood by while Europe, Turkey, Lebanon and Jordan have shouldered much of the crisis. Some of those states themselves suffer and struggle to feed and support their own citizens. The small state of Lebanon has taken in an estimated 1.1 million refugees. We must provide serious support, both nationally and at EU level, to those states and ultimately seek a long-term, lasting solution to end the evil that we see in Syria and Iraq in the form of Assad and the group that calls itself Islamic State.

Compassion and action is what is needed to end this crisis. The United Kingdom Government must fulfil their international, legal and moral obligations and accept their fair share of refugees. We must show solidarity with our European neighbours, but, most of all, with the people escaping conflict from wretched regimes that seek to destroy the human spirit and denigrate utterly the value of human life.

It is for those reasons that I know that the House will support the motion.

11.45 am

"No one chooses to be a refugee"

Those are words that were said in the Chamber today, but those who are refugees should be made welcome in the United Kingdom, and in this corner of the United Kingdom.

Question put and agreed to.

Resolved:

That this Assembly expresses its despair at the ongoing international humanitarian crisis in Syria; notes the tragic deaths of refugees fleeing to Europe seeking sanctuary and the terrible conditions endured by those refugees in transport to Europe and in refugee camps upon arrival; believes that EU nations have a moral obligation to assist people seeking refuge from war and persecution; further notes the Prime Minister's eventual decision to accept 20,000 refugees; further believes that the UK Government and some other EU Governments have not acted in line with their humanitarian obligations; and calls on the Executive to ensure provisions are in place for Northern Ireland to welcome refugees from Syria.

Health: Impact of Ministerial Vacancy

Mr Deputy Speaker (Mr Dallat): The Business Committee has agreed to allow up to one hour and 30 minutes for the debate. The proposer of the motion will have 10 minutes to propose and 10 minutes in which to make a winding-up speech. All other Members who are called to speak will have five minutes.

Ms Maeve McLaughlin: I beg to move

That this Assembly expresses grave concern that there is no Minister of Health, Social Services and Public Safety in place given the urgent need to implement speedily Transforming Your Care, to address the important issues of waiting times, workforce planning and the health sector pay review and to provide the essential leadership and policy direction that our health service requires in the current difficult and challenging environment.

Go raibh maith agat, a LeasCheann Comhairle. I welcome the opportunity to move the motion. However it is unacceptable that, as we speak, there is no Health Minister at his desk or, indeed, in the House to answer the difficult questions that are required in relation to leadership across the delivery of health and social care, to provide that leadership to the people who elected him to lead, and to the many, many people across many sections of society whose health decisions are literally in his hands. As we have this debate, that is little comfort to the 373,000 people who are waiting for their first outpatient appointment, many of whom are in severe pain.

Health has the biggest budget of all the Departments. It has a budget of £4.6 billion and employs almost 55,000 people. Simply put, it affects all of us in our daily lives. It is false to say that an empty chair or having a Minister for only half an hour is not impacting decisions. The fact that we have a captain who jumped ship — who has put the DUP's electoral fortunes over his party and over lives of our citizens — is quite shameful.

On 11 May 2015, Simon Hamilton said that he would continue to drive the "momentum for change" across the health service. He said:

"There will be tough decisions ahead, but I will not shy away from doing what's right."

On 21 May 2015, the former Minister told us that health and social care could not stand still, that major reform was required and that a

strategic leadership group was being established. Last week, the former, former Health Minister described what was happening as "ugly" and not tidy. How is that advancing reform or doing what is right?

It is well documented that our health service needs radical reform. There is duplication in commissioning, a lack of accountability and a lack of clarity in decision-making. The system, as it is configured, means that the Department can say that it wants to protect front-line services, but the same Department allows the trusts to cut the very services needed to provide front-line services. The system, as it is currently configured, moved the former, former Health Minister to say that commissioning was a "barrier to innovation". That is severe criticism of the system that we have and shows the absolute need for reform.

Over the last 12 days with no Minister at his desk, I have met people from many sectors and individuals who have depended on ministerial decisions. The all-Ireland network for children's heart services needs investment in the Clark Clinic. The majority of children are still going to England for surgery, and the business case is on his desk, so who is making that decision?

I visited William Street and Rectory Field —

Mr Swann: Will the Member give way?

Ms Maeve McLaughlin: I will indeed.

Mr Swann: The Member is the Chair of the Health Committee, and I have had representations, as has she, from parents who do not know whether the recommendations from the international working group, which would mean a considerable number of our children going to Dublin for heart surgery, have even been considered and, if so, what stage those considerations are at. There is great frustration among the parents of children who need surgery now, because they do not know where their children's care pathways will lie.

Ms Maeve McLaughlin: I thank the Member for his intervention. He is absolutely right. Whilst there has been progress on agreeing the Dublin/Belfast model, progress is urgently required to establish the investment needed in the Clark Clinic and to look at the network in Dublin. Again, I stress the urgency of those decisions being taken, because, if we move to a second tier of children facing their operations in England, we will have taken a step backwards. Yes, absolute clarity and action are required on that.

I also visited William Street and Rectory Field care homes in Derry, where one elderly lady had been moved from another home. She was in tears as she asked me about her future.

Lifeline received 92,266 calls in 2013-14. There are huge changes proposed to the delivery of that model. They need clarity on and intervention in the future of that vital resource.

People in my community were on the streets on Friday night, protesting about a cut to the Divert project, which deals with substance misuse and young people. All of those issues need intervention and strategic decision-making.

On Wednesday of last week, I attended the Transforming Your Care policy forum, where a packed room of medical professionals called for leadership and reform of the system. Only last week, GPs referred to the system "heading for the rocks" and demanded 400 training places and reform of the system.

On Friday, I spent some time with a young woman who is in severe pain and faces at least two hip operations but does not know when they will happen. That young woman's life has been on hold since Christmas and whether she will be able to have children in the future is not clear. How is any of that showing strategic leadership or intervention?

Decisions are required on the 1% pay increase for our front-line staff.

The situation has become farcical, but for many patients and others who depend on the health service, it is not farcical; it is a calamity. A system that requires tough decisions now has an empty desk. We need a Minister for health, not a Minister for half an hour. Much has been said about welfare cuts in this debate on health, but is the former Health Minister saying that we should take money from the most vulnerable and the disabled to pay for our health service? That is shameful.

I call on the DUP's former Health Minister to get back behind his desk to deliver for the people who elected him and for those who are crying out for intervention and decisions.

Mr McKinney: I welcome the opportunity to participate in the debate. I do so as health spokesperson for the SDLP. I do so more in sorrow than in anger, though with a healthy dose of both.

The debate is a very important one. It reflects last week's debate on the motion on waiting times for elective care, which the SDLP successfully amended to call for greater leadership, funding and strategic focus in the health Ministry. Last week, I reflected the genuine concerns of the SDLP, this Chamber and the public at large that, as we continue to witness the biggest crisis that the health service has ever faced, we have no Health Minister to respond. I think that it is important to remind the House of just exactly the scale of work for which the Minister has abdicated responsibility: wastage, which is running into tens of millions of pounds; 360,000 cancelled appointments every year; the elective-care crisis; the A&E crisis; waiting lists at doctors' surgeries; the shortage of doctors; pay increases for nurses and health staff; cancer drugs; and domiciliary care. All of them need strategic answers whether the DUP gets the answers that it claims it wants from others.

Last week, the DUP opted not to be here and not to address the widespread concern of the public and health professionals. Instead, the former Health Minister sought to spin his way out of the problem. Did he come to the House to explain? No, he did not. Did he issue a statement? No. He went to the press to release welcome but limited funding for some newly approved cancer drugs. Remember that his announcement was all about NICE-approved drugs and treatments, which should be routinely available for patients here. These are drugs that have been deemed clinically effective and cost-effective and are readily available in other parts of the UK. I agree that it is a welcome announcement, but does it address the fact that over 40 cancer drugs that are available in England and the rest of the UK are not available here? No, it does not. Does it address the list of issues that I have just articulated? No, it does not. Does it address that widespread concern? It certainly does not. If anything, it exacerbates it. The Minister is not in his seat again today.

All that public concern has not diminished over the last number of years. In fact, it has grown with DUP stewardship of the health service. These are genuine concerns that are compounded by the fact that A&E four- and 12-hour targets are continually breached as a matter of routine while, at the same time, the domiciliary care sector, which is meant to be picking up the slack in the community, particularly for older people, is buckling at the knees. That is unsustainable. These concerns have been rehearsed over and over in the public domain. We believe that it is completely unacceptable that, due to internal unionist

wrangling, the Health Minister is not in his post as he continues to be embroiled in party politicking. The DUP calls this escalation over wider political concerns. At least, the grand old Duke of York actually marched his men up the hill. The DUP might pretend differently, but it does not even know whether it is halfway up or halfway down, for Mr Hamilton was back at his seat, pretending to be resigned and pretending not to be, all within the same half hour. It is appalling. If what is described in the health service was not happening, it might even be funny, but it certainly is not funny because it is happening in the health service.

The motion comes from Sinn Féin, but it, too, has questions to answer. Just as the DUP needs to stop acting like rogue Ministers and honour their commitment to power-sharing and delivering for all the people of Northern Ireland, so, too, does Sinn Féin need to face up to some stark realities, which actually involve something very simple: telling the truth. Tell the truth and stop giving others excuses. Tell the truth about Robert McCartney. Tell the truth about the Northern Bank. Tell the truth about Joe Rafferty. Tell the truth about Paul Quinn and others. Do not tell us to go to the police as some kind of cover: just tell the truth. You have an electoral mandate that entitles you to places in Government. You do not have to keep lying. Tell the truth and set yourselves free —

Mr Deputy Speaker (Mr Dallat): Order, please. The Member is now well off the subject.

Mr McKinney: — and, in so doing, all of us.

12.00 noon

Mr Cochrane-Watson: I welcome today's motion to address the fact that we have a hokey-cokey Minister of Health. As was said last week, I hope that the television cameras focus on the empty chair during the debate, because that is what the public will see: no interest, no heart, not caring for the people of Northern Ireland.

What is the debate about? It is about 373,000 people waiting for their first outpatient appointment, a diagnostic test or inpatient treatment in all our hospitals throughout Northern Ireland. That is equivalent to over 20% of the entire population — my and your constituents. It is worse now than at any time in recent history. People have been waiting in pain and under emotional distress for far too long. We are accepting that targets are set in the interest of quality and safety and are being

totally ignored by the hokey-cokey Minister. Those people have been waiting for months, if not years, for a crucial appointment. When they turn on their television set tonight, as they did last week, what will they see? They will see the farcical scenes at Stormont.

The total number of people waiting for their first outpatient appointment is over 212,000, which is a 46% increase on the 145,000 waiting during the same period last year. Of all those waiting, 86,000, or 40%, have been doing so for more than 18 weeks, even though the target says that no one should wait more than 18 weeks.

I know that many of those who approach me through my constituency office are also in fear for their job prospects. Long-term sickness may mean long-term unemployment. People who go to a GP and are referred to the hospital or a specialist now face one of two choices. They can either wait the six, 12 or 18 months that it may take, which is now becoming the norm, or they can go private. That is happening under the watch of the absent hokey-cokey Minister.

Take our A&E attendances, for example. During 2014-15, only 73.8% of people attending the main emergency care departments were treated and discharged or admitted within four hours of their arrival. That happened under the watch of the hokey-cokey Minister. We are dealing with matters of life or death, but the most frustrating thing is that we are simply being asked to accept it. Try telling that to the young woman who is facing breast cancer treatment or the grandfather watching his grandchildren and knowing that he may not be around to see them grow up. I am in no doubt that every MLA in the Chamber cares. Every MLA in the Chamber will be coming down with case files or absolutely desperate constituents who have been told that they have to wait. That is no longer acceptable.

A&E staff have been left completely emotionally drained and demoralised. They are not to blame for the current problems. In fact, I believe that they are our last remaining defence against total collapse. Those pressures, combined with the cavalier attitude of the former, former in-out hokey-cokey Minister — whatever you want to call him — are not going to get any better by the Minister's absence and by his uncaring, heartless attitude.

Mr McKinney: Will the Member give way?

Mr Cochrane-Watson: I will indeed.

Mr McKinney: Will the Member accept that the Chamber probably would probably interpret your remarks somewhat differently if your Minister had not actually resigned his seat and did the hokey, as opposed to the hokey-cokey, and abdicated complete responsibility for roads and important infrastructure?

Mr Deputy Speaker (Mr Dallat): The Member has an extra minute.

Mr Cochrane-Watson: I remind the Member that our Minister resigned completely. He stood down and was replaced — for several minutes, that Department had someone at the helm once again.

Our Minister did what he and the Ulster Unionists thought was the right thing for Northern Ireland, which was to not ignore murder on the streets of our capital city, Belfast.

Mr McKinney: Will the Member give way?

Mr Cochrane-Watson: I will indeed.

Mr McKinney: The Member has used the image of the hokey-cokey over and over again: is he telling the House now that the UUP did the "hokey" bit to give the DUP the right to do the "cokey"?

Mr Cochrane-Watson: No, I am reminding the Member that the Ulster Unionist Party did the honourable thing after much debate and consultation to make a stand against those who committed cold murder on the streets of the capital city of Northern Ireland.

Mr Deputy Speaker (Mr Dallat): Order. I encourage the Member to return to the motion and forget the hokey-cokey.

Mr Cochrane-Watson: We will forget about the dance lessons. I know that there are more who are better skilled to teach the hokey-cokey in the Chamber than me. We simply need a Minister of Health who will be at his desk —

Mr Deputy Speaker (Mr Dallat): The Member must bring his remarks to a close.

Mr Cochrane-Watson: — to make decisions.

Mr McCarthy: The motion gives me the opportunity to express my heartfelt anger and disgust at how the DUP has turned its back on so many of our constituents who continue to

languish on long waiting lists and suffer pain and agony. This is a real bread-and-butter issue, because many of our constituents depend on the health service to provide them with the necessary medicines, scans and operations etc to ensure they get well again and to relieve them of aches and pains at the earliest possible moment. I pay tribute to all our hospitals, surgeries, medical staff and ambulance staff etc for the fantastic work that they do despite the shortage of funding that continues to hamper their work. In this time of health crisis, it is shocking and shameful that the DUP chose to play games with the Assembly and to totally disregard the pain and suffering of so many patients across Northern Ireland. That includes the lack of mental health facilities for so many of our people.

Along with Simon Hamilton, I received an email from a constituent last week that was headed, "Appeal to your good nature". She asked for our help to get rid of the agony in her back, which had endured since the summer of 2012. She needs an operation and now an MRI scan, but she has been told to wait for yet another 38 weeks. I say, for God's sake, Mr Hamilton and the DUP, get back to your desks and help this lady and thousands like her. That is what you are being paid for. Have you no shame at all? Our community is crying out for help, and all you do is sulk in the corner. It is ridiculous and a total and absolute disgrace. What action have you taken as a result of the motion on waiting lists that was debated in the Chamber last week? Today's motion pleads with the Minister to get to grips with these excessive waiting times, workforce planning, the pay review and many other issues. What about Transforming Your Care and the Donaldson report and, indeed, the cry from everyone involved in the health service?

I am a member of the Health Committee, which was told that the Minister's officials had bid for £98 million from the June monitoring round to enable them to provide a better service. Not one pound of that money has been allocated as a result of the June monitoring round. How can Mr Hamilton look people in the eye and say that he is working to provide them with a modern health service? It is simply not true, and the sooner Mr Hamilton and his party acknowledge the pain being suffered by our population and the expectations of the public, the sooner our health service can be improved.

Transforming Your Care is the journey that we are on, but, so far, not enough progress has been made and, certainly, funding has not followed the changes that need to be made. Only last week I chaired a conference dealing

with Transforming Your Care, as indeed did the chair of the Health Committee. Speaker after speaker — pharmacists, Age NI, GPs and nurses — expressed the desire to get moving but said they were being hampered by the insufficient support coming from the top. That is you, Minister Hamilton.

The message to the DUP and the Minister is loud and clear: end the hokey-cokey nightmare being waged against the population. Act responsibly and give leadership to the Department, and let the people see that the Assembly can work for the benefit of everyone. I ask the Health Minister, as did his constituent who made the appeal to his good nature, to please, please help that lady and the hundreds on the waiting lists. There is no more room for excuses. Drop the boycott of your Department, and prove that you are worth the office of Health Minister. Our Committee is going through the Mental Capacity Bill. It needs ministerial engagement: are you prepared to let that Bill slip through the net?

I should also comment on those who tabled the motion and ask them to reflect on their contribution to the current problem in the health service. The financial difficulties in the health service predate the current impasse on welfare reform and the wider budgetary crisis.

Mr Deputy Speaker (Mr Dallat): Would the Member bring his remarks to a close?

Mr McCarthy: I appeal to the Minister to listen to what is said in the Assembly today and to get back to serving the constituents.

Mr Allister: Let me assure the House that the Health Minister and all his DUP colleagues will be back. The first fig leaf that comes along will be grasped to get them back into the House. The DUP is a party addicted to power, and the lure of office is irresistible. Of course, what we are witnessing is but a stunt: a stunt to buy time and a stunt to save face. When the IRA brought murder back to our streets, a response was necessary because Mrs Foster told us that Sinn Féin were inextricably linked to the IRA and therefore the DUP had to respond. They had been outmanoeuvred —

Mr Deputy Speaker (Mr Dallat): Order, please. I simply express caution that the Member really should stick to the motion before the House.

Mr Allister: That is a matter for your judgement, but I think I am right on message in that I am explaining why the DUP Minister is not today in post.

A response was required. The Ulster Unionist Party, having taken the right and honourable step of departing from government with those so linked, had outmanoeuvred the DUP. Therefore, they had to think up some other stratagem to create the appearance that it was not business as usual and that they were really taking things on and taking on Sinn Féin on the issue. Of course, the real issue was the presence of Sinn Féin in government. By deploying the stunt they deployed, they guaranteed and secured Sinn Féin in government, as opposed to the logical step that had been taken by another of tipping Sinn Féin out of government by resigning. That would have been the consequence of the First Minister resigning, but he did not resign, because he did not want to tip Sinn Féin out of government and he was scared of an election. The DUP has been running away from an election ever since. That is why they came up with this stunt of pretending that it is not business as usual and that they are really taking the battle to Sinn Féin, when they have run away from the battle in respect of the core issue. It is, as I say, nothing short of a stunt.

Mr Swann: Has he any rationale for how the DUP was able to come here yesterday to move a motion on the agriculture crisis but not on the health crisis? Is there maybe a level of crisis in the DUP that they cannot work out?

Mr Allister: It was another face-saving —

Mr Deputy Speaker (Mr Dallat): Order, please. Apart from telling the Member that he has an extra minute, I really need to encourage all Members, please, to stick to the motion before us.

Mr Allister: I will answer very briefly: that was another face-saving exercise on the part of that party.

Today we are in the situation where we do not have a Minister.

Whether he is being paid or not, I do not know. Whether coming back every seven days keeps his pension rights intact and whether the special advisers are reappointed every seven days to keep their continuity of service in place, I do not know. I think that the public are entitled to know those things, but, of course, they are concealed from the House. I am absolutely sure, however, that the DUP will be back, because it does not have the bottle to take on the issue that is staring it in the face and prefers to sweep murder under the carpet.

12.15 pm

How many times does this system have to crash before people realise that it is unworkable and unfixable and before they face up to the reality that sticking plasters cannot go on being applied to a system that is incapable of being repaired? It is time that we addressed the issue of getting proper democratic structures in the House, based on a voluntary coalition and a proper opposition, rather than the constant failure of what we have.

As I say, when the first fig leaf comes along, the Minister will be back, because that is the consequence of the DUP being unable to face the reality that it should be facing; namely, that the inextricable link is there and that the consequences need to be faced. Instead, we have this pitiful stunt, as a decoy, to divert attention away from the fact that it is not facing up to the issue and will not face up to the issue.

Ms McCorley: Go raibh maith agat, a LeasCheann Comhairle. Baineann an díospóireacht seo le heaspa Aire Sláinte, agus tá go leor imní faoi sin. Today, we are debating the absence of a Health Minister, and there are huge concerns around the issue.

Our health service is in real crisis. Day and daily, we hear about problems relating to TYC, waiting times, emergency departments, workforce planning, the review of health-sector pay and other areas. At a time when those and, indeed, many other elements of the health service are impacting negatively on our population, the Minister prefers to ignore the pain and anguish of people in our community who suffer daily and who sit at home hoping and praying that the appointment that they so badly need will come their way. What does the Minister think? He thinks that it is a good idea to adopt a form of in-and-out political chicanery, which serves only his party political interests and does nothing to alleviate the illness and stresses that are affecting our ailing public.

Only last week, Members reported on the shameful record of our Health Department and how it is failing miserably to deal with waiting times. Agus is fiú dúinn cuimhniú air siúd inniu. It is worth reminding ourselves of the figures today. The Minister's target for 2015-16 was that at least 60% of patients would have a first appointment within nine weeks and that no patient would wait longer than 18 weeks, yet, at the end of June this year, we saw that neither the nine-week target nor the 18-week target was achieved. Le fírinne, bhí 45% de dhaoine

ag fanacht 18 seachtain. In fact, 40-5% of people were still waiting at the 18-week point. At a time that patients are waiting in pain and trauma, we have no Health Minister. Níl Aire Sláinte againn. Added to that is the impact of delays in receiving treatment for diseases and medical conditions. It is well known that early diagnosis is key when it comes to all forms of cancer and other illnesses, so any delay in seeing a specialist could have devastating effects for some people. It is unacceptable that avoidable premature deaths could be happening as a result of the delays in the health system.

Níl mé á rá go bhfuil sé ar chumas an Aire gach rud a athrú. I am not saying that the Minister can change everything, and I know that health is an extremely challenging environment, but it must be tackled. He must accept that, as Minister, he is the one in ultimate control. All the major decisions are his, and it neither helps nor serves anyone when he decides to resign his post when there are so many stresses in the system.

Mr Eastwood: I thank the Member very much for giving way. Does she remember, like I do, that, in previous times when we had no Minister, the practice of the Civil Service here was to basically follow the lead of the English Departments? Does she agree with me that it would be a good idea for the Civil Service, in the week or so that they are free from DUP control, to bring in the pay increase that NHS workers in this part of the world have been denied for far too long?

Ms McCorley: I thank the Member for his comments. I agree that it would be a very good thing if someone could take the decisions that are necessary on the pay review and, indeed, on all the other major health issues that are keeping people in distress. That should happen as soon as possible.

In 2011, TYC was introduced as the new way forward for the delivery of health services. The shift left was broadly welcomed, with agreement that a move towards more community provision and less dependence on hospitalisation was a good thing. Successive Health Ministers received support from all parties for that policy shift. Four years on, there is little confidence in or evidence of what has been achieved; only a fraction of the promised £83 million has been transferred to TYC initiatives.

To drive the agreed policy forward, we need a cast-iron assurance that the development of service models and workforce planning will reflect the requirement to be joined at the hip

with the implementation of TYC. What we do not need is an absent Minister. An rud nach bhfuil de dhíth orainn is é Aire atá ar strae. We need a working Minister, who will deal with the health service problems such as residential homes, domiciliary care, the staff pay review, the shortage of GPs and nursing staff, cancer drugs and many more.

Many of the Members who spoke referred to a lot of those issues, and I will mention some of the specific things that people referred to. Fearghal McKinney mentioned the need for a Minister to take the big strategic decisions that I mentioned. That was before he went on a rant against Sinn Féin, calling us liars. I resent that and think that he should take back those remarks. Adrian Cochrane-Watson talked about a hokey-cokey Minister. Kieran McCarthy paid tribute to hospital and ambulance staff for their commitment at a time when the DUP is playing games. Jim Allister called what the DUP is doing a "stunt" to buy time and save face.

I think that all Members are in agreement that the Minister should come back to work. Well, maybe not all, but most Members. With that in mind, glaoim ar an Aire an ceannaireacht a sholáthar atá de dhíth le haghaidh a thabhairt ar na fadhbanna seo agus le gabháil ar ais ar obair gan mhoill. I call on the Minister to provide the leadership that is required to address these issues and get back to work immediately.

Question put.

The Assembly divided:

Ayes 48; Noes 31.

AYES

Mr Agnew, Mr Allen, Mr Attwood, Ms Boyle, Mr D Bradley, Mr Byrne, Mrs Cochrane, Mr Cochrane-Watson, Mr Dickson, Mr Durkan, Mr Eastwood, Ms Fearon, Mr Gardiner, Ms Hanna, Mr Hazzard, Mr Hussey, Mr G Kelly, Ms Lo, Mr Lunn, Mr Lynch, Mr Lyttle, Mr McAleer, Mr McCallister, Mr F McCann, Ms J McCann, Mr McCarthy, Ms McCorley, Mr McElduff, Ms McGahan, Mr McGlone, Mr McKinney, Ms Maeve McLaughlin, Mr A Maginness, Mr Maskey, Mr Murphy, Mr Nesbitt, Ms Ní Chuilín, Mr Ó hOisín, Mr Ó Muilleoir, Mr O'Dowd, Mrs O'Neill, Mrs Overend, Mr Ramsey, Mr Rogers, Ms Ruane, Mr Sheehan, Mr Somerville, Mr Swann.

Tellers for the Ayes: Ms McCorley and Ms Maeve McLaughlin

NOES

Mr Anderson, Ms P Bradley, Mr Buchanan, Mrs Cameron, Mr Campbell, Mr Clarke, Mr Douglas, Mr Dunne, Mr Easton, Mr Frew, Mr Girvan, Mr Givan, Mr Hilditch, Mr Humphrey, Mr Irwin, Mr Lyons, Mr McCausland, Mr B McCrea, Mr I McCrea, Mr D McIlveen, Miss M McIlveen, Mr McQuillan, Mr Middleton, Lord Morrow, Mr Moutray, Mr Newton, Mr G Robinson, Mr Ross, Mr Spratt, Mr Weir, Mr Wells.

Tellers for the Noes: Mr McQuillan and Mr G Robinson.

The following Member voted in both Lobbies and is therefore not counted in the result: Mr Allister

Question accordingly agreed to.

Resolved:

That this Assembly expresses grave concern that there is no Minister of Health, Social Services and Public Safety in place given the urgent need to implement speedily Transforming Your Care, to address the important issues of waiting times, workforce planning and the health sector pay review and to provide the essential leadership and policy direction that our health service requires in the current difficult and challenging environment.

Mr Deputy Speaker (Mr Dallat): The Business Committee has arranged to meet at 1.00 pm today. I propose therefore, by leave of the Assembly, to suspend the sitting until 2.00 pm. The first item of business when we return will be Question Time.

The sitting was suspended at 12.37 pm.

On resuming (Mr Principal Deputy Speaker [Mr Newton] in the Chair) —

2.00 pm

Oral Answers to Questions

Environment

Mr Principal Deputy Speaker: Before we commence, I inform the House that questions 1, 4 and 5 have been withdrawn.

GM Crops

2. **Mr Byrne** asked the Minister of the Environment whether he plans to prohibit the local growing of genetically modified crops. (AQO 8688/11-16)

Mr Durkan (The Minister of the Environment): The European Commission has put in place transitional arrangements to allow member states to opt out of growing approved GM crops. To take advantage of those arrangements, member states must let the Commission know by Friday 2 October. Responsibility for matters relating to the deliberate release of GM material into the environment, including GM crops, rests with me. Accordingly, the Member may be aware that, last night, I announced that I am prohibiting the cultivation of GM crops here.

As I remain unconvinced of their advantages, I considered it prudent to prohibit their cultivation for the foreseeable future. In addition, the pattern of land use here and the relatively small size of many agricultural holdings would create potential difficulties if we were to seek to keep GM and non-GM crops separate. I consider that the costs of doing so could be significant and, in many cases, totally impractical. Furthermore, we are rightly proud of our natural environment and rich biodiversity. We are perceived internationally to have a clean, green image. I am concerned that the growing of GM crops, which is acknowledged to be controversial, could damage that image.

Mr Byrne: I thank the Minister for his answer. Does the Minister accept that there is some concern that there may be some foodstuffs being imported into Northern Ireland that have been genetically modified in their country of origin and that that may happen to animal feedstuffs? Secondly, can the Minister state whether he has had any discussions with his counterparts in the Republic, given that we have a relatively small island and GM is an issue for all in the farming community?

Mr Durkan: I thank Mr Byrne for those supplementaries. I certainly do accept that the agriculture industry as we know it would not be viable without the use of imported GM animal feed. However, I am certainly satisfied that the approved varieties of genetically modified feed pose no risk to either the environment or human health.

As regards conversations or discussions with my counterpart in the Republic, Minister Alan Kelly, there has been ongoing dialogue on this issue at official level over the past month. While no announcement has been made yet by

those in Dublin, I anticipate that there will be one soon and that they will make the right choice too. The Member quite rightly identifies potential issues, should the Republic of Ireland take a different approach to us on this. However, given the similarities between the size of agricultural holdings in the Republic and, indeed, the fact that they, like us, depend so heavily on that clean, green image when it comes to exporting our produce across the world, which we do so well, I am fairly confident that they will agree with me on this issue.

Mrs Overend: There are many questions that could be asked of the Minister on GM crops and, indeed, the importation of meat that has come from animals fed by GM crops. Does the Minister agree that the guiding principles should be to follow science in this perspective? Can the Minister confirm that that was the case with his decision yesterday?

Mr Durkan: I thank the Member for that supplementary question. With all these GM questions, I feel like I am on 'GMU'. There is a lot of science out there on this issue. Scientists are like lawyers. Different scientists have different opinions and draw different conclusions on different subjects. There is science out there, and over the past 24 hours I have received criticism and correspondence on my stance from scientists who say that GM crops are great and pose no risk at all. However, there are also scientists out there who take a contrary view.

My guiding principle, when it comes to making decisions, is a precautionary one. I am charged with safeguarding our environment here in the North, and until there is complete and robust scientific evidence that it is safe, I am unable to approve the cultivation of GM crops here. However, we are talking about the current EU Commission's GM-approved list. I have no doubt that, in the future, there will be additions to the list, and while I have made my decision and it is a strong statement of intent, it is not carved in stone. As and when new crops are added to the list, I or a future Minister will have the ability to revisit that position.

Mr Allister: This is patently a controversial and cross-cutting issue, given the Department of Agriculture's interest. Did the Minister take the decision to the Executive, and has he got Executive approval? Has he not, in fact, created an untenable conundrum whereby he acquiesces in the feeding of our livestock with imported GM product but rejects the cultivation of GM-approved products which have passed through the entire sifting process of the EU?

Mr Durkan: I thank the Member for that question. As it stands, I can make decisions on what is before me. I was required to make a decision on genetically modified crops by 3 October, and I have done so. I understand the Member's confusion as regards other genetically modified foods, and it is not dissimilar to the point that Joe Byrne raised with regard to GM feedstocks.

Responsibility for the deliberate release of GM material into the environment, including GM crops, rests with me as Minister of the Environment. However, as a courtesy, I wrote to Michelle O'Neill, the Minister of Agriculture and Rural Development, to notify her of my position and my decision.

Sellafield Nuclear Power Plant

3. **Mr Hazzard** asked the Minister of the Environment whether his Department has any involvement in monitoring accidents at, and environmental problems associated with, the Sellafield nuclear power plant. (AQO 8689/11-16)

Mr Durkan: Nuclear energy and nuclear installations are excepted matters under the Northern Ireland Act 1998 and, as such, are not within the remit of the Department of the Environment. Radioactive discharges from the Sellafield site are regulated by the Environment Agency and the Office for Nuclear Regulation. My Department has responsibility for monitoring the environment in Northern Ireland to assess the impact of radioactivity produced elsewhere, including nuclear facilities such as Sellafield.

The Northern Ireland Environment Agency (NIEA) has a comprehensive environmental monitoring programme to assess any such impact on the Northern Ireland coastline. The programme includes checks on the radiation levels of the coastline at approximately 50 locations around the North, as well as monitoring the levels of radioactivity in seawater, seaweed, shellfish and fish. The adequacy of the monitoring programme is reviewed regularly and, where appropriate, will take into account any changes in the discharge of radioactivity from Sellafield.

The results of the programme are published annually in a joint report entitled 'Radioactivity in Food and the Environment' produced by the four UK environment agencies, in conjunction with the Food Standards Agency. Results for last year, like those in previous years, indicate that the levels of contamination are negligible in

terms of radiological impact on the population of the North.

On average, people in Northern Ireland receive 2,500 microsieverts of radiation a year from all natural and artificial sources. Of that, 50% is due to exposure to radon in the home, 12% is from medical exposure, and less than 0.1% is from nuclear discharges. It should be noted that the lowest yearly dose likely linked to increased cancer risk is 100,000 microsieverts.

In addition to that comprehensive monitoring programme, the UK has a 24/7 nuclear radiation monitoring and emergency response network known as Radioactive Incident Monitoring Network (RIMNET).

Mr Hazzard: Go raibh maith agat, a LeasCheann Comhairle. I thank the Minister for his answer thus far. In answer to a previous question, the Minister said that he had responsibility for "safeguarding our environment". In the light of that, in connection with the radioactive impact of the plant at Sellafield, in recent months we have had news of British munitions washing up on the south Down beaches in increasing numbers. A lot of them were dumped after the First and Second World Wars, including nerve gas and sarin gas. To what extent does his Department have a responsibility to safeguard the south Down environment and to look at the issue of possible radioactive military materials that were dumped now washing up on the our beaches?

Mr Durkan: I thank the Member for that supplementary question. Neither I nor my Department are experts when it comes to arms dumps. *[Interruption.]* The dumps to which the Member refers fall within Scottish waters and are therefore not the direct responsibility of my Department or the Northern Ireland Environment Agency. However, I am aware of the issues raised by the dumps in many areas across the North, in particular and in recent times the south Down coastline. Correspondence on the matter came to my Department before my time as Minister. When something comes ashore, responsibility rests with the local authority, so it would be up to the local council to remove it. However, given the dangerous nature of the materials, there would be assistance from Britain to do so, and there would be an input from the Northern Ireland Environment Agency as well.

Mr Rogers: Will the Minister outline his assessment of how the Sellafield nuclear power plant impacts on the North's coastal environment communities? Over the years,

Eddie McGrady campaigned against Sellafield. Given the major health concerns in south Down and the higher-than normal incidences of cancer in the area, what is his assessment?

Mr Durkan: Since the 1970s, my Department has had a very comprehensive programme in place to assess the impact of radioactive discharges into the Irish Sea on the coastline of Northern Ireland. The results of the programme are published annually in a report titled, as I outlined in an earlier answer, 'Radioactivity in Food and the Environment' which is issued jointly by all the environment agencies on these islands. The report focuses on key information that demonstrates that, in the North, food is safe and the public's exposure to ionising radiation from discharges is insignificant.

The health concerns raised by the Member have been raised before, and there have been long and loud campaigns from South Down elected representatives on behalf of its people over the years. People have concerns about potential impacts on their health, and rightly so, and, although the reports indicate that the effect of discharge from Sellafield and other nuclear plants is negligible, I fully appreciate that those concerns will persist. All that I can do is ensure, as Minister, that my Department and the agency will continue to do everything that they can to monitor the situation.

Regarding other health impacts, questions would probably be better directed to the Minister of Health. There will probably be a 10-minute window next Monday when the Member can do that.

Climate Change Conference

6. **Mr B McCrea** asked the Minister of the Environment whether he, or his departmental officials, will be attending the 2015 United Nations' climate change conference. (AQO 8692/11-16)

Mr Durkan: Although climate change is often and rightly seen as a global issue, we are all too aware of the impacts that it is having at a local level, such as severe weather events that threaten our health, homes, businesses and way of life. That is why I have publicly stated many times my view that we all can and, indeed, must do more to reduce our greenhouse gas emissions.

The main aim of the 2015 United Nations conference in Paris will be to achieve a new international agreement to create the vital framework that the world needs to limit the

average global temperature increase to below 2°C. By successfully doing so, we will help to combat climate change effectively, boost the transition towards resilient, low-carbon societies and avoid the worst impacts of climate change. The Paris conference is, without doubt, an opportunity for the world's leaders to deliver a global climate agreement that is unquestionably in our, and the entire global community's, best interests. We cannot underestimate how critical that is, and that was further underlined last week when Pope Francis held an unprecedented audience with all the European Environment Ministers and Commissioners and appealed to them to show leadership and push for a long-term decarbonisation goal.

2.15 pm

I have written to the Secretary of State for Energy and Climate Change, Amber Rudd, indicating that I do intend to go to Paris, where I will make it clear that we should be striving to secure an ambitious international agreement this year and pushing for opportunities to increase the EU emissions reduction target further as a result.

Mr B McCrea: I say to the Minister that I fully support his decision to attend the UN meeting in Paris. My question for him in this environment is this: how many other MLAs in the Chamber do you think would support your concern about climate change? Given that we are in the middle of Environment Week — I know that Ms Lo and the Minister were in attendance last night — what importance do you think that has for Northern Ireland, in a local sense, in tackling climate change?

Mr Durkan: I thank the Member for that question. In response to the first part of the question: there are not that many MLAs in the Chamber, but, of those present, I am confident that the vast majority will support me in my efforts to tackle climate change and to secure the international agreement that is required. With regards to the other question, Environment Week did kick off last night and has been extremely successful so far. I encourage all Members to drop into the Long Gallery to participate, or at least to observe events today. I congratulate the Environment Committee for its initiative and the Northern Ireland Environment Link (NIEL) for its work in making the week possible and coordinating events.

I would like to reiterate to the Member my commitment to working across government and with all sectors of our society, as well as all sections within the House, to agree on

measures that can help to address both future and current climate change. My Department has already implemented a number of key actions to help reduce greenhouse gas emissions. It is not something that my Department can do alone. We need other Departments to sign up and buy in. There are ongoing cross-departmental working groups and meetings in that regard, and I believe that progress is being made. It may not be being made as quickly or dramatically as we would like, but it is being made. I think that some people in the Chamber and maybe some not in the Chamber at the moment — maybe not in the Chamber anymore — are beginning to accept the impact of climate change and the importance of doing something about it.

Mr Somerville: Can the Minister give his assessment of the emphasis that our new local councils have placed on reducing their emissions?

Mr Durkan: I thank the Member for the question, his first to me. I know that he is just fresh out of local government, so hopefully he had some input into his former council's stance on reducing greenhouse gas emissions before coming here. I think that the new councils have an extremely important role to play and that, by and large, councils have embraced that when it comes to tackling climate change. I believe that the opportunities that they have to do so are huge, be it through their community planning or even through their work on their own local development plans, because it will now become more of a factor when applications come in for planning permission. Factors such as environmental or wider impact around the emission of greenhouse gases and so forth will be taken into consideration when applications are being assessed.

To date, I think that councils have recognised that they have a role to play. They have signed up to play that role, but it is important that we as a Department and we as an Assembly support them in doing so.

Ms Lo: I am delighted that the Minister is going to the Paris conference on behalf of the Northern Ireland Assembly. Does he agree that the lack of a climate change Act for Northern Ireland will hinder our role or any actions in addressing climate change?

Mr Durkan: I thank the Member for her question. Unfortunately, my wife does not share Ms Lo's delight that I could be going to Paris in December. Hopefully, a present on my return —

Ms Lo: She should go with you.

Mr Durkan: I do not think that Mr Allister would approve of that. *[Laughter.]* I believe that a climate change Bill and consequent Act is very important for Northern Ireland. I now have a mandate to pursue such a Bill in the Assembly following a vote taken last year on an amendment tabled by Mr Agnew to a motion on an illegal landfill. However, I have to be sure that, if I am going to bring a Bill forward, I will have the support of the whole Assembly in doing so. That is the only way that this can work, and that is why the work that I have been doing to date with other Departments and other sectors — not just the environmental NGOs but, very importantly, industry, those who might perceive that a climate change Act would inhibit or prohibit their growth — is extremely important. We have to bring people along. We also have to explore the opportunities that could be created in our local economy by a climate change Act, through new green energy initiatives and so forth.

In response to an earlier question, I touched on the clean, green image of the North and how that has helped our agrifood industry become so successful. The development of that clean, green image can only help us grow from strength to strength in that regard.

Mr A Maginness: I thank the Minister for his answers. I join the Minister in congratulating Northern Ireland Environment Link and the Chair and Deputy Chair of the Environment Committee for promoting Environment Week here. I congratulate the Minister for his participation in that.

Apropos what he said about climate change legislation, does the Minister think that there is any way of building consensus in the Northern Ireland Executive and, indeed, the Assembly in order that we can all go forward together in bringing about an agreed Act? It is essential that we work together and map out an approach that will be beneficial to the whole community.

Mr Durkan: I thank the Member for his question. I will repeat the point that I made to Ms Lo: collaboration is vital to reaching consensus, and consensus is vital to achieving success in this regard. I have constantly, I think, outlined the need for our own climate change legislation with challenging greenhouse gas emission reduction targets. I believe that that would create greater clarity and the long-term certainty that business and industry need, even though some members of those sectors feel that climate change legislation would be

detrimental to their growth. As I said, I have had some extremely challenging yet extremely productive meetings with representatives of those sectors. There is still a lot more work to do, but I believe that an initiative around prosperity agreements that I launched last year demonstrates clearly to industry and business the benefits of environmental compliance or of going beyond compliance in terms of how successful their business can be. I have established a prosperity panel, composed of local and international experts, to advise me how to turn issues such as climate change around from being a barrier to growth into economic and social opportunities. I am glad that that panel also has representatives of business and industry and, very importantly, the agri-food industry. Again, I cannot emphasise enough the importance of that industry to our economy here in the North.

Environmental Protection

7. **Mr Eastwood** asked the Minister of the Environment, in light of departmental restructuring, to outline his plans to ensure the protection of the environment. (AQO 8693/11-16)

Mr Durkan: Under departmental restructuring, most of my Department's environmental functions would be inherited by a proposed new Department, the Department of Agriculture, Environment and Rural Affairs (DAERA). I believe that the proposals, as they stand, could create conflicts of priorities and responsibilities within the new DAERA. In short, the present arrangements for environmental governance will become even more out of line with what is regarded as good practice in Ireland, Britain and elsewhere in Europe. Most of these jurisdictions have some form of independent environmental protection agency.

In August 2011, my predecessor, Minister Attwood, published a discussion document on environmental governance in Northern Ireland. Most respondents expressed support for the creation of some form of agency or body within the public sector but operating separately from central government to undertake a range of environmental roles and responsibilities. However, it was recognised that, without sufficient support from other political parties, making such changes to our environmental governance arrangements could not be pursued at the time. With such large changes to our departmental structures being made in the very near future, I believe that now is the right time to revisit this debate.

I have reached the clear conclusion that our present governance models are in need of radical review and need to be replaced quickly. As a first step, I intend to open up a debate in the Assembly and Executive about an independent body so that this can be factored into restructuring plans that are under way. I will do everything that I can to deliver this quickly, but I also need other political parties to give their support and commitment to make this happen.

Mr Eastwood: I thank the Minister for his answer. Does he agree with me that any independent body — any independent environmental protection agency — should be on an all-Ireland basis if we want to protect the environment in the places that it is needed?

Mr Durkan: I thank the Member for that supplementary. Ireland's environment knows no borders, therefore I believe that we should ensure that, at this time of great change, our environmental governance arrangements are well aligned with arrangements in the South. In that way, we would be well positioned to build on the collaborative work already carried out under the auspices of the NSMC. In my view, an independent, all-island environment protection agency is the best way forward to allow us to develop collaboration and pool resources. I recognise that officials, North and South, have not yet fully considered the implications of an all-island environmental protection agency, and so, as a first step, I am opening up the debate in the Assembly and in the Executive about an independent body in the North.

Car Parking: George Best Belfast City Airport

8. **Mr Maskey** asked the Minister of the Environment to outline the rationale behind the decision to close the Boal car parking service at George Best Belfast City Airport. (AQO 8694/11-16)

Mr Durkan: The Boal car parking service was an unauthorised car park use that was refused planning permission in December 2013. The refusal was subsequently appealed and comprehensively reviewed by the independent Planning Appeals Commission (PAC). The PAC dismissed the appeal in June 2015. It found that there had been a failure to demonstrate a quantitative need for the car park and that there were sufficient parking areas, including overflow parking areas, to meet the needs of the City Airport. The PAC, in coming to its view, concluded, taking account of

all the evidence, that, whilst there might be a demand for cheaper parking, it did not equate to a need for additional parking at the airport. I understand that the car park was closed by the owner of the site following the PAC decision to dismiss the appeal and his receipt of a warning letter from Belfast City Council to cease use of the site.

Mr Maskey: Go raibh maith agat, a Phríomh-LeasCheann Comhairle. I thank the Minister for that response. Does the Minister not agree that there was no legislative requirement to block this planning application, on the basis that it was a question of demand as opposed to need? Would he not be prepared to work with the Boals, given that the demand speaks for itself? Would it not be worthwhile for the Minister to have some discussion with the Boals to see whether the facility can work?

2.30 pm

Mr Durkan: I thank the Member for that question. I agree fully with the Member. When the decision was first reached, the first I heard about it, after its initial refusal in December 2013, was through the media. A refusal had been issued, at which stage nothing really could be done about it. Given how ridiculous it seemed to me at the time, I invited the Boals to appeal, and I was disappointed by the outcome of that appeal. I subsequently met Mr Pat Boal, the owner of the business, along with planners in the Department to discuss the best way forward for him. I fully accept that that gentleman and enterprise tried to do everything by the book. On that occasion, the system did not work for them, and it is now not allowing them to work.

In the strategic planning policy statement (SPPS), which is still awaiting Executive approval — hopefully, I will be able to get it out soon — greater flexibilities will be afforded to councils, which are now the planning authorities, to make decisions within their areas on what would be deemed sufficient car parking. I very much hope that Belfast City Council, along with Mr Boal, or, potentially, someone else, will be able to work together and that they will know what the need is in their own city or council area.

Mr Principal Deputy Speaker: That ends the period for listed questions. We now move on to topical questions. The Members listed for topical questions 1, 4 and 9 have withdrawn their names.

Northern Area Plan: Implementation

T2. Mr Swann asked the Minister of the Environment for an update on how the information his colleagues on the Causeway Coast and Glens Borough Council received yesterday, when they were told that the Minister decided last week that the northern area plan would come into effect today, will affect his constituents. (AQT 2852/11-16)

Mr Durkan: I thank the Member for that question. While the council may have been informed just last week that the publication of the area plan was imminent, the council and its predecessors have been integral in the formation and formulation of that plan. The publication of the plan is a positive news story for the Causeway Coast and Glens Borough Council area, as it will provide certainty to developers, potential inward investors, providers of social housing and communities. It will also be of great benefit to the council as it proceeds with the drawing up of its new local development plan. I have yet to hear any negative rumblings from the council or from constituents in that area about the content of the plan. However, should there be any, I would be more than happy to meet the Member or whoever to discuss them.

Mr Swann: I thank the Minister for his answer. He referred to giving certainty to investors and the community. Will he assure the House that the area plan will ensure that lignite mining and fracking will not proceed in the area?

Mr Durkan: I thank the Member for that question. As regards the issues that the Member raises, the area plan does not deal with such things. They are dealt with separately under planning policy. I remind the Member of my view on fracking and lignite mining, which, I hope, will be strengthened following the publication of the SPPS: no such activity should, could or will be carried out in the absence of sound and safe evidence that it is sustainable and is not detrimental to our environment or to human health. Each application will be judged on its own merits. To date, no application has been received anywhere in the North for fracking. If the Member has ongoing concerns about lignite mining, I would be happy to meet him to discuss those at a later date or even later this afternoon.

Mr Principal Deputy Speaker: Mr Oliver McMullan is not in his place. I call Ms Anna Lo.

Environmental Protection Agency

T5. Ms Lo asked the Minister of the Environment, while sympathising and sharing his rationale, how, realistically, he will achieve consensus for his proposed North/South environmental protection agency, which he has referred to during various events relating to Environment Week. (AQT 2855/11-16)

Ms Lo: You called me pretty quickly, Mr Principal Deputy Speaker. I thank those Members who attended Environment Week yesterday and today. A number of Members spoke of that. Events are still being held in the Long Gallery and outside, and I encourage Members to participate in them.

Mr Durkan: I thank the Member for that question. Before I answer it, in defence of Mr McMullan, Mr Principal Deputy Speaker, I had received notification of his question having been withdrawn.

I believe that winning consensus for my proposal or vision will not necessarily be easy, but that certainly will not discourage me from the pursuit of what I believe to be the best outcome for the environment, North and South, of this island. In response to an earlier question, I outlined that the first debate that we have to have, and the first debate that I will need your support in, is on establishing the principle here in Northern Ireland of setting up an independent environmental protection agency. I believe that strong arguments can be made for that. I have yet to hear any compelling argument why we should not have an independent environmental protection agency. Every other jurisdiction in these islands has one, as do the vast majority of countries in Europe. It is seen as best practice there, and it works there. I think we should be looking at models in other countries to see what is good about them and how we could make things better here.

However, like I said, I want to do this quickly. Fortunately, because of the relative recentness of the consultation that was done in 2011 by my predecessor, I do not think we have to start from scratch when we open the debate. There is a template, and we have the views that were expressed at that time. I do not expect all of them, or many of them, to have changed too drastically. There will be views that maybe will have changed, and they may have changed in a way that is more welcoming of an independent environmental protection agency than they maybe were four years ago. This is not something that I want to force down people's throats —

Mr Principal Deputy Speaker: I ask the Minister to conclude.

Mr Durkan: OK; thank you.

Ms Lo: I think that the Minister is right. Maybe the first step is to look at establishing an independent EPA in Northern Ireland, but, given the short time that we have from now until the end of the mandate and before the merging of the two Departments, what process is the Minister planning to carry out to establish the organisation?

Mr Durkan: I thank Ms Lo for that supplementary question. I believe that it is because of the restructuring, or the amalgamation, of Departments that this is exactly the right time to carry out this piece of work. There are huge concerns across the environmental NGO sector and beyond that it will not be so much an amalgamation of Departments as a takeover of one Department by another, and there is a huge fear that, as a result, the environmental standards or regulations will be compromised. I will do everything I can to allay those fears. I have said many times in the Chamber that the mantra I have tried to bring to this Ministry is the desire to create a better environment and a stronger economy. I believe that that can be achieved and that it can be achieved with an independent environment agency.

However, we need to convince other parties and sectors of the merits of that. As I said before I got cut off, it is not something I want to ram down the throats of people or groups; it is something that we can make people understand, see the merits of and sign up to.

Mr Principal Deputy Speaker: I thank the Minister for letting us know about Mr McMullan's withdrawal. I feel certain that Mr McMullan's party know the procedure for withdrawing questions.

Dungiven: Nitrogen Dioxide Levels

T6. Mr Ó hOisín asked the Minister of the Environment to assure him that all efforts will be made by every means possible to reduce the levels of nitrogen dioxide — NO₂ — in Dungiven, given that he will be aware of the unacceptable and dangerously high levels of NO₂ in the Dungiven area, particularly in the vicinity of the main street, which are some 10 times more than the recommended European level, with a solution to be found only with the

construction of the Dungiven bypass. (AQT 2856/11-16)

Mr Durkan: I thank the Member for that question. I am aware of the issue of traffic congestion in Dungiven; I encounter it regularly and agree entirely with him that one way of tackling the very high pollution levels in Dungiven will be the creation of a bypass. My party colleague John Dallat has been particularly vociferous in campaigning for such a bypass. However, successive Regional Development Ministers have failed to progress the issue.

Air quality is the responsibility of district councils, under the Environment (Northern Ireland) Order 2002, to periodically review and assess air quality within their areas. Where air quality is poor — and it is very poor in Dungiven — councils must declare an air quality management area, accompanied by an action plan containing measures to improve air quality.

Limavady Borough Council, as it was known then, identified levels of nitrogen dioxide arising from transport emissions to be above the objectives set out in the UK air quality strategy. The council therefore declared an air quality management area in 2008, which encompasses Main Street in Dungiven. Levels reported for Dungiven, as high as they seem to us, are comparable to those in other UK cities. However, you are comparing Dungiven with UK cities that might have the same population as Northern Ireland and have air quality problems related to transport. However, those levels are not the highest. Maybe London and Manchester have higher levels of nitrogen dioxide.

Mr Ó hOisín: Go raibh maith agat, a Phríomh-LeasCheann Comhairle. I think that Dungiven should get city status at some time in the future. Will the Minister also address the issue of other chemicals, such as sulphur, and particulates being emitted that may not be covered in the monitoring that is part of the air quality management agreement?

Mr Durkan: I thank the Member for that supplementary question. As I have outlined, responsibility for air quality lies with councils. The NIEA works closely with councils to identify problems in areas and, importantly, identify and seek solutions. I reiterate my commitment to the Member that my Department will work closely with the council on this issue as we all work together on the bypass issue.

Bonfires

T7. Ms Hanna asked the Minister of the Environment what is being done about summer bonfire sites, given that he will be aware of the issues with unregulated summer bonfires, the attachment that people have to them and the risk to property and community relations, particularly from those bonfires that are not part of any management programme. (AQT 2857/11-16)

Mr Durkan: I thank Ms Hanna for that question. Every summer, the media coverage of massive bonfires that are in very close proximity to people's homes, and the sectarian burning of effigies on bonfires, does nothing to promote good community relations, nor is it any advertisement for a place that is moving on from the past and is working towards a better shared future.

The legislative position relating to bonfires is extremely complicated and involves a number of public bodies. That makes enforcement less effective, unless there is a joined-up approach. Legally, the ultimate responsibility for bonfires rests with the landowner — often a public body — although those engaged in antisocial and associated activities also carry certain responsibilities.

District councils often take lead responsibility for the overall management of bonfires, and some very good work is being done on that. A number of other bodies have enforcement powers. Those include the PSNI, the Fire and Rescue Service, and the NIEA in my Department. It is likely that none of the major bonfires complies fully with the requirements of existing legislation.

2.45 pm

I think that it is well past the time for hand-wringing about it being too difficult and emotive an issue to tackle. I am prepared to take leadership to try to find workable solutions. I have been discussing the matter with my officials and asked them to consider future options that may have the potential to improve bonfire management and control. It is my intention to bring those options to the Environment Committee in the near future for discussion and consultation on the way forward and then take a paper to the Executive.

Finance and Personnel

Mr Principal Deputy Speaker: I inform the House that questions 1 and 2 have been withdrawn.

Corporation Tax: Update

3. **Mr Ross** asked the Minister of Finance and Personnel for an update on the devolution of corporation tax powers. (AQO 8702/11-16)

Mrs Foster (The Minister of Finance and Personnel): We have the Corporation Tax (Northern Ireland) Act 2015, which enables powers to transfer from April 2017. However, that, of course, is subject to the Executive demonstrating that their finances remain on a sustainable footing for the long term. For my part, I want to see the devolution of those important powers. My officials are engaging with their Whitehall Government counterparts to ensure that appropriate arrangements are in place to realise that ambition.

Mr Ross: First, I commend the Minister for her work in her current and previous roles to help us get to the point at which the devolution of corporation tax powers is a reality. The Minister will know the expectation that there was in the business community and the frustration at the failure of some to implement the Stormont House Agreement, which potentially jeopardised the possibility of getting corporation tax powers. I agree with the Minister that hopefully the talks process that is ongoing at the moment will help us get to the point at which we can realise the potential of lowering the rate of corporation tax.

Can the Minister tell the House whether the cost to devolve corporation tax and of lowering it to the level that we had talked about previously has reduced as a working-out of that Budget announcement on 8 July?

Mrs Foster: I thank the Member for his question. He will understand that the Azores principle applies to the Northern Ireland block grant. Although the position of corporation tax was in the high twenties, as the main rate, as I call it, in the UK continues to come down, the cost to the Northern Ireland block grant also falls. An initial assessment of the impact of the Budget announcement back on 8 July, whereby the corporation tax rate reduction will be 19% in 2017 and 18% in 2020, means that the cost to our block grant will probably be, on full implementation, in the region of £240 million in 2020-21. That presumes that we set a date and a rate for corporation tax in 2018. Of

course, we have not had that agreement as yet, but we are hopeful that we are moving in the right direction.

Voluntary Exit Scheme: Update

4. **Mr Easton** asked the Minister of Finance and Personnel for an update on the voluntary exit scheme. (AQO 8703/11-16)

Mrs Foster: The Secretary of State has confirmed that funding, as set out in the Stormont House Agreement, will be released to enable public-sector voluntary exit schemes to come into operation as planned. As a result, I have authorised allocations from the transformation fund to allow the first exits under the scheme to progress in accordance with the recommendations of the public sector's restructuring steering group. Executive colleagues were advised of the position on 7 September.

Mr Easton: I thank the Minister for her answer. How many posts will be lost by the 2015-16 period and what are the expected pay bill savings?

Mrs Foster: For the Northern Ireland Civil Service, which has the largest of the public-sector voluntary exit schemes, around 867 staff will leave at the end of this month, with a further 763 scheduled to leave at the end of November.

In total, the first two tranches of exits, which I have just indicated will come to about 1,630 individuals, will deliver a pay bill saving of almost £48 million per annum. Departments have indicated a requirement to exit around 2,700 full-time equivalent posts this financial year, and further offers will be made in due course.

Ms McCorley: Go raibh maith agat, a Phríomh-LeasCheann Comhairle. Can the Minister confirm that all Departments will be able to offer a first-class service to all citizens in the wake of the departures?

Mrs Foster: Of course, it is very important that we continue to provide essential public services in the way that our citizens are used to. Therefore, a range of measures have been put in place, including redeployment arrangements in some cases to move staff into essential posts left vacant by staff who leave via the exit scheme at the end of the month and, indeed, in November. Each Department is undertaking an assessment of business continuity and is

prioritising its work accordingly, so I can confirm that that is the case.

Mr G Kelly: Ceist a ceathair, le do thoil. Question 4, please. Sorry, question 5. I do beg your pardon.

NAMA Allegations: Impact on Business

5. **Mr G Kelly** asked the Minister of Finance and Personnel for her assessment of the impact of the allegations in relation to the National Asset Management Agency on international confidence in our business environment. (AQO 8704/11-16)

Mrs Foster: Everybody is confused today.

Many factors impact on the business environment and, crucially, business confidence. Some of the most important include the quality and stability of our political institutions, a supportive business infrastructure and a high-quality education system. Those are areas that the Executive have focused on, not least in delivering their economic strategy, for example.

It is right that any allegations in relation to the sale of NAMA assets are investigated thoroughly by the appropriate authorities. However, I am not aware of any evidence that suggests that they are having a negative impact on international business confidence.

Mr G Kelly: Gabhaim buíochas leis an Aire as a cuid freagraí go dtí seo. I thank the Minister for her answers up to now. Does she agree, on the basis of what she said, with Transparency International, which compiles an annual list of corruption with Governments throughout the world to root out robustly embezzlement, fraud etc, so that we do not have our international investment attacked in the way in which, I believe, it is being at the moment?

Mrs Foster: I absolutely agree that we have to have an open and transparent system of government. Indeed, the index that we use in that respect is the global competitive index. That looks at a number of key factors and has a particular focus on the importance of the macroeconomic environment. In that respect, I am sure that everyone in the House will agree with me that the absence of paramilitary activity is a key element of that macroeconomic environment. Therefore, we have to deal with paramilitary activity, if it is proven to be present, and that is a key element for the Stormont

House talks, as you are aware, Mr Principal Deputy Speaker.

Mr I McCrea: The Minister will be aware that the Finance Committee is carrying out an inquiry into the claims around NAMA. Has she any concerns that, if the inquiry gets too close to the wire in certain enquiries or information that it receives, there may be the potential to cause difficulties for the NCA's investigations?

Mrs Foster: As I said in my original answer, it is important that there is a thorough investigation by the appropriate authorities. I understand that Committee members are to meet representatives of the National Crime Agency in, I think, the coming week. It will be important to listen to the advice that they give them in relation to their inquiry to make sure that there are no issues that prevent the NCA completing its inquiry in the most robust way possible.

NAMA: Project Eagle/PIMCO

6. **Ms Fearon** asked the Minister of Finance and Personnel what contact her Department has had with the National Asset Management Agency relating to the proposed sale of Project Eagle to PIMCO. (AQO 8705/11-16)

Mrs Foster: My Department routinely engaged with NAMA to discuss a range of issues prior to the sale of the Project Eagle portfolio. The purpose of the discussions was to make representations about any known NAMA actions or plans that might have been detrimental or, indeed, damaging to the recovery of the Northern Ireland economy, including the local property market at that time.

Ms Fearon: Go raibh maith agat, a Cheann Comhairle. I thank the Minister for her answer so far. Why has her Department's permanent secretary continued to hide from the Finance Committee's inquiry into the NAMA issue? Is it for party political reasons? I do not know whether anyone really believes the NCA excuse that the DUP is hiding behind.

Mrs Foster: I am sorry; I did not catch the last bit of the question. As regards my permanent secretary, Mr Sterling, hiding from the Committee, he has been to the Committee on two occasions now and has been very helpful to the Committee, as I understand it. I am not sure where the Member is coming from in relation to her question.

Mr Allister: On what basis did the Finance Minister back in January 2014 advise NAMA that the First Minister and the deputy First Minister were both fully engaged with the PIMCO bid? What did that mean? Given the role of her Department in the appointment of Frank Cushnahan to NAMA's Northern Ireland advisory committee, is it part of her anxiety to stay in office and act as a self-professed gatekeeper that she can protect the chronicles of NAMA from vigorous scrutiny?

Mrs Foster: I know that Jim is fond of fiction, and I am sure that he enjoys 'The Chronicles of Narnia' on an ongoing basis.

Mr Allister: It is the chronicles of NAMA that I am concerned about.

Mrs Foster: Yes, well, I think it would do him good to read 'The Chronicles of Narnia' as well, with its Christian basis. In any event, when Minister Wilson —

Mr Allister: It is still a work of fantasy.

Mrs Foster: I am waiting for the Member to finish. Minister Wilson simply responded to a request from the Irish Government to put forward nominations for NAMA's Northern Ireland advisory committee, and Mr Cushnahan was one of those nominees. There is no mystery surrounding that issue. I think that the Member was referring to my colleague Minister Hamilton in relation to what he had to say: obviously, that is an issue that he will have to take up with Minister Hamilton. I cannot say what was in Minister Hamilton's mind at that time, because I am not Minister Hamilton.

Mr Cochrane-Watson: Can the Minister assure the House that all transactions and discussions involving the Department with regard to NAMA and the subsequent sale have been or will be shared with the House and the relevant Committee?

Mrs Foster: I understand that the documents that the Finance Committee has asked for are currently being gone through. Indeed, we are in discussion with the National Crime Agency to make sure that we do not hinder any investigation that it is involved in. That is where we are at present.

Mr Principal Deputy Speaker: Mr Colum Eastwood is not in his place.

DEL Resource Bids/Surrendered Funds

8. **Mr Hussey** asked the Minister of Finance and Personnel for her assessment of how the DEL resource bids compared to the surrendered funds in the June monitoring round. (AQO 8707/11-16)

Financial Position 2015-16: Update

10. **Mr Givan** asked the Minister of Finance and Personnel for an update on the Executive 2015-16 financial position. (AQO 8709/11-16)

Budget 2015-16: Pressures

13. **Mr Gardiner** asked the Minister of Finance and Personnel for a breakdown of the pressures across the 2015-16 budget. (AQO 8712/11-16)

Mrs Foster: With your permission, Mr Principal Deputy Speaker, I will answer questions 8, 10 and 13 together.

Failure to implement welfare reform has put at risk the Budget flexibilities negotiated in the Stormont House Agreement, which included the flexibility to repay both the £100 million reserve claim in 2014-15 and the £114 million reduction in our Budget for the non-implementation of welfare reform from capital budgets. In addition to these central pressures, Departments have registered resource departmental expenditure limit (DEL) pressures in the June monitoring round of £234.6 million, with only £10,000 of resource DEL reduced requirements declared by Departments.

Mr Hussey: What is the Minister's best assessment of the amount by which Northern Ireland is likely to exceed this year's resource allocations if it remains on the current trajectory?

Mrs Foster: I am hoping that we do not remain on the current trajectory and that we are able to deal with some of the financial issues from the Stormont House Agreement. We really need to have the flexibilities that were agreed in the initial Stormont House Agreement to allow us to proceed with our Budget. We do not want to breach our control totals at the end of the year because, of course, that would be looked on in a very bad light by the Treasury and might have impacts for us in following years.

We are working hard to deal with those issues, but, as you can see from my substantive answer, there is quite a challenge ahead in dealing with our resource DEL.

3.00 pm

Mr Givan: The Finance Minister would be in a much better position had the parties that reneged on the Stormont House Agreement, which they signed up to last year, implemented it. How much funding will be lost to Northern Ireland if the Stormont House Agreement is not now implemented?

Mrs Foster: In addition to the flexibilities that I referred to, we will lose £150 million over five years to pay for institutions to help us to deal with the past, which is a significant issue that needs to be dealt with, and dealt with quickly; and £500 million over 10 years for capital projects to support shared and integrated education. That is a significant amount, and we really could do with that for capital projects for shared education. I am aware of some of those, and they were very worthy.

Mr Gardiner: Minister, is it possible for the Executive to survive this financial year without an agreement on welfare reform?

Mrs Foster: My view has always been that we need to agree welfare reform to allow us to move forward with the Budget that we agreed at the end of the summer. As you know, that Budget was predicated on welfare reform going ahead. Therefore, we need to have that agreement and, indeed, all the other flexibilities in place so that we do not breach our control totals by the end of the year.

Yesterday, we heard from the deputy First Minister that we should, "Put up or shut up." That applies in many other cases as well.

Mr Principal Deputy Speaker: Mr Fearghal McKinney is not in his place.

NAMA Inquiry: DFP Cooperation

11. **Mr D Bradley** asked the Minister of Finance and Personnel whether she has instructed her officials to cooperate fully with the Committee for Finance and Personnel's inquiry into the sale of National Asset Management Agency assets in Northern Ireland. (AQO 8710/11-16)

Mrs Foster: As with all business matters, I expect my officials to cooperate fully with the Committee as it continues with its inquiry into the sale of NAMA assets in Northern Ireland.

Mr D Bradley: Go raibh míle maith agat, a LeasCheann Comhairle. Does the Minister

agree that, if the public or, indeed, Members have the impression that something is being withheld by any party or Department, that creates the impression in the public mind that there is some sort of cover-up? Does she agree with me that there is a necessity in these matters for total transparency?

Mrs Foster: I absolutely agree that there is a need for transparency. There is also a need to respect the ongoing investigation by the National Crime Agency (NCA). I imagine that Mr Bradley, being the Deputy Chairman of the Committee, would appreciate that it is important that that proceeds in the proper way as well. Therefore, there is a need to make sure that we do not directly, indirectly or inadvertently do something that will cause difficulties for that investigation. That is my sole concern in terms of DFP.

Mr Beggs: I, too, believe that it is important that there is total transparency on this issue. Will the Minister assure the House that she will put into the public domain any involvement that her Department had with NAMA and, in particular, the fees that were part of the sale to Cerberus and Pimco? Will she put all that into the public domain? That does not prejudice anybody; it simply provides transparency for the public.

Mrs Foster: I am not sure whether the Member asking the question has expertise in the NCA inquiry. I hope that he is not suggesting that he has some expertise that the NCA does not have. We have been engaging with the National Crime Agency and are sharing the information — all of the information — that the Department has.

The Member mentioned fees, but I am not sure what he was talking about. Nothing I have seen talks about fees in any one way. We have shared all the information that we have held in order to seek confirmation that its release will not, in the NCA's determination, be prejudicial. Everybody in the House should be concerned that that is the case. They want to ensure that the NCA is able to do its job in the most efficient and effective way possible.

Departmental Spending Audit: Update

12. **Mr Lyttle** asked the Minister of Finance and Personnel for an update on the delivery of the independent audit of departmental spending as included in the Stormont House Agreement. (AQO 8711/11-16)

Mrs Foster: I have commissioned the Ulster University's economic policy centre to carry out an independent audit into the costs of division, and I anticipate that a draft report will be available later in this calendar year.

Mr Lyttle: I thank the Minister for her update. It is encouraging to hear of progress on that Stormont House Agreement commitment to audit the cost of division to Departments. Given that the Executive have to deal with significant pressure on our public finances, how urgent a priority does she consider the study in order to feed into a reconfiguration of our public-service delivery on a shared rather than on a separate basis?

Mrs Foster: I thank the Member for his supplementary question. I do not think that I am breaching any confidences when I say this, but that issue was raised today at the Stormont House talks. The report is not due to be with us until November, but I will try to have it with me by October if possible so that we can figure it into what we are trying to do around our budgetary processes at the moment. Members are probably aware that the comprehensive spending review is not supposed to kick off until, I think, 25 November. That causes us some difficulties with our draft Budget process, and, therefore, we are trying to get a clearer picture of how we move forward. We have, of course, outlined forecasts for our budgetary process, but it is difficult to be definitive because we do not get the actual figures until the end of November, and that causes us some difficulty. I am trying to have all the other pieces in place before then.

Mr Principal Deputy Speaker: Mr Pat Ramsey is not in his place. Mr Gordon Dunne is not in his place. That ends the period for listed questions.

We will now move on to topical questions. The Members listed for questions 4, 6 and 7 have withdrawn their names.

Volkswagen: Diesel Emissions

T1. **Mr G Kelly** asked the Minister of Finance and Personnel whether she has raised, or intends to raise, with Volkswagen, locally or in Great Britain, the growing scandal around emissions from its diesel engines and the effect that that will have on customers not only in America but here. (AQT 2861/11-16)

Mrs Foster: No, I have not raised that issue. With emissions, there are stricter criteria in the USA than here in Europe, and that is what has

caused the difficulty in America. It seems that Volkswagen has taken an innovative approach to try to disguise the emissions from its cars. It will cause the company severe embarrassment, and it looks as if billions of pounds have been wiped off its share price literally overnight because of it. It is a very serious issue, and the question of emissions is probably more for the Environment Minister. It will cause great difficulties in production for Volkswagen.

Mr G Kelly: Gabhaim buíochas leis an Aire. I thank the Minister for her answer and I agree that it is very serious. While there may be a difference in terms of the emissions, I understand that questions about it are already being raised in Europe. I am simply asking the Minister whether it could be raised on behalf of the Assembly and the people who are affected by it in the North. The smart chips that the cars are using could easily be used in other vehicles and by other manufacturers as well. This scandal could be much bigger than it already is. Can we make some effort to make an intervention to see what the story is?

Mrs Foster: I can certainly pass on the Member's concerns about the emissions problem to the Minister of the Environment and to the Executive more widely through correspondence. I think that, in America, they are taking steps to check other vehicles to see whether they have been involved in what will be known as the Volkswagen scandal. There is no doubt that it will cause great difficulties for the company.

Stormont Estate: Public Access

T2. **Mr Lynch** asked the Minister of Finance and Personnel for a progress report on the opening of the Stormont grounds to the public for leisure and recreation. (AQT 2862/11-16)

Mrs Foster: I agree with the previous Speaker. As you know, he took a very progressive view in relation to opening up Parliament Buildings to the public, and that has continued under the current incumbent. I really welcome that. A lot of people had not visited Parliament Buildings before then, and it is great to see the number of young people who now engage in visits to Parliament Buildings.

We are looking at what we can do with the grounds of Stormont, and the Member will be aware that a number of events have taken place there. Hopefully, we will be able to come forward with proposals and share those with the Committee.

Mr Lynch: I thank the Minister for her answer. She intimated that there are other events and will be aware that there is a run each Sunday morning through the grounds. Will she make the car parking facilities in Parliament Buildings available to participants of that run?

Mrs Foster: I will have to check whether those car parks are under my control or that of Parliament Buildings and the Commission. That is certainly something that I can come back to the Member on.

Segregated Education System: Cost

T3. **Mr Dickson** asked the Minister of Finance and Personnel whether she believes that spending hundreds of millions of pounds to sustain our segregated education system is tenable and a sensible use of funds in light of the cuts to university places. (AQT 2863/11-16)

Mrs Foster: I was going to say, Mr Dickson, that that is above my pay grade in terms of the different sectors in education. Of course, if we had a clean slate, we would not start from here; that much is very clear. We have a large number of different sectors, and we have to try to deal with what we have.

He may not agree with me on this point, but I have engaged on numerous occasions with the shared education sector. I have seen the work that has been going on between the controlled and maintained sectors in Fermanagh in particular and how that is bringing young people together. It is very impactful for those communities: it not only brings the young people together but brings the parents together in a way that has not happened before.

Mr Dickson: I thank the Minister for her answers so far. The use of public funds to continue segregation, whether in education or other services, distorts our public service obligations in Northern Ireland and how we spend our money. For us to become the first-class region that we all aspire to be, we need to remove those distortions from our budgeting.

Mrs Foster: I say again, we would not start from here on a wide range of issues, but we have to deal with where we are and, therefore, have to have transitional arrangements to do that. I look forward to the report from the University of Ulster — or Ulster University, to give it its proper title. I hope that we can have that sooner rather than later so that we can discuss its findings.

Desertcreat: Treasury Negotiations

T5. **Mr McGlone** asked the Minister of Finance and Personnel whether she has renewed or resumed negotiations with the Treasury in relation to the reinstatement of the moneys for the Desertcreat project outside Cookstown, given that, previously, an estimated £53 million was lost because the project had not been initiated and, on those occasions when the Minister of Justice and his officials appeared before the Justice Committee, they apportioned responsibility for that loss to the Department of Finance and Personnel. (AQT 2865/11-16)

Mrs Foster: I received some recent correspondence from the Minister of Justice in relation to the ongoing work. I am glad that that work is progressing. When we have a definitive figure for the site, we will certainly work with colleagues to make sure that we make as many representations to the Treasury as we can. As the Member knows, the money was ring-fenced at the time, and then it went back to the Treasury. It was never actually ours; it was ring-fenced in the Treasury. We need to make the case again for Desertcreat, and I am happy to do so along with colleagues.

3.15 pm

Mr McGlone: I appreciate that and thank the Minister for her response. Will she give some indication — it will do later on in writing if she does not have it immediately — of the Executive's present level of financial commitment to the project?

Mrs Foster: I do not have those figures in front of me, so I am happy to write to the Member and give him those figures.

Welfare Reform: Westminster Implementation

T8. **Mr Agnew** asked the Minister of Finance and Personnel, given that she will be aware that the focus of today's Stormont House talks was to have been on welfare reform and financial issues, with one possible outcome mooted of the UK Government taking back power for welfare reform and legislating, to some extent, over our heads, whether, if that were to happen, there any legislative barriers to Northern Ireland still agreeing its own top-up fund. (AQT 2868/11-16)

Mrs Foster: Let us be clear: we hope that that does not happen and that the parties can finally, finally come to a decision on the

implementation of the Stormont House Agreement and welfare reform. If that is not to be the case, the Secretary of State has indicated that she will legislate at Westminster, and it will then depend on what powers she takes to do that and what that will look like. A number of options are open to her, and we will have to wait and see. However, as I said, I hope that we can come to an agreement in Stormont House and that that will not happen.

Mr Agnew: I thank the Minister for her answer. Obviously, it is preferable that we legislate and use the powers that we have available in Northern Ireland. I point to Scotland, where welfare was not devolved, yet it still implemented a fund to negate the impacts of the bedroom tax. Barring failure to political agreement on that, is there any major difference between Westminster legislating and our putting forward the legislative difference? We can still introduce our own top-up fund to mitigate the impacts.

Mrs Foster: I hear what the Member says, but we are concerned that there may be a gap between the primary legislation and the secondary legislation, and, during that gap, what happens to welfare recipients? Will they have to deal with GB instead of having the mitigations that we agreed in the Stormont House Agreement? That is a matter of concern. I note what the Member said about the Scottish system, but you have to remember that Scotland was in the GB system for quite a while before it had the mitigations put in place. As I understand it, the mitigations were agreed only a couple of months ago, and I think that they were of the order of £100 million. Scotland has put that in place.

I am sure that the whole House agrees that it would not be a good situation if we were to have the GB model in place for I do not know how long without the mitigation measures. That would be a problem.

Mr Principal Deputy Speaker: Mr Colum Eastwood is not in his place.

Social Value Legislation

T10. **Ms Fearon** asked the Minister of Finance and Personnel whether she will introduce proposals for the North to have its own social value legislation so that public competition is fairer and goes further to support social enterprises and SMEs. (AQT 2870/11-16)

Mrs Foster: As the Member is probably aware, the Central Procurement Directorate has

engaged on that issue quite extensively. If the Member has a particular suggestion about how we should take it forward, I am happy to meet her to discuss the issues. Social clauses have been included in many public-sector procurements. From my experience in DETI, when we were involved in the building of Titanic Belfast, we had a number of social clauses, which worked to great effect. However, if the Member has other suggestions, I am quite happy to look at them.

Ms Fearon: I thank the Minister for her answer. Thanks for the offer, and I am sure that my party colleagues and I will be more than happy to take it up. Does the Minister agree that our focus should be on furthering our Programme for Government commitment to social values?

Mrs Foster: Yes. It is important to look at all our Programme for Government targets and make sure that we deliver on them. I am sure that everybody in the House would agree with that.

Mr Principal Deputy Speaker: Time is now up. Before we move on, during questions to the Minister of the Environment, he made it known that he was aware that Mr Oliver McMullan had withdrawn his question. I indicated to the Minister that Mr McMullan should follow the correct procedure. We now understand that he did follow the correct procedure but that the top Table was not aware of him having done so. We apologise to him.

Members should now take their ease while we change the top Table.

Motion made:

That the Assembly do now adjourn. — [Mr Principal Deputy Speaker.]

Adjournment

Daisy Hill Hospital: Emergency Department

Mr Principal Deputy Speaker: The proposer of the topic will have 15 minutes, and all other Members who wish to speak will have approximately six minutes.

Mr D Bradley: Go raibh míle maith agat, a Phríomh-LeasCheann Comhairle. Tá áthas orm an díospóireacht seo faoin roinn éigeandála in Ospidéal Chnoc na Nóiníní in Iúr Cinn Trá a mholadh. Thank you very much. I

am pleased to propose this topic for debate on the emergency department at Daisy Hill Hospital in Newry. I thank those colleagues who have remained behind to participate in the debate. I am aware that Mr Kennedy and Mrs McKevitt have been in touch to send apologies. They are unable to attend because of other matters.

As you probably know, Daisy Hill is one of the most outstanding hospitals on this island. I begin by placing on record my sincere thanks to and appreciation of all the dedicated staff in the hospital for their continuous care, compassion and professionalism as they care for the thousands of patients who pass through the hospital each way. On a personal note, I thank them for the emergency care that they gave recently to a close relative of mine who was admitted in the early hours of the morning and received excellent care — care, I have to say, that saved his life. Whilst I speak here today, I have to say that this is not something that is theoretical to me or to anyone here. It is a life-and-death topic to our constituents and our families in the area.

As I said, Daisy Hill is one of two acute hospitals in the Southern Trust area; the other, of course, being Craigavon Area Hospital. Whilst I raise this issue here today, it is not a question of pitching one hospital against another. Obviously, we need both hospitals, but we need to sustain proper investment on both sites. In recent years, there has been the perception that services have been withdrawn from Daisy Hill and transferred to Craigavon Area Hospital. The most recent decision was that to relocate the stroke unit from Daisy Hill to Craigavon. That incensed the local people, and it is a decision that I am on record as opposing in the House and elsewhere.

Today, I want to raise the issue of the pressures on the emergency department at Daisy Hill Hospital. Obviously, I am bitterly disappointed that there is no Minister here to respond to the speeches made by Members, including me. The members of the public who are viewing today's proceedings and those in our constituency who are interested in the sustainability of the emergency services at Daisy Hill will quite rightly take a very dim view of the Minister's non-attendance.

Obviously, our health service is under great strain. I do not have to leave my constituency to see that for myself. I referred to the decision to withdraw the stroke services from Newry. In south Armagh, we also have extremely poor ambulance response times to the extent that the local community had to get together to form

a first responders group. I praise the local people who had the foresight to do that under circumstances where, because of the terrain, the roads and the location, many people's lives would be in danger in an emergency situation. We also have the trust's proposal to permanently close the minor injuries unit in Armagh.

These may be viewed as different parts of our health service, but, taken together, the picture they paint is not a very good one. In fact, taking these issues together, it is no wonder that the emergency department in Daisy Hill has had increases in attendance of up to 10%. Numbers presenting to the service are continually increasing. People are waiting longer to be seen, and the trust is struggling to recruit the staff required to maintain the 24-hour-a-day, seven-days-a-week service. It is indeed that which has prompted me to take this matter to the House, because there are real and genuine concerns among the hospital staff and in the community at large that this could lead to reduced operating hours.

Earlier, I referred to my personal experience with a close relative. I spoke to ambulance paramedics and the staff in the emergency department that night, and they told me very clearly that, had the emergency department in Newry been closed and had the journey had to be made to Craigavon or elsewhere, that relative would not have survived. That is why I say that it is a very serious matter.

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

I have met the previous chief executive, Mrs McAlinden, and the current acting chief executive, Mrs Clarke, and the executive team. As I said, I appreciate the efforts they are making to address this problem, but, without the help of the Department and the Minister, there is only a certain amount they can do. The Southern Trust has already engaged in recruitment exercises on a continual basis on some 16 separate occasions, yet it has not managed to attract the staff that it needs. In such a situation, there needs to be ministerial involvement in order that attractive packages

can be put together to ensure that we are able to attract the level of staff needed.

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

3.30 pm

(Mr Speaker in the Chair)

Sustaining the service in the medium to long term without the help, support and assistance of the Minister and his departmental team is a significant challenge for the trust. Hopefully, we will not have to continue too long with the "Here today, gone tomorrow" Ministers, who are leaving the health service in the lurch. I want a Minister here in the House who is answerable and accountable to Members and the public at large. We do not have that at present, so I repeat my appeal to the Department and the Minister, when he returns, to lend the Southern Trust the help, support and assistance that it needs to ensure that it is able to attract the staff that it needs to keep the Daisy Hill emergency department open 24 hours a day, seven days a week. That is what Members want, and it is what the public and the patients want.

Sin a bhfuil le rá agam ar an ábhar seo ag an bhomaite. Mar a dúirt mé, tá mé buíoch go raibh deis agam an t-ábhar tábhachtach seo a ardú sa Teach anseo inniu. Gabhaim buíochas arís leis na Comhaltáí a bhéas ag glacadh páirte sa díospóireacht. Thank you very much, Mr Speaker, for the opportunity to raise this important matter. Once again, I thank the Members who will participate in the debate in due course.

Ms Fearon: Go raibh maith agat, a Cheann Comhairle. I thank the Member for tabling the topic for debate and welcome the opportunity to speak on such a serious and important issue for the people of my area. I have to say at the outset that it is shameful and a disgrace that there is no Health Minister here to respond on such a crucial and critical issue for the people of Newry and Armagh.

Daisy Hill emergency department has an excellent track record, treating over 35,000 patients annually, including over 3,000 from the

north Louth area. It is a crucial service for local people, and it is crucial in the cross-border sense to have that service. It is important to note as well that Daisy Hill has the best record for thrombolysis treatment, with many, many lives being saved in the emergency department over the past number of years. What is also unique about the situation at Daisy Hill emergency department is that out-of-hours is located on-site, meaning that patients can be referred directly and that patient care comes first, as it always should.

Recently, Conor Murphy MLA, who will participate in the debate, the MP for Newry and Armagh — Mickey Brady — and I met the Southern Trust to discuss healthcare issues across the area, with Daisy Hill obviously to the fore. We were told that the numbers using the emergency department in Daisy Hill had increased more than those for any other hospital. I am led to believe that, in the past year alone, the increase was over 10% or over 4,200 patients and that that was putting a lot of added pressure on staff. We were assured that the trust would do all in its power to ensure that there was adequate cover and that the service was maintained.

I think that we can all agree that this needs to be treated as a matter of urgency. It is my understanding that posts have been advertised but, although doctors have applied for posts, there have not been any interviews. That process needs to begin as soon as possible. Another point is that there should not be anything stopping emergency department consultants rotating between the two acute hospitals in the Southern Trust area. That happens in other departments in the Southern Trust. We already know that there are some consultants from Craigavon doing shifts as locums in the Daisy Hill emergency department. Joint working to resolve the problem needs to be given serious consideration.

We know that a lot of money has been invested in the emergency department recently, as it has been upgraded and refurbished. However, as Mr Bradley pointed out, there is a huge amount of fear in our area about the future of Daisy Hill, particularly after the decision made on the local stroke unit, so much so that people took to the streets. The huge turnout showed the depth of feeling that there is about our hospital. We hope that the assurances that we received at the meeting around the paediatric centre of excellence, which is expected to be completed by August 2017, indicates the hospital's future viability.

The emergency department is the heart of any hospital, so it is vital that the service in Daisy Hill is protected, particularly for the people of south Armagh, many of whom are outside the recommended ambulance response time. For example, if someone in Cullaville, an area that I represent and the most southern point in the North, takes seriously ill, without a fully functioning and accessible emergency department in Newry they are told that their next closest option is Craigavon. However, even that is not necessarily true, given the state of local roads. The state of the road to Craigavon is not the best for getting there in an emergency, so, realistically, the next port of call is the Royal, which is over an hour away. That would be a disgraceful situation, given that those situations can often be a matter of life or death.

I feel very strongly that the people of south Armagh deserve better than they have been getting from this Health Department, which, in my opinion, is very little. There is an unfolding GP crisis from Crossmaglen to Meigh, totally inadequate ambulance service cover in south Armagh and an inability of the Department to deliver a day-care centre in Crossmaglen, all wrapped up with what appears to be a complete lack of interest by the Health Department. It cannot be overstated how crucial a part Daisy Hill plays in all of this. It must be protected, because the reality is that, if it is not, people will suffer.

Mr Cochrane-Watson: I thank Mr Bradley for bringing the issue forward for debate this afternoon. I speak on behalf of my party colleague Mr Danny Kennedy, who is attending a funeral and sends his apologies.

Danny has asked me to emphasise the value that the hospital has across the community and across Newry and Armagh. It is very highly thought of not only for the treatment that it provides but for the skills of the staff who work in it. Even in the most difficult circumstances, the staff are managing to keep the hospital working very efficiently. Indeed, I note in the publication of the latest A&E figures for waiting times that 89% of people presenting to Daisy Hill are seen within the four-hour standard. That compares very favourably with the performance of my hospital in Antrim, which saw a further deterioration to 61%. That is a credit to the doctors, nurses and entire staff at Daisy Hill. I am very aware that we are not comparing like with like, and I am sure that the staff in Daisy Hill will have every sympathy for their colleagues working under intense pressure in Antrim.

Whilst Daisy Hill may not face the same pressures as some other hospitals, by no means can it afford to rest on its laurels. In fact, I am aware that there has been significant change in health service provision in the wider south Down area. The downscaling of services in the Downe Hospital will have a knock-on effect and impact on those offered by Daisy Hill. Whilst I appreciate that the minor injuries unit in the Downe will mitigate the worst of the reductions, it is only open part time. After 8.00 pm during the week and after 5.00 pm at the weekends, there is no emergency or minor service in that hospital, so Daisy Hill plays the only important role.

The future of Daisy Hill is now under some threat. Whether the previous Minister would like to admit it or not, the Donaldson report, as well as TYC, quite clearly shone the spotlight on our smaller hospitals. Whilst my party is not stubbornly opposed to any change, we would be opposed to change just for the sake of it. Every decision needs to be taken for sound medical reasons, and, right now, Daisy Hill appears to be offering and efficiently delivering safe and effective care. We see no reason to change that. What the patients and staff of the hospital need is some certainty about their future. If a cloud begins to hang over the hospital, very quickly it will find it difficult to recruit staff in the numbers that it needs, and, ultimately, more money will have to be spent on locums, and that will become unsustainable.

Unfortunately, however, the Minister's absence today is a great disservice to the good people of Newry and Armagh, and the sideshow that we are witnessing and the in-out effect of having no Minister at times or having a Minister for only a few hours will do nothing to protect the hospital or offer it the support that it needs.

Mr Murphy: Go raibh maith agat, a Cheann Comhairle. You caught me on the hop there.

Before I start, I apologise. I missed being present at a question to the Agriculture Minister last week. I was in Stormont House at the talks, trying, obviously, to secure the future of this institution, but nonetheless I neglected my duties in the Assembly Chamber, and I apologise for that.

I thank the Member for bringing forward the debate. As he and others have said, it is an extremely important debate for our constituency and probably for a large part of the South Down constituency as well. This is probably the primary public-service discussion, debate or concern that applies right across the region. Daisy Hill Hospital is such a vital part of our

public-sector infrastructure. It provides a vital service to a largely rural, dispersed community that is not well served by either public transport or roads. I say that as a former Regional Development Minister. The history of the area has been one of poor infrastructure that it will take some time to improve.

As Mr Bradley said, the Southern Trust area is served by two hospitals. This issue is not about trying to play one hospital off against the other, although, as you meet the people who work in Daisy Hill and those who use the service, you find that they quite often feel the poor relation to the needs of the Craigavon Area Hospital. One of the telling features in recent times is that the Southern Trust management produced a 50-page document outlining its plans for the next three years and in it they stated that they would build a new hospital at the Craigavon site, but there was no mention of the impact that such a development would have on the existing hospital and services provided at Daisy Hill. Others have outlined the most recent service to migrate from Daisy Hill to Craigavon: an essential part of the stroke service — not the entirety of it, but a key part of it. So there is a justifiable concern among the staff, patients and families and people who use Daisy Hill. Like Mr Bradley and others, we have all had very direct experience of availing ourselves of the services of Daisy Hill Hospital, and very much appreciate both the quality of the service and the proximity to our community of where that service is provided.

I acknowledge the efforts of the trust. We have met its representatives, as others have done. Megan Fearon repeated that we met the trust to discuss the problems that it faces in the retention and recruitment of staff in the emergency department. I acknowledge the efforts that the trust has made to try to meet those problems. The trust sent us a very belated briefing note this afternoon to tell us that it is still struggling with recruitment and retention of suitably qualified doctors and will continue to exhaust every recruitment option in relation to it. It has now implemented a management plan to allow the emergency department to remain open overnight.

The trust goes on to say, worryingly, that it is still extremely vulnerable to further loss of any medical staff. In sustaining the service in the medium to long term, that remains a significant challenge for it. Ironically, it goes on in its briefing document to encourage us to avoid media speculation over the future of the emergency department, which could hinder its ability to attract medical staff to help the situation. I have to say that, whether intentional

or not, the approach of the trust over a long number of years — I do not apply this to its current leadership — has been to reduce confidence in the longevity of the services at Daisy Hill Hospital. That, in some way, contributes to its ability to attract and retain significant senior staff there. The trust has said — others have mentioned this — that it has struggled to attract suitably qualified staff to cover the night-time service at Daisy Hill Hospital. However, I have been told that four staff posts have been advertised and, although suitably qualified doctors have applied for them, there have not been any interviews as yet. That is something that the trust needs to apply itself to very quickly.

Another suggestion that was put to me is that other medical staff in the employment of the trust are employed on a trust basis, not on a hospital-site-specific basis. The trust is able thereby to rotate their services between the hospitals and provide cover in both, yet it seems that, for cover in the emergency department, staff are being sought on the basis of a specific hospital site. I think that the trust should look at the idea of having consultants who can rotate between both hospital sites to ensure an appropriate level of cover. The case for that level of cover to service our community has been very well made by other Members who have spoken. I endorse what they have said and encourage the trust to continue to do its utmost to provide that service and to create some level of certainty in relation to the services at Daisy Hill and, in doing so, provide a level of certainty for Daisy Hill Hospital as a whole. Go raibh míle maith agat, a Cheann Comhairle.

3.45 pm

Mr Rogers: At the outset, I would like to thank all Members and staff who supported today's Macmillan coffee morning in honour of our good friend Stephen McKiernan.

I welcome the opportunity to speak on the motion and want to start by paying tribute to the front-line healthcare professionals who do a fantastic job working under extreme pressure. It is a common occurrence for a nurse who finishes a shift at 8.00 pm still to be caring for his or her patients an hour later. Like the Member who spoke previously, I acknowledge the efforts of the trust to maintain the A&E at Daisy Hill as a 24-hour service.

The most worrying aspect today is that we do not have a Health Minister in charge. Who is running the health service? We hear grand references to equality in access to services in

rural areas, but all we see is centralisation. I will talk more from a South Down perspective. Mourne has lost its hospital and its minor injuries unit, the out-of-hours service operates occasionally and attempts are being made to close the Slieve Roe residential home. We in Mourne depend more than ever on Daisy Hill. The reduction in many critical services, such as A&E at the Downe Hospital and the planned removal of stroke services from Daisy Hill, serve as indicators of the direction of travel that the health service is taking.

Patients who are unable to secure appointments via GP surgeries are presenting at already overstretched accident and emergency departments. Cost savings in one department are leading to chaos in others. Patients who rely on services at Daisy Hill and Downe are being denied access to vital care. South Down constituents are now possibly the most disadvantaged citizens in the North.

What is the clinical basis for the removal of the stroke unit from Daisy Hill? We all know the reasons why it needs to be retained — to provide quicker access for people living in the hospital catchment area to life-saving treatment. Yes, it is life-saving because, if you have a stroke and live in Mourne, in places such as Attical or Ballyvea, you will do very well to get an ambulance and get to Daisy Hill in 90 minutes, never mind the golden hour. I do not want to detract in any way from the level of service at Craigavon, but, without an air ambulance, the journey there from the Mournes is too long. Frequently in the winter, we have only a coastal road to get to hospital.

The towns and rural communities of South Down are being marginalised and let down by the gradual erosion of services, first at the Downe and now at Daisy Hill. I have yet to hear a valid reason why stroke services in the form of a specialised stroke unit at Daisy Hill cannot be maintained. I understand that ongoing consultation with the Dublin Government could result in patients from Louth and Monaghan accessing services at Daisy Hill. Daisy Hill has a fine reputation as a stroke centre. Let us build on it to serve all the people.

During the summer, speculation was rife that accident and emergency provision at Daisy Hill was facing a reduction in services due to staff shortages. At a recent meeting, the acting chief executive of the trust outlined the difficulties in attracting middle-grade doctors and consultants to accident and emergency. As the trusts have reduced services at the Downe and Armagh minor injuries, that has put even more pressure

on Daisy Hill, which, in turn, puts more pressure on Craigavon and, in turn, the Belfast hospitals.

In a recent consultation, Improving through Care, the SDLP voiced its concern. We recognised that it is critical for local people to have confidence in the health service and that healthcare is best delivered at a local level, where the facilities exist. I will give one example of a constituent, an elderly lady who is in a nursing home in Newcastle. If she takes ill during the night, she is moved to Daisy Hill. That has happened on a number of occasions, and she has received first-class care. However, if she takes ill during the day, she is taken to Downpatrick. Recently, her family were contacted and told that she had been taken to Downpatrick, only to discover that she was lying on a trolley there for three or four hours, waiting for a bed to be made available in Downe. That woman will be 84 in a few months' time. How would you like your mother or grandmother to be treated like that? Where is the patient care? Where is Transforming Your Care? Such inhuman treatment is happening in our health service, and it is disgraceful.

The SDLP recognises that, while financial responsibility is a major constraint in determining future strategy, it cannot be the sole focus. If services at Daisy Hill were made more readily available, North and South, it would contribute to making the hospital even more sustainable in the long term. The trust must realise that a health service must operate on the basis of a community's best interest, not strictly on the basis of the financial bottom line.

Mr Hazzard: Go raibh maith agat, a Cheann Comhairle. I thank the Member for bringing this very important topic to the Chamber today. Like everyone else who has spoken, I want to put on record that it is regrettable that the Health Minister and, indeed, the former Health Minister, the Member for South Down Jim Wells, are not here. This is a very important issue for our constituents.

I also wish to pay tribute to the staff at the Daisy Hill and Downe hospitals. They do a great service for our community and have done for a long time. Often, when public reps become frustrated at the situation, we are often portrayed as attacking the entire institution of a hospital, including the staff and front-line staff. That is of course a long way from the truth. We would be lost without them.

Mr Rogers touched on the fact that we cannot separate the future of the Downe and Daisy Hill hospitals; they are two very proud hospitals that

have served the people of south Down well for many years. Their futures are very much intertwined. The Ulster Hospital is sucking so much out of the Downe Hospital, and I think that there is a similar situation with Craigavon. If we see the loss of the coronary care and emergency department from the Downe — read strokes unit — and the fear of the emergency department moving from Daisy Hill to Craigavon. There is a 'Big Brother' effect that is sucking the life and hope out of so many people who rely upon these services. Other Members have alluded to the rural aspect of a constituency such as South Down. Ms Fearon mentioned the failings in ambulance cover in what is a very rural area, and Mr Rogers talked about an elderly constituent who was affected. We see that time and time again. In recent months, we have seen tens of thousands of people on the streets of Downpatrick and Newry. I do not think that any of these people are immune to change.

We know that our health system is changing and we know that there is a need for change. How we deliver services in a first-class manner needs to change, but what we are seeing all too often is a complete lack of engagement from the higher echelons of the Department of Health. We need to see a Minister take control of the situation. We need to see the Department of Health carefully lay out a plan and engage with people. There was a totally regrettable situation with the Downe Hospital where news of its closure was leaked the night before Christmas Eve. Understandably, panic set in. That should not be how things are done.

Where do we go from here? I have spoken to recruitment agencies that deal with medical practitioners who say that it is very possible to follow what they have done in the South and bring in medical doctors from eastern Europe who are more than capable. They have come into the Midland Hospital in Roscommon and are doing a great job. This is where perhaps it would have been good to have Jim Wells in the Chamber, who showed some reluctance to look at this the last time, because I think that this is an avenue that we need to look at. If there are people in the EU or further afield who can come and do a good job, we need to search them out.

How we approach this matter is a big test for the Minister, and, so far, he is failing. If we had to close schools because there were no teachers to teach our kids, there would be pandemonium and we would not tolerate it. We should not tolerate instances in which we have had to close medical departments because we cannot get the doctors. This is a big test for the Minister, and, so far, we have not seen enough.

Finally, we have seen the success that Altnagelvin has had through its cross-border solution for cancer care. There are no good reasons why the likes of Daisy Hill cannot become a champion hospital for those in the border areas. We looked at working alongside Drogheda with the Downe, but it is clear that the people of South Down, and Newry and Armagh, will not be best served by concentrating all our services in Craigavon or the Ulster Hospital in Belfast. It does not serve our people well. We need to see a focus now from the Minister and the Department to reinstate a bit of confidence in these services.

Mr Speaker: Thank you, Members. That was an important topic.

Adjourned at 3.54 pm.

Suggested amendments or corrections that arrive no later than two weeks after the publication of each report will be considered by the Editor of Debates.

They should be sent to:

✉ **Editor of Debates, Room 248, Parliament Buildings, BELFAST BT4 3XX**

☎ **028 9052 1135**

📧 **simon.burrowes** Personal Information redacted
by the USI

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✉ **Hansard Admin Unit, Room 251, Parliament Buildings, BELFAST BT4 3XX**

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📧 **hansard@niassembly.gov.uk**

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Continuous Improvement

'Introduction to Quality Improvement' E-Learning

The Trust's new 'Introduction to Quality Improvement' E-Learning module has been launched and is available for all staff on the Trust's E-Learning Platform NOW!



The 'Introduction to Quality Improvement' module provides staff with an understanding of what Quality Improvement is and how we can play our part in improving care and services.

The module includes an overview of Quality Improvement tools and methodologies and is suitable for all staff.

The 'Introduction to Quality Improvement' E-learning module has been developed in-house by our own Continuous Improvement Team. Clifford Mitchell, Senior Service Improvement Lead said;

"The team spent time researching many Different service improvement models and identified that the NHS 5 Step Model was the most appropriate for our Trust vision and would support us to provide quality improvement throughout the Trust."



The Continuous Improvement Team
(L-R) Kelly McFarland, Clifford Mitchell, Blaitheid McCooey and Jacqueline Morton,



NHS 5 Step Model

"Using the 5 Step Model enabled us to create a tailor made E learning package, combining project management skills and relevant, easy to use quality improvement tools and techniques that can be used by all staff to drive forward quality improvement here at the Southern Trust"

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'Introduction to Quality Improvement' E-Learning

**Learn Your
Way!**

Quick Quiz - Drop & drag - Data Types

Qualitative

Quantitative

Drop & drag each
data type into the
correct box below.
Click Submit to check
your answer.

Number of New Referrals Data

Patient Satisfaction Survey Questionnaire Data

Interactive

- ~ Individual E-learning
- ~ E-learning as part of a team with your manager
- ~ E-Learning as part of a 'Time Out for Teams' session

The training is interactive, user friendly and provides a wealth of resources and materials as well as quick quizzes to test your knowledge

**Aldrina Magwood,
Director (Interim) of Performance & Reform said:**

"The Quality Improvement E Learning encourages staff to reflect and challenge how and why we do things as we do, engaging staff to seek opportunities to enhance the experiences of service users and staff, and to consider existing systems, processes and outcomes. The tools introduced offer a challenge to individuals and teams to consider their service in a wider context making connections and providing assurance that we are doing the best that we can. If the e learning encourages us all to do even one small thing better, then it is worthwhile. As an Organisation with more than 13,000 staff we are constantly seeking opportunities for staff development and the new Quality Improvement E learning affords staff this opportunity.



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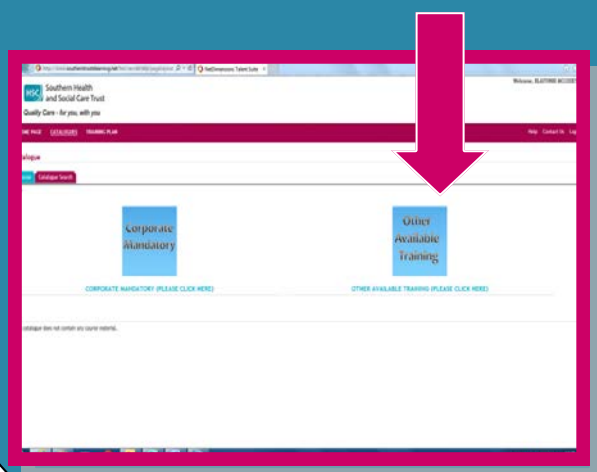
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'Introduction to Quality Improvement' E-Learning

Learning outcomes within the 'Introduction to Quality Improvement' E-Learning describe individual staff roles and responsibilities in relation to:

- ◆ Quality improvement
- ◆ Patient Safety
- ◆ Effective team working,
- ◆ Proactive service user involvement
- ◆ What to do when things go wrong



You can access the Introduction to Quality Improvement module on the Trust E-Learning platform.

You can find it by selecting the Catalogues tab in the top left hand corner of the screen and then by selecting Other available training.

Module Summary

Congratulations, you have now reached the end of the Introduction to Quality Improvement module.

You should now:

- Understand what is meant by quality improvement and using measures and data
- Understand the 5 Step Quality Improvement Model
- Understand the benefits of using small steps to improve care and services using the Model for Improvement / PDSA
- Understand why and how we put patients / service users at the centre of everything we do
- Understand your responsibility to speak up if something goes wrong and how to do this

I enjoyed the module, there was a lot of content to read and retain. It makes you think differently about how you work and what could be improved.



Register NOW for Quality Improvement E-Learning

If you would like to register to complete the e-learning please enrol directly on the Trust E-Learning Platform: www.southerntrustelearning.net

If you require further information please email: [Redacted]

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Quality Improvement Leader Programme *Supporting our staff Lead Change*

The Trust has launched a new 'Quality Improvement Leader' programme which will provide a structured project management system for the implementation of a significant service improvement project. January 2016 will see the first cohort of Southern Trust multi-professional staff embark on this newly developed and externally accredited programme.

The aim of the QI Leader programme is to develop quality improvement capacity and capability whilst promoting and supporting an improvement culture. The programme uses an evidence-based approach to support leaders find a better way to do things; understanding why we do things the way we do and seeking and testing a better way.

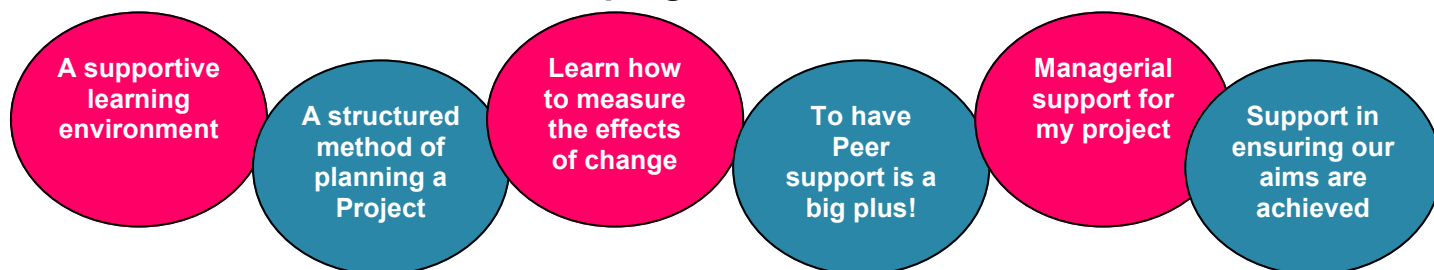
Projects will be aligned to the Trust Quality Improvement priorities for 2016:

Communication: Focusing on areas that reduce harm and increase safety and
Infection Prevention and Control

Participants in the programme will:

- ♦ Build on and develop quality improvement knowledge, skills and experience
- ♦ Complete the Quality Improvement Leader E-Learning programme
- ♦ Participate in monthly learning sets between January and October 2016
- ♦ Have a dedicated facilitator aligned to their project
- ♦ Access a range of wraparound support

Please see below some feedback from participants who are embarking on the programme



We wish our Quality Improvement Leaders every success and look forward to regular updates in future editions of the Continuous Improvement Newsletter.



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Radiographers Win Team of the Year Award and are Honoured at Houses of Parliament



Radiographers Helena Kinkaid, Janet Eagle and Audrey Mitchell have won the UK Radiography Team of the Year Award for their innovative service improvement project; ensuring that women in the Southern Trust who are undergoing infertility tests can be seen quicker and with more continuity of care.

A hysterosalpingogram (HSG) examination is an invasive diagnostic procedure that is the front line test to diagnose infertility in women. The procedure is both emotionally and psychologically challenging for the women who undergo it.

The Radiography Team identified a service improvement opportunity by demonstrating that a radiography-led clinic where HSGs could be carried out by trained radiographers would not only ensure that women were seen in a more timely fashion but also there would be an increased continuity of care without exhausting capacity at gynaecology clinics.

Janet Eagle said of the service: **“We set up a stringent in-house training programme and kept log books to ensure all standards were met and we were working within our scope of practice. This information was audited and we were formally signed off as competent to perform and independently report HSGs. Further training in the gynaecological aspect of care was commenced in order to enhance the service offered.”**



Back row: Samantha Jones, Director of New Care Models Programme, NHS England (Guest of Honour) and Charlie McCaffrey, Carestream UK (Event Sponsors). Front row: Janet Eagle, Lead Radiographer Fluoroscopy, Helena Kinkaid, Senior Radiographer, Audrey Mitchell, Radiography Assistant

The Radiography team were presented with both the **NI** and **UK Team of the Year** Awards by the **Society and College of Radiographers** at a ceremony in the House of Commons on 10 November 2015. The awards were a special recognition of the innovation, team dedication and intuition in delivering a life changing service to women with fertility problems.

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Radiographers Win Team of the Year Award and are Honoured at House's of Parliament

...Continued from Page 5

Back row: Richard Evans, CEO Society of Radiographers, Samantha Jones, Director of New Care Models Programme, NHS England (Guest of Honour).

Front row: Janet Eagle, Lead Radiographer Fluoroscopy, Helena Kinkaid, Senior Radiographer, Audrey Mitchell, Radiography Assistant



Janet Eagle comments on how humbling it is to win these awards:

“Our journey to date has exceeded all of our expectations and has provided the women attending our department with a service they deserve. We are very proud of what we have achieved, winning not only the Regional Society of Radiographers Team of the Year but also the UK Team of the Year, it has been a tremendous honour. Whilst It is humbling to have your work recognised in such a way, providing a high quality, caring and effective diagnostic imaging service, accessible and responsive to women who are experiencing fertility problems within the Southern Trust continues to be at the heart of all we do.”



“There are some people who have been instrumental in the success of our project and who we wish to thank; without their help, support and belief in us we would not have been able to achieve this outcome. They are;
Dr Stephen Hall, our Consultant Radiologist and mentor,
Dr Tim McCormick, Dr Suzie Finnegan and Dr Tsveta Hadjieva our Gynaecology mentors,
Jeanette Robinson our Radiology Manager, **Andrene Graham** our Site Lead and **Pauline Lavery** our Team Lead.”



Congratulations to the Team!

Please contact [Redacted]
if you would like any information about the service they provide



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Unlock Your Potential! 'Taking the Lead' SHSCT Leadership Development Programme **Now Recruiting**

The aim of this programme is to develop individuals who hold, or aspire to hold, a managerial post within the Trust, to enable them to unlock their potential so they can continue to '**Take the Lead**' in their own roles.

The programme will provide the opportunity to reinforce key skills and enhance confidence to meet the growing demands for top quality services in an environment where resources are increasingly constrained.

We are currently recruiting 2 cohorts of Band 7 Team Leader / Ward Manager level staff, or equivalent, to undertake this programme commencing **March 2016**.

Staff wishing to book a place should e-mail their

- Name
- Job title
- Staff number
- Contact number
- Line manager's name to:
Learning.Development@southerntrust.hscni.net



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BOOK NOW

Telephone: 028 3861 4095

Line managers can Email:

Personal Information redacted by the USI



Staff may also wish to register interest for the below course(s);

OUTLOOK

BASIC WORD

BASIC EXCEL

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Southern HSC Trust Breakfast Seminars

Breakfast Seminars provide an opportunity for staff to share innovation and improvement experiences across the Trust. These topic-focused short presentations share team experience of service redesign, project management, the driving forces behind change and the measures used to gauge improvement.

To celebrate World Quality Day a series of breakfast seminars were held in November and December across the CAH and DHH sites

Increasing Early Detection of Lung Cancer delivered by Dr Rory Convery, Consultant Physician, was the first in this series of seminars and was held on World Quality Day, 12 November 2015. The seminar was well attended with useful discussion on this excellent pilot programme



Dr Rory Convery presented our first Breakfast Seminar on World Quality Day



Eamon Farrell delivering his Breakfast Seminar at CAH with a video link to DHH

On Friday 27 November 2015 Eamon Farrell, Transforming Your Care, Service Implementation Lead, OPPC, presented a breakfast seminar on the new ***'Acute Care at Home'*** model of care. Attendance was multidisciplinary with various staff asking questions about the project plan for such a large scale improvement.

Consultant Paediatrician, Dr Bassam Aljarad presented a seminar on ***'Routine Saturation Screening in the Newborn'*** on Friday 11 December 2015. This innovative pilot has been welcomed not only by service users and staff but by regional peers.



Dr Aljarad and Paul Morgan, at the 'Routine Saturation Screening in the Newborn' Breakfast Seminar

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Southern HSC Trust 2016 Breakfast Seminar Programme

Due to the success of the Breakfast Seminar programme at the end of 2015 a new series of Breakfast Seminars will kick off in January 2016. Breakfast seminars are an excellent way to share best practise across the Trust and to learn from quality improvement initiatives that other teams have put in place.

You can view Part 1 of the 2016 programme [HERE](#)

January Dates for Diary:

Tuesday 12 January 2016 @ 8.30am

Craigavon Area Hospital - Boardroom, Ground Floor

Daisy Hill Hospital - Committee Room 1

Roisin Lynch, Physiotherapist, shares her experience of the Implementation of the STarT Back approach to improve the management of patients in the Physiotherapy Service with Low Back Pain.

Wednesday 20 January 2016 @ 8.30am

Craigavon Area Hospital - Boardroom, Ground Floor

Daisy Hill Hospital - Committee Room 1

Grainne Forsythe, Radiographer, shares the experience of The Plain Film Reporting Service Provided by Radiographers



World Quality Day, 12 November 2015

World Quality Day promotes awareness of quality around the world and encourages not only individual but Organisational growth; focusing on quality, innovation and sustainability

To celebrate World Quality Day we asked our service users and staff about what quality means for them:

"Treat everybody as you would like to be treated yourself"

"Treating patients with dignity and respect. Always."

"There is always room for improvement, Quality should always be optimum"

"Going the extra mile to help my patients"

"To Patients it's the little things that mean the most, a smile, a quiet word"

"Quality is going the extra distance to make patients feel comfortable and have a positive experience"

"Quality is being able to provide a good service and a friendly smile to all clients and patients"

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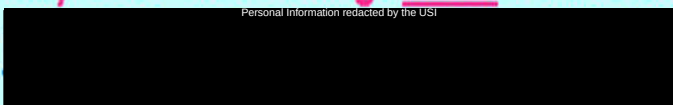
Attention!

Calling all
Mentors &
Practice
Teachers



WE'RE CHANGING! Changes to mentorship programme booking procedures

Bookings for programmes relating to Nursing & Midwifery Mentorship is changing with effect from Tuesday 9 February 2016

- ✓ From Tuesday 9 February 2016 all bookings must be submitted via the following email: 
- ✓ You must use the appropriate booking form(s) when submitting your request.

Click [HERE](#) to access the Booking Form(s)

For further information, contact your aligned
Practice Education Facilitator.

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Performance and Reform Christmas Coffee Morning



Staff from the Performance and Reform Directorate hosted a Christmas coffee morning on Friday 18 December in aid of Marie Curie, the Trust Charity of the year.

The morning consisted of festive treats, quizzes, raffles and Christmas cheer. It was a great success raising **£553** for Marie Curie.

Thank you to everyone who helped or contributed and participated in the coffee morning.



Some of the organisers of the Coffee Morning: Paula Tally, Lesley Leeman, Blaithnid McCooley, Lynn Lappin, Jacqueline Morton and Clifford Mitchell



Aldrina Magwood presenting Eileen Shine, Corporate Governance Office, with the raffle prize of a luxury hamper donated by Performance and Reform staff



There was a great turnout for the coffee morning hosted at Trust Headquarters Dining Room



"The Brackettes" winners of the coffee morning quiz: Pauline Grant, Janet McConville, Sandra Waddell, Andrea Turbitt, Paula Vennard and Nicky Hayes from the Trust's Planning department

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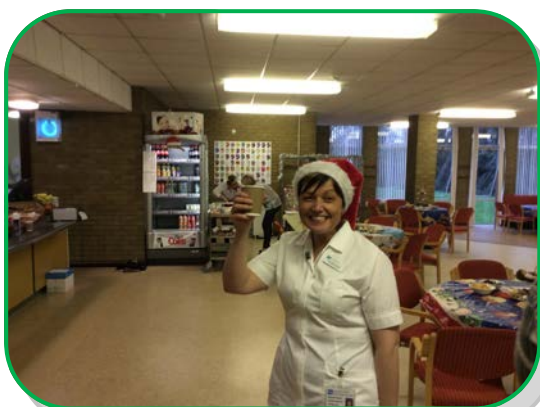
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Christmas Coffee Morning .. Continued from page 11



Aldrina Magwood presenting Phil Higgins with a prize from the raffle



Linda McClinchey, Dining Room Trust HQ, Getting in the Christmas Spirit



Aldrina Magwood presenting Colum Robinson with a prize from the raffle



Trust Staff enjoying the festive food at the coffee morning



Staff from the Estates Dept enjoying the Christmas fun



Kieran Donaghy, Director HROD with Anne Forsythe and Jenny Johnston



Sandra Judt & Elaine Wright from Trust HQ supporting Marie Curie



Dawn Livingstone & Dr Wright on Tea duty at the Marie Curie coffee morning



Anna Donnelly & Maria Conway testing the scones!

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Quality Improvement: What does it really mean?



Aldrina Magwood, Director of Performance and Reform (Interim) talks to us about what Quality is and why getting Quality right within the Southern Trust is so important for our Service Users and our Staff.

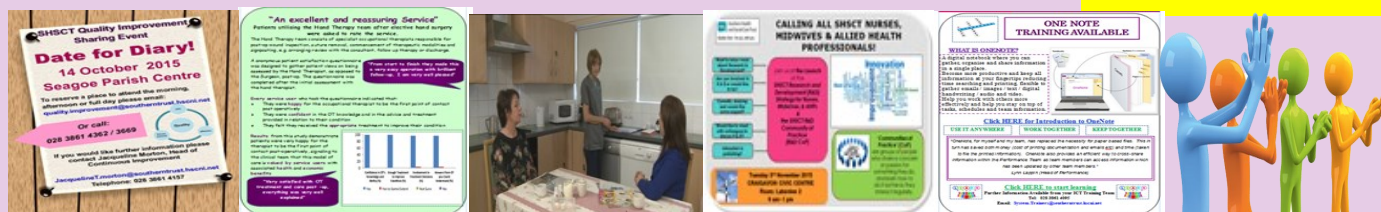
There is much said about efforts to improve quality and while it is obvious and commendable for any organisation to be committed to “continuous” improvement, within the Southern Trust we are pausing to consider: **What does quality mean?** - to those who use our services and to those of us working within our health and social care system.

Within our Trust we have multiple examples of good practice of individuals and teams who take forward real changes that lead to better patient experience, better system performance and better professional development. We recognise that quality improvement needs to be an intrinsic part of everyone's job, every day and right across the whole system. This begs the question, are we clear and focussed on the most important things and ensuring our collective efforts are harnessed in these areas? What are these ‘most important things’?

To crystallise our thinking on what quality really means we are currently engaging with staff and users to feed into our emerging Quality Improvement Framework (QIF). The aim is not to create a glossy strategy document but to agree a framework for the Trust that supports our efforts to:

- Increase the co-ordination and prioritisation of our efforts to innovate and improve
- Ensure we are monitoring, measuring and evaluating outcomes and experiences - this is about **better**, not more, it's about making connections
- Listen, learn and take action on what we know, and
- Strengthen assurance

In this issue...



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Sharing Event **14 October 2015**

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user feedback

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Experience in
taking Medications

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Calling all Nurses,
Midwives & AHPs

Page 6:
ONENOTE Training

NEXT Edition:
Quality
Improvement
Sharing Event
SPECIAL

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The Trust is committed to improving quality and the quest for new ideas by ensuring that all staff have the opportunity to 'think differently' about how we can make change happen across our health and social care system.

The Trust Senior Management Team (SMT) introduced proposals such as '**Dare to Do Differently**', '**Time out for Teams**', leadership development, training and e-learning to support staff to consider opportunities to do, think and act differently. If patient care and outcomes are to be the very best they can be, we need to ensure that care is based on a strong evidence base and is delivered by confident and competent health and social care professionals who can demonstrate that any change we implement is making an improvement to patient care and experience.

The development of a Quality Improvement Framework will provide us with a roadmap on **how to improve patient care and experience** and will reflect what our staff and users tell us is most important.

We are currently seeking your thoughts on **what quality means to you**.
If you haven't been asked yet, don't wait, have your say by emailing:

Personal Information redacted by the USI

The Trust **2nd annual Quality Improvement Sharing Event** takes place on **14 October 2015** at Seagoe Parish Centre, Portadown. This event is an opportunity to showcase the improvement work you or your team have taken forward in the past 12 months. **For more information on the Event or to register to attend, please contact the Continuous Improvement Team on** Personal Information redacted by the USI **or at** Personal Information redacted by the USI

Many staff are availing of the 'Time out for Teams' opportunity. If you would like to find out more ask your line manager or click on the [link](#) to find out how your team can use this opportunity.

This year 48 operational managers participated in our 'Taking the Lead' programme which included leading a small change within their Service. To find out what they have achieved click [here](#)

Quality is about protecting people from harm, providing treatment and support that works and making sure they have a good experience when they interact with us or with our partner providers

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Date for Diary:

SHSCT 2nd Annual
**Quality
Improvement
Sharing Event**
is taking place on
**Wednesday 14
October 2015**

To register to attend either the
Morning, Afternoon or Both sessions please contact

Personal Information redacted by the USI

The **Morning session** will include:

- Oral & poster presentations
- Audrey Fenton; Living with Cancer
- Hannah Shields, NI's first woman to conquer Mount Everest
- Launch of SHSCT Quality Improvement E Learning programme
- Hear more about what Quality really means to our Service users and Staff

In the **Afternoon** participate in a range of practical and interactive sessions including:

- Liam Creagh, Redbox Media
See yourself as others see you & sharpen up your communication skills
- John McClune, InvestNI, What can process reengineering offer you when it comes to improving quality?
- Join Roni McMillan, Leadership Centre in a "Dragons Den" experiential session.

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Patients Utilising the Hand Therapy Team After Elective Hand Surgery Were Asked to Rate the Service

"An Excellent and Reassuring Service"

The Hand Therapy team consists of specialist Occupational Therapists responsible for post-op wound inspection, suture removal, commencement of therapeutic modalities and signposting, e.g. arranging review with the consultant, follow up therapy or discharge.

An anonymous patient satisfaction questionnaire was designed to gather patient views on being reviewed by the Hand Therapist post-operatively as opposed to the traditional model of the Surgeon. The questionnaire was completed after the initial assessment with the Hand Therapist.

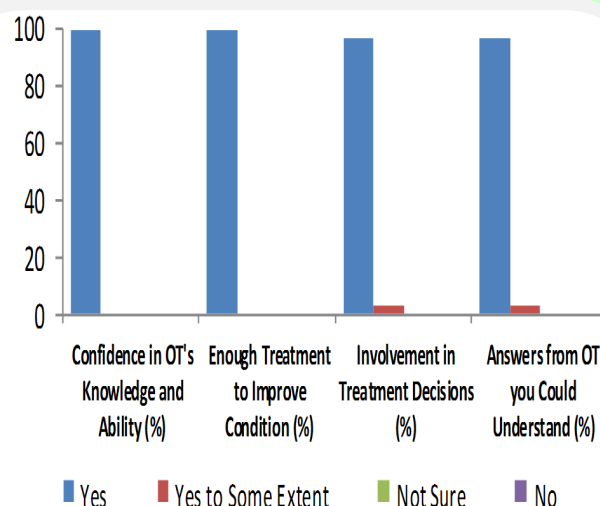
"From start to finish they made this a very easy operation with brilliant follow up, I am very well pleased"

Each service user who completed the questionnaire indicated that:

- They were **happy** for the Occupational Therapist (OT) to be the first point of contact post operatively
- They were **confident** in the OTs knowledge, skill and advice provided
- The patients surveyed felt they received the **appropriate** treatment and care

This study demonstrates that patients were very happy for the Occupational Therapist to be the first point of contact post-operatively. This would indicate that this model of care is **valued by service users** and **maximizes available resources**.

"Very satisfied with OT treatment and care post op, everything was very well explained"



For further information please contact:
Denise McKeown, Occupational Therapist, CAH

Personal information redacted by the Usl

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Enhanced Patient Experience in Taking Medications

Over the last 20 years, the role of the Trust's Domiciliary Care Workers (DCWs) has evolved from performing primarily domestic duties to providing assistance and support with personal care, mobility and the taking of prescribed medicines.

In order to equip DCWs with the skills to assist service users with their prescribed medicines, the Trust's Medicines Management Specialist Nurse (MMSN) Elizabeth Smyth, has designed and delivered a comprehensive knowledge-based training programme for the DCWs. This includes a modified version of the Objective Structured Clinical Examination (OSCE) to assess the skills of home care workers in assisting older people taking prescribed medications.

An OSCE is a practical test carried out in a simulated environment and is used in medicine, nursing and pharmacy.

Tasks included:

- ♦ Administration of prescribed oral medicines
- ♦ Instillation of prescribed eye drop
- ♦ Application of prescribed cream
- ♦ Application of prescribed medicated patch



A paper outlining the development and implementation of the OSCEs has been published in the August edition of the British Journal of Community Nursing.

Click [HERE](#) to view the Article

Success!

Application of this model has:

- ♦ Developed the confidence and competence of the DCW
- ♦ Enhanced the patient experience
- ♦ Supported the safe administration of patient medication
- ♦ Significantly reduced the time spent by community nursing teams in the delivery of individual DCW training and assessment
- ♦ Improved the relationship between commissioner and provider

Overall this training has provided assurances for the Trust that domiciliary care workers are competent in assisting older people in this high risk activity.

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Enhanced Patient Experience in Taking Medications

...Continued from page 5

Next phase of Objective Structured Clinical Examination (OSCEs)



The OSCE process has been further developed following feedback from Domiciliary Care Workers (DCWs). The DCW will now be individually assessed carrying out all four medication tasks at 1 OSCE station, taking approx. 30 – 40 minutes instead of the previous 3 hours. This will streamline the assessment process and should be less stressful for staff.

Supporting learning resources include a video which has been produced to facilitate flexible learning for the DCW. This standardised approach to training promotes consistency and reduces repetitiveness.

Click [HERE](#) to
view the full
length video

A special Thank You to all
involved in helping to
produce the video.

Left to Right
Michael McConville, Sheila
McCamley, Elizabeth Smyth,
Brea Crothers & Marie
Loughran



For further information please contact:
Elizabeth Smyth, Medicines Management Specialist Nurse,
CAH

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CALLING ALL SHSCT NURSES, MIDWIVES & ALLIED HEALTH PROFESSIONALS!

Want to know more
about Research &
Development?

Are you involved in
R & D or would like
to be?

Currently studying
and would like
some support?

Would like to meet
with colleagues to
discuss R & D?

Interested in
publishing?

Join us at the Launch
of the
**SHSCT Research and
Development (R&D)
Strategy for Nurses,
Midwives, & AHPs**
&
**the SHSCT R&D
Community of
Practice
(R&D CoP)**



**'Communities of
Practice' (CoP)**
are groups of people
who share a concern
or passion for
something they do,
and learn how to
do it better as they
interact regularly.



Tuesday 3rd November 2015
CRAIGAVON CIVIC CENTRE
Room: Lakeview 2
9 am - 1 pm

The Launch of the SHSCT Research and Development (R&D) Strategy for Nurses, Midwives & AHPs and the SHSCT R&D Community of Practice (R&D CoP) is taking place on Tuesday 3 November 2015 in Craigavon Civic Centre in Lakeview 2 from 9am - 1pm.

There will be an opportunity to:

- ♦ Find out more about the R&D Strategy
- ♦ Hear from Nurses, Midwives and AHPs who have undertaken R&D activity in the Trust
- ♦ Learn about Communities of Practice and how the R&D Community of Practice will help to support nurses, midwives and AHPs as they undertake research and development in the Trust
- ♦ There will also be an opportunity to network with colleagues and make links for collaboration and support. *Light lunch and refreshments will be provided*

Please email [Redacted] by **September 30th** if you are planning to attend

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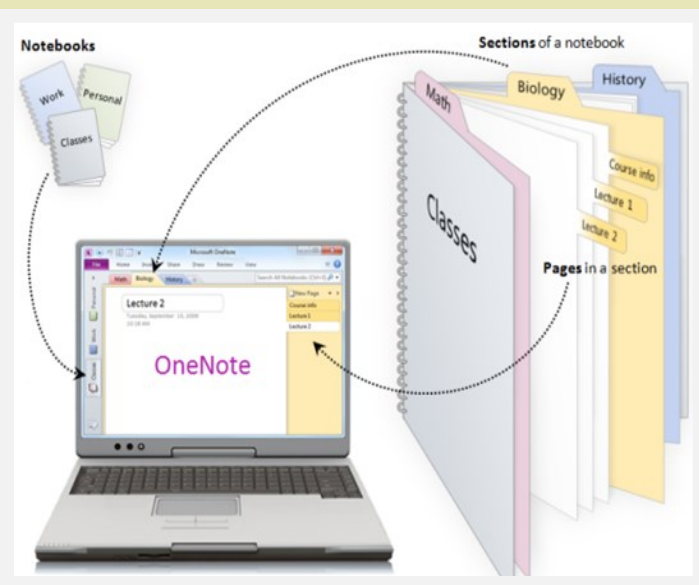
ONENOTE TRAINING AVAILABLE

WHAT IS ONENOTE?

A digital notebook where you can gather, organise and share information in a single place.

Become more productive and keep all information at your fingertips reducing time searching and printing, flexible to gather emails / images / text / digital handwriting / audio and video.

Help you work with others more effectively and help you stay on top of tasks, schedules and team information.



[Click HERE for Introduction to OneNote](#)

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WORK TOGETHER

KEEP TOGETHER

"OneNote, for myself and my team, has replaced the necessity for paper based files. This in turn has saved both money (cost of printing documentation and emails etc.) and time (taken to file the printed information). OneNote also provides an efficient way to cross-share information within the Performance Team as team members can access information which has been updated by other team members."

Lynn Lappin (Head of Performance)

[Click HERE to start learning](#)

Further Information Available from your ICT Training Team

Tel: Personal Information redacted by the USI

Email: Personal Information redacted by the USI



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Follow the Southern Health & Social Care Trust



Coming Soon!

BEST
PRACTICE

Look out for our
November 2015 *SPECIAL EDITION* Newsletter,
Featuring highlights from the
2nd Annual Quality Improvement Sharing Event
(Wednesday 14 October 2015, Seagoe Parish Centre, Portadown)

Content will include:

- ⇒ Patient stories,
- ⇒ Inspirational speakers
- ⇒ Quality Improvement Oral Presentations
- ⇒ Poster presentations
- ⇒ Practical skills and tips on Quality Improvement
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DHSSPS ARM'S LENGTH BODY: MID-YEAR ASSURANCE STATEMENT

This statement concerns the condition of the system of internal governance in **the Southern Health and Social Care Trust** as at 30 September 2015.

The scope of my responsibilities as Accounting Officer for the Southern Health and Social Care Trust, the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organisation's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed on 11 June 2015. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

1. Governance framework

The Governance framework as described in the most recent Governance Statement continues in operation. The Board exercises strategic control over the organisation through this framework which includes a Committee structure comprising five sub committees: - Audit; Governance; Remuneration; Patient and Client Experience and Endowments and Gifts. These Committees have continued to meet and to discharge their assigned business. Minutes of their meetings are presented to Trust Board in a timely manner and the Committee Chairs provide an update, using a report template, which summarises the key issues discussed as well as decisions or recommendations made. Attendance records are maintained for all sub committees. The Chairs of the Audit, Governance and Patient and Client Experience Committees provide the Board with an Annual Report each year to provide assurance that these Committees have discharged their duties in line with their Terms of Reference. Each of the Committees, exception Remuneration, completes a self-assessment on an annual basis. The outcome of these is reported to Trust Board.

The Trust's system of corporate governance includes Standing Orders, Schemes of Reservation and Delegation of Powers and Standing Financial Instructions. These documents have recently been updated and approved through Trust Board to ensure

that the Trust's processes and procedures conform to relevant and updated legislation and guidance.

The Trust Board has a continued focus on the effectiveness of the organisation's governance arrangements and to that end I, as the Interim Chief Executive, have requested a revisit of the Clinical and Social Care Governance arrangements to provide assurance that the outcomes of our 2010 Review of Clinical and Social Care Governance remain effective and robust in the following areas:-

- To provide clarity and transparency of function;
- To drive Quality and Safety;
- To provide adequate assurances to the Senior Management Team, Trust Board, professional bodies and the public on areas relating to risk, patient safety and non-compliance;
- To take cognisance of recent external reviews

This revisit is currently underway and the outcome will be reported to the Senior Management Team, Governance Committee and Trust Board during 2015/16.

2. Assurance Framework

An Assurance Framework, which operates to maintain, and help provide reasonable assurance of the effectiveness of controls, has been approved and is reviewed by the board on a twice-yearly basis. The Framework is an integral part of the Trust's governance arrangements and Board Minutes attest to the challenge and scrutiny applied to the Board Assurance Framework. The Framework will be next presented to the Trust Board meeting on 26th November 2015.

3. Risk Register

As part of the board-led system of risk management, I confirm that the Corporate Risk Register has been regularly reviewed by the Governance Committee, most recently on 8th September 2015 and by the Trust Board on a twice-yearly basis, along with the Board Assurance Framework.

The Senior Management Team reviews the Corporate Risk Register on a monthly basis, most recently on 30th September 2015.

The revisit of the Clinical and Social Care Governance arrangements underway within the Trust will focus on the effectiveness of existing mechanisms, systems and processes to provide assurance on areas relating to risk. However, I can confirm that existing risk managements/processes remain in place throughout the organisation.

In addition I confirm that Information Risk continues to be managed and controlled as part of this process.

4. Performance against Business Plan Objectives/Targets

I confirm satisfactory progress towards the achievement of the objectives and targets set by out in the organisation's business plan as approved by the Department with the following exceptions:

- **Fracture Neck of Femur**

The Trust is seeking to, at minimum, sustain the access performance achieved in March 2015 and ensure that 95% of patients wait no longer than 48 hours for treatment for fractured neck of femur. Currently performance is averaged at 92% which, is in line with the regional average of 92% but is below the target of 95%. Performance in August was the lowest to date with 85% (5 patients breached) of patients treated within the 48 hour target. This is due to a combination of factors including higher levels of general trauma cases, a range of complex non-neck of femur cases including compound fractures and multiple trauma cases. This resulted in reduced throughput of neck of femur cases with lower clinical prioritisation. To date in 15/16 there have been 58 elective orthopaedic cases cancelled to facilitate urgent trauma cases. Cancellation of elective orthopaedic theatre sessions has exacerbated the impact of no in year funding on access times, with an anticipated

orthopaedic waiting time of up to 80-weeks by the end of September for individual body part areas.

The following actions are being taken to manage waiting lists:

- 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 Measures to minimise lost capacity from those who do not attend or cancel on their appointments/procedures on the day, and
- o Providing monthly information to General Practitioners to ensure referrers and patients are aware of current and projected waiting times by specialty.

The Trust has also formally highlighted a number of emergent risks to the HSCB.

- Cancer 62-Day Pathway

The Trust is currently not achieving the target that 95% of patients with a suspect cancer urgently referred should begin their treatment within 62 days. In July 2015 87% had their first treatment date within 62 days, the 13% who did not receive their first treatment within 62 days equates to 6 patients. A shortage in consultant radiologists and pathologists is contributing to underperformance. These posts have been advertised but no applications received. The Trust is currently advertising Europe wide in an attempt to address this workforce shortage. At the end of August 2015, there is one patient breaching the day 85 target, this is a very complex ENT case and the complexity has resulted in the breach. It should be noted that the SHSCT is consistently the second best performing Trust against this target regionally where the average percentage of patients seen within 62 days is 72%.

- 14-Day Breast Cancer

In 15/16 the Trust has shown significant improvement against the 14 day breast cancer target that all urgent referrals should be seen in 14 days. From April 2015 to August 2015, there have been three 14 day breaches. The 15/16 cumulative position is currently 99.76%. The SHSCT is performing above regional average. The Trust continues to closely monitor demand for this service which has shown recent increases.

- Emergency Department Target

At the 20th Sept 2015 82%, (62,096) of patients were admitted or discharged within 4 hours. This is significantly below the 95% target however the SHSCT has consistently been the top performing Trust in the region with the regional cumulative average for 15/16 being 77%.

The Trust has had 1 breach of the 12-hour standard from April to August. The SHSCT is the top performing Trust in the region against this target.

The Trust continues to work with local stakeholders to identify and action any remaining areas for improvement in patient flow and demand management. Regional agreement has been reached on the establishment of a set of unscheduled care system measures that will provide a broader context for assessing the quality of ED performance. The Trust is also working with Alamac to progress 'predictive' measures that will be used to improve performance.

It should be noted that due to critical Estates maintenance work between September and December 15 there will be some impact on reduced beds for admissions, whilst the Trust is actively mitigating risk associated with these works it is expected this will have an effect on patient flow and the Trust's ability to maintain performance.

- Service and Budget Agreements

The Trust continues to focus on ensuring delivery against SBA. The delivery of access times is also reliant upon the delivery of agreed levels of commissioned activity, as per the SBA. Whilst there are a number of specialty areas where performance is not currently in line with the profiled activity to deliver the whole year volumes, where performance is not on track, Directorates have developed recovery plans to indicate when the profiled activity will be on track.

- Elective Access Targets

The Trust continues to work to the access standards of 9-weeks/13-weeks however due to increasing access times; it is now increasing focus on measuring performance against the maximum backstops of 18-weeks/26-weeks for out-patients and in-patients/day cases.

Performance has become increasingly challenging for the following reasons:

- Demand exceeding commissioned capacity – regionally increased referrals estimated at 6% year on year has been identified;
- Recurrent investment, made in 14/15 and planned in year, will be insufficient to address all capacity gaps resulting in increasing access times; and
- Non-recurrent funding to address access times in –year has not been available to date (except for diagnostics). It is unlikely that significant additional capacity will be provided in year for outpatients and inpatient/day cases.

Outpatients – The trust is working to achieve 60% of patients seen within 9-weeks by March 2016, however, at August it is only achieving 36.5% (12,962 patients). Although not performing to target, based on regional figures for July 2015, the SHSCT is the second best performing Trust in the region for Outpatients seen within 9 weeks.

- o At the end of August the Trust had 38% (13,216 patients) waiting greater than the 18 week backstop. Although not performing to target, based on regional figures for July 2015, the SHSCT had the second lowest number of patients waiting in excess of 18 weeks.
- o Specialties, at the end of September, that are predicted to be in excess of 18-weeks are: Dermatology (incl ICATS), Urology (incl ICATS), Ortho-geriatrics, Neurology, Orthopaedic (Consultant Led), Cardiology (Consultant Led and ICATS), Orthopaedic ICATS, ENT (Consultant Led), General Surgery, Pain Management, Endo-Diabetes, Respiratory, Rheumatology, Gynaecology, Gastroenterology, Haematology, Paediatrics, Chemical Pathology, Thoracic Medicine

In-Patients and Day Cases – The Trust is working to achieve 65% of patients seen within 13-weeks by March 2016, however, at 31st August it is only achieving 56% (5,104 patients). While the numbers of patients waiting > 13 weeks continues to rise, it should be noted that based on July regional figures the SHSCT was the second highest performing Trust in the region.

- o At 31st August 2015 the Trust had 20% (1,832 patients) waiting greater than 26 weeks.
- o Specialties, at the end of September, that are predicted to be in excess of 26-weeks are: Breast Surgery; Cardiology; General Surgery; Gynaecology; Orthopaedics; Pain Management; and Urology.

Endoscopy – The Trust is working to achieve a 9-week position, however, significant on-going increases in total demand; demand for red flag and urgent examinations; and planned repeat scopes continues to present risk to achievement of same. This is in part related to the time-lag for on-going training of new nurse Endoscopists which will partly address capacity gaps and the inability to address this by securing additional capacity in the independent sector in Q1/2 and fully utilising additional funding provided.

- o The Trust has secured additional capacity for Q3/4 in-house and is working with the independent sector to secure further capacity to utilise funding rolled over from Q1/2 and new additional funding provided in Q3/4.

Diagnostics – The Trust is seeking to maintain the access performance achieved at March 2015, however this is proving challenging. Non-recurrent allocations provided have not been sufficient to bring many specialties to the 9 week target. The focus has remained on those red flag and urgent patients who are a clinical priority. The Trust did outline to the HSCB additional volumes of activity which would be undertaken if funding was available.

- o At 1/09/15 there were 5,410 (35%) patients waiting >9 weeks for a diagnostic test. At the end of September the following diagnostic areas will not be achieving the 9 week access time; Urodynamics; Cardiac Investigations; CT; CT Colongraphy; Non Obstetric Ultrasound; Dexa; MRI and Fluroscopy.

- Out-Patient Review Backlog

Whilst this is not a Commissioning Plan target this is affected by elective access targets and recurrent capacity gaps in elective specialty areas which has resulted in accrued volumes of patients waiting beyond their clinically indicated timescale. Whilst the Trust had previously made significant progress in reducing the backlogs when additional funding was available, this has regressed with increases to the volumes of patients waiting beyond clinically indicated timescales. Lack of additional funding in-year and an inability to effect recurrent solutions to address capacity gaps in key specialties will continue to challenge the ability to address this area of risk. Where possible, the Trust is re-directing internal resources to the longest waiting review backlogs and processes are in place to ensure reviews which are urgent or present high clinical risk, are given priority.

At 1 September 2015 there were a total of 24,493 patients past their clinically indicated timescale for review of which 36.6% were waiting over 6 months; 21% were waiting between 3-6 months and 42% were waiting less than 3 months.

- Urgent Diagnostic Reporting Turnaround Time

The Trust's performance against the 2-day standard for urgent reporting at 31/08/15 was 79% for imaging and 96% for Physiological Measurement, against the 100% standard. Consultant manpower issues and vacancies are affecting performance against the target. There are particular pressures on routine diagnostic reporting time of less than 28 days for plain film and chest plain films. The Trust continues to utilise both additional in-house and independent sector capacity to manage reporting on plain films.

- Allied Health Professionals Access Times

From April 15 no patient should wait longer than 13 weeks from referral to commencement of AHP treatment. At 31/08/15, 24% of patients (3044 patients) were waiting greater than 13 weeks. The volumes of patients waiting greater than 13 weeks has been increasing month on month associated with issues related to demand and manpower issues. The Trust is currently undertaking a demand and capacity exercise in conjunction with the HSCB and PHA to establish the capacity available for each specialty and identified capacity gaps. It is anticipated this work will be completed by the end of Q3. In addition the Trust is taking action to maximise AHP capacity with actions identified through an internal review.

All Professions, with the exception of Orthoptics, will be in excess of 13 weeks at the end of September 2015.

- Discharge Targets

The Trust continues to meet the target that 90% of complex discharges from acute hospitals should take place in 48 hours. However performance against the 6 hour target for non-complex admissions remains relatively static at an average of 92%.

It should be noted though that while the Trust's operational performance against discharges is good, it continues to strive to improve the % of data completeness required for discharges. Actions are in place to see an improvement of the current position whereby only 64% of discharge activity was coded in July.

In relation to Mental Health targets, Mental Health continues to achieve an average of 99% of patients discharged within 7-days (only two patients have breached this financial year); learning disability is maintaining 100% of discharges within 7 days since April 15 although due to small cohort of patients it is prone to fluctuation.

- Mental Health Access Targets

- o **Psychological Therapies** – The 13 week access time target remains challenging within the SHSCT and regionally and at 18/09/15 there were 143 patients waiting in excess of 13 weeks in the Trust. Inability to secure additional posts impacted on performance and although recruitment is now complete long term sick leave is now further impacting on performance with an accrued backlog. The implementation of new working practices should see improvement against the target in Q3/Q4 although it is estimated that the access time at September will be 27 weeks.
- o **Dementia / Memory** – The Trust continues to be challenged to achieve the 9-week target for this specialty. At the 21/09/15 there were 102

(37.5%) patients waiting greater than 9 weeks from a total of 272 patients waiting. It is estimated that the access time at September will be 19 weeks. Investment has been confirmed and this will go some way to improving access times

- o **Primary Mental health Care** - Adult mental health services has always reported (TDP) that any increase in demand or loss of capacity to meet that demand would lead to breaches of the waiting time target of nine weeks. Towards the end of 2015 for a three month period the Trust experienced an increase in referrals and at the same time lost capacity through long term sick leave. Every effort was made to fully utilise internal resources to meet demand and the waiting time extended to 14 weeks. The Trust advised that there would be little change in this position until a procurement exercise completed with the award of a contract to an independent organisation to undertake low intensity interventions for diversion from Secondary mental health services. The contract has been awarded and has just started. Progress will be monitored closely to determine the impact on demand for secondary mental health services. This development will eventually form part of a Primary Care Talking Therapies Hub currently being developed in the SLCG.

5. Controls Assurance

I confirm implementation of action plans arising from the year-end self-assessments of compliance with the 22 Controls Assurance Standards. In addition, a composite action plan is in place to address areas where the Trust's performance fell short of substantive in 2014-15, particularly in relation to individual criterion where performance was <75%. The Trust has commenced the CAS process for 2015/16 and an implementation plan was agreed by the Senior Management Team on 23rd September 2015.

6. External audit reports

I confirm that action is being taken on all the External auditor's Priority 1 (4) and 2 (3) accepted recommendations. Not all of these recommendations are wholly within the control of the Trust but dependent on action by other HSC bodies in some cases as below:

- The Trust should work with BSO Payroll Shared Services and other bodies in the sector to address the points raised by Internal Audit and to clearly define the roles and responsibilities in the payroll process.
- The Trust should work with DHSSPS and PaLS to ensure that a strategy is put in place to address the procurement of social care as soon as possible.
- The Trust should work with PaLS to actively monitor contracts so that those which are due to expire are identified on a timely basis.
- Trust management should work with their counterparts in other HSC bodies to resolve the calculation of sick pay for employees who work 'non-standard hours'.
- The Trust should co-ordinate with the BSO Payments SSC department to ensure that the Trust complies as far as possible with all Departmental targets.

Progress on the implementation of all external audit recommendations as detailed in the Report to those Charged with Governance is reviewed regularly at Audit Committee meetings with the next review scheduled for 15th October 2015. Full implementation of the audit recommendations, where not currently achieved and within the full control of the Trust, is planned for 31 March 2016.

7. Internal audit

To date, Internal Audit has issued the following 14 reports:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE PROVIDED BY INTERNAL AUDIT
Bank and cash	Satisfactory
Systems Administration in FPL	Satisfactory
Management of Client Monies and Cash/Valuables Handling at Social Care Facilities	Satisfactory
Management of Client Monies in the Independent Sector	Satisfactory: 10 facilities visited (Glenview Nursing Home – Limited)
Client Monies – Valley Nursing Home	Satisfactory
Client Monies – St Francis Private Nursing Home	Satisfactory
Management and Use of Agency and Locum staff	Satisfactory
Laboratory Procurement and Contract Management	Limited
Fostering and Adoption Payments	Limited
Corporate Mandatory Training & Appraisals	Satisfactory – Human Resources & Organisational Development Limited – Other Directorates
Management of Standards and Guidelines	Satisfactory
Management of Licences and Accreditations	Satisfactory (DRAFT)
Haven Private Nursing Home	N/A
GP Out Of Hours Financial Procedures	N/A

15 priority one findings were identified in the above finalised audit assignments.

These will be addressed by Trust management. They related to:

- Management of client monies, including inappropriate use of the clients' comfort fund , lack of appropriate residents' agreement in place, permission of negative balances, delays in repayment of monies in respect of deceased clients and appropriate banking arrangements.
- Lack of appropriate supporting documentation and authorisation of petty cash float re-imbursements
- Use of a single regional password for the E-Financials security module in FPL
- Lack of approved Direct Contract Award documentation for Agency spend through non contracted agencies.
- Need for signed agreement with Belfast Health and Social Care Trust for laboratory service provided, including appropriate contract performance processes in place. Also, maintenance of comprehensive Laboratory contracts register and adherence to DAC/STA process where appropriate.
- Payment of fostering and adoption payments at inappropriate rates and incomplete contract documentation
- Low uptake of mandatory training and completion of Personal Development Plans under KSF. KSF gateways have also not been implemented as part of KSF staff appraisal process.
- The Trust does not have a formal audit process to provide assurance over compliance with Standards and Guidelines issued.

The Trust has a system in place to track progress on the implementation of all outstanding internal audit recommendations in conjunction with Internal Audit.

Progress is reviewed and robustly challenged at each meeting of the Audit Committee and most recently on 15th October 2015. In addition, Internal Audit has audited the one area which received unacceptable assurance in 2014/15 (Valley Nursing Home) as part of the 2015/16 Internal Audit plan. This is reported above.

Shared Services Audits

The Trust has been made aware of the results of three internal audits carried out in BSO Shared Services, of which the Trust is a client. A satisfactory level of assurance was provided in respect of Payment Services and the Business Services Team, with 3 priority one issues. Trust management will monitor the implementation of associated action plans through SLA/Performance meetings with BSO Shared Services.

However, a limited assurance has been provided again in respect of BSO Payroll Shared Services with five priority one findings.

These relate to:

- Management and recording of overpayments;
- Authorisation and processing of additional payments;
- Calculation of maternity payments;
- Management and assurance over supplier access and responsibilities;
- HRPTS access controls and privileges.

Four of these recommendations were made in 2014/15 with a new recommendation in relation to the calculation of maternity pay being raised in this report.

Internal Audit report that there is evidence of progress having been made to address the previous audit findings but it is insufficient to remove priority one status.

This has been further referenced below in internal control divergences.

During their Mid-Year Follow up, Internal Audit found that 76% of the Trust's recommendations examined were fully implemented, a further 21% were partially

implemented and 3% were not implemented at the time of review. Monitoring of the progress of all outstanding recommendations will continue on a regular basis through Audit Committee.

8. RQIA and other reports

Summary reports from RQIA thematic reviews, inspections and unannounced hygiene inspections, together with action plans in response to any recommendations emerging from these were reviewed by the Governance Committee. The Committee sought assurance that action plans were being effectively implemented through measurable outcomes. Where the Committee has not been assured that sufficient action had been taken, Directors have been asked to put in place further controls and have updated the Governance Committee accordingly.

The Trust also receives independent assurance from the General Medical Council in relation to Medical Appraisal and Revalidation. The GMC has accepted all of the revalidation recommendations made by the Responsible Officer of the Trust (Medical Director). In addition, the GMC meets with the Medical Director and senior staff on a quarterly basis to discuss issues of professional governance.

In relation to trainee doctors, assurance is also received from NIMDTA via on-going Deanery visits and reports.

9. NAO Audit Committee Checklist

I confirm completion of the NAO Audit Committee Checklist by the Audit Committee at its meeting on 9th June 2015. As a point of good practice, this included seeking the views of External Audit and the NIAO as to their opinion of the effectiveness of the Committee and feedback was positive. One action emerged regarding ensuring effective induction and training of new Audit Committee members. This will be taken forward in 2015/16.

10. Internal Control Divergences

New Control Issues 2015/16

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 £80k. 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.

Fraud cases

There have been three cases of fraud reported by the Trust to the Counter Fraud and Probity Services in this financial year. All of these represent losses to public funds and have/are being investigated. The serious adverse incident reported in 2014/15 remains the subject of an on-going investigation by CFPS. Internal Audit has issued new procedures for use by the service in which the incident occurred to strengthen the control environment. The Trust is seeking recovery of the loss incurred.

In addition to this, the Counter Fraud and Probity Service has recently reported on its findings into a pilot carried out in the Western Health and Social Care Trust regarding domiciliary care contracts. The findings of this report are being considered on a regional HSC basis.

Progress on each of the on-going internal control divergences as reported in the Governance statement for the year ended 31 March 2015 is given below:

Estates 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 the plan is reviewed annually by an independent specialist and the plan updated accordingly.

Installation of a Copper Silver ionisation system for the treatment of water and control of pathogens such as Legionella and Pseudomonas in CAH has been successful in reducing the instances of positive legionella detections (reduced from approximately 40% to 10% over 5 months).

Based on this success, plans are underway to install similar systems in Daisy Hill Hospital; Lurgan Hospital; Loane House; Roxborough House; Crozier House; Slieve Roe and Cloughreagh. These should be completed by March 2016.

The Trust's Water Safety Contract has also now been awarded through local PALS and is valid from 1st June 2015 to 31st May 2020.

Trust Estate Risks

The following Estates risks as previously reported continue:

Electrical infrastructure, Craigavon Area Hospital: Good progress has been made against the action plan which is focussed around a three phased approach for low/high voltage works and consists of: (1) Installation of Peak Lopping to prevent the risk of power outages on site due to site demand exceeding available NIE supply (complete); (2) Installation of CHP units to increase on site generation capacity and resilience (to be operational by end September); and (3) Installation of a new NIE HV supply and upgrade of on-site LV/HV infrastructure (anticipated completion April 2016).

Fire Safety: The most recent Fire Safety Report shows 70% of staff are up to date with their Fire Safety Training.

Staff can now avail of Face to Face or E-Learning in order to complete Fire Safety Training and a rolling programme is now in place for General Fire Safety, Ski Sheet Pad and Evacuation Chair Training.

The Trust is currently in the process of tendering for a new Fire Safety Training Contract. This process is expected to be completed September / October 2015.

All baseline fire risk assessments for high risk facilities/buildings have been completed. Approximately 98% of baseline fire risk assessments have been carried out for all other buildings. A rolling programme is in place for the on-going review of Fire Risk Assessments.

Fire code works to the value of £160k have been approved for 2015/16.

Following on from the successful multi-agency live exercise conducted in Craigavon Area Hospital last year, a further exercise is being planned for the last quarter of 2015/16 – this time at Daisy Hill Hospital. This will both test the existing arrangements and provide a further opportunity for improvements.

Business Continuity: little progress has been able to be achieved so far in 2015/16 in the development of the Service Area Recovery Management Plan due to resource constraints.

Estates Staffing

Trust financial contingency measures in 2014/15 meant that a number of vacancies remained unfilled within the Estates structure during 2014/15. Whilst a number of key vacancies have now been filled some posts remain vacant, primarily in the Procurement and Operational areas. It is anticipated that the majority of these will be filled by the final quarter 2015/16.

Sewage

An extensive sewage pipe replacement programme commenced in August and involves a carefully co-ordinated and phased programme of ward decants. Works will be carried out to the most critical areas over the next few months (subject to the availability of decant space in context of winter pressures). The sewage system serving the wards at Craigavon Area Hospital has reached a critical point with frequent blockages leading to bursts and subsequent contamination of patient and support areas. This presents a serious infection control risk; causes disruption to services; and has been reported in the press potentially damaging service user confidence. Whilst significant efforts had been made to mitigate the risk it became clear that the system needed replaced urgently.

Further works may be necessary after the winter period to complete the programme.

Contract & Procurement Management**Estates**

The Trust has highlighted the risk regarding the procurement of Estates managed service and maintenance contracts with an annual value of approximately £2.8M for a number of years.

However, the implementation of a new regional model (including the requirement for additional PaLS resources) for PaLS to undertake Estates procurement in collaboration with Trust Estates teams, has now commenced.

A Regional Estates Procurement Group has been established to have oversight of this area of procurement. All Trusts have submitted full lists of contracts which have been categorised and prioritised for procurement. A workshop was held on the 6th August 2015 to further develop this prioritisation as a basis for the development of a regional Estates procurement plan.

Additional procurement resources have been approved, with appointments anticipated to be made by December 2015, within the Trust. PaLS have begun recruitment of their new BSO PaLS Service and Maintenance Division which will have as their prime responsibility and priority the procurement of all Regional EU tenders on behalf of participating Trusts.

PALS have delivered training to key Trust Estates staff on awareness of the appropriate regulations and PaLS will provide further training to Estates contract staff on new tendering procedures for processing tenders on the new portal:- eTendersNI. Goods and services Estates procurement manual is also to follow later in the year, once the new service has been established.

The whole development and establishment of this approach is expected to take around five years.

In the meantime, within the Trust, significant improvements have been achieved in the levels of procurement compliance and, with the assistance of both the COPE and DLS, a set of robust procurement procedures have been developed for use. These procedures are rigorously applied within Estates and monthly Estates Procurement meetings are held at which progress is reported and monitored by Heads of Service within Estates.

Internal Audit is scheduled to undertake a further audit of Estates procurement and contract management in 2015/16. Good progress continues to be made on the implementation of previous audit recommendations made in this area.

Social Care Procurement

It has not been possible to make any significant progress with the procurement of health & social care contracts in the absence of an agreed regional approach to be adopted in light of the new 2015 Public Contract Regulations. A regional interim agreement however on an approach to social care procurement structures has been agreed at Regional Procurement Board in August 2015. As such the Trust is now working to bring forward internal proposals to build capacity for social care

procurement resources and develop a local procurement plan. This will provide an agreed direction of travel to seek compliance.

General Contract Management

No progress has been possible in this area in 2015/16 due to lack of resources. Therefore no progress has been possible on the implementation of a central contract database or improvement in contract management arrangements/training.

Clinical and Social Care Risks

Hyponatraemia Enquiry

The Trust continues to await the learning points and recommendations from this Enquiry. These have not yet been published.

Elective Care

The position with respect to Elective Care continues to deteriorate, as outlined in section 4 above.

Unscheduled Care

The Trust continues to be challenged in respect of significant service demand for unscheduled care services on both acute sites. The Trust is experiencing significant medical staffing issues in Daisy Hill Hospital ED, especially with recruitment to posts middle grade to consultant level. The Trust have an oversight group in place and are taking steps to manage this risk, however this continues to be a major challenge for the Trust and continues to attract significant elected representative and public challenge.

Child Sexual Exploitation/Marshall inquiry/SBNI Thematic Review

The position remains the same as reported in the Governance statement for 2014/15 and the Trust is awaiting the outcome of the final Thematic Review Report.

Financial Risks

Safeguarding of Residents' Interests

The Trust continues to liaise with the home owners, their legal representatives and external agencies in relation to the issues identified following two adult safeguarding investigations into two independent sector residential homes. The Trust continues to suspend admissions to the two Homes. RQIA are pursuing a prosecution of the Home Owners under Article 42 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. A summons was issued by RQIA to the Home Owners via the court. Court Hearings have been held from August 2014 with the latest special hearing scheduled for 30th September 2015.

The implementation and embedding of the new case management procedures across Trust Directorates and NISAT within Physical Disability & Learning Disability is almost at completion. The Trust continues to monitor all clients via the case management process and additional controls initiated following the investigation remain in place.

Compliance by Independent Sector Homes with circular HSC (F) 8/2015

The Trust has continued to follow up with independent sector homes/facilities regarding compliance with this circular in early 2015/16. The Trust is continuing to develop performance management arrangements for this sector which incorporate all aspects of contract compliance.

Transfer of Finance functions to BSO Shared Services Centres

The Trust has continued throughout 2015/16 to work with the BSO Shared Services Centres at both a regional and local level to manage the risks, resolve the issues identified, review performance and embed learning. Improvements in some services have been experienced as services begin to bed down.

However, as reported above, the BSO Payroll Shared Services Centre has continued to receive a limited assurance from Internal Audit in 2015/16. This is due to insufficient progress being made as outlined above. Whilst these issues did not have a significant impact for the Trust in 2014/15 because the Trust only transferred its services to Payroll Shared Services in January 2015, there is a potential greater impact on the Trust in 2015/16 as its payroll function will be provided by PSSC for the full year. In addition, the Trust has a number of concerns regarding the recruitment and selection services which it has raised with BSO.

The Audit Committee of the Trust has requested that the Chief Executive of BSO provides a written report to Audit Committee on the audit issues raised for Shared Services functions, including details of how BSO will manage less than satisfactory assurances and their process for following up on audit recommendations.

The Trust will continue to work with BSO and monitor progress on the implementation of audit recommendations in 2015/16.

11. Mid-year assurance report from the Head of Internal Audit

I confirm that I have referred to the Mid-Year Assurance report from the Head of Internal Audit, which is attached as Appendix 1, and details the assurances the organisation has received from Internal Audit in the first six months of this year and also reports on the organisation's implementation of accepted audit recommendations.

INTERIM CHIEF EXECUTIVE & ACCOUNTING OFFICER

16 October 2015

Wright, Elaine

From: Clarke, Paula [Personal Information redacted by the USI]
Sent: 01 April 2015 18:14
To: Stinson, Emma M
Subject: RE: Urology Services
Attachments: image001.png; image002.png; image003.jpg; image004.jpg

No emma – previously just Michael and Debbie attended. Don't think I will manage to miss TB workshop just yet!

From: Stinson, Emma M
Sent: 01 April 2015 13:39
To: Clarke, Paula
Subject: Urology Services

Paula

Debbie asked me to check if you were also intending to attend this meeting?

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]

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

'You can follow us on Facebook and Twitter'

From: Stinson, Emma M
Sent: 01 April 2015 10:57
To: 'Dean SullivanPA' [Personal Information redacted by the USI]
Subject: Urology Services

Hello

Attendees at this meeting will be:

Mrs Debbie Burns, Interim Director of Acute Services
[Personal Information redacted by the USI]

Mr Michael Young, Consultant Urologist
[Personal Information redacted by the USI]

Mr Mark Haynes, Consultant Urologist
[Personal Information redacted by the USI]

Mr Aidan O'Brien, Consultant Urologist or Mr Anthony Glackin, Consultant Urologist (will know closer to the time)

[Personal Information redacted by the USI] or
[Personal Information redacted by the USI]

Heather Trouton, Assistant Director of Acute Services
[Personal Information redacted by the USI]

Martina Corrigan, Head of Service
[Personal Information redacted by the USI]

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

Personal Information redacted by the USI

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From: Dean SullivanPA

Personal Information redacted by the USI

Sent: 13 March 2015 09:15

To: 'Geraldine.Mckay

Personal Information redacted by the USI

'margaret.ohagan

Personal Information redacted by the USI

'jennifer.welsh

Personal Information redacted by the USI

Seamus.McGoran setrust; Burns,

Deborah; Janet Little; Miriam McCarthy; Michael Bloomfield; David

McCormick; Bride Harkin; Paul Cavanagh; Lyn Donnelly; Iain Deboys;

Paul Turley; 'colin.mulholland

Personal Information redacted by the USI

'chris.hagan

Personal Information redacted by the USI

'sam.gray

Personal Information redacted by the USI

Young, Michael; Paul Kavanagh; Sara Long; Lynne Charlton

Cc: 'michael.mcbride

Personal Information redacted by the USI

Clarke, Paula; Clarke,

Paula; McAlinden, Mairead; Elaine Way Western Trust;

'tony.stevens

Personal Information redacted by the USI

Hugh McCaughey SE Trust;

'roisin.coulter

Personal Information redacted by the USI

'Shane.devlin

Personal Information redacted by the USI

'Briege.Donaghy

Personal Information redacted by the USI

'teresa.molloy

Personal Information redacted by the USI

Pat Cullen; Carolyn Harper; Beth

Minnis; Michael Killen; Dean Sullivan

Subject: Urology Services

Importance: High

"This email is covered by the disclaimer found at the end of the message."

SENT OBO DEAN SULLIVAN

Dear Colleague

I refer to the urology meeting held in late January, specifically the agreement to hold a regional urology meeting.

I can confirm this meeting will take place at 12pm – 4.30pm on Thursday 30th April 2015, CR2 & 3, Linenhall Street, Belfast (lunch will be provided).

If possible, it would be helpful for you to attend in person, meeting objectives and agenda items will follow.

Please confirm attendees to Dean.SullivanPA [Personal Information redacted by the USI] by Friday 10th April 2015.

Many thanks.

Dean Sullivan

Lucyna Edgar

PA to Dean Sullivan, Director of Commissioning, HSCB

12-22 Linenhall Street, Belfast BT2 8BS Tel: [Personal Information redacted by the USI]

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Wright, Elaine

From: Clarke, Paula Personal information redacted by the USI
Sent: 06 November 2015 17:27
To: Trouton, Heather
Subject: RE: Regional review of urology and OP gynae regional work stream

Follow Up Flag: Follow up
Flag Status: Flagged

Thanks

-----Original Message-----

From: Trouton, Heather
 Sent: 06 November 2015 17:20
 To: Clarke, Paula
 Subject: RE: Regional review of urology and OP gynae regional work stream

I think the next one is Esther , myself and I think Tony Glackin

Heather

-----Original Message-----

From: Clarke, Paula
 Sent: 06 November 2015 17:18
 To: Trouton, Heather; McVey, Anne; Gishkori, Esther
 Cc: Gibson, Simon
 Subject: RE: Regional review of urology and OP gynae regional work stream

Heather sorry but do we know who is attending the next meeting - Debbie had been going with a clinician I didn't realise was a different one each time

-----Original Message-----

From: Trouton, Heather
 Sent: 06 November 2015 17:06
 To: Clarke, Paula; McVey, Anne; Gishkori, Esther
 Cc: Gibson, Simon
 Subject: RE: Regional review of urology and OP gynae regional work stream

Apologies

All the Urologists have been involved at different meetings and at different times but the main contacts would be Mr Young, Mr O'Brien, Mr Glackin and Mr Haynes.

Heather

-----Original Message-----

From: Clarke, Paula
 Sent: 06 November 2015 17:04
 To: Trouton, Heather; McVey, Anne; Gishkori, Esther
 Cc: Gibson, Simon
 Subject: RE: Regional review of urology and OP gynae regional work stream

Heather question for you was the regional urology review attendance not the OP one thanks P

-----Original Message-----

From: Trouton, Heather
 Sent: 06 November 2015 17:02
 To: McVey, Anne; Clarke, Paula; Gishkori, Esther

Cc: Gibson, Simon
Subject: RE: Regional review of urology and OP gynae regional work stream

Paula

Form a clinical perspective , Dr Maiden is representing Rheumatology, Mr McCaul is representing ENT, Dr Murdock and Dr Seamus Murphy are representing Gastroenterology , I am awaiting a nomination from General surgery and Anne , I'm not sure who will be representing Gynae. I will let you know re GS asap.

Best regards
Heather

-----Original Message-----

From: McVey, Anne
Sent: 05 November 2015 18:52
To: Trouton, Heather
Subject: FW: Regional review of urology and OP gynae regional work stream

Heather just in case email below did not reach you as I note your surname is incorrect

Anne

Anne McVey
Assistant Director of Acute Services
Integrated Maternity & Women's Health
Craigavon Area Hospital
Tel: Personal information redacted by the USI
Mobile: Personal information redacted by the USI

-----Original Message-----

From: Clarke, Paula
Sent: 05 November 2015 18:51
To: Gishkori, Esther; Personal information redacted by the USI McVey, Anne
Cc: Magwood, Aldrina
Subject: Regional review of urology and OP gynae regional work stream

I just bumped into Frances O'Hagan secretary of local LMC AND NI GPC rep on a number of groups. She has been asked to attend mtgs in next couple of weeks on above and keen to link with our attendees particularly clinical guys before hand informally. This would be good for us to influence the regional direction indirectly. Can you advise who is attending please thanks

Sent from my iPad



Board guidance on risk appetite

Good Governance Institute (GGI)

May 2020

Board guidance on risk appetite

Risk appetite, defined as ‘the amount and type of risk that an organisation is prepared to pursue, retain or take’¹ in pursuit of its strategic objectives, is key to achieving effective risk management. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings, and therefore should be at the heart of an organisation’s risk management strategy – and indeed its overarching strategy.

It is important that boards understand and apply risk appetite because:

- If they do not know what their organisation’s collective appetite for risk is and the reasons for it, this may lead to erratic or inopportune risk-taking, exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development
- If they do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient and user outcomes affected
- It can serve as the basis for consistent and explicit communication at different levels, and to different stakeholders. Risk appetite will be influenced by a number of factors including personal experience, political factors and external events among others.

Risk can generate significant opportunities and therefore should be considered in terms of both opportunities and threats:

- When considering threats, the concept of risk appetite embraces the level of exposure which is considered tolerable and justifiable should it be realised
- When considering opportunities, the concept embraces consideration of how much one is prepared to actively put at risk in order to obtain the benefits of the opportunity
- It is important that boards understand that in order to achieve their strategic objectives they may have to adopt a more assertive risk appetite, recognising that risk appetite should be forward-looking.

Risk tolerance is subtly different to risk appetite in that it reflects the boundaries within which the executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the board’s strategy and risk appetite. It is the level of residual risk within which the board expects sub-committees to operate and management to manage. Breaching the tolerance requires escalation to the board for consideration of the impact on other objectives, competing resources, and timescales.

At least once a year, the board should set specific limits for the levels of risk the organisation is able to tolerate in the pursuit of its strategic objectives. The board should also review these limits during periods of increased uncertainty or adverse changes in the business environment.

In setting these risk appetite and tolerance levels, the board should consider risk factors in both the external and internal business environments. These levels could be measured quantitatively, qualitatively, or both, and should be specific to each of the relevant core activities and outcomes.

The board may also set limits regarding the enterprise’s risk appetite, i.e. the risk limits that the board desires, or is willing to take.

The board should monitor and audit the management of significant risk undertaken by managers and clinical staff and satisfy itself that decisions balance performance within the defined appetite and tolerance limits. The board should ensure that it understands the implications of risks taken by management in pursuit of better outcomes, as well as the potential impact of risk-taking by, and on, local communities, partner organisations, strategic providers and other stakeholders.

This process is dynamic; risk probability and impact as well as risk appetite can change through circumstances and experience. The perception of the public to risk and confidence in the organisation’s ability to identify and mitigate risk successfully can shift quickly in the light of publicity and risk failures often outside the direct control of the organisation. As such, risk awareness and communication play an important part in protecting the reputation of the organisation from such instances of outrage.

1. ISO 31000



GGI believes that it helps to identify different types of risk (including, but not limited to, finance, regulation, quality, reputation, and people) but it is important to always assess these in the round. To support this, we have developed the risk appetite matrix.

The matrix sets five levels of risk appetite for each of the risk types. There are no right answers, but the matrix allows board members to articulate their appetite and tolerances and arrive at a corporate view, considering the risk appetite of others and the capacity for management to communicate and deliver.

Boards should consider each strategic objective against the matrix and agree its level of risk appetite, what it can delegate, and what additional assurance it requires. The matrix can also be used for individual initiatives and emerging problems and should help the board to better manage its agenda and the level of routine reporting required.

Breaches of agreed appetite must be escalated with agility.

Strategic risks and the board assurance framework

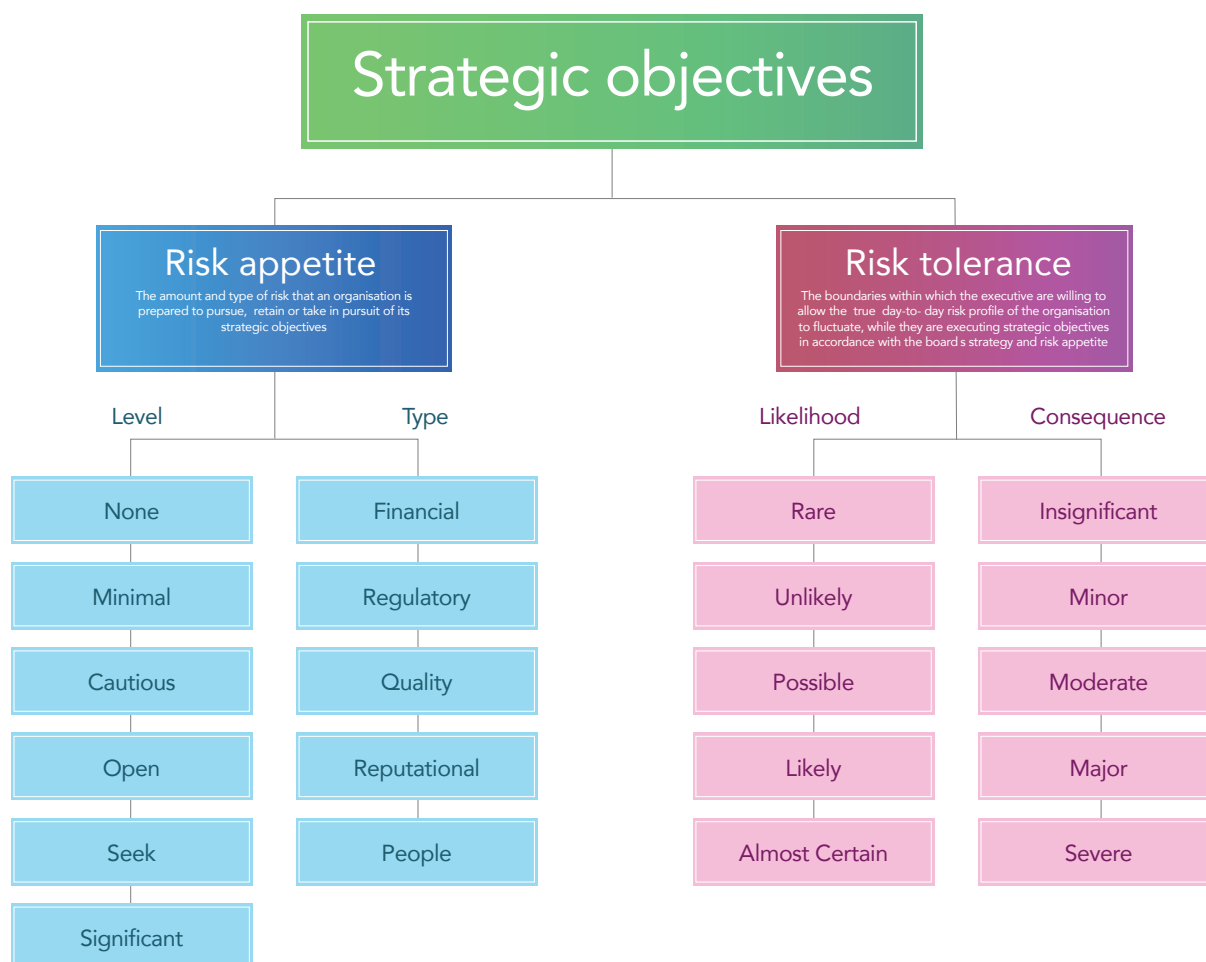
A critical role of any board is to focus on the risks that may compromise the achievement of the organisation's strategic objectives. In order to be confident that the systems of internal control are robust, a board must be able to provide evidence that it has systematically identified its strategic objectives and managed the principal risks to achieving them.

A good board assurance framework (BAF) is a live tool that helps boards to undertake this duty by providing a simple yet comprehensive means by which to effectively manage the principal risks to meeting the strategic objectives. The Audit Committee Handbook identifies the BAF as 'the key source of evidence that links strategic objectives to risks and assurances, and the main tool that the board should use in discharging its overall responsibility for internal control'.²

The BAF, therefore, is the key document that should be driving the board and committee agendas. It provides a structure that enables the board to focus on the significant risks, highlights any key controls (management actions to avoid or mitigate risks) that have been put in place to manage the risk, any areas requiring further action, sources of evidence or assurance, and any gaps.

The BAF is, in GGI's view, the original invest-to-save scheme for boards. Time spent on getting the various elements of the BAF right will help boards streamline assurance, locate where and how assurance is tested and develop proportionality in board reporting.

Key to this will be boards taking responsibility for identifying their risk appetite and risk tolerance for each strategic objective and agreeing what is sufficient in terms of controls and the assurances that the controls are operating effectively. The greater the risk appetite, the more controls should be put in place by management to avoid or mitigate the risk.



2. DH/HFMA, 2005, Gateway Ref 5706

Applying risk appetite matrix

RISK APPETITE LEVEL ▶	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
RISK TYPES ▼						
FINANCIAL How will we use our resources? ▶	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator? ▶	We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services? ▶	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners? ▶	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners? ▶	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.

Wright, Elaine

From: Judt, Sandra [Personal Information redacted by the USI]
Sent: 24 November 2015 09:01
To: Brownlee, Roberta; Clarke, Paula; Magwood, Aldrina
Cc: Comac, Jennifer; Wright, Elaine; Murphy, Jane S
Subject: SHSCT Ground Clearing meeting - 25.11.2015
Attachments: Draft agenda for ground clearing meeting.docx

Please see attached draft agenda for tomorrow's ground clearing meeting with DHSSPS – final agenda awaited.

At this meeting, they will be seeking issues you intend to raise at Strategic Accountability Review. Suggestions include:-

- Capital Investment/CAH Redevelopment
- Workforce Planning
- At Risk Services, specifically Daisy Hill Hospital Emergency Department
- Expert Panel

Please let me know of any others in advance of tomorrow morning's meeting.

Regards

Sandra
Sandra Judt
Board Assurance Manager
SH&SCT
Trust Headquarters
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ
Tel: [Personal Information redacted by the USI]
Email: [Personal Information redacted by the USI]

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Notes of SMT Meeting held on
Wednesday 8 July 2015
@ 2pm in the Boardroom, Trust Headquarters

Present: Paula Clarke
Angela McVeigh
Paul Morgan
Debbie Burns
Dr Richard Wright
Kieran Donaghy
Helen O'Neill (for Stephen McNally)
Miceal Crilly (for Francis Rice)
Lesley Leeman (for Aldrina Magwood)
Elaine Wright (Notes)

Apologies: Stephen McNally
Francis Rice
Aldrina Magwood

Review of HSC Commissioning: Stakeholder Interview
John Farrell & Alison Joynes

John Farrell and Alison Joynes attended SMT to talk to members about the Review of HSC Commissioning.

Mr Farrell provided the background to the purpose of the review which he advised is being led by the DHSSPS and whilst there are a number of various reviews taking place regionally, they will feed into this overall review. Mr Farrell advised that the timeframe for completion is to aim to identify a series of options, based on the feedback from such stakeholder interviews, by the end of August 2015.

Discussion took place around key areas such as commissioning in general and members provided their comments and views on how they feel commissioning works from a Trust perspective in terms of funding, priorities, incentivisation and modernisation. Specific reference was made to certain specialities such as Community Paediatrics and Dental where it was felt there was less focus.

Discussion also took place regarding appropriateness of Programmes of Care and if indeed this was still the right thing to do. It was felt- 'yes', as it protects more vulnerable groups.

Members referred to relationships between the various bodies and the degree of openness and accountability in the system. It was felt that there should be more focus on outcome and quality and the need for commissioning to drive innovation therefore requiring more flexibility to allow Trusts to deliver. It was agreed that a critical part of future commissioning is the need for joined up commissioning approach across primary care and other services.

In concluding, Mr Farrell and Ms Joynes thanked members for their input into the stakeholder process and agreed to share findings in due course.

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Stephen McNally, Francis Rice and Aldrina Magwood.	
2	NOTES FROM THE PREVIOUS MEETING The notes from the previous meeting held on 1 July 2015 were approved.	<i>Approved</i>
3	CHIEF EXECUTIVE BUSINESS Personal Information redacted by the USI The Chief Executive expressed her sadness at the recent untimely passing of a valued Trust colleague – Personal Information redacted by the USI Personal Information redacted by the USI Members expressed their condolences to his Personal Information redacted by the USI family. DHH ED – Media Coverage The Chief Executive referred to the recent media coverage regarding DHH and meetings held with Political Parties. A briefing will be prepared and issued to Trust Board.	<i>Briefing to be shared with Trust Board</i>

4	MATTERS ARISING There were no matters arising.	
5	STRATEGIC PLANNING 5.1 Future of Commissioning of Vascular Services for NI – letter from Dean Sullivan dated 14 April 2015 – Trust response to consultation Mrs Burns advised that the response would be submitted by her office by Friday 10 July 2015. 5.2 Newry CTCC – Final ABC for approval Mrs Janet McConville attended the meeting to present to members the final ABC for Newry CTCC. Mrs McConville advised that the final evaluation of bidders had concluded and the outcome of the design, technical and legal evaluations were now included in the final ABC. Discussions had completed in terms of financial sections with the Trust, KPMG and the SIB. Following discussion and consideration, members agreed in principal, pending final consideration by the Director of Finance on his return on Friday, to: - approval subject to final wording re VFM by Mr McNally - agreement to submit to DHSSPS subject to Trust Board considering at its meeting on 27 August 2015.	<i>Mrs Burns to submit response</i> <i>Approved (pending final consideration by DoF)</i>
6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plans Ms O'Neil advised that there was no further update since full discussion at the previous meeting.	
7	PERFORMANCE UPDATE There were no specific performance issues to address.	

8	INNOVATION/CONTINUOUS IMPROVEMENT There was no specific business to discuss.	
9	GOVERNANCE ISSUES There were no specific Governance issues.	
10	INFECTION CONTROL UPDATE 10.1 HCAI Update/Briefing Dr Wright updated members on the current infection control position within the Trust. Dr Wright advised members that an official outbreak of CPE has been declared and all steps are being taken to work through the process in conjunction with the PHA. 10.2 HCAI Update – PFA Targets Dr Wright updated members on the performance targets. 10.3 Proposal for Renewal of UptoDate Subscription 2015/16 Dr Wright referred to the briefing paper for the renewal of UptoDate Subscription for 2015/16. Following consideration, members approved.	<i>Dr Wright progressing actions</i> <i>Approved</i>
11	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 11.1 Cases for approval: - Home Oxygen Therapy IPT - Establishment of a Minor Stream in CAH ED - Physiotherapy, OT and SW Support within ED - Radiology Services 7 days a week Members noted the above Business Cases and following consideration and discussion, the cases were approved.	<i>Approved</i>
12	WORKFORCE ISSUES There were no specific issues.	

13	COMMUNICATIONS & PUBLIC AFFAIRS Members were aware of current issues in the media and the Trusts response/position regarding same.	
14	DHSSPS CIRCULARS/CORRESPONDENCE There were no circulars to note.	
15	ANY OTHER BUSINESS Members noted that the process for Scrutiny, previously tabled at SMT was being implemented.	
16	DATE OF NEXT MEETING Wednesday 22 July 2015 There will be no SMT meeting next week 15 July 2015	



**Notes of SMT Meeting held on
Wednesday 17 February 2016
@ 2pm in the Boardroom, Trust Headquarters**

Present: Paula Clarke (to 2.50 pm)
Kieran Donaghy
Paul Morgan
Francis Rice
Dr Richard Wright
Stephen McNally
Roisin Toner (for Angela McVeigh)
Aldrina Magwood
/Paula Tally (for part of meeting)
Esther Gishkori
Jane McKimm
Elaine Wright (Notes)

Apologies: Angela McVeigh
Aldrina Magwood (for part of meeting)

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Angela McVeigh.	
2	NOTES FROM THE PREVIOUS MEETING The notes from the previous meeting on 10 February will be tabled at SMT on 24 February 2016 for approval.	<i>SMT 24 February 2016</i>
3	CHIEF EXECUTIVE BUSINESS 3.1 Approval of Papers for Director's Workshop 25 February 2016 Members considered the draft agenda for the forthcoming Director's Workshop to be held on 25 February 2016.	