12. Commitment is manifested by everyone in the organisation taking responsibility and making it a personal priority to ensure the success of the organisation as a whole, rather than focusing only on their individual or immediate team's success in isolation[6].

2.1 United Kingdom Regional Workforce Strategy Policy Direction

13. All NHS UK regional Departments of Heath have endorsed leadership models that require clinicians to become more actively involved in the planning, delivery and transformation of health and social care services[7,8,9,10.]

14. Current NHS Workforce Strategies are based on the concept of a shared or collective leadership model where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

15. Statements that endorse and support leadership and leadership development are found throughout supporting UK NHS Workforce Development Documentation:

Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services

"*Health and Social Care needs excellent leadership and management. Health and Social care organisations provide increasingly complex services, requiring highly skilled managers. The pace of change is unrelenting and staff look to their managers for clear direction and support."*

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[6] *Drath, W. H., McCauley, C. D., Palus, C. J., Van Velsor, E., O'Connor, P. M. G., and McGuire, J. B. (2008). Direction, alignment, commitment: Toward a more integrative ontology of leadership. The Leadership Quarterly, 19 (6), 635–653.*

[7] *Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services (2009)*

[8] *Department of Health England, Next Stage Review: High Quality Care for All (2008)*

[9] *NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership*

[10] *National Leadership and Innovation Agency for Healthcare Wales*

Department of Health England, Next Stage Review: High Quality Care for All

"Greater freedom, enhanced accountability and empowering staff are necessary but not sufficient in the pursuit of high quality care. Making change actually happen takes leadership. It is central to our expectations of the healthcare professionals of tomorrow."

NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership

"Effective leadership at all levels is essential to delivering the goals of NHS Scotland and ensuring high quality, safe and effective care. It is recognised that leadership development is a life-long activity and not confined to specific levels or groups of the workforce."

National Leadership and Innovation Agency for Healthcare Wales

"Effective clinical leadership is pivotal in ensuring that improvement in healthcare is not only on the agenda of all NHS organisations – but becomes part of their very DNA. Transforming healthcare is everyone's business with the provision of high quality care being at the heart of everything we do. Creating a culture of visible commitment to patient safety and quality requires clinical and professional leaders to work together so that NHS Wales can meet the healthcare challenges of the future."

3. The Collective Leadership Model

1. The 2014 King's Fund paper titled 'Developing Collective Leadership'[11] stated the need to move on from a concept of command and control leadership to a shared and distributed throughout organisations. The report also argues that leaders must engage their colleagues and other stakeholders in bringing about improvements in patient care and transforming the way in which care is provided.

[11] West, M. A., Eckert, R., Steward, K., & Pasmore, W. A. (2014). Developing collective leadership for health care. London: King's Fund.

2. A successful collective leadership model emerges from a conscious and intelligent effort to plan for an integrated, collective network of leaders distributed throughout the organisation and embodying shared values and practices[12].

3.1 Collective Leadership and Organisational Culture

3. The culture of healthcare, which so critically affects all other aspects of the service which patients receive, must develop and evolve to meet the needs of current and future service provision.[13]

4. The most important determinant of the development and maintenance of an organisation's culture is current and future leadership. Every interaction by every leader at every level shapes the merging culture of an organisation. [14]

5. An NHS Innovation review found that by enhancing the engagement of doctors in leadership there is potential for positive impact on both clinical and organisational performance. [15]

6. Due to the power and control which doctors possess they may block potential change efforts and confound improvement initiatives. However, by engaging doctors within the collective leadership model, significant differences may be achieved which enhance performance.[16]

[12] A. West, Michael, et al. "Collective leadership for cultures of high quality health care." Journal of Organizational Effectiveness: People and Performance 1.3 (2014): 240-260.
[13] Kennedy I. The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. Learning from Bristol. 2001
[14] A. West, Michael, et al. "Collective leadership for cultures of high quality health care." Journal of Organizational Effectiveness: People and Performance 1.3 (2014): 240-260.
[15] Ham, Chris, and Helen Dickinson. "Engaging doctors in leadership." Coventry: NHS Institute for Innovation and Improvement (2008) p16
[16] Ham, Chris, and Helen Dickinson. "Engaging doctors in leadership." Coventry: NHS Institute for Innovation and Improvement (2008) p33

4. Investing In Medical Leadership

7. Clinicians across Health and Social Care must be supported to lead and drive a culture that is Compassionate, Collective, Open and Excellent and which focuses on the quality and safety of services for patients and service users and the experiences of staff.

8. This can be realised through aligning the Culture and Values of the Trust with talent management and appraisal, along with supports to help make the necessary transformation into these roles.[17].

9. Organisations that invest in leadership can equip leaders with the skills that allow them to build alliances with a wide range of professionals and across organisational boundaries to serve the needs of diverse communities with enduringly complex needs.

10. The benefits of investing in healthcare leadership are well documented, these include:

- *West et al* have demonstrated the link between good leadership and HR practice in healthcare and patient mortality and morbidity rates – more engaged staff, through better leadership, saves lives[18]
- The Journal of Occupational and Environmental Medicine reports that workers with good leadership were 40% more likely to be in the highest category of job well-being, with low rates of symptoms like anxiety, depression, and job stress[19]
- The Corporate Leadership Council estimates that employees working for good leaders put in around 57% more effort and are 87% less likely to leave than those with poor leaders[20]

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[17] *NHS Leadership Academy https://www.leadershipacademy.nhs.uk/reasonstoinvest/ Accessed June 2018*
[18] *West, Michael, and Jeremy Dawson. "Employee engagement and NHS performance." The King's Fund 1 (2012): 23.*
[19] *Jacobs, Christine, et al. "The influence of transformational leadership on employee well-being: results from a survey of companies in the information and communication technology sector in Germany." Journal of occupational and environmental medicine 55.7 (2013): 772-778.*
[20] *Council, Corporate Leadership. Driving performance and retention through employee engagement. Vol. 14. Washington, DC: Corporate Executive Board, 2004.*

- A study in the Harvard Business Review (2007) provides a strong link between leadership skills and organisational performance[21]
- The Care Quality Commission's report *The state of health care and adult social care in England* highlighted that you can't have a well-performing organisation that isn't well-led. In fact, over 94% of services that were rated good or outstanding overall were also good or outstanding for their leadership and similarly, 84% of inadequate services were inadequately led[22]

5. Review of Best Practice Literature

5.1 NHS Medical Leadership Competency Framework (MLCF)

11. The MLCF describes the leadership competences that doctors need to become more actively involved in the planning, delivery and transformation of health services.

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

13. While the primary focus for doctors is on their professional practice, all doctors work in systems and within organisations. It is a vitally important fact that doctors have a direct and far-reaching impact on patient experience and outcomes. Doctors have a legal duty broader than any other health professionals and therefore have an intrinsic leadership role within healthcare services.

14. Doctors also have a responsibility to contribute to the effective leadership and the running of the organisation in which they work and to its future direction. The development of leadership competence is an integral part of a doctor's training and

[21] *Bassi, Laurie & McMurrer, Daniel. (2007). Maximizing your return on people. Harvard business review. 85. 115-23, 144.*
[22] *Care Quality Commission. The state of health care and adult social care in England in 2011/12. Vol. 763. The Stationery Office, 2012.*

learning. The MLCF is intended as an aid and driver for this and to enable a doctor in the NHS to be a practitioner, a partner and a leader.

15. The Medical Leadership Competency Framework (MLCF) is built on the concept of collective leadership where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

5.2 Clinical Leadership Competency Framework (CLCF)

16. The Clinical Leadership Competency Framework (CLCF) was developed through consultation with a wide cross section of staff, patients, professional bodies and academics, and with the input of all the clinical professional bodies throughout the UK and has the support of the chief professions officers, the professions advisory boards, the peak education bodies and the Department of Health.

17. The CLCF states that while the primary focus of clinicians is on their professional practice, all clinicians, registered or otherwise, work in systems and most within organisations. It reinforces the vitally important role that clinicians have regarding influence on these wider organisational systems and thereby improve the patient experience and outcome.

18. Doctors have an intrinsic leadership role within health and care services and have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction. Therefore the development of leadership capability as an integral part of a clinician's core work is a critical factor.

5.3 Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base

19. The Kings Fund Evidence Base paper on Leadership and Leadership Development (2008) highlights the importance of strong medical leadership stating medical leaders create a strong sense of team identity by ensuring:
    - The team has articulated a clear and inspiring vision of the team's work
    - There is clarity about the team's membership
    - Team members agree five or six clear, challenging, measureable team objectives
    - There is strong commitment to collaborative cross-team and cross-boundary working

20. The paper presents a large scale review of medical leadership models where it was found that medical or clinical leadership varied across the case study sites they assessed. The paper reports variations both between, and within organisations in the extent to which doctors felt engaged in the work of their organisations.

21. Those organisations with high levels of engagement performed better on available measures of organisational performance than others. In addition, it found that in high-performing trusts, interviewees consistently identified higher levels of medical engagement.

6. Current Trust Medical Leadership Structure

6.1 Medical Leadership Structure (since 2011)

22. The Southern Health and Social Care Trust medical leadership structure last underwent review in 2011. As an outcome of this review three new sessional posts were created to support the introduction of medical revalidation and revised appraisal processes (1 Corporate Lead, 1 Consultant Lead and 1 SAS doctor lead to support Appraisal and Revalidation with a total additional allocation of 4 PA's per week which has now been reduced to 3 PAs).

23. The central medical leadership structure remained unchanged as a result of the review with the number and ratios of Associate Medical Directors remaining constant. However, in the intervening years changes were made which included the discontinuation of three AMD positions, the rationale for this is unclear:

- **AMD Emergency Care - *Post absorbed into Medicine and Unscheduled Care (2016)***
- **AMD Infection Prevention and Control – *Post not retained (2015)***
- **AMD Standard and Guidelines – *Post not retained (2015)***

24. The current Southern Trust Medical Leadership Structure is outlined below

Medical Leadership Structure Today (May 2019)

Corporate AMD Roles
AMD Medical Education
AMD Research and Development
AMD Older Persons and Primary Care
Operational AMD Roles (and Supporting CD's)
AMD Cancer and Clinical Services *3 x Supporting Clinical Director Roles*
AMD Children's and Young Peoples Services *3 x Supporting Clinical Director Roles*
AMD Anaesthetics and Intensive Care *3 x Supporting Clinical Director Roles*
AMD Surgery and Elective Care *3 x Supporting Clinical Director Roles*
AMD Medicine and Unscheduled Care *5 x Supporting Clinical Director Roles*
AMD Integrated Maternity and Women's Health *2 x Supporting Clinical Director Roles*
AMD Mental Health and Disability Services *3 x Supporting Clinical Director Roles*
Appraisal and Revalidation Roles
Corporate Lead for Appraisal & Revalidation
Consultant Lead for Appraisal & Revalidation
SAS Lead for Appraisal & Revalidation
Morbidity and Mortality Roles
DHH Medicine Chair

CAH Medicine Chair*
Trustwide Surgery Chair*
Trustwide CYPS Chair
Trustwide IMWH Chair
Trustwide MHLD Chair

* *Medicine and Surgical Specialities are supported*

7. The Case for Change

25. Given the significant body of evidence available on Medical Leadership development three key areas feature strongly.

7.1 Performance of Frontline Teams

26. There is a growing body of literature on the specific relationship between the performance of frontline organisational teams and medical outcomes. This literature confirms that patient outcomes are not a function of the potential of the technology or the skill of individual caregivers alone but also depend on the functioning of the systems in which these individuals apply medical technology to address patients' health problems. Better management of the care itself, as well as management of the organisational setting in which the care takes place, leads to better outcomes.

7.2 Providing a Link from Bed to Board

27. Medical leaders understand the complexity of modern health care services and how to optimise organisational performance and influence clinical practice. Health and Social Care is subject to an increasing level of competing demands while trying to balance the allocation of scarce resources to individual patient care and the care of communities and populations. Medical leaders are ideally suited to provide expertise when these decisions are being made as they understand what is possible, what is doable and what is affordable[23].

[23] *Brook RH (2010). 'Medical leadership in an increasingly complex world'. JAMA, vol 304, no 4, pp 465–6.*

7.3 Supporting and Influencing Service Planning

28. Doctors in strong leadership roles have the ability to influence senior managers and shape service delivery to strengthen focus on patient well-being. Given the inherent tension between costs and patient welfare it is of vital importance there is a strong clinical voice ensuring that best value is sought for every patient on every interaction with our services.
29. Furthermore, decisions made by senior management influence the amount and kind of care patients receive on the ward, the clinic, or in the community, administrative and policy changes do have the potential to have an impact on medical outcomes. Doctors are uniquely positioned to understand the potential impact of policy or funding changes[24].

[24] Darzi A (2009). 'A time for revolutions: the role of clinicians in health care reform'. The New England Journal of Medicine, vol 361, no 6, e8.

8. Consultation with Trust Medical Leadership

30. As part of the scoping exercise to review the current medical leadership structure, an independent survey of medical leaders was carried out to identify barriers and enablers to achieving a robust medical leadership structure and engagement model (2018/19). A supplementary paper titled *Consultation with Trust Medical Leadership* can be found in appendix 4. A summary of key findings that relate to the current medical leadership model is found in the table below.

	Key Themes
Motivation to Become Involved in Medical Leadership	• There is a high level of motivation among Trust Medical Leaders • Medical Leaders feel acknowledged by their colleagues and the Trust • While there is acknowledgement that medical leadership is challenging, current leaders feel a sense of purpose and achievement in their roles
Challenges to Developing Medical Leadership	• There is a lack of engagement in leadership roles throughout the Trust • There is not adequate PA allocation and backfilling • Clear links between medical leadership and tangible improvements to the quality of services should be sought
Barriers to Implementing Medical Leadership	• Associate Medical Directors perceive that they are often left out of decision making • Medical Leaders often undertake their leadership roles in unpaid time
The Medical Leadership Setting	• Medical leaders regard themselves as having autonomy and freedom to get on with the job • While medical leaders feel recognised in their roles, the provision of protected time to deliver the job is only available to a small proportion

31. The survey brings to attention several key findings including a high level of motivation to become and remain a medical leader that is contrasted with restrictions imposed by limited time and balancing clinical commitments.

32. Associate Medical Directors feel they would like a bigger role in decision making regarding services provided, however acknowledge that this will require allocated resource to ensure existing service levels are maintained.

9. Consultation with Trust Directors

33. Trust Directors were asked to give their views and opinions on the current medical leadership structure (2018). A short questionnaire was provided to participants asking for views on the current medical leadership functions and roles including contribution to leading and developing services, integration with operational management teams and what opportunities exist to strengthen the medical leader role. A summary of key findings that relate to the current medical leadership model is found in the table below (appendix 4 contains full reponses).

	Key Themes
Strengthening the Role of Medical Leaders	• Clarification of roles and responsibilities of Medical Leaders and how they relate to operational management roles • Requirement to identify clear areas of responsibility and accountability for medical leaders • Need for protected time to conduct medical leadership role • Provide support for service innovation and quality improvement • Stronger links between directorate senior managers and senior medical leaders • Increased opportunities to gain understanding of wider directorate service demands / pressures • Trust senior managers and Medical Leaders to agree a set of corporate annual objectives for service improvements
Integration of Medical Leadership with Operational Management	• Can be dependent on the nature of the directorate services • The role of Clinical Directors is less clear than that of Associate Medical Director • Clarification of medical leadership roles with more structured engagement

Strengthening Medical Leadership Structures	• Increasing the profile and visibility of Medical Leaders • Ensure appropriate tasks are delegated • Agreement of outcome measures for each role • Build relationships and strengthen channels of communication between medical specialties • Joint Leadership development programmes with well embedded multidisciplinary approaches

34. The questionnaire found several areas of commonality between directorates, namely the benefit of clearly defining medical leaders roles and accountabilities, protected time to deliver in their roles and greater integration with operational management teams.

10. Comparison with Analogous Organisations

10.1 Northern Ireland Regional Trusts

35. The following comparisons of medical leadership structures with regional Health and Social Care Trusts is found below:

Northern Health and Social Care Trust	South Eastern Health and Social Care Trust

• Medical Director (Director for Governance, Patient Safety)
• 2 Deputy Medical Directors
• Divisional Director Structure*
• Clinical Director Structure
  • Governance and Safety Roles
	• Medical Director (Director for Governance, Patient Safety)
	• 3 Deputy Medical Directors
	• Clinical Director Structure*
	• Associate Clinical Director Structure
	  • Governance and Safety Roles

Western Health and Social Care Trust	**Belfast Health and Social Care Trust**
• Medical Director (Director for Governance, Patient Safety and QI) • Divisional Medical Director Structure	• Medical Director (Director for Governance, Patient Safety and QI • 3 x Deputy Medical Directors (5 PA

• Clinical Director Structure* • Governance and Safety Roles	each post) • 12 Divisional Medical Directors (3PA per post) • 38 Clinical Director Structure* - including CDs for litigation, coronal affairs, appraisal and revlaidation (2PA per post) • Patient Safety Lead Clinicians**(1PA per post) • Governance Lead Clinicians (1PA per post)

*Clinical Directors are equivalent of SHSCT AMD roles

** Lead clinicians are formal roles within the medical leadership structure

Section 2 – Proposed Medical Leadership Structure

11. Medical Leadership Development and Competence

36. A supplementary paper titled Medical Management and Leadership Development will follow.

12. Medical Leadership Appointments

37. It is proposed that if approved, all Medical Leadership management posts will be vacated and reappointed collectively.

38. This paper proposes that all senior medical leadership positions commencing from August 2019 are fixed-term appointments (details found in subdivision 14 below) and do not carry any expectancy of automatic renewal or conversion to any other type of appointment. A fixed-term appointment may be extended, under the conditions set by the Medical Director, provided that the total duration of service under consecutive fixed-term appointments does not exceed more than one year beyond the original appointment end date.

13. Proposed Medical Leadership Roles and Responsibilities

The below sections provide outlines of both existing and new medical leadership posts.

13.1 Medical Director

Role Description	**Medical Director** The Medical Director is an Executive Director position, responsible for providing assurance to Trust Board those effective systems and processes for good governance, including those arrangements to support good medical practice, are in place. • Responsible for providing strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matter across Directorates. • Leadership role in the provision of safe, high quality services,

	support the reform and modernisation programme and drive initiatives for continuous quality improvement. • Lead responsibility for clinical and social care governance. • Responsible Officer (RO), with statutory duty to make recommendations to the General Medical Council with regard to a doctor or dentist's fitness for revalidation, for those doctors and dentists who have a prescribed connection with the Southern HSC Trust. • As a member of the Trust Board and the Senior Management Team have both individual and corporate leadership responsibility for the governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.
Number of Posts	1 Post (Existing)
PA Allocation	WTE
Areas of Responsibility	Medical Professional Governance, Clinical and Social Care Governance, Medical Workforce Development, Patient Safety, Quality Improvement and Audit, Infection Prevention and Control
Appointment Term	Permanent Post

13.2 Deputy Medical Directors (3 Posts Total)

Role Description	**DMD – Professional and Workforce Development (New Post)** The Deputy Medical Director (Workforce Development) will focus with the Medical Director on providing strong leadership, systems and process to lead on professional standards and leadership development across the organisation, providing expert advice, develop a leadership and workforce development strategy, support the development of job plans, and participate in training programmes as required.
Number of Posts	1 New Post
PA Allocation	6 PA
Areas of	• Medical Appraisal & Revalidation

Responsibility	• Job Planning • Medical Professional Governance • Oversight of Locum Doctors • Support and Oversight of International Recruitment • Medical Engagement and Recruitment • Coroner Services Oversight • Litigation Services Oversight • Oversight of Locum Management • Deputise Responsible Officer function for Medical Director
Appointment Term	Permanent

Role Description	**DMD Governance, Safety and Quality Improvement (New Post)** The Deputy Medical Director (Governance and Quality Improvement) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, develop a clinical governance strategy, support the development of clinical governance plans, and participate in education and training programmes as required.
Areas of Responsibility	• Morbidity and Mortality • Adverse Incident / Serious Adverse Incidents • Complaints Oversight • Clinical Leadership for Quality Improvement • Clinical Audit (National and Local inc. NCEPOD Ambassador) • Research and Development • Standards and Guideline Oversight • Infection Prevention and Control Oversight
PA Allocation	6 PA
Appointment Term	Permanent

Role Description	**DMD Medical Education and Training (Existing Post Reconfigured)** The Deputy Medical Director (Medical Education and Training) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, develop a clinical governance strategy, support the development of clinical governance plans, and participate in education and training programmes as required.
Areas of Responsibility	• Undergraduate Education Leadership and Development • Postgraduate Education Leadership and Development • Physician Associate and Medical Associated Professions Governance • SAS Grade Leadership and Development
PA Allocation	4 PA (Currently funded at 2.5 PA)
Appointment Term	Permanent

13.3 Chairs of Division (9 Posts Total)

Role Description	**Chairs of Division (Operational Services)**
Number of Posts	9 Posts (All existing fully funded)
Areas of Responsibility	• Cancer and Clinical Services • Children's and Young Peoples Services • Anaesthetics and Intensive Care • Surgery and Elective Care • Medicine • OPCC • Emergency & Unscheduled Care • Integrated Maternity and Women's Health • Mental Health and Disability Services
PA Allocation	PA between 2 and 4
Appointment Term	3 Years Initially

Role Description	**Associate Medical Director – General Practice** Associate Medical Director will have professional and corporate responsibility for Primary Care.
Number of Posts	1 Post (Existing fully funded)
Areas of Responsibility	• Primary Care
PA Allocation	3 PA
Appointment Term	3 Years initially

13.4 Clinical Directors (24 Posts Total)

Role Description	**Clinical Directors (Operational Services)** Clinical Directors will be responsible for services as directed within their divisional structures
Number of Posts	24 Posts (All existing fully funded)
Areas of Responsibility	• Assigned as per existing AMD Structure • New Clinical Director post for Research and Development • Reinstatement of Clinical Director roles (x2) for Emergency Department previously funded
PA Allocation	1PA per post (2 PA's for Research and Development post)
Appointment Term	3 Years Initially

13.5 Lead Clinicians

Role Description	**Lead Clinicians for Governance (Per speciality basis, as identified by Operational management)** Lead clinicians will provide local departmental leadership in speciality areas. Exact activities and responsibilities will be coordinated by operational directorates however at minimum will include a lead role in oversight of speciality clinical and social care governance activity.
Number of Posts	To be decided at directorate level
Areas of Responsibility	Governance
PA Allocation	PA cost to be agreed and funded by responsible operational directorate

Appointment Term	2 years initially

13.6 Appraisal and Revalidation Corporate and Consultant Leads (2 Posts Total)

Role Description	**Appraisal and Revalidation Corporate Lead** The Corporate Lead Role for Appraisal and Revalidation will continue to support the Medical Director and the Head of Revalidation Team in the implementation of revalidation. A key focus of the role will be the development of quality assurance and evaluation of the Trust's medical appraisal and revalidation process.
Number of Posts	2 Posts
Areas of Responsibility	• Participate in Appraisal and Revalidation Strategic Group and Revalidation Team meetings • Evaluation and Quality Assurance of appraisers roles • Evaluation of quality assurance of training and skills development programme • Quality assurance and evaluation of Patient and Colleague Feedback • Audit of all medical appraisal documentation received • Contribute to improvement of GMC Supporting Information processes implemented by the Trust including governance information • Contribute to Department of Health working groups / RO Forums • Pre-screen of information prior to revalidation • Ensure College standards are communicated, understood and embedded into the appraisal process • Ensure GMC standards are communicated and understood
PA Allocation	1 PA cost per post (Currently funded from MD Budget)
Appointment Term	3 Years Initially

13.7 Appraisal and Revalidation Lead SAS Doctor (2 Posts Total)

Role Description	**Appraisal and Revalidation Lead SAS Doctors** To deliver at a Trust level on the Department of Health agreed Northern Ireland Charter for SAS Doctors which includes specific responsibilities to support local SAS doctors via job planning, appraisal and revalidation, support for quality improvement and capturing SAS doctor clinical activity.
Number of Posts	2 Posts
Areas of Responsibility	• Support SAS doctor job planning, • Support and oversee quality improvement work and promote safety & audit projects undertaken by SAS doctors • Develop systems for capturing SAS doctor activity • Provide guidance and support to SAS Doctors on compilation of supporting information for appraisal. • Development of SAS Doctor Appraiser and Mentor Roles. • Increase SAS doctor engagement across the Trust via regular link-up sessions and the organisation of an annual regional NI conference for SAS doctors. • On behalf of SAS doctors, participate in the Trust's Appraisal & Revalidation Strategic Group, Medical Forum and other committees as appropriate.
PA Allocation	1 PA cost per post (1 PA currently funded from MD budget)
Appointment Term	3 Years Initially

13.8 Patient Safety Leads (Morbidity and Mortality Chairpersons) (19 Posts Total)

Role Description	**Patient Safety Leads (Incorporating Morbidity and Mortality Chairs) (Per speciality basis, as identified by Operational management)** Patient Safety Leads chairs will be responsible for the following • Setting and maintaining the agenda for meeting in line with Trust M & M Framework

	• Determine, support and develop appropriate patient safety inputs to the meeting • Ensure and monitor the appropriate multi-disciplinary attendance by all relevant professional groups. • Monitoring timely completion of screening templates and sign-off on NIECR • Monitoring of medical staff participation in Case Presentation • Ensure speciality meetings identify outcomes and sharing learning
Number of Posts	19 Posts (6 existing fully funded)
Areas of Responsibility	• DHH Medicine Chair (1PA) • CAH Medicine Chair (1PA) • Trustwide Surgery Chair (1PA) • Trustwide CYPS Chair (1PA) • Trustwide IMWH Chair (1PA) • Trustwide MHLD Chair (1PA) 13 Speciality Lead posts (0.5PA per post)
PA Allocation	(0.5 - 1 PA per post, depending on volume)
Appointment Term	3 Years Initially

13.9 Clinical Standards and Audit Lead (1 Post Total)

Role Description	**Clinical Standards and Audit Lead** The Clinical Standards and Audit Lead will lead the coordination and monitoring of systems and processes to ensure maximum compliance with clinical standards as endorsed or mandated by regional or professional bodies. This role will include brokering actions across divisions and directorates where standards span same. This role will not remove or undermine operational DMD clinical governance responsibilities and accountabilities to their areas of service.
Number of Posts	1 Post (Previously Funded)
Areas of Responsibility	• Provide independent assessment of action taken to ensure compliance on a range of standards, guidelines and review recommendations

	• Identify and challenge where compliance is not being achieved and lead discussions on how to improve compliance • Monitor the effectiveness of agreed action on compliance and take appropriate action to ensure clinical leadership is applied to address improved outcomes • Lead on the co-ordination of compliance discussions / actions across directorate interface areas
PA Allocation	1 PA
Appointment Term	3 Years Initially

13.10 Medical Lead for Coroners Services (1 Post Total)

Role Description	**Medical Lead for Coroners Services** The Medical Lead for Coroners Services will work with the Legal Services Manager Clinical Directors to provide professional and clinical input into the management of Coroner's cases.
Number of Posts	1 Post
Areas of Responsibility	• Support Legal Services Manager in the process of obtaining statements from involved staff as requested by the Coroner's Office and advise on action to be taken • Support the Legal Services Manager from whom statements and reports should be sought, review reports • Directly liaise with the Trust's legal advisors (DLS) as required • Advise the Legal Services Manager on who should be requested to provide expert reports. • When required, advise the Medical Director and the Medical Director's Office on all matters relating to the Coroner's Office. • Provide, with the Legal Services Manager, a direct liaison and efficient communication with the Coroner's Office. • Provide, along with the Legal Services Manager, support to Trust staff who are to appear in the Coroner's Court which may mean attending that Court.

PA Allocation	(3 PA, not funded)
Appointment Term	3 Years Initially

13.11 Medical Lead for Litigation Services (1 Post Total)

Role Description	**Medical Lead for Litigation Services**
Number of Posts	1 Post
Areas of Responsibility	• Support Legal Services Manager in the process of obtaining statements from involved staff as requested by the Courts and advise on action to be taken • Support the Legal Services Manager from whom statements and reports should be sought, review reports • Directly liaise with the Trust's legal advisors (DLS) as required • Advise the Legal Services Manager on who should be requested to provide expert reports. • When required, advise the Medical Director and the Medical Director's Office on all matters relating to the Courts. • Provide, along with the Legal Services Manager, support to Trust staff who are to appear in the Court which may mean attending that Court.
PA Allocation	(1 PA, not funded)
Appointment Term	3 Years Initially

13.12 Clinical Governance Leads and Safety and Quality Improvement Leads

39. Each directorate will have the opportunity to develop Clinical Governance Lead and Safety and Quality Improvement Lead posts based on local needs. These posts will be funded from directorate budgets, an outline role description will be developed as a guide by the Medical Director.

13.13 Administrative and Clerical Support Requirements

40. To support the administration of the new posts and to manage new interfaces between Medical Leaders and Operational Managers it is proposed the following new posts are allocated.

Deputy Medical Director Support	37.5 Hours per week	1 WTE Band 4
Chair Of Division Support	Allocated within each directorate	Allocated within each directorate
Clinical Director Support	Allocated within each directorate	Allocated within each directorate
Lead Clinician Support	To be agreed and supported by operational directorates	To be agreed at operational directorate level

14. Proposal Costings

41. The current medical leadership structure is significantly smaller than the structure that emerged following the 2011 medical leadership review. As previously noted, AMD posts for Emergency Medicine (3 PA's), Infection Prevention and Control (2 PA's) and Standard and Guidelines (1 PA) were stood down and the duties merged into operational AMD roles.

42. The following costings for the revised medical leadership structure are as follows:

Domain	Role	PA Required	PA Currently Funded	Investment Required	Comment
Medical Executive Posts	Deputy Medical Director – Governance , Patient Safety & Quality Improvement	6	5	1	*New post previously approved by SMT*
	Deputy Medical Director - Workforce Development	6	5	1	*New post previously approved by SMT*
	Deputy Medical Director - Professional and Workforce Development	4	2.5	1.5	
Operational Chair Of Division Posts	COD Surgery and Elective Care	3	0.79	2.21	
	COD ATICS	2	2	0	
	COD Medicine	4	4	0	
	COD Integrated Maternity and Women's Health	2.85	2.85	0	
	COD Children's and Young Peoples Services	3	3	0	
	COD Mental Health and Learning Disability	2	2	0	

	COD Cancer and Clinical Services	3	3	0	
	COD Unscheduled Care &Emergency Medicine	3	3	0	
	COD Older People	3	3	0	
Corporate Services	CD Research and Development	2	2	0	*Post converted to Clinical Director Role*
	AMD Primary Care	3	3	0	
	Medical Lead for Coroner Services	1	0	1	*New Post currently unfunded*
	Medical Lead for Standards and Guidelines	1	0	1	*New Post currently unfunded*
	Medical Lead for Litigation	1	0	1	*New Post currently unfunded*
Revalidation Support	Medical Lead Corporate Appraisal & Revalidation	1	1	0	
	Medical Lead Consultant Appraisal & Revalidation	1	1	0	
	Lead SAS Doctors Appraisal and Revalidation	2	2	0	*Two Existing Funded Posts*
Patient Safety Leads	Patient Safety Leads (19 posts)	12.5	6	6.5	*Six posts Trustwide (6.5 new PA to include sub speciality M&M meetings)*
Total		**66.35**	**51.14**	**15.21**	

Domain	Role	PA Required	PA Currently Funded	Investment Required	Comment
New Operational Clinical Director Posts	Clinical Director Posts Emergency Care (DHH and CAH)*	2	2	0	*Two previously funded posts*
Total		**2**	**2**	**0**	

**As of March 2020 one post has currently been recruited*

43. The following costings for the revised medical leadership structure administration support are as follows.

Role	Currently Funded	New / Additional Required
Deputy Medical Director Support (1WTE Band 4)	0 WTE	1WTE

15. Proposed Service Enhancements and Accountabilities

15.1 Service Enhancements (Measurable Outcomes)

44. Pending SMT approval funding the Medical Director will devise unique role descriptors for each existing and new post will agree individual accountabilities and performance measures.

45. At a corporate level the following service enhancements have been identified.

Accountability	Method of Assurance
Strengthened clinical oversight and assurance of Trust Morbidity and Mortality (M&M) Process	• Responsibility for reviewing and monitoring M&M processes and outputs and identifying areas for systems strengthening • Responsibility for initiating mortality case reviews and reporting outcomes • Twice yearly assurance reporting to SMT and Trust Governance Committee on M&M processes and outputs
Strengthened clinical oversight and assurance of Trust Adverse Incident Identification and Investigation Processes	• Responsibility for reviewing and monitoring Adverse Incident processes and outputs and identifying areas for systems strengthening • Provide clinical quality assurance of Adverse Incident Investigations • Strengthen SAI investigation teams • Twice yearly reporting to SMT and Trust Governance Committee to quality assure SAI processes
Strengthened clinical oversight and assurance of Standard and Guideline	• Responsibility for providing assurance on Trust Standard and Guideline processes

processes and outputs	and outputs • Support directorate governance teams in identifying appropriate 'change leads' for Standards and Guidelines received by the Trust • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Standard and Guideline processes
Strengthened clinical oversight and assurance of Trust clinical audit process and subsequent learning outputs	• Responsibility for the creation of a Trustwide priority based clinical audit programme that considers a range of potential audit activity inputs: - National and regional audits - Standard and guidelines - Adverse incident and complaints - Medical incidents - Near miss events - Audits of local interest • Responsibility to identify audit learning from audits to improve services • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Clinical Audit processes
Strengthened Learning from Experience functions	• Responsibility for the oversight and implementation of the Trust Learning from Experience function • Responsibility for ensuring that sources of learning are identified including, national regional and local learning • Responsibility to interface with local sources of learning including litigation, complaints, SAI's and patient / staff

	feedback and M & M learning. • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Learning from Experience processes
Strengthened support for Trust Safety & Quality Improvement initiatives	• Responsible for oversight of local safety and quality improvement initiatives • Support for quality improvement collaborations with national and international improvement organisations, universities, health and other social care providers. • Developing capability in the medical workforce to design, deliver and evaluate a quality and safety improvement programmes. • Work with the quality improvement team towards developing a Trust quality improvement 'hub'

15.2 Integration with Operational Management Roles

46. It is proposed the following collective forums will be created / enhanced between operational managers and medical leaders. This list is not prescriptive and is aimed to set the context of a renewed phase of engagement, accountability and shared responsibility between Medical Leaders and Operational Managers.

Type of Interface	Name	Composition
Corporate Interfaces & Collective Forums	Senior Leaders Forum	Trust Directors, AMDs and CDs (Bi-monthly)
	Clinical and Social Care Governance Meeting	Directorate Governance Coordinators, DMD Representation (Weekly /

		Monthly)
	Trust SMT Attendance	Medical Director to delegate / include relevant medical leaders based on meeting requirements as required (Weekly)
Directorate Forums	Directorate Governance Meetings	Directorate SMT Meetings (Fortnightly)
	Speciality Meetings	Operational Management present at speciality meetings (Including M&M, Clinical Governance and Service Improvement meetings)
	One-to-One Director / Assistant Director meetings	Meetings to discuss Medical Leader and Operational Manager performance

16. SMT Endorsement

47. The Medical Director asks the Senior Management Team to consider the previously set out proposal and approve its implementation

Appendix 1 - Focus of Medical Leadership Review

The 2018 Trust medical leadership review will focus on strengthening four key areas:

Development Aim	Rationale	Intended Outcomes
Support Medical Leadership Development	Leadership skills should be an essential component of development all medical staff[1]. Doctors should not only be strong academically and clinically but must begin early in their careers to develop a set of knowledge, skills and behaviours that will enable them to engage and lead in highly complex, rapidly changing environments.	• Implement a Trust Medical Leadership Framework for development
Increase the Role of Succession Planning	Staff are the Trust's most valuable asset, managing, nurturing and keeping medical staff engaged and motivated important for the Trust's ability to provide high-quality care. To achieve this will require the development of a medical succession planning strategy, which must be related to the organisation's vision and strategic objectives.	• Development of a medical succession planning strategy • Creation structured opportunities for staff to develop and gain insight into more senior roles
Enhanced Accountability for Medical Leaders	Enhancing accountability for medical leadership roles can assist in ensuring ownership, setting expectations and strengthen culture[25] within clinical teams.	• Link accountability to the Trust Medical Leadership Framework • Agree performance indicators for each

[25] Niven, Paul R. Balanced scorecard step-by-step: Maximizing performance and maintaining results. John Wiley & Sons, 2002.

		service area
Review the Current Structure of Medical Leadership	Review the Trust medical leadership form and function, on the basis of an assessment of how fit for purpose it remains in a constantly changing environment.	• Provide an updated medical leadership structure for SMT approval

Appendix 2 - Review Process

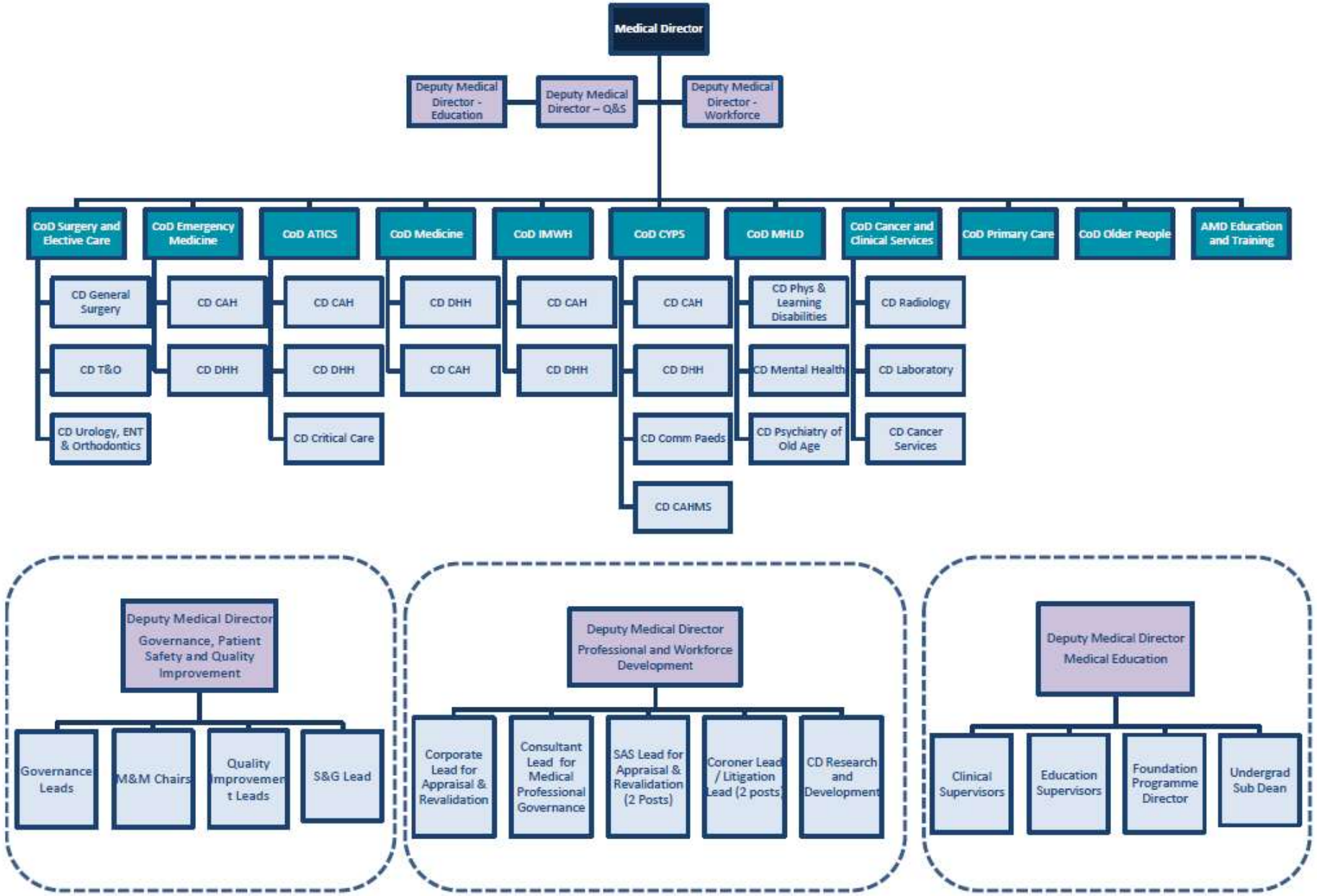
Throughout the review process Trust Medical Leaders and Directors were engaged through a variety of mechanisms to ensure all views, experiences and requirements are fully captured.

The following staged approach to delivering the Medical Leadership review and proposal was enacted:

Stage	Stage Title	Elements	Timeline
1	**Literature and Practice Review**	• Review of best practice literature regarding medical leadership (including NHS Medical Leadership Competency Framework) • Review of other regional Trusts / NHS UK Trusts existing Medical Leadership structures	30th May 2018
2	**Stakeholder Engagement**	• Conduct a face to face SWOT[26] analysis via a with existing Trust medical leaders (AMDs and CDs) • Engage Trust Medical Leaders (AMDs and CDs) in a qualitative and quantitative evaluation • Engage SHSCT Directors via a survey	2018 /2019
3	**Development of a Proposal Paper for Approval**	• Draft of proposal paper to meet review aims for agreement by AMD's • Proposal Paper for presentation to SMT for approval	May 2019
4	**Implementation**	• Development of prioritised action plan for AMD approval • Development of project milestones for monitoring project progress	Quarter 2 2019

[26] (Strengths, Weaknesses, Opportunities and Threats)
https://www.mindtools.com/pages/article/newTMC_05.htm

Appendix 3 – Proposed Revised Medical Leadership Structure



Appendix 4 –Consultation with Trust Senior Staff

How do you feel the role of medical leaders could be strengthened to increase contribution to leading and developing Trust services?

- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- Stronger links, (two way) between CD ↔ AMD ↔ Operational Director of management and service delivery issues
- Opportunities to gain a greater appreciation of the pressures/demands of operational teams/staff (nursing, SW, AHP etc)
- Look at taking forward a quality improvement project for the Trust via, for example the Scottish Fellowship Leadership programme or our Trust Quality Improvement Team
- Increased consultant protected time for governance, leadership, standards and guidelines.
- We need clarity in the leader's role and the areas that they are to be held accountable for.
- Current leaders need to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, etc.

How well do you feel existing medical leadership roles integrate with operational management roles with regards to leading and developing services?

- There is a very well established and legacy practice of medical staff being an integral part of MHD operational business.
- Translating this into medical leaders being part of many key Directorate and Corporate operational groups to develop policy directions, improvement plans and operationalisation of services. This can feel like it is done in professional silos in some operational services.
- It's quite good between AMD & Director. Needs more time/effort to develop the input of the CD
- Possibly some joint training or project work would help with working relationships, appreciating that there is a lot of pressure in the system.
- Clarity re role and responsibility for medical leaders vs operational managers, need clear guidance

- Support for innovation and quality services is required
- The AMDs and CDs work very well with the ADs and their teams, given the limited time they have available for this role.
- The integration with operational management needs to perhaps have a more structured approach with clarity on roles, agendas, their remit, etc.

Overall how effective do you feel the current Trust medical leadership structure is contributing to the overall delivery of Trust services

- Start early- Medical trainee placements in MDT depts.
- Engage medical staff in MDT improvement plans
- PC AMD took a very refreshing and upstream approach to joined up working.
- Complete leadership training together as an MDT ethos and not in professional silo groups.
- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- M&M meetings could be more MDT focused.
- A Learning from Experience MDT forum that focuses on the key recurring SAI themes for change improvement.
- From the outside looking in, there are some real tensions/issues between some of the medical specialities. This needs addressed, as it can impact significantly on service development/delivery.
- It's about communication, relationship building and resolving issues, early on and face to face
- By taking a more strategic holistic overview of population health, rather than focusing solely on their own speciality.
- Varies from director to director and practitioner to practitioner
- In OPPC this I belive this works better that in some areas
- Greater profile and ownership key delegated tasks and outcomes agreed and measured
- Increased consultant protected time for governance, leadership, standards and guidelines.

- Clarity in each of the leader's role and the areas that they are to be held accountable for.
- Guidance for our current medical leaders is need so that they are clear as to how they are to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, patient flow issues, etc.

Any other comments /Suggestions

- Relationships is key to making a difference
- Currently Acute is experiencing difficulty in securing consultant leadership for activities such as chairing of SAI panels, change leadership for standards and guidelines, reviewing clinical guidelines and clinical audit leadership.
- This seems to be as a result of other areas having dedicated PA time for these activities. This needs to be addressed as quickly as possible as it is affecting Acute Governance.

Southern Health and Social Care Trust

REPORT SUMMARY SHEET

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

Overview:

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

Key Issues / Risks for SMT Consideration:

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

Outcome of SMT Discussion:

Background and Context

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

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

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

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

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

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

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

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

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

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

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

Rationale for Change of Clinical Director Posts

Expansion of Role and Responsibilities of the Clinical Director

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

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

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

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

Expansion of the Trust Medical Workforce

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

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

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

Grade	2013	2021
Training Grades	240	294

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

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

Increased Role of Medical Leaders in Professional Governance

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

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

Increased Use of Medical Locums

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

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

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

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

Number of Doctors Managed Per Clinical Director

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

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

Clinical Director Proposal

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

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

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

Appendix 1 – Updated Proposed Divisional Medical Leadership Structures

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

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

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

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

Costing Table (Total Costs)

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

**Midpoint of scale*

Appendix 2 Clinical Director Job Description

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Clinical Director – XXXXXXXXXXXXX

DIRECTORATE: XXXXXXXXXXX

RESPONSIBLE TO: Divisional Medical Director XXXXXXXXXXXXX

ACCOUNTABLE TO: Medical Director

COMMITMENT: X PAs

LOCATION: XXXXXXXXXXX

Context:

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

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

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

Job Purpose:

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

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

Specialties / Areas Responsible For

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

Main Duties / Responsibilities

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

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

Specific Divisional Responsibilities

- X
- X
- X
- X

Leadership Responsibilities

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

clinical and social care governance structures and culture.

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

Appraisal and Revalidation

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

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

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

Job Planning

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

Implementation of HR policies for medical staff

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

Budgetary management

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

GENERAL REQUIREMENTS:

The post holder will be required to:

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

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

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

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

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

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

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

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

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

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

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

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

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

Clinical and Social Care Governance Review

Final Draft Report

November 2019

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

Contents

Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.0 Introduction

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

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

2.0 Scope of the Clinical and Social Care Governance Review

2.1 Terms of Reference

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

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

Objectives

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

Specifically the work will include;

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

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

2.2 Limitations to Review

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

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

3.0 Methodology

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

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

3.1 Analysis of Documentary Evidence

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

Regional Documents:

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

Core SHSCT Documents/Evidence:

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

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

3.2 Meetings with internal stakeholders

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

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

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

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

4.0 Findings and Analysis

4.1 Governance Structures

4.1.1 Trust Board

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

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

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

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

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

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

4.1.2 Trust Board Meetings

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

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

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

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

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

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

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

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

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

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

4.1.3 Trust Board Committees

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

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

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

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

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

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

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

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

4.1.4 Audit Committee

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

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

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

4.1.5 Governance Committee

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

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

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

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

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

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

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

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

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

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

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

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

4.1.6 Patient and Client Experience Committee

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

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

4.1.7 Performance Management

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

4.1.8 Senior Management Team/Governance Management Board

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

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

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

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

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

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

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

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

4.1.9 Good Governance Structure: Trust Board Sub Committees

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

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

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

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

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

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

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

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

[12] Integrated Governance Framework 2017, Figure 2.

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

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

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

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

4.1.10 Committee Terms of Reference

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

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

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

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

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

4.2. Role of Board Secretary/Head of Office

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

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

4.3 Professional Executive Directors – roles and responsibilities

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

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

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

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

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

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

4.4 Integrated Governance

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

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

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

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

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

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

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

[17] DoH 'Integrated Governance Handbook' 2006.

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

4.5 Social Care Governance

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

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

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

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

4.6 Being Open

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

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

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

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

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

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

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

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

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

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

4.7 Controls Assurance

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

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

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

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

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

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

4.8 Risk Management Strategy

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

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

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

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

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

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

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

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

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

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

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

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

4.9 Risk Registers including Board Assurance Framework

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

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

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

4.9.1 Board Assurance Framework

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

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

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

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

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

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

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

4.9.2 Corporate Risk Register

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

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

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

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

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

4.9.3 Directorate Risk Registers

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

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

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

4.10 Management of Adverse Incidents including Serious Adverse Incidents

4.10.1 Management of Adverse Incidents

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

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

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

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

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

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

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

4.10.2 Serious Adverse Incidents

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

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

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

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

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

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

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

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

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

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

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

4.11 Health and Safety Management

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

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

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

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

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

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

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

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

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

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

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

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

4.12 Management of Complaints

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

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

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

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

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

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

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

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

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

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

4.13 Litigation Management

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

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

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

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

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

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

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

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

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

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

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

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

4.14 Policies, Standards and Guidelines

4.14.1 Policy Scrutiny Committee

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

4.14.2 Management of Standards and Guidelines

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.15 Clinical Audit

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.17 Raising Concerns

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

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

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

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

4.18 Information Governance

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

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

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

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

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

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

4.19 Emergency Planning and Business Continuity

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

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

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

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

4.20 Shared Learning for Improvement

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

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

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

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

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

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

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

4.21 Medical Leadership

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

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

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

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

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

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

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

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

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

4.22 Governance Information Management Systems

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

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

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

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

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

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

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

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

4.23 Integrated Governance Structures

4.23.1 Corporate Clinical and Social Care Governance, Medical Directorate

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.23.2 Directorate Governance Arrangements

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

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

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

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

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

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

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

4.23.3 Interface between Corporate C&SGC and Directorates

Weekly Governance Meeting

The Medical Director and Interim Assistant Director Clinical and Social Care Governance have reinstated a weekly Governance Meeting with Directorate Clinical and Social Care Governance Coordinators. The meetings are short, lasting approximately one hour. Currently, the Medical Director where possible, either attends the meeting or joins by teleconference. The Reviewer has been advised that the rationale is to provide an opportunity for both a briefing (e.g. learning and internal safety alerts) and debriefing on newly emerging issues e.g. serious adverse incidents or complaints. These meetings meet the spirit of 'no surprises'. The

meetings are currently held on a Thursday and members can currently 'dial in'. There is a mixed reaction to the weekly Governance meeting with stakeholders identifying that the 'dial in' facility is not conducive to debrief meetings. Stakeholders have also identified that due to the nature of Acute Services the agenda can, at times be described as Acute centric.

The interface meetings are an important development and will underpin the integrated governance arrangements of the Trust's assurance and accountability framework. It is important that this interface meeting continues and develops to meet the needs of all concerned. The Interim Assistant Director advised that the process was at an early stage and the agenda was still being tested and evolving. She further advised that maintaining the efficacy of the interface meetings had resulted in increased workload for both corporate and directorate clinical and social care governance teams. More recently, the membership has increased to include safeguarding, medicines management, litigation management and standards and guidelines and this addition was being positively evaluated.

The Trust has systems in place to brief the Board of Directors of emerging issues in a timely fashion. The output of this meeting will complement existing systems and should be further developed to provide a summary briefing note which when ratified by SMT can be circulated to the Chair and Non-Executive Directors. This will assist the Trust meet IHRD Recommendation 81 ~ *Trust's should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within he Trust are brought to the immediate attention or every Board member*.

It is recommended that the agenda, membership and timeliness of the weekly Governance Meeting is reviewed and terms of reference developed. The meetings should be kept as short briefing meetings and held face to face with members. There should be a short summary template report developed which can then be used as an internal communication to NEDs.

Monthly Clinical and Social Care Governance Meeting

The monthly governance meeting provides an opportunity to consider a wider range of integrated governance issues in more detail. In light of the weekly governance meeting, ***it is recommended that a review of the terms of reference including purpose, membership and frequency is undertaken.***

Appendices

Summary of Recommendations **Appendix 1**

Theme/ Rec No	Recommendation	Timescale[40]
Good Governance Structures – Board Governance		
1	The Trust Board should review the cycle of Trust Board Reports and the Board of Directors' public meeting agenda by April 2020. .	M
2	The Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director.	M
3	The Chair of the Governance Committee should be involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020	S
4	The clinical and social care key performance indicators should be further developed and submitted for approval through the Senior Management Team.	S
5	The SMT Terms of Reference should be reviewed including the provision for tabling urgent papers.	M
6	The remit and responsibilities of the SMT Governance Board should be reviewed and a separate Terms of Reference developed to include the purpose, membership and reporting lines to Trust Board via the Governance Committee of Trust Board. (See also Assurance & Accountability Framework proposals at Section 4 1.9). The role of the SMT Governance Board should also be clearly defined in the Integrated Governance Strategy.	M
7	The Trust Governance Structures should be reviewed and Trust Board Sub Committee/Oversight/Steering Groups constituted to which the various integrated governance steering groups, forum and committees will report and provide the organisation with a first level of assurance (see Appendix 2).	S-M
8	The Terms of Reference and annual work plans/action plans (where applicable) for Board Committees and Sub Committees should be held centrally.	M
9	Any short – medium term Director's Oversight Groups should be added to the Governance Structure (Integrated Assurance Framework) for the duration of their remit as 'Task and Finish Groups' e.g. IHRD Directors Oversight Group.	S

[40] Short Term (S) action within 3 months, Medium Term (M) action within 6 months, Long Term (L) action within 9-12 months.

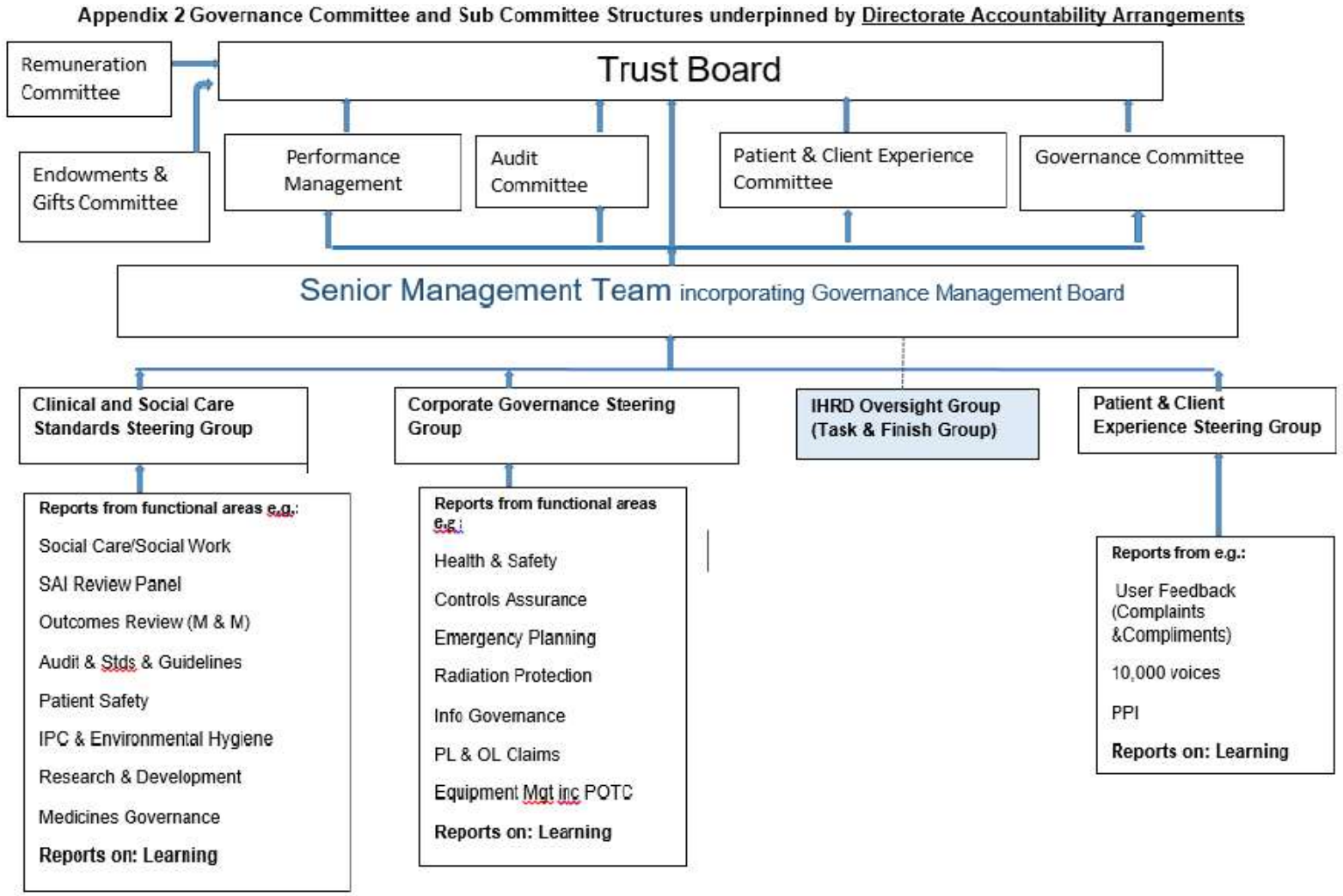
Theme/ Rec No	Recommendation	Timescale[40]
10	To ensure that all committees provide clarity in their terms of reference, delegated powers and reporting requirements the Trust should consider developing a standard template to define the terms of reference for all Board Sub Committees, Steering Groups and Advisory/Specialist Groups.	M
11	The Trust should consider introducing the role of Board Secretary/Head of Office to support the Trust Board and the Integrated Governance Framework.	M
12	The Integrated Governance Framework should be reviewed as a matter of urgency to ensure it provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Framework provides electronic links to key corporate Trust Strategies and Policies and extant guidance where applicable.	S
13	Arrangements for Adult Safeguarding should be reviewed to identify any potential risks/gaps in control or assurance in this area.	S
'Being Open'		
14	The Trust should consider the implications of implementing the Regional 'Being Open' framework which includes compliance with IHRD Recommendation 69 (i) ~ Trusts should appoint and train Executive Directors with specific responsibility for 'Issues of Candour'.	M
Controls Assurance		
15	The Trust should undertake an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation.	S-M
16	The Trust should develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards.	M-L
Risk Management Strategy		
17	The Draft Risk Management Strategy should be submitted for approval as a matter of urgency.	S
18	The Trust Board should consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register.	M
19	A risk management training programme should be developed and delivered to underpin the publication of the approved Risk Management Strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers	L

Theme/ Rec No	Recommendation	Timescale[40]
20	The management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy.	M-L
21	A standardised Directorate risk register template should be considered when Datix risk register module is implemented.	M
Management of Adverse Incidents including SAIs		
22	A Trust flow chart should be developed to underpin the Regional Adverse Incident Reporting Policy/Procedure (when disseminated) which accurately reflects local/ Trust roles and responsibilities especially at Executive Director level.	L
23	Corporate oversight of the management of adverse incidents should be strengthened to include a quality assurance component which will be dependent upon the resources and skills available within the Clinical and Social Care department (see Section 4.23.1)	S-M
24	The Trust should constitute an SAI Review Group and/or SAI Rapid Review Group [or similar] which should provide independent scrutiny and challenge to the SAI process including review of level of investigation, independence of review panel and approval of terms of reference when SAIs are initiated. In addition, the Review Group should oversee completed reports before submission to the HSCB. The Review Group should be chaired by the MD or his/her Deputy and will report to a Trust Board Sub Committee. The Review Group should meet on a four weekly basis initially.	S
25	The Trust should develop a database of SAI Review Panel Chairs who have undertaken SAI/Systems Analysis Training.	L
26	The Trust should develop an SAI RCA/Systems Analysis toolkit based on the training provided by external provider.	L
27	The Trust should consider developing the role of a Service User Liaison Officer [or similar] for engagement with families throughout the SAI process.	S
Management of Health & Safety		
28	The Trust Health and Safety Committee should review their Terms of Reference and submit to the relevant Board Sub Committee for approval.	S
29	The Trust should review and revise the existing H & S audit tool for use as outlined above in Recommendation 16.	M-L
30	The Trust should undertake an organisational audit of	M

Theme/ Rec No	Recommendation	Timescale[40]
	compliance with COSHH Regulations.	
Complaints Management		
31	The remit of the Corporate Complaints Officer should be reviewed in line with the extant Trust Complaints Management policy.	M
32	The current process of screening of complaints should be reviewed and parameters for alerts to be clearly defined to include alerts to professional Executive Directors	S-M
33	It is recommended that the Trust constitutes a Director's Oversight Complaints Review Group as a task and finish group to focus on reviewing Policy and Procedure and improving the management of complaints and experience of the service user. Membership should include a Non-Executive Director and/or a Service User(s).	M
Litigation Management		
34	The management of Legal Services should be reviewed in line with IHRD Recommendations 36, 51 and 52.	S-M
Policies, Standards and Clinical Guidelines		
35	The Trust should explore the options for an electronic policy and procedure management system that is accessible, easy to navigate, contains a search facility and includes the capacity for email notification of new/changed policy and automates a review/revise reminder.	L
36	The Corporate oversight of the management of Standards and Guidelines should be reinstated and the former Accountability (Compliance) reporting arrangements are also reinstated.	S
37	The Trust should further develop the Standards and Guidelines model developed within Acute Services and provide a central management system within the Corporate Clinical and Social Care Team under the leadership of the Medical Director.	
38	The Trust should review the Sub Committee Structure to include an oversight committee for the management of Standards and Guidelines either a full time committee or a Task and Finish Sub Committee (see also Recommendation 7).	M-L
Clinical Audit		
39	The 2018 Clinical Audit Strategy and Action Plan should be reviewed and updated.	S
40	The Clinical Audit Committee should be reinstated and	M-L

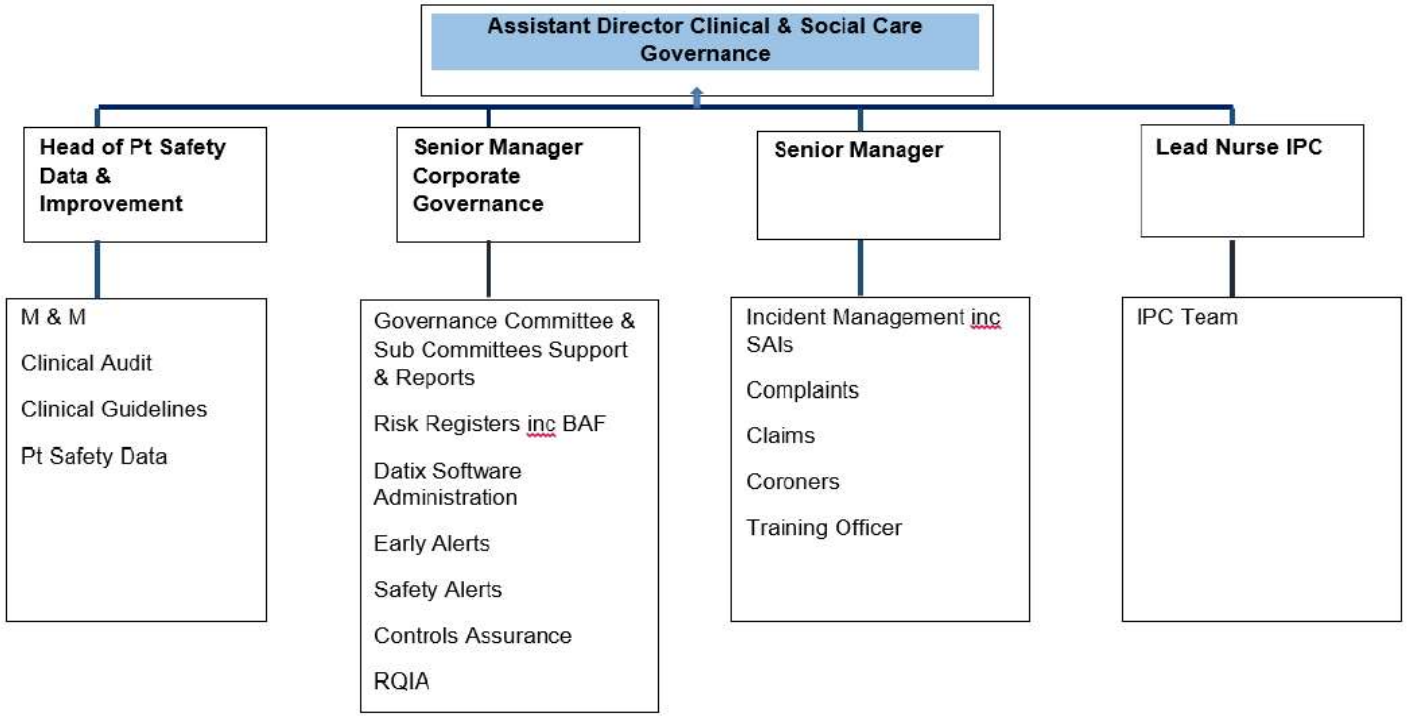
Theme/ Rec No	Recommendation	Timescale[40]
	the reporting arrangements considered in the review of the Trust Board Committee Structure Section 4.2.6 and Appendix 1.	
Morbidity & Mortality – link with Medical Leadership below		
41	The resource implications for the delivery of the RMMR should be considered in line with the proposals for the Medical Leadership model. (Section 4.21 Medical Leadership and Section 4. 23.1 Corporate Clinical and Social Care Governance Department).	S
42	The RMMR process should be adequately resourced and supported to ensure optimum outputs and clinical engagement. This includes the resources required within the Corporate Clinical and Social Care Clinical Audit team to ensure the development of administrative systems for the central suppository of minutes and attendance logs (see also Recommendation 44 and 45 below).	M
Shared Learning for Improvement		
43	The Trust should review the Terms of Reference, including membership, and strengthen the purpose of the Lessons Learned Forum.	S-M
Governance Information Management Systems (Datix)		
44	1) It is recommended that the Trust consider the information management systems and administrative support required to support the implementation of the Governance Review recommendations. 2) To ensure that the Trust maximises the potential for the use of patient safety software it is vital that a dedicated Datix systems administrator is appointed who can ensure the quality of data provided as this has been identified as a gap at present (see also Clinical and Social Care Governance Structures below).	M
Corporate Clinical and Social Care Governance Structures		
45	It is recommended that the Corporate Clinical and Social Care Governance team is re-structured and two additional Senior Manager posts are considered to provide leadership to related functional areas. It is further recommended that there is an urgent review of the Corporate Clinical & Social Care Governance structure and business case development for consideration by the SMT.	S
46	The Trust should ensure that the directorate governance reporting arrangements are included in a review of Trust Board Sub Committee Structure and the review of the SMT Terms of Reference as above	M
Corporate & Directorate CSCG Interface		

Theme/ Rec No	Recommendation	Timescale[40]
47	It is recommended that the agenda, membership and timeliness of the weekly Governance Meeting is reviewed and terms of reference developed. The meetings should be kept as short briefing meetings and held face to face with members. There should be a short summary template report developed which can then be used as an internal communication to NEDs.	S-M
48	In light of the weekly governance meeting, it is recommended that a review of the terms of reference including purpose, membership and frequency is undertaken.	M



Directorate Accountability Arrangements

Appendix 3 Corporate Clinical & Social Care Governance Department Structure reporting to Executive Medical Director



Theme/Rec No.	Recommendation	Progress at 9th June 2022
1	The Trust Board should review the cycle of Trust Board Reports and the Board of Directors' public meeting	Completed – Annual Cycle of Board reporting in place
2	The Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director.	Completed – Director of Finance, Procurement and Estates has been attending meetings since December 2018
3	The Chair of the Governance Committee should be involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020	Completed – Chair and Board Assurance Manager meet prior to each meeting to develop and agree agenda. Annual programme of reporting in place. Agreed by the Chair and approved by the Committee in November each year
4	The clinical and social care key performance indicators should be further developed and submitted for approval through the Senior Management Team.	Outstanding
5	The SMT Terms of Reference should be reviewed including the provision for tabling urgent papers	5 – 8 needs developed
6	The remit and responsibilities of the SMT Governance Board should be reviewed and a separate Terms of Reference developed to include the purpose, membership and reporting lines to Trust Board via the Governance Committee of Trust Board. (See also Assurance & Accountability Framework proposals at Section 4 1.9). The role of the SMT Governance Board should also be clearly defined in the Integrated Governance Strategy	

7	The Trust Governance Structures should be reviewed and Trust Board Sub Committee/Oversight/Steering Groups constituted to which the various integrated governance steering groups, forum and committees will report and provide the organisation with a first level of assurance (see Appendix 2).	
8	The Terms of Reference and annual work plans/action plans (where applicable) for Board Committees and Sub Committees should be held centrally.	
9	Any short – medium term Director's Oversight Groups should be added to the Governance Structure (Integrated Assurance Framework) for the duration of their remit as 'Task and Finish Groups' e.g. IHRD Directors Oversight Group.	Directors Oversight groups have been developed. Alignment of Terms of Reference is required.
10	To ensure that all committees provide clarity in their terms of reference, delegated powers and reporting requirements the Trust should consider developing a standard template to define the terms of reference for all Board Sub Committees, Steering Groups and Advisory/Specialist Groups.	Outstanding – all to be reviewed
11	The Trust should consider introducing the role of Board Secretary/Head of Office to support the Trust Board and the Integrated Governance Framework.	Outstanding – Chair and Chief Executive to further discuss
12	The Integrated Governance Framework should be reviewed as a matter of urgency to ensure it provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Framework provides electronic links to key corporate Trust Strategies and Policies and extant guidance where applicable.	Some progress has been made but significant work still to be done
13	Arrangements for Adult Safeguarding should be reviewed to identify any potential risks/gaps in control or assurance in this area.	Outstanding

14	The Trust should consider the implications of implementing the Regional 'Being Open' framework which includes compliance with IHRD Recommendation 69 (i) ~ Trusts should appoint and train Executive Directors with specific responsibility for 'Issues of Candour'.	Trust awaits the outcome of the Duty of Candour consultation
15	The Trust should undertake an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation.	BSO Internal Audit completed an audit of the Management of Medical Equipment in 2021/22 which resulted in Limited Assurance. Work underway to implement accepted recommendations
16	The Trust should develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards.	Risk assessment and Controls assurance separate. No underpinning of our scores. Suggest replacing Controls Assurance with Risk Assessment.
17	The Draft Risk Management Strategy should be submitted for approval as a matter of urgency.	Completed
18	The Trust Board should consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register.	Board workshop took place November 2021
19	A risk management training programme should be developed and delivered to underpin the publication of the approved Risk Management Strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers	A Senior Manager for Standards, Risk and Learning has been appointed. Has initially concentrated on the Standards & Guidelines aspect of her role. Recruitment is currently underway for support to develop Risk Management training
20	The management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy.	This would require a transfer of resource to the Medical Directorate. Chair and Chief Executive to further discuss

21	A standardised Directorate risk register template should be considered when Datix risk register module is implemented.	Datix upgrade has been completed. Datix Cloud will be considered as this may bring standardisation
22	A Trust flow chart should be developed to underpin the Regional Adverse Incident Reporting Policy/Procedure (when disseminated) which accurately reflects local/ Trust roles and responsibilities especially at Executive Director level.	This rests on this being managed corporately
23	Corporate oversight of the management of adverse incidents should be strengthened to include a quality assurance component which will be dependent upon the resources and skills available within the Clinical and Social Care department	This rests on this being managed corporately
24	The Trust should constitute an SAI Review Group and/or SAI Rapid Review Group [or similar] which should provide independent scrutiny and challenge to the SAI process including review of level of investigation, independence of review panel and approval of terms of reference when SAIs are initiated. In addition, the Review Group should oversee completed reports before submission to the HSCB. The Review Group should be chaired by the MD or his/her Deputy and will report to a Trust Board Sub Committee. The Review Group should meet on a four weekly basis initially.	This rests on this being managed corporately
25	The Trust should develop a database of SAI Review Panel Chairs who have undertaken SAI/Systems Analysis Training.	Currently being developed
26	The Trust should develop an SAI RCA/Systems Analysis toolkit based on the training provided by external provider.	This rests on this being managed corporately
27	The Trust should consider developing the role of a Service User Liaison Officer [or similar] for engagement with families throughout the SAI process	Completed – 2 currently in post; third appointed and due to commence shortly
28	The Trust Health and Safety Committee should review their Terms of Reference and submit to the relevant Board Sub Committee for approval.	Active consideration underway regarding overlap of H&S Committee with V&A Committee

CSCG
SMT 14th JUNE 2022

29	The Trust should review and revise the existing H & S audit tool for use as outlined above in Recommendation 16.	DoF to confirm
30	The Trust should undertake an organisational audit of compliance with COSHH regulations	DoF to confirm
31	The remit of the Corporate Complaints Officer should be reviewed in line with the extant Trust Complaints Management Policy	Complaints Management Policy being reviewed. Trust received a limited assurance audit report for the Management of Complaints. Workplan has been developed and is actively being monitored. Standardisation of Complaints Handling would assist in the development of the Complaints Officer role and enable greater oversight of the function Trustwide
32	The current process of screening of complaints should be reviewed and parameters for alerts to be clearly defined to include alerts to professional Executive Directors	Standardisation of Complaints Handling would assist this process
33	It is recommended that the Trust constitutes a Director's Oversight Complaints Review Group as a task and finish group to focus on reviewing Policy and Procedure and improving the management of complaints and experience of the service user. Membership should include a Non-Executive Director and/or a Service User(s).	Work is progressing on the Complaints Policy and Procedure. Group needs to be extended to include service user involvement and Non-Executive Director
34	The management of Legal Services should be reviewed in line with IHRD Recommendations 36, 51 and 52	Operating well as is
35	The Trust should explore the options for an electronic policy and procedure management system that is accessible, easy to navigate, contains a search facility and includes the capacity for email notification of new/changed policy and automates a review/revise reminder	Completed

36	The Corporate oversight of the management of Standards and Guidelines should be reinstated and the former Accountability (Compliance) reporting arrangements are also reinstated.	Completed
37	The Trust should further develop the Standards and Guidelines model developed within Acute Services and provide a central management system within the Corporate Clinical and Social Care Team under the leadership of the Medical Director.	Completed
38	The Trust should review the Sub Committee Structure to include an oversight committee for the management of Standards and Guidelines either a full time committee or a Task and Finish Sub Committee (see also Recommendation 7).	Management of Standards and Guidelines is reported directly to Governance Committee. An S&G group including governance coordinators also operates
39	The 2018 Clinical Audit Strategy and Action Plan should be reviewed and updated	Completed
40	The Clinical Audit Committee should be reinstated and the reporting arrangements considered in the review of the Trust Board Committee Structure Section 4.2.6 and Appendix 1	
41	The resource implications for the delivery of the RMMR should be considered in line with the proposals for the Medical Leadership model. (Section 4.21 Medical Leadership and Section 4. 23.1 Corporate Clinical and Social Care Governance Department).	
42	The RMMR process should be adequately resourced and supported to ensure optimum outputs and clinical engagement. This includes the resources required within the Corporate Clinical and Social Care Clinical Audit team to ensure the development of administrative systems for the central suppository of minutes and attendance logs (see also Recommendation 44 and 45 below)	Progressing

43	The Trust should review the Terms of Reference, including membership, and strengthen the purpose of the Lessons Learned Forum.	
44	1) It is recommended that the Trust consider the information management systems and administrative support required to support the implementation of the Governance Review recommendations. 2) To ensure that the Trust maximises the potential for the use of patient safety software it is vital that a dedicated Datix systems administrator is appointed who can ensure the quality of data provided as this has been identified as a gap at present (see also Clinical and Social Care Governance Structures below).	
45	It is recommended that the Corporate Clinical and Social Care Governance team is re-structured and two additional Senior Manager posts are considered to provide leadership to related functional areas. It is further recommended that there is an urgent review of the Corporate Clinical & Social Care Governance structure and business case development for consideration by the SMT.	
46	The Trust should ensure that the directorate governance reporting arrangements are included in a review of Trust Board Sub Committee Structure and the review of the SMT Terms of Reference as above	Links with proposed changes to governance structures
47	It is recommended that the agenda, membership and timeliness of the weekly Governance Meeting is reviewed and terms of reference developed. The meetings should be kept as short briefing meetings and held face to face with members. There should be a short summary template report developed which can then be used as an internal communication to NEDs.	
48	In light of the weekly governance meeting, it is recommended that a review of the terms of reference including purpose, membership and frequency is undertaken.	

Draft Response to the Clinical and Social Care Governance Review

Southern Health and Social Care Trust

Quality Care - for you, with you

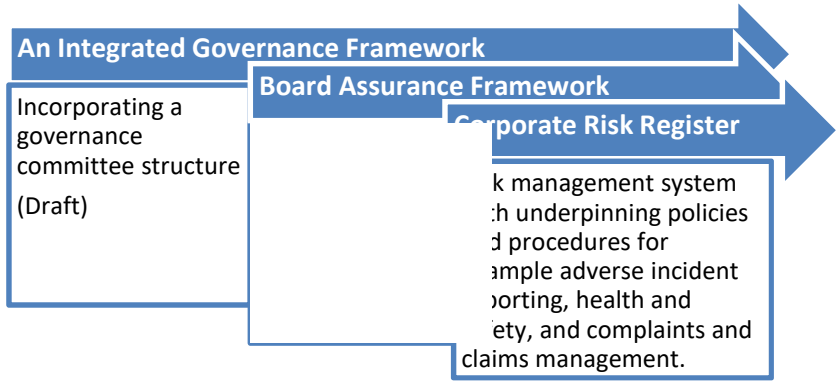
September 2019

Clinical and Social Care Governance Review – Draft August 2019

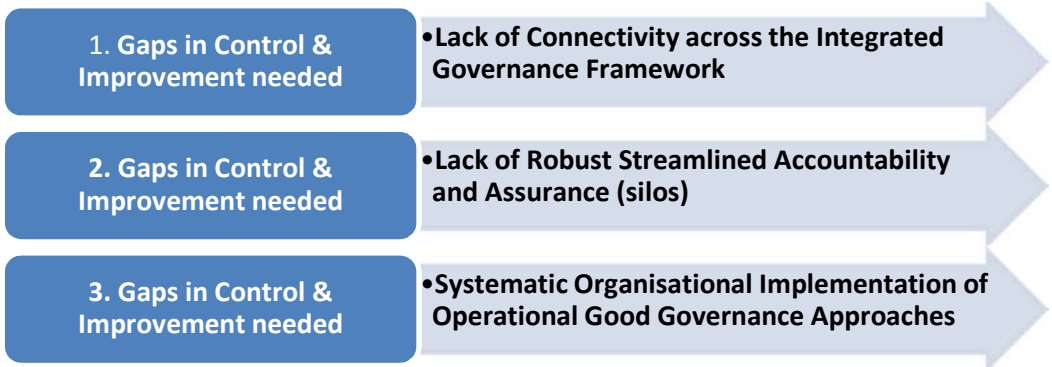
This draft response comprises of the response to the review report and recommendations (including areas not referenced in the review)

Executive Summary – Key Points (page 3)

- The Context: – Significant previous reviews[1] and of senior executive position turnover at Trust Board / SMT level.
- The review analysis has demonstrated that many of the building blocks for good integrated governance are already in place.



- The review however also identifies gaps in controls assurance and areas of improvement, making 48[2] recommendations across 12 review areas.



[1] 2010 implemented in 2013, re-visited in 2015, Draft IGF, 2017 and further 2019 review

[2] Recommendation on QI connectivity and IGF is noted in the clinical audit section, but not listed in Appendix 1.

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*Short Term (S) action within 3 months, Medium Term (M) action within 6 months, Long Term (L) action within 9-12 months.

Clinical and Social Care Governance Review – Draft August 2019

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Report Section No:	Review Extract & Response				
2.0 Scope 2.1 ToR & Objectives (page 5)	**Terms of Reference** The purpose of the review is to ensure the Trust has a robust governance structure and arrangements in place which offers assurance on patient safety and that help people learn. The Trust is seeking to undertake a comprehensive review of the current governance structure including the formulation of recommendations on what a **good structure** should look like; The Review will consider existing governance processes and particularly governance assurance, moving the Trust towards a position where there is a **whole governance approach** to the organisation rather than in two reporting lines. It will include a review of both clinical and social care governance.				
2.2 Limitations (page 5)	Given the breadth of the terms of reference and the timeframe allocated to complete this report **does not claim to provide an exhaustive or exclusive list of all potential gaps in controls or assurance at local level.** The Review is intended to be **an evaluation of the overarching integrated governance arrangements and related strategies, policies and procedures.**				
Draft Response to the Scope and Limitations	The limitations as clearly set out in the report mean that the review ToR and objectives **have not been fully met**. In this draft response to the review cognisance has taken that: 1. What a 'Good' structure would look like is not clearly evident and as a consequence what a 'whole' governance approach to the organisation (or options for achieving this) are not defined. 2. An analysis of the gaps in assurance of two reporting lines in comparison to any benefits of a re-structured whole governance approach (which integrates the current corporate C&CSG and operational functions) is absent. The 48 review recommendations which are responded to below need to be viewed in the context of these two significant deficits from the original objectives.				
4.0.	**Review Recommendations:**	**Draft**	**Improvement /**	**Dependency / Pre-Requisite**	**Priority**

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Findings & Analysis / Timescale *	Board Governance	Response Opinion Accepted / Not Accepted	Gap Identified		
1. M	The Trust Board should review the cycle of Trust Board Reports and the Board of Directors' public meeting agenda by April 2020.	Accepted	Improvement in accountability and assurance	Consideration given to linkages to existing and proposed committees	Completed – new schedule approved by TB on 29/08/2019
2. M	The Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director.	Accepted	Improvement in IGF connectivity and accountability and assurance	Not Applicable	Implemented
3. S	The Chair of the Governance Committee should be involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020	Accepted	Improvement in accountability and assurance	Proposed reporting cycle to be developed, including assurance indicators and agreed with safety science Director level training (as per IHRD)	High – delivery potential long term
4. S	The clinical and social care key performance indicators should be further developed and submitted for approval through the Senior Management Team.	Accepted	Improvement in accountability and assurance	-Strategy development through engagement -KPI development -Collation and analysis investment	High – delivery potential long term

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				-Audit and Quality Improvement programmes	
5. M	The SMT Terms of Reference should be reviewed.	Accepted	Improvement in accountability and assurance Improvement in IGF connectivity	SMT Workshop to review ToR for individual and collective responsibilities (pg. 13 4.2.5)	High
6. M	The remit and responsibilities of the SMT Governance Board should be reviewed and a separate Terms of Reference developed to include the purpose, membership and reporting lines to Trust Board via the Governance Committee of Trust Board. (See also Sub Committee Structure proposals at Section 4.2.6). The role of the SMT Governance Board should also be clearly defined in the Integrated Governance Strategy.	Accepted	Improvement in accountability and assurance	-ToR -Specification of the assurance reporting required. -Capacity (experts, admin support and ICT infrastructure) to support the information and assurance. -Could be included with SMT workshop (above)	High – delivery potential long term
7. S - M	The Trust Governance Structures should be reviewed and Trust Board Sub Committee/Oversight/Steering Groups constituted to which the various integrated governance steering groups, forum and committees will report and provide the organisation with a first level of assurance (see Appendix 2).	Accepted	Improvement in accountability and assurance Improvement in IGF connectivity	-ToR -Specification of the assurance reporting required. -Capacity (experts, admin support and ICT infrastructure) to support the information and assurance. -Trust Board Workshop	High – delivery potential long term
8.0 M	The Terms of Reference and annual work plans/action plans (where applicable) for Board Committees and Sub Committees	Accepted	Improvement in accountability and assurance	-ToR and annual work plans / action plans will require assurance (expert evaluated	High

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	should be held centrally.		Improvement in IGF connectivity	opinion) and administrative support to ensure that accurate and timely records can be held centrally.	
9. S	Any short – medium term Director's Oversight Groups should be added to the Governance Structure (Integrated Assurance Framework) for the duration of their remit as 'Task and Finish Groups' e.g. IHRD Directors Oversight Group.	Accepted	Improvement in accountability and assurance Improvement in IGF connectivity	Any short term group requires: -ToR -Specification of the assurance reporting required. -Capacity (experts, admin support and ICT infrastructure) to support the information and assurance.	High
10. M	To ensure that all committees provide clarity in their terms of reference, delegated powers and reporting requirements the Trust should consider developing a standard template to define the terms of reference for all Board Sub Committees, Steering Groups and Advisory/Specialist Groups.	Accepted	Improvement in accountability and assurance	Engagement in template development and implementation and centralisation.	High
11. M	The Trust should consider introducing the role of Board Secretary/Head of Office to support the Trust Board and the Integrated Governance Framework.	For further consideration			Office of Chief Executive
12. S	The Integrated Governance Framework should be reviewed as a matter of urgency to ensure it provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Framework provides electronic links to	Accepted	Improvement in accountability and assurance Improvement in IGF connectivity	The review does not consider the investment required to undertake an urgent review of the integrated governance framework. This would include:	High

*Short Term (S) action within 3 months, Medium Term (M) action within 6 months, Long Term (L) action within 9-12 months.

	key corporate Trust Strategies and Policies and extant guidance where applicable.			Systems and structures to deliver integrated governance, processes and behaviours. The timescale suggested is therefore likely to be independent of these considerations. This urgent review however would be essential to help remedy the limitations identified under section 2.0 (pg2.0)	
13. S	Arrangements for Adult Safeguarding should be reviewed to identify any potential risks/gaps in control or assurance in this area.	Accepted	Improvement in accountability and assurance	-Develop methodology / approach to gap identification -Cross directorate stakeholder engagement	
Summary of Section & Potential Weakness 1.0 – 11.0	These 11 recommendations all relate to Trust Board, Board Sub-Committee and SMT structures, meetings and procedures. - The ToR and annual work plans / action plans will require assurance (expert evaluated opinion) and administrative support to ensure that accurate and timely records can be held centrally. - The assurance information provided needs to be of the required quality and standard. As per IHRD recommendation 80, HSCTS are required to ensure that healthcare data is expertly analysed for poor performance and issues of patient safety. Sufficient time is required on TB agenda and sub-committee agendas to allow the TB to carry out it's effectiveness function for Governance / Risk scrutiny by Directors. - The report does not reflect the requirements of reporting and information gathering and expert analysis that would be required to adequately service the SMT Governance Board. - The report recommends two new steering Groups – Clinical and Social Care Standards and Corporate Governance Standards Group. - The report recommends 17 sub-groups to these steering groups (existing and new) However no consideration is outlined in the review as to the requirements of reporting and information gathering and analysis that would be required to adequately service these sub-groups, steering groups through to SMT Governance Board				

*Short Term (S) action within 3 months, Medium Term (M) action within 6 months, Long Term (L) action within 9-12 months.

	- Whilst all these recommendations contain as aspect of 'housekeeping' which is in addition to the key function of assurance. Robust housekeeping arrangements for Trust Board and delegated sub-committees and SMT will require support streamlined terms of reference, administration and central repository - Recommendation 11 requires the investment and the development of job role and function on which other recommendations would be reliant.
12.	The review does not consider the investment required to undertake an urgent review of the integrated governance framework. (Integrated Governance is defined as: "The systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community and partner organisations." (Integrated Governance Handbook, Department of Health February 2006). This would include an appraisal of the systems and structures to deliver integrated governance, processes and behaviours. The timescale suggested is therefore likely to be independent of these considerations. The recommendation of an urgent review however **would be essential to help remedy the limitations identified under section 2.0, page 2 of this draft response.**
13.	This recommendation would lead to improvement in systematic approaches to cross directorate governance. However the report stops short of describing the methodology / approach that would be required to identify potential risks and gaps in control or assurance in ASG to take this recommendation forward within the 3 month timescale. Underpinning these recommendations is the requirement for Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)

4.0. Findings & Analysis / Timescale	**Review Recommendation:** **Being Open**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
14. M	The Trust should consider the training implications of implementing the 'Being Open' framework which includes	Accepted	Systematic Improvement in	Regional 'Being Open'	High

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	compliance with IHRD Recommendation 69 (i) ~ Trusts should appoint and train Executive Directors with specific responsibility for 'Issues of Candour'.		cross-directorate approaches	Guidance	
Potential Weakness	- The report refers to both the development of the 'Being Open' Framework and the Training requirements for Being Open. However the recommendation deals only with the training implications. - The framework development is both dependent on the regional working group and local implementation structures to progress to final implementation. Our current plans are to develop an interim solution and the review does not outline the resourcing required to bring this recommendation to full implementation				
4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Controls Assurance**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
15. S-M	The Trust should undertake an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation.	For further consideration			Finance, Procurement & Estates Directorate
16. M-L	The Trust should develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards.	For further consideration			Finance, Procurement & Estates Directorate
4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Risk Management Strategy**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
17. S	The Draft Risk Management Strategy should be submitted for approval as a matter of urgency.	Accepted	Improvement in accountability and assurance	See potential weakness section below	High
18. M	The Trust Board should consider the application of the	Accepted	Improvement in	See potential	

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	Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register.		accountability and assurance	weakness section below	
19. L	A risk management training programme should be developed and delivered to underpin the publication of the approved Risk Management Strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers	Accepted	Improvement in accountability and assurance	See potential weakness section below	
20. M-L	The management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy.	Accepted	Improvement in accountability and assurance	See potential weakness section below	
21. M	A standardised Directorate risk register template should be considered when Datix risk register module is implemented.	Accepted	Improvement in accountability and assurance	See potential weakness section below	
Potential Weakness	- Whilst these 5 recommendations reflect the elements necessary to implement the risk management strategy they do not consider the pre-requisite resource aspects required to deliver upon them. The training cost, release of staff time, investment in Datix, as the risk management system and required supporting staff. - The review of the integrated governance framework (recommendation 12) would need to examine the linkages for operationally and corporately reporting assurance on risk. - The report does not reflect how the Board Assurance Framework and Corporate Risk Register integrate. - The housekeeping nature of recommendation 5 will require engagement across directorates for template design and system development, otherwise the opportunity for standardisation will not be realised. - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)				
4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Management of Adverse Incidents including SAIs**	**Draft Response Opinion Accepted /**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**

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		Not Accepted			
22. L	A Trust flow chart should be developed to underpin the Regional Adverse Incident Reporting Policy/Procedure (when disseminated) which accurately reflects local/ Trust roles and responsibilities especially at Executive Director level.	Accepted	Improvement in accountability and assurance	Regional process agreement and dissemination	High
23 S-M	Corporate oversight of the management of adverse incidents should be strengthened to include a quality assurance component which will be dependent upon the resources and skills available within the Clinical and Social Care department (see Section 4.23.1)	Accepted	Improvement in accountability and assurance	-Datix investment -Datix Team -Training -Reporting specification	High
24 S	The Trust should constitute an SAI Review Group and/or SAI Rapid Review Group [or similar] which should provide independent scrutiny and challenge to the SAI process including review of level of investigation, independence of review panel and approval of terms of reference when SAIs are initiated. In addition, the Review Group should oversee completed reports before submission to the HSCB. The Review Group should be chaired by the MD or his/her Deputy and will report to a Trust Board Sub Committee. The Review Group should meet on a four weekly basis initially.	Accepted	Improvement in accountability and assurance	- ToR -Specification of the assurance reporting required. -Capacity (SAI experts, admin support and ICT infrastructure) to support the information and assurance.	High
25 L	The Trust should develop a database of SAI Review Panel Chairs who have undertaken SAI/Systems Analysis Training.	Accepted	Improvement in accountability and assurance	-ICT investment	High
26 L	The Trust should develop an SAI RCA/Systems Analysis toolkit based on the training provided by external provider.	Accepted	Improvement in accountability and assurance	-Training resourcing	High
27 S	The Trust should consider developing the role of a Service User Liaison Officer [or similar] for engagement with families throughout the SAI process.	Accepted	Improvement in accountability and assurance	-Role development, funding, recruitment and training.	High

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Potential Weakness	-These 6 recommendations will require significant additional training costs in SAI, RCA, and Human Factors, release of staff time, investment in IT support. -No consideration is outlined in the review as to the requirements of reporting and information gathering and analysis that would be required to adequately service the AI oversight function and SAI Rapid Review Group with pre-requisites of ToR, clinical engagement, specification of the assurance reporting required, capacity (i.e. the experts, admin support and ICT infrastructure) to support the information and assurance. -The implementation of these recommendations will be influenced by the 21 IHRD recommendations relating to SAI including family engagement etc. - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)

4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Management of Health & Safety**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
28. S	The Trust Health and Safety Committee should review their Terms of Reference and submit to the relevant Board Sub Committee for approval.	For further consideration			Finance, Procurement & Estates Directorate
29. M-L	The Trust should review and revise the existing H & S audit tool for use as outlined above in Recommendation 16.	For further consideration			Finance, Procurement & Estates Directorate
30. M	The Trust should undertake an organisational audit of compliance with COSHH Regulations.	For further consideration			Finance, Procurement & Estates Directorate
4.0. Findings & Analysis /	**Review Recommendations:** **Complaints Management**	**Draft Response Opinion Accepted / Not**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**

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Clinical and Social Care Governance Review – Draft August 2019

This draft response comprises of the response to the review report and recommendations (including areas not referenced in the review)

Timescale		Accepted			
31. M	The remit of the Corporate Complaints Officer should be reviewed in line with the extant Trust Complaints Management policy.	Accepted	Systematic Improvement in cross-directorate approaches	See potential weakness section below	High
32. S-M	The current process of screening of complaints should be reviewed and parameters for alerts to be clearly defined to include alerts to professional Executive Directors	Accepted	Systematic Improvement in cross-directorate approaches	See potential weakness section below	High
33. M	It is recommended that the Trust constitutes a Director's Oversight Complaints Review Group as a task and finish group to focus on reviewing Policy and Procedure and improving the management of complaints and experience of the service user. Membership should include a Non-Executive Director and/or a Service User(s).	Accepted	Systematic Improvement in cross-directorate approaches	See potential weakness section below	High
Potential Weakness	-These 3 recommendations will require significant additional investment in what 'Good' complaints management and alert systems would require in terms of engagement with stakeholder groups of staff, service user and families and external agencies. -No consideration is outlined in the review as to the requirements of reporting and information gathering and analysis that would be required to adequately service the Director's oversight complaints review group, with pre-requisites of ToR, PPI engagement, training requirements and the specification of the assurance reporting required, capacity (i.e. the experts, admin support and ICT infrastructure) to support the information and assurance. -Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)				

4.0. Findings & Analysis / Timescale	**Review Recommendation:** **Litigation Management**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
34. S-M	The management of Legal Services should transfer to the Corporate Clinical and Social Care Governance team,	Not Accepted	IHRD recommendation No.	Not Applicable	Not Applicable

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Clinical and Social Care Governance Review – Draft August 2019

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	Medical Directorate.		36		
4.0. Findings & Analysis / Timescale	**Policies, Standards and Clinical Guidelines**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
35. L	The Trust should explore the options for an electronic policy and procedure management system that is accessible, easy to navigate, contains a search facility and includes the capacity for email notification of new/changed policy and automates a review/revise reminder.	Accepted	Improvement in accountability and assurance, IGR connectivity and systematic improvement in cross directorate approaches	-system investment, support and training	High
36. S	The Corporate oversight of the management of Standards and Guidelines should be reinstated and the former Accountability (Compliance) reporting arrangements are also reinstated.	Accepted	Improvement in accountability and assurance, IGR connectivity and systematic improvement in cross directorate approaches	See potential weakness section below	High
37.	The Trust should further develop the Standards and Guidelines model developed within Acute Services and provide a central management system within the Corporate Clinical and Social Care Team under the leadership of the Medical Director.	Accepted	Improvement in accountability and assurance, IGR connectivity and systematic improvement in cross directorate approaches	See potential weakness section below	High

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Clinical and Social Care Governance Review – Draft August 2019

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38. M-L	The Trust should review the Sub Committee Structure to include an oversight committee for the management of Standards and Guidelines either a full time committee or a Task and Finish Sub Committee (see also Recommendation 7).	Accepted	Improvement in accountability and assurance, IGR connectivity and systematic improvement in cross directorate approaches	See potential weakness section below	High
Potential Weakness	- The oversight of Standards and Guidelines management requires significant additional investment in ICT systems, trained personnel, release of clinician time (change lead) and assurance mechanisms for receipt, allocation, dissemination, implementation and audit above the current baseline of S & G investment. - IHRD recommendations nos. 57, 77 & 78 reference standards and guidelines and the connectedness to publication and audit of standards to provide assurance of implementation. - S&G oversight committee will have pre-requisites of ToR, clinical engagement, specification of the assurance reporting required, capacity (i.e. the experts, admin support and ICT infrastructure) to support the information and assurance. - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)				
4.0. Findings & Analysis / Timescale	**Clinical Audit**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
39. S	The 2018 Clinical Audit Strategy and Action Plan should be reviewed and updated.	Accepted	Improvement in accountability and assurance	See potential weakness section below	High
40. M-L	The Clinical Audit Committee should be reinstated and the reporting arrangements considered in the review of the Trust Board Committee Structure Section 4.2.6 and Appendix 1.	Accepted	Improvement in accountability and assurance	See potential weakness section below	High
Potential Weakness	- Page 10 of the review 'assurance', defined as: "an evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework". The function of clinical audit is required to provide an evaluated				

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	opinion, with recommendations driving learning and improvement processes in safety and quality. The assurance information provided by clinical audit needs to be of the required quality and standard and performed systematically across the organisation and supporting the necessary multi-disciplinary involvement. The resourcing and form of this function or options for it are not described or benchmarked to undertake national and local studies, and assurance of the implementation of audit recommendations including NCEPOD. - The review does not reference the organisation's governance, risk management and internal control framework for RQIA inspections, audit and assurances regarding implementation of recommendations. - The increasing assurance role for audit in IHRD recommendations is referenced (19, 40, 48, 76, 78 and 90), but its significant resource implications for staffing and training are not defined. - **Although not contained in appendix 1 - the review does recommend that the integration between quality improvement and the integrated governance function is reviewed to ensure optimum connectivity.** - Clinical audit committee re-instatement has pre-requisites of ToR, clinical engagement, specification of the assurance reporting required, capacity (i.e. the experts, admin support and ICT infrastructure) to support the information and assurance. - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)				
4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Morbidity & Mortality**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
41. S	The resource implications for the delivery of the RMMR should be considered in line with the proposals for the Medical Leadership model. (Section 4.21 Medical Leadership and Section 4. 23.1 Corporate Clinical and Social Care Governance Department).	Accepted	Improvement in accountability and assurance Improvement in IGF connectivity	See potential weakness section below	High
42. M	The RMMR process should be adequately resourced and supported to ensure optimum outputs and clinical engagement. This includes the resources required within the Corporate Clinical and Social Care Clinical Audit team to ensure the development of administrative	Accepted	Improvement in accountability and assurance Improvement in IGF	See potential weakness section below	High

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	systems for the central suppository of minutes and attendance logs (see also Recommendation 44 and 45 below).		connectivity		
Potential Weakness	- The review acknowledges that adequate resourcing is required to optimise the learning outputs from M&M forums. This will require an exercise to benchmark against other models of M&M facilitation and embedding learning, as well as the assurance function to be provided by the Oversight Group on the systematic review of all deaths. - The review does not reference a requirement for an additional level of objective review of mortality and morbidity cases which is currently being considered regionally and has implications for clinician review time, training and ICT infrastructure to aggregate themes across an organisational system. - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)				
4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Shared Learning for Improvement**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
43. S-M	The Trust should review the Terms of Reference, including membership, and strengthen the purpose of the Lessons Learned Forum.	Partially accepted	Systematic Improvement in cross-directorate approaches Improve Connectivity across the Integrated Governance Framework	See potential weakness below	High
Potential Weakness	The review does not reflect the elements and pre-requisites necessary for the sharing and implementation of 'lessons learned' systematically across the organisation and supporting the necessary multi-disciplinary involvement.				

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	- The resourcing and form of this function or options for it are not described - The implementation of this recommendations will be influenced by the 6 IHRD recommendations which refer to 'learning' including clinician being afforded time to consider and assimilate learning and feedback from SAI investigations within contracted hours and Director level training - The lessons learned forum will have pre-requisites of clinical engagement to review the ToR, specification of the assurance reporting required, capacity (i.e. the experts, admin support, ICT infrastructure) to support the information and assurance. - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)				
4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Governance Information Management Systems (Datix)**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
44. S-M	To ensure that the Trust maximises the potential for the use of patient safety software it is vital that a dedicated Datix systems administrator is appointed who can ensure the quality of data provided as this has been identified as a gap at present (see also Clinical and Social Care Governance Structures below).	Accepted	Improvement in accountability and assurance	Engagement, specification of the assurance reporting required, capacity (i.e. the experts, admin support and Datix and other IT infrastructure investment) to support the information and	High

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				assurance.	
Potential Weakness	The review acknowledges that adequate resourcing is required to optimise the potential for the use of patient safety software. Pre-requisites. - Specification of the assurance reporting required and capacity (experts in data and safety science, admin support and ICT infrastructure) to support the information and assurance. - Data collection and reporting infrastructure (Datix, QlikView etc.) - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)				
4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Corporate Clinical and Social Care Governance Structures**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**PriorityH**
45. S	It is recommended that the Corporate Clinical and Social Care Governance team is re-structured and two additional Senior Manager posts are considered to provide leadership to related functional areas. Therefore, it is further recommended that there is an urgent review of the administrative resources and business case development.	**Partially accept**	Improvement in accountability and assurance Improvement in IGF connectivity	See potential weakness below	**High**
46. M	The Trust should ensure that the directorate governance reporting arrangements are included in a review of Trust Board Sub Committee Structure and the review of the SMT Terms of Reference as above	Accepted	Improvement in accountability and assurance Improvement in IGF connectivity	See potential weakness below	**High**
Potential Weakness	- The review does not describe what a 'Good' structure would look like and as a consequence what a 'whole' governance approach to the organisation (or options for achieving this) is not defined. The review does not reference the requirement for robust safety measurement, indicators or expertise to provide assurance.				

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	Prerequisites include - A review of the integrated governance framework. This would include an appraisal of the systems and structures to deliver integrated governance, processes and behaviours. The timescale suggested is therefore likely to be independent of these considerations. However this **would be essential to help remedy the limitations identified under section 2.0, page 2 of this draft response.** This will allow for triangulation of information and assurance. The review does not consider the investment required to undertake such a review. - Specification of the assurance reporting required and capacity (experts, admin support and ICT infrastructure) to support the information and assurance. - Engagement and development of ToR. This could be included with SMT workshop (above) - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs) are not described in the review				
4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Corporate & Directorate CSCG Interface**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
47. S-M	It is recommended that the agenda, membership and timeliness of the weekly Governance Meeting is reviewed and terms of reference developed. The meetings should be kept as short briefing meetings and held face to face with members. There should be a short summary template report developed which can then be used as an internal communication to NEDs.	**Accepted**	Improvement in accountability and assurance Improvement in IGF connectivity	See potential weakness below	**High**
48. M	Monthly Clinical and Social Care Governance Meeting -In light of the weekly governance meeting, it is recommended that a review of the terms of reference including purpose, membership and frequency is undertaken.	**Accepted**	Improvement in accountability and assurance Improvement in IGF connectivity	See potential weakness below	**High**
Potential	The review acknowledges that there are existing systems in place which should be further developed to provide a briefing summary to				

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Weakness	SMT, the Chair and Non-Executive Directors, however does not reflect the pre-requisites required to support the information and assurance Pre-requisites - A review of the integrated governance framework. This would include an appraisal of the systems and structures to deliver integrated governance, processes and behaviours. The timescale suggested is therefore likely to be independent of these considerations. However this **would be essential to help remedy the limitations identified under section 2.0, page 2 of this draft response.** The review does not consider the investment required to undertake such a review - ToR, engagement, specification of the assurance reporting required, capacity (i.e. the experts, admin support and ICT infrastructure) to support the information and assurance - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs) are not described in the review

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Southern Health and Social Care Trust

Quality Care - for you, with you

Corporate Clinical & So

Co-Ordinator Band 8b

Working together Excellence Openness & Honesty Compassion

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JOB DESCRIPTION

JOB TITLE :	Corporate Clinical & Social Care Governance (CCSCG) Co-Ordinator
BAND	8b
DIRECTORATE	Medical Directorate
INITIAL LOCATION	Trustwide
REPORTS TO	Assistant Director of Clinical & Social Care Governance (ADCSCG)
ACCOUNTABLE TO	Medical Director

JOB SUMMARY

The post holder will have responsibility for driving forward and coordinating all aspects of the Trust CSCG agenda on behalf of, the Medical Director and the Assistant Director Clinical and Social Care Governance. They will provide Trustwide oversight of the prioritisation, linking, implementation and review and monitoring of both the operational and professional governance agenda for the Directorate.

The post holder will, on behalf of the ADCSCG, provide a key challenge function to the service teams within the Directorate to ensure that areas where performance improvement in relation to CSCG is required are identified and addressed. They will contribute to developing corporate and operational strategy, policy and decision making within the Trust. They will be responsible for advising on and actively participating in planning, delivering, reviewing and monitoring Corporate CSCG plans and will act as a focal point for the Medical Director and the Trust's AD CSCG in respect of any issues relating to the development, implementation, performance management and assurance of CSCG plans, systems and procedures and their associated improvement plans.

The post holder will provide enhanced CSCG support and performance improvement expertise and intervention in this area Trustwide where required. They will provide their Directorate and the organisation with a suite of intelligent information analyses which demonstrate real time performance in relation to all areas of CSCG, including Incidents, Complaints, Risk, Litigation, Audit, Clinical Indicators and Patient Safety, and Service User, Carer and Staff feedback. The post holder will also be required, in collaboration with the Trust Senior Management Team and the Trust CSCG Senior Manager, to develop

the organisation's capacity for continuous improvement in the area of CSCG and to facilitate a culture of openness and learning from experience using dynamic, collaborative and compassionate leadership and facilitation skills.

KEY DUTIES / RESPONSIBILITIES

1. On behalf of the Medical Director, to take the lead within the Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and are providing timely assurance and alerts to both the Medical Director and the organisation.

2. Lead on ensuring that at each level of the Medical Directorate, staff have access to timely, high quality and appropriate information in relation to incidents, complaints, audit, clinical indicators, litigation and risk.

3. To provide support and guidance to Directorate governance teams to support timely and appropriate responses to both incidents and complaints and to ensure standards of response times and patient / client satisfaction in the complaints process is maintained. This will include providing to directorate teams through:

    - Support and guidance of reviews in progress
    - Support for teams conducting reviews to advise on review technical issues
    - Provision of corporate tracking of review progress
    - Provision of bespoke training / guidance to local teams in the conduct of review elements including where appropriate, systems analysis, root cause analysis, human factors training
    - Provision of guidance to assist with the coordination of cross directorate / cross Trust or interagency reviews
    - Provision of guidance for developing recommendations in response to incident review findings
    - Provision of guidance and support to assist with the consolidation of themed recommendations across services and directorates
    - Development and use of Structured Clinical Reviews as appropriate
    - Development of an overarching Patient Safety approach to embedding learning from Serious Adverse Incidents
    - Measurement of impact of lessons learned from SAIs

4. To ensure that strong links are maintained between Directorates and corporate functions such as complaints, the management of SAI's and litigation.

5. Represent the Medical Director at directorate governance meetings providing a challenge and scrutiny function of governance information including reviews of serious adverse incidents to ensure that a consistently high standard of review and report writing is maintained at all times.

6. Provide project management leadership when required in relation to implementation of new Trustwide systems and processes related to CSCG. Identify any constraints, including resources, to implementation in a timely way and immediately report this to the Medical Director and AD CSCG.

7. Use expert analytical skills to interpret the broad range of performance information and other data, including internal and external benchmarking, to identify service and Trust trends, exceptions, risks and alerts in relation to CSCG issues and to present these in an appropriate format to the AD CSCG and Medical Director.

8. Lead on provision of specialist clinical governance and risk management knowledge and expertise to sensitively and constructively challenge and assist directorate teams in diagnosing and addressing the complex issues and factors which are preventing them maximizing their CSCG performance in relation to patient and client quality care and safety.

9. Lead on provision of specialist expertise to all Trust Directorates and their senior managerial and clinical staff in relation to the management of incidents and complaints requiring detailed analysis and significant learning.

10. Provide expert advice and knowledge to all Trust Directorates in relation to the concepts of risk management and mitigation and ensure that the proactive manages risk at all levels of service on a continuous basis.

11. Develop and foster excellent working relationships with service teams at all levels of the Trust based on confidentiality and trust to enable and foster an organisational culture of openness in relation to patient and client care.

12. Hold the other members of governance teams to account in relation to the successful delivery of all aspects of CSCG across all Directorates.

13. On behalf of the Director take the lead on ensuring good communication and clear lines of accountability relating to operational and professional CSCG.

14. Lead on the provision of appropriate training in all aspects of CSCG for Trust staff including topics of Being Open, Risk Management, Complaints and Conducting Reviews.

15. Develop and maintain strong networks with organisational, regional and national CSCG colleagues, keeping up to date with latest thinking and developments and bring this intelligence back to the organisation to inform and drive improvement.

Organisational Responsibilities

1. On behalf of the Medical Director lead on the provision of key Trust information and data in a timely and appropriate format to the organisation which provides corporate assurance that both the operational and professional aspects of CSCG are of a sufficiently high standard.

2. Lead as appropriate, on the development, implementation and audit of organisational wide CSCG policies and procedures.

3. Work collaboratively with the Trust's Corporate AD CSCG to ensure that there is a clear, two way line of communication from each Operational Director, SMT Governance and Trust Governance Committees.

4. Act as one of a small number of experts in CSCG who advise the Trust, via the CSCG working body, on organisational, regional and national policies, their organisational implications and potential implementation plans / methodologies.

5. Take the lead in planning and implementation of Trust wide policies and procedures as required via the CSCG working body and actively bring forward strategic plans for driving forward the CSCG agenda within the Southern Trust and influencing and shaping this agenda regionally.

6. Ensure through providing robust monitoring arrangements, that at all times the Directorate is complying with and operating within the CSCG policies, procedures and standards that the Trust has agreed. Where monitoring indicates any exception or deviation this must first be brought to the attention of the Medical Director.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

1. Line manage the team of professional and administrative governance support staff within the Directorate.

2. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

3. Maintain staff relationships and morale amongst the staff reporting to him/her.

4. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend 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. Manage the budget allocated to the Corporate Governance Team, including approval of team members travel and related expenses.

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

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

The Trust supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.
2. Ensure access to skills and personal development through appropriate training and support.
3. Promote a culture of openness and honesty to enable shared learning.
4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.
5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

INFORMATION MANAGEMENT

1. Ensure the effective implementation of all Trust information management policies and procedures by the team.

2. Ensure the systems and procedures for the management and storage of information by the Corporate Governance team meet internal and external reporting requirements.

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy

- IT Security Policy and Code of Conduct
- standards of attendance, appearance and behaviour

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

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

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

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

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

9. 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 Band may be assigned from time to time.

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

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

17 May 2021

Southern Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE AND BAND Corporate Clinical & Social Care Governance (CSCG) Co-ordinator 8b

DEPARTMENT / DIRECTORATE Medical Directorate

HOURS Full Time

Ref No: <to be inserted by HR> **May 2021**

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA

SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Experience	1. Have delivered against challenging performance management programmes for a minimum of 2 years meeting a full range of key targets and making significant improvements. 2. Have worked with a diverse range of stakeholders, both internal and external	Shortlisting by Application Form

	to the organisation, to achieve successful outcomes for a minimum of 2 years. 3. Have successfully demonstrated high level strategic and people management, and organisational skills for a minimum of 2 years.	
Qualifications/ Registration	University Degree or a relevant[1] professional qualification AND 4 years' experience as a Band 7 or above in a major complex organisation with responsibilities for aspects of risk management and governance.	Shortlisting by Application Form
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.*	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities/ Knowledge	1. Have good communication skills (written, oral, presentational and interpersonal) with the ability to communicate effectively with all levels of staff. 2. Evidence of highly effective planning and organisational skills. 3. Demonstrate the ability to assess risk and problem-solve based on excellent analytical skills. 4. A good level of computer literacy	Interview / Test

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

	5. Demonstrate the ability to write clear and concise reports related to complex subject matter.	

DESIRABLE CRITERIA		
SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted		
Factor	**Criteria**	**Method of Assessment**
Experience	Experience of statistical analysis	Shortlisting by Application Form

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

Quality Care - for you, with you

ue	What does this mean?	What does this look like in practice? - Behaviours
W king Together	ether for the best outcome for people we upport. We work across Health and Social ith other external organisations and ecognising that leadership is the ty of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
ompassion	itive, caring, respectful and understanding se we care for and support and our We listen carefully to others to better and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	o being the best we can be in our work, prove and develop services to achieve nges. We deliver safe, high-quality, e care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
ess & Honest	nd honest with each other and act with ndour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

Southern Health and Social Care Trust

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Head of Patient Safety Data and Improvement

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	Head of Patient Safety Data and Improvement
BAND	8B
DIRECTORATE	Medical Directorate
INITIAL LOCATION	Beechfield House, Craigavon Area Hospital in the first instance
REPORTS TO	Assistant Director Clinical and Social Care Governance
ACCOUNTABLE TO	Medical Director

JOB SUMMARY

The post holder will be responsible for the development, implementation and maintenance of systems and processes which enable the provision of accurate Patient Safety data and its use in driving improved outcomes for service users. He/she will lead the development and implementation of the Trust's Patient Safety Strategy. He/she will have responsibility for service development including the practical implementation of strategic plans, policies and procedures. He/she will be the organisational senior manager in respect of the services under his/her remit. The Head of Service – Patient Safety Data and Improvement will provide strong professional leadership and manage and develop the Trust's Patient Safety Data and Improvement portfolio to enable the quality of care to be monitored and improved. He/she will promote the development of a culture that values quality, accessible information as a key corporate resource and be capable of working independently to persuade, motivate and negotiate with management and staff of all grades, both internal and external to the Trust.

The role will focus on safety, quality and innovation as key drivers to deliver improved outcomes for patients and clients and has a key strategic component to develop and implement key strategies in relation to patient safety Trust-wide. The post-holder will be involved in areas of organisational development with direct links to patient safety, such as leadership development, learning from experience and excellence, creating an open and just culture and partnership working with service users, carers and other key stakeholders.

The post-holder will be required to demonstrate a high level of leadership, knowledge, skills and attributes and support and promote a culture of collective leadership within his/her service and when collaborating with others.

KEY DUTIES / RESPONSIBILITIES
Service Delivery

1. Lead the development and implementation of the Trust's Patient Safety Strategy.
2. Be responsible for the day-to-day systems and processes to support patient safety data collation, storage, analysis and reporting in line with Trust assurance structures and requirements.
3. Lead and oversee participation in regional co-ordination of patient safety initiatives, bringing intelligence and direction on these approaches into the Trust and providing strategic and professional advice on implementation.
4. Co-ordinate the implementation of agreed Patient Safety priority projects and monitoring systems, as endorsed by the Senior Management Team, within the wider Clinical and Social Care Governance arrangements of the Trust.
5. Review and monitor the impact of Patient Safety initiatives and provide regular Patient Safety reports to Governance Committee, Trust Board and other sub-committees.
6. Lead the development, implementation and maintenance of mechanisms to improve patient safety, data collation and enhance its reporting to Senior Management, Governance Committee, other sub committees and Trust Board. Identify and oversee implementation of evidence-based models, tools and systems to enhance centralisation, storage and retrieval of safety information.
7. Oversee and quality assure regular and ad-hoc information analyses and other management reports and dashboards on service metrics, for Senior Management Team, Governance Committee, Trust Board, Patient Safety (Morbidity & Mortality (M&M)) meetings, Patient Safety (Morbidity & Mortality (M&M)) Chair and Oversight Groups and other sub committees.
8. Ensure that the administration of Patient Safety (Morbidity & Mortality (M&M)) meetings and Patient Safety (Morbidity & Mortality (M&M)) Chair meetings is adequately supported.
9. Oversee completion of the Quarterly Mortality Report, interpreting the results and providing summarised information for Governance Committee and other sub committees.

10. Work with clinicians, senior managers and staff to understand data analysis and identified trends within their areas to enable improvement initiatives and/or monitoring to be undertaken. Work in collaboration to develop practical solutions to problems and decide and/or make recommendations for improvement.

11. Develop patient involvement in the Patient Safety Data and Improvement process.

12. Represent the Trust as required at sector and external forums.

13. Attend meetings, advise and support relevant staff, groups and committees within the Trust in respect of service/s under the remit of the post holder.

14. Be responsible for undertaking specific projects on behalf of the Medical Director.

15. Support and contribute to the overall quality improvement work programme within the Trust, working in conjunction with the Head of Improvement and their team and utilising a variety of improvement methodologies, building on current initiatives and promoting the development of quality improvement skills for teams and individuals.

16. Act on any relevant published reports in terms of quality improvement and patient safety data that may impact on services or provide useful learning for the Trust.

17. Ensure that all projects managed by the team have clear aims and objectives, meet confidentiality and data protection guidelines, are completed, reported, implemented and have outcomes monitored.

18. Lead on provision of specialist advice, enhanced support, performance improvement expertise and guidance to senior managers, clinicians and staff in respect of service/s under the remit of the post holder.

19. Develop strategies, systems, policies and procedures to address the key areas of risk under the remit of the post holder, which support the strategic direction of the Trust.

20. Lead the development of annual programmes of work for all service/s under his/her remit to ensure the achievement and maintenance of internal and external governance and other relevant standards.

21. Deputise for the Assistant Director of Clinical and Social Care Governance and Medical Director where required by taking a lead role in developing links between the Medical Director's office and the wider organisation in respect of Patient Safety Data & improvement and governance.

22. Secure effective engagement with clinicians at all levels and encourage cross professional collaboration to deliver service improvement.

23. Engage Trust-wide in relation to Patient Safety with individuals, teams and services to ensure a focus on safety is embedded in all care we deliver.

Quality and Governance

24. Coordinate and supply patient safety data required for the overall assurance process required by Governance Committee and other sub-committee of the Trust Board.

25. Work with governance colleagues to ensure improved triangulated reporting to provide greater understanding and learning of the risks to the quality of patient care.

26. Facilitate senior managers and staff in meeting legislative requirements relevant to their areas of responsibility as per postholder's area of responsibility.

27. Ensure that the needs of patients, clients and their carers are at the core of the services provided.

28. Benchmark performance against local, regional and national patient safety data standards, within work programmes approved by the Trust's Senior Management Team.

Financial and Resource Management

29. As budget holder, manage the pay and non-pay Patient Safety Data and Improvement budget, ensuring that the budget is used effectively, seek opportunities to generate additional income where possible and contribute to the Trust Cost Improvement Plan where necessary.

30. Where required, develop business cases for the improvement or development of services.

Leadership and People Management

31. Effectively manage the Patient Safety Data and Improvement staff to ensure an efficient, effective and responsive service.

32. Be responsible for recruitment, retention, and ongoing development, ensuring that all staff have an annual appraisal, current objectives and Personal Development Plan and that identified training needs are met.

33. Ensure that appropriate patient safety data and improvement resources and training are developed and available to all staff.

34. Identify own training and development needs and undertake appropriate training/education as required.

35. Participate in an annual individual performance review process where objectives will be agreed, performance monitored and personal development needs discussed.

36. Attend all statutory and mandatory training as and when required to do so.

37. Act responsibly in respect of colleague's health, safety and welfare following safe work practices and complying with the Trust's Health and Safety Policies.

Collaborative Working / Key Working Relationships

38. Work collaboratively at a regional level with DOH, SPPG, PHA and other Trusts to identify and implement best practice in pursuit of enhanced performance and continuous improvement.

39. Engage Trust-wide in relation to Patient Safety with individuals, teams and services to ensure a focus on safety is embedded in all care we deliver.

40. Work collaboratively with relevant internal departments to ensure a seamless approach to the implementation of corporately agreed workplans within the postholder's remit.

41. Develop and maintain productive working relationships with operational and professional leads within the Trust, ensuring the provision of accurate and timely information as required.

42. Work collaboratively with Assistant Directors and senior managers within the Trust and other external organisations, and represent the Trust on local and regional groups.

43. Work closely with the Senior Manager, Risk and Learning and Head of Audit to analyse regional standards and guidance and audit outcomes in terms of patient safety. Identify the implications for patient safety processes and systems and ensure that the necessary changes are disseminated and implemented.

44. Implement and maintain systems and procedures to inform and receive feedback on the services within the postholder's portfolio from stakeholders. Evaluate that feedback and take appropriate action for continuous improvement.

Communication and Information Management

45. Implement and maintain systems and procedures to inform and receive feedback on the services within the postholder's portfolio from stakeholders. Evaluate that feedback and take appropriate action for continuous improvement.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Trust supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.

2. Ensure access to skills and personal development through appropriate training and support.

3. Promote a culture of openness and honesty to enable shared learning.

4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.

5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

RAISING CONCERNS - RESPONSIBILITIES

1. The post holder will promote and support effective team working, fostering a culture of openness and transparency.

2. The post holder will ensure that they take all concerns raised with them seriously and act in accordance with the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and their professional code of conduct, where applicable.

3. The post holder will, in the event of a concern being raised with them, ensure that it is managed correctly under the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and ensure feedback/learning is communicated at individual, team and organisational level.

EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

Work proactively with the Trust's Emergency planner and other internal and external stakeholders to develop appropriate emergency response and business continuity plans to ensure the service can maintain a state of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption.

PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

Lead on and be responsible for the co-ordination of the Trust's PPI Strategy within the Division or other sphere of responsibility. This will include supporting active engagement with user groups and the voluntary and independent sectors in the design and delivery of services.

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    a. Smoke Free policy
    b. IT Security Policy and Code of Conduct
    c. standards of attendance, appearance and behaviour

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

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

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the SHSCT policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

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

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

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

May 2022

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE Head of Patient Safety Data and Improvement

BAND Band 8B

DIRECTORATE Medical Directorate

HOURS 37.5 per week

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA	
SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.	
Factor	**Criteria**
Experience / Qualifications/ Registration	1. Hold a University Degree or recognised Professional Qualification in a relevant[1] subject AND have a minimum of 4 years' experience as a Band 7 or above with responsibility for aspects of governance or a minimum of 2 years' experience as a Band 8a or above with responsibility for aspects of governance.

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

	2. Have delivered against challenging performance management programmes for a minimum of 2 years meeting a full range of key targets and making significant improvements. 3. Have worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years. 4. Have successfully demonstrated high level strategic and people management, and organisational skills for a minimum of 2 years.
Other	5. Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.*
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:	
Knowledge/ Skills / Abilities	6. Knowledge of improvement and governance systems, processes and outcomes. 7. Have good communication skills (written, oral, presentational and interpersonal) with the ability to communicate effectively with all levels of staff. 8. Evidence of highly effective planning and organisational skills. 9. Demonstrate the ability to assess risk and problem-solve based on excellent analytical skills. 10. A good level of computer literacy 11. Demonstrate the ability to write clear and concise reports related to complex subject matter.

PLEASE NOTE:

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. It is intended that shortlisted applicants will be assessed against the criteria stated in

this specification, linked to all seven domains of the NHS Leadership Framework found at the following link[2];
http://www.leadershipacademy.nhs.uk/discover/leadership-framework/supporting-tools/documents-to-download/

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants:

- *may be required to attend for a Health Assessment*
- *can expect to be placed at the minimum point of the pay scale, although a higher starting salary, within the range of the pay band may be available if the person appointed has experience relevant & equivalent to the post. If the successful candidate is an existing HSC employee moving to a higher band, AfC Pay on Promotion will apply.*

2

Southern Health and Social Care Trust

Quality Care - for you, with you

HSC Value	What does this mean?	What does this look like in practice? - Behaviours
Working Together	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
Openness & Honesty	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

Southern Health and Social Care Trust

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WORKING TOGETHER · EXCELLENCE · COMPASSION · OPENNESS & HONESTY

Southern Health and Social Care Trust

Quality Care - for you, with you

Senior Manager of Standards, Risk and Learning Band 8B

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	Senior Manager of Standards, Risk and Learning
BAND	8B
DIRECTORATE	Clinical and Social Care Governance
INITIAL LOCATION	Beechfield House, Craigavon Area Hospital in the first instance
REPORTS TO	Assistant Director of Clinical and Social Care Governance
ACCOUNTABLE TO	Medical Director

JOB SUMMARY

The post-holder will be the Senior Manager of Standards, Risk and Learning and is responsible for ensuring that the implementation of the Trust's Risk Management Strategy. The facilitation and coordination formal learning and learning from experience will compliment Trust-Wide Risk Management agenda and the delivery of safe services to patients and clients.

Senior Manager of Standards, Risk and Learning will provide strong professional leadership and manage and develop the Trust's Standards and Guidelines portfolio and the guidance and regulation advice necessary to enable the quality of care to be monitored and improved. He/she will promote the development of a culture that values quality, accessible information as key corporate resource and be capable of working independently to persuade, motivate and negotiate with management and staff of all grades, both internal and external to the Trust.

KEY DUTIES / RESPONSIBILITIES

Clinical Standards and Guidelines Responsibilities

1. Provide oversight and assurance to the Medical Director and Trust Senior Management Team regarding the implementation / monitoring of compliance of new regionally endorsed standards and guidelines to ensure compliance is achieved within specified timescales.
2. Support directorate standard and guideline managers and change leads to develop directorate, and were required Trustwide, action plans to direct operational Standard and Guidelines implementation including the review and update of legacy Standard and Guidelines.
3. Responsible for the development of a Trustwide clinical standards and governance strategy.
4. Responsible for the oversight of Trust Clinical Guidelines including development and maintenance of mechanisms to alert staff of expiring guidelines and appropriate corporate archiving of the same.
5. To implement and oversee the introduction of an electronic standard and guideline software package to track, validate and archive Standards and Guidelines
6. Where required support operational teams in the development of clinical standards and governance plans as appropriate and provide expert advice.
7. Communicate complex information concerning standards and governance practice
8. Advise the Medical Director and Trust Senior Management Team on clinical standards and priorities.
9. Deliver an annual Standards & Guidelines Accountability report /annual Quality Report / HSCB reports and regular reporting to associated subgroups, the Trust Senior Management Team and Trust Board.
10. Deputise for the Assistant Director of Clinical and Social Care Governance and Medical Director where required by taking a lead role in developing links between the

Medical Director's office and the wider organisation in respect of clinical standards and governance

11. Secure effective engagement with clinicians at all levels and encourage cross professional collaboration to deliver service improvement

Risk Management Responsibilities

12. Support the development and maintenance of the Trust Corporate Risk Register including oversight of quality assurance of contained risk entries
13. Provide support to operational directorates to ensure that each directorate level risk register is dynamically populated and consistent with corporate requirements
14. Bring to the attention of the Medical Director and Senior Management Team recently identified significant risks to the delivery of services
15. Support the implementation of the Datix system upgrade and adaptation of modules regarding the management of risk
16. Coordinate the Trustwide Risk and Clinical Governance Training programmes for all relevant staff including developing a training matrix for Clinical and Social Care Governance activities

Learning from Experience Responsibilities

17. Support the creation and provision of an education and learning programme which integrates learning between SAI's/M&M/Litigation/Datix Trust-wide
18. Support the creation and implementation of governance e-learning packages for all Trust staff
19. Oversee and maintain the Trust Learning from Experience function and provide regular reports to Trust Senior Management Team and Trust Governance Committee.
20. Lead a team to provide supportive structures to services to give up to date safe and effective care to service users within the Southern Trust through shared learning and collaborative working overcoming challenges and barriers together through partnership working.
21. Create, implement and lead on a suite of learning and training sessions/ workshops for Serious Adverse Incidents/ Mortality and Morbidity, Litigation and Datix trustwide,

which recognises the need to integrate and encourage opportunities of shared learning and risk management within the Southern Trust.

22. Develop and maintain the required systems and processes to project manage, monitor and report on implementation compliance for a wide range of standards, guidelines, review recommendations and patient safety initiatives across the organisation.
23. Facilitate, motivate and negotiate with service teams to design service changes to encompass standards and guidelines, risk register recommendations and other learning outcomes, monitoring these changes and reporting on levels of compliance with clinical and non-clinical standards. The expectation is to act appropriate to progress areas of non-compliance and escalate where necessary.
24. Negotiate between a wide range of clinical specialist teams across divisions (and in some cases across Directorates) to ensure that where standards are to be implemented there is uniformity of approach, thereby ensuring consistency in practice along the entire patient pathway.
25. On behalf of the SHSCT, attend a regional meetings / forums to progress regional work plans, ensuring that good networks are established upon which to keep up to date and well briefed on regional change initiatives.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Trust supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.
2. Ensure access to skills and personal development through appropriate training and support.
3. Promote a culture of openness and honesty to enable shared learning.
4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.

5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

RAISING CONCERNS - RESPONSIBILITIES

1. The post holder will promote and support effective team working, fostering a culture of openness and transparency.
2. The post holder will ensure that they take all concerns raised with them seriously and act in accordance with the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and their professional code of conduct, where applicable.
3. The post holder will, in the event of a concern being raised with them, ensure that it is managed correctly under the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and ensure feedback/learning is communicated at individual, team and organisational level.

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

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

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

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

October 2020

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

Senior Manager of Standards, Risk and Learning, Band 8b

Clinical and Social Care Governance

37.5 hours FULL TIME

Ref No: <to be inserted by HR> **October 2020**

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA

SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Experience	1. University Degree or a relevant[1] professional qualification **AND** 4 years' experience as a Band 7 or above 2. Hold or be willing to undertake a post graduate qualification in a clinical governance related field or risk management. 3. Experience in delivering objectives which have led to significant improvement in	Shortlisting by Application Form

	services 4. 2 years' experience working with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes, including implementation of change/ lessons learned within services. 5. 2 years' experience in demonstrating personal responsibility for achieving measurable improvements in outcomes for services 6. Experience of the practical implementation of project management/ service improvement methodologies and techniques [1] University degree or relevant professional qualification is defined as being in a health-care related subject; business and management or risk management	
Other	7. Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *This criteria will be waived in the case of applicants* whose *disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.*	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities & Knowledge	1. Excellent communication skills to meet the needs of the post in full 2. Have high level interpersonal, verbal and written communication skills 3. Have an ability to provide effective leadership 4. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement 5. Thorough understanding of the principles and practice of risk management systems	Interview

	and their use in clinical practice. 6. Good organisational skills 7. Ability to work effectively within a multi-disciplinary setting. 8. Flexible with regard to working arrangements to facilitate the demands of the post. 9. Ability to extract, analyse, interpret and present complex statistical information from a range of HSC systems/sources. 10. Extensive experience of report writing and presenting to a range of stakeholders.	

DESIRABLE CRITERIA		
SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted		
Factor	**Criteria**	**Method of Assessment**
Experience	1. Experience of statistical analysis 2. Experience of using and creating databases. 3. Experience of using quantitative information to stimulate performance improvement using Excel, as well as Word and Power Point. 4. Have an understanding of clinical pathways and operational processes within a Health and Social Care setting.	Shortlisting by Application Form
Qualifications	5. Postgraduate qualification.	Shortlisting by Application Form

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at

http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model.
Particular attention will be given to the following dimensions:

- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results.

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

Quality Care - for you, with you

HSC Value	What does this mean?	What does this look like in practice? - Behaviours
Working Together	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
Openness & Honesty	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

Southern Health and Social Care Trust

Quality Care - for you, with you

#teamSHSCT
#bettertogether

Follow us on:

WORKING TOGETHER · EXCELLENCE · COMPASSION · OPENNESS & HONESTY

Southern Health and Social Care Trust

Quality Care - for you, with you

Assistant Director
Systems Assurance and Improvement

Southern Health and Social Care Trust

Quality Care - for you, with you

ROLE DESCRIPTION

JOB TITLE	Assistant Director Systems Assurance and Improvement
BAND	Band 8c
DIRECTORATE	Medical Directorate
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Medical Director
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

This post holder will work with the Medical Director to ensure effective processes are in place, spanning both clinical and professional governance. The post holder will be responsible for leading on development activities to strengthening assurance across both domains. The post holder will also support the coordination of the Trust response to the statutory public inquiry regarding urology services including providing liaison with statutory and professional bodies including the Department of Health, Health and Social Care Board, Public Health Agency, Royal College of Surgeons and British Association of Urological Surgeons.

The post holder will ensure that they are up to date with developments outside the Trust from both a service development and national policy perspective. The post holder will ensure that service developments and business cases are well coordinated and fit with the overall direction and strategy of the organisation, and incorporate current thinking on national policy and service improvement.

The post holder will be required to produce reports on a regular basis covering areas of responsibility within the job description. The post holder may be required to produce multiple reports on the same subject matter for a variety of different

audiences ensuring that the message is clearly communicated and any risks appropriately highlighted.

KEY DUTIES / RESPONSIBILITIES

1. In conjunction with the Medical Director and senior Medical Leaders, strengthen processes for medical Appraisal and Revalidation including development of robust quality assurance processes.
2. Lead on the development of systems to support the triangulation of clinical and social care governance and professional governance information to improve assurance mechanisms.
3. Lead on the development of systems and processes for providing assurance regarding learning, improvement and communication.
4. Provide support to the Trust's Communications Team regarding issues relating to the statutory public inquiry regarding urology services.
5. Support the benchmarking of Trust service developments against regional and national perspectives.
6. Support liaison and communications with PHA / HSCB and Department of Health on matters relating to the statutory public inquiry regarding urology services.
7. Work in partnership with the Department of Health, Public Health Agency, Health and Social Care Board other agencies and organisations to identify gaps in service and interventions in relation to clinical and professional governance, and in identifying areas for improvement.

MEDICAL APPRAISAL AND REVALIDATION

8. Lead on the revision of medical Appraisal and Revalidation processes to strengthen medical professional governance in line with best practices.
9. Develop systems to quality assure systems in relation to medical Appraisal and Revalidation including incorporating enhanced reporting processes.
10. Conduct ongoing benchmarking of medical Appraisal and Revalidation systems to ensure that these remain high performing and fit for purpose.
11. Scope, design, plan, manage improvement work regarding medical Appraisal and Revalidation working closely with medical leaders and to ensure on time delivery.
12. Responsibility for ensuring the medical Appraisal and Revalidation improvement strategy is delivered to time, to quality standards and in an effective manner, adjusting plans and resources as required.

CLINICAL AND PROFESSIONAL GOVERNANCE TRIANGULATION

13. Development of systems and processes that marry professional and clinical governance information streams to assist with pattern and trend recognition.
14. Support triangulation of clinical and social care governance and professional governance information to improve assurance mechanisms.
15. Develop processes to allow dynamic review of clinical governance information to inform professional governance processes.
16. Employ effective communication, negotiation and influencing skills to enable internal clinical and managerial leaders to deliver objectives.
17. Have a high level of understanding of the national and regional perspective and future strategy for Health and Social Care to prepare the organisation for potential changes as a result of revised policies and processes relating to clinical and professional governance.

CLINICAL AUDIT

18. Oversee the development and implementation of strategies for clinical audit and clinical effectiveness, ensuring that these are forward thinking and challenging.
19. Oversee the interpretation of national clinical audit and effectiveness policy and develop this locally.
20. In conjunction with the Head of Improvement, contribute to a strategy for quality improvement for the Trust, building on current initiatives and promote the development of quality improvement skills for teams and individuals.
21. Ensure the Trust acts on any relevant published reports in terms of quality improvement, clinical audit and effectiveness that may impact on services or provide useful learning for the Trust.
22. Work with internal auditors to ensure strategic alignment of the Trust's clinical audit and internal audit programmes and ensure that the Clinical Audit Committee and its subgroups are a robust part of the Trust's committee structure.

STRATEGY DEVELOPMENT

23. In collaboration with the Medical Director, lead the development and delivery of key operational strategies and plans to support the delivery of high quality clinical services by Operational Directorates.
24. Support the development of a clinically-led approach to operational strategy that encourages cross-care group and cross-site integration and embraces a culture of collective leadership.

25. Support the Medical Director in senior stakeholder engagement and aligning strategic plans with strategic business objectives.

PLANNING

26. Scope, design, plan, manage complex programmes and projects. Work closely with clinical and social care teams and corporate business partners and service improvement, cultural and quality improvement teams to ensure these are delivered.
27. Responsibility for ensuring the strategy is delivered to time, to quality standards and in a cost effective manner, adjusting plans and resources as required.
28. Work with operational and clinical and social care managers to develop business plans and processes, defining resources required to scope and implement the long-term strategic plan.
29. Influence the development of an approach to strategic planning that is more productive and maximises financial and clinical outcomes for the Trust.

SUPPORT FOR STATUTORY PUBLIC INQUIRY REGARDING UROLOGY SERVICES

30. Coordinate the Trust response to the statutory public inquiry regarding urology on behalf of matters relating to the Medical Directors Office.
31. Provide and receive highly complex, sensitive and contentious information, including presenting information about projects and dependencies to a wide range of internal and external stakeholders in formal settings that relates to the statutory public enquiry regarding urology services.
32. Deal with complex and conflicting subject matter problems in workshops, meetings, one to one communications and other formats.
33. Build and maintain effective relationships with PHA / HSCB and Department of Health on matters relating to the statutory public enquiry regarding urology services.
34. Proactively build good working relationships and provide information and advice to a wide range of internal stakeholders on a range of sensitive issues.
35. Develop and maintain effective networks in pursuit of strategy and planning improvements, representing the Trust at external meetings.
36. Support the benchmarking of Trust service developments against regional and national similar work.

LEADERSHIP

37. Working with the Medical Director, Chief Executive, Trust Directors and others to create an organisational climate which encourages staff to understand and enact their roles and responsibilities in relation to clinical and social care governance, proactively review practice in line with these roles, report untoward incidents, implement local resolution or appropriate escalation to manage the identified risks from same, and draw conclusions and identify areas for action without fear of recrimination or censure.

38. Provide leadership to ensure a systematic approach to the reporting of clinical and social care incidents and near misses and a culture of appropriate and timely reporting, analysis and learning across the organisation.

39. To work on behalf of the Senior Management Team and with Trust's multidisciplinary Clinical and Social Care Governance Team to develop for approval the Trust's Clinical and Social Care Governance Action Plan, identifying and providing evidence to support the prioritisation of actions, and leading the integration of these priorities and actions into the Trust's Board Assurance Framework.

40. To lead the delivery of the Clinical and Social Care Governance Action Plan on a yearly work cycle with the focus on providing assurance to the Senior Management Team and the Trust Board, that systems, policies and procedures are in place and work effectively and that the organisation's services are safe and of high quality.

41. To ensure there are mechanisms in place to share information and update staff in governance and risk management issues.

RESEARCH & DEVELOPMENT

42. To develop systems and processes to ensure that evidence based practice is embedded within the Trust that takes into account the latest developments in research.

43. Within the Trust's overall clinical and social care governance structures and arrangements, to work with the Executive Directors for Nursing and AHPs, Social Work and Medical Director to embed structures and systems to ensure the Trust is complying with new regulations on practice and the latest workforce standards

and developments emerging from Department, Commissioner and Professional bodies. Where the Trust is not compliant with these regulations and standards, to ensure that governance systems are effective in properly alerting this to SMT Governance and Trust Board for action.

44. To lead and manage the Effectiveness and Evaluation Unit within the Trust, ensuring that the Trust's Audit Programme is in line with corporate objectives, service needs and the Clinical & Social Care Governance Action Plan.

45. Co-ordinate and monitor the planned programmes of multi-professional audit across the Trust and ensure these are implemented and integrated within the overall governance priorities of the Trust.

46. To ensure the effective implementation and evaluation of audits commissioned by the Senior Management Team Governance Committee.

47. To lead the development and population of a Trust wide Audit database.

48. To provide quarterly reports of clinical and social care incidents indicating trends, making recommendations for risk management, co-ordinating and quality assuring the risk management action plans, and leading and supporting the delivery of these plans.

COMMUNICATIONS

49. To ensure systems and processes are effective in resolving difficult situations and contentious issues that may arise as a consequence of changing practice and developments within the Trust in relation to governance issues.

50. To ensure that effective policies and procedure are in place to investigate untoward clinical and social care incidents as appropriate and ensure that remedial action is taken as necessary to reduce the Trust's exposure to future risks.

51. To ensure links between clinical / social care effectiveness, clinical / social care audit, risk management, education and research and development.

PATIENT SAFETY AND CLINICAL QUALITY INDICATORS

52. Work with the Clinical Audit and Governance teams in the development of **in-house clinical indicators**, including research of best practice, development of methodologies, development, pilot and implementation.

53. Keep up to date with guidelines, best practice in relation to clinical indicators and patient safety and implement learning where appropriate.

54. Responsibility for the management of the implementation of **external clinical guidelines** and standards apportioned to the Medical Director, including their interpretation, development of implementation plans and on-going monitoring.

55. Implement and co-ordinate the Trust's M&M programme.

56. Liaise with regional bodies to develop further M&M reporting systems.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Trust supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

57. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.

58. Ensure access to skills and personal development through appropriate training and support.

59. Promote a culture of openness and honesty to enable shared learning.

60. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.

61. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

GENERAL REQUIREMENTS

The post holder will be required to:

62. 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.

63. 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.

64. 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

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

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

67. 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 exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.

68. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

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

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

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

November 2021

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE AND BAND Assistant Director of Systems Assurance and Improvement, Band 8C

DIRECTORATE Medical Directorate

HOURS 37.5 per week

Ref No: <to be inserted by HR> **November 2021**

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2.
3. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
4.
5. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA	
SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.	
Factor	**Criteria**
Experience / Qualifications/ Registration	1. Hold a University Degree or recognised Professional Qualification or equivalent qualification in a relevant[1] subject AND have a minimum of 2 years' experience in a Senior[2] Role in a major complex organisation[3] **OR** have a minimum of 5 years' experience in a senior[ii] Role in a major complex organisation.[iii] 2. Have a minimum of 2 years' experience in delivering against challenging performance management programmes meeting a full range of key Corporate goals, demonstrated through personal involvement in; o The associated strategy development, o Implementation and; o Sustainability of the objectives. 3. Have a minimum of 2 years' experience of managing major change programmes addressing significant[4] organisational change, demonstrated through personal involvement in; o Risk management, o Planning and implementation of the change, o Evaluating the impact of the change in transforming services for the better. 4. Have a minimum of 2 years' experience working with a diverse range of internal and external stakeholders; o To deliver and improve services, o Demonstrating effectiveness in developing and maintaining

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

[2] *'Senior' will be interpreted to mean Band 8A or equivalent or above.*

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

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

	networks through lasting working relationships, o Which contribute to service improvement, and; o Where the contribution of others is encouraged. 5. Have a minimum of 2 years' experience in managing services where; o Successful outcomes can be evidenced, o Leadership is demonstrated in the areas of strategic planning, inspiring and motivating individuals and teams to strengthen performance, o The best use of resources is made, in line with service values and goals. 6. Have a minimum of 2 years' experience in ensuring robust governance arrangements are in place which ensure high performance service outcomes, demonstrated through; o Rigorous performance management measures, and; o Holding others to account for achieving performance standards.
Other	7. Hold a full current driving licence[v] valid for use in the UK and have access to a car on appointment

SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:	
Skills / Abilities	8. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement. 9. Demonstrate evidence of highly effective planning and organisational skills. 10. Have an ability to effectively manage a delegated budget to maximize utilization of available resources. 11. Have an ability to provide effective leadership to enable transformation of services. 12. Demonstrate effective communication skills to meet the needs of the post in full.

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

DESIRABLE CRITERIA	
SECTION 3: These will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. **You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted**.	
Factor	**Criteria**
Experience	Experience in a Corporate, Clinical and Social Care Governance role within a health and / or social care setting.

PLEASE NOTE:

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. It is intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to all seven domains of the NHS Leadership Framework found at the following link[5];
http://www.leadershipacademy.nhs.uk/discover/leadership-framework/supporting-tools/documents-to-download/

If this post is being sought on secondment then the individual MUST have the permission of their line manager IN ADVANCE of making application.

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

Successful applicants may be required to attend for a Health Assessment

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

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

[5] *The Trust would highlight that this is NOT the 2013 Leadership Model and candidates should ensure they use the link stated in the pack*

Southern Health and Social Care Trust

Quality Care - for you, with you

HSC Value	What does this mean?	What does this look like in practice? - Behaviours
 Working Together	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
 Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
 Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
 Openness & Honesty	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

Southern Health and Social Care Trust

Quality Care - for you, with you

Head of Service
Systems Assurance and Clinical Audit

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	Head of Service – Systems Assurance and Clinical Audit
BAND	8b
DIRECTORATE	Medical
LOCATION	To Be Confirmed / Beechfield House
REPORTS TO	Assistant Director Systems Assurance
ACCOUNTABLE TO	Medical Director

JOB SUMMARY

The postholder will be responsible for the development and implementation of audit and improvement processes to strengthen assurance in delivering improved outcomes for patients and clients. He/she will have overall responsibility for policy and service development including the practical implementation of strategic plans, policies and procedures. The post holder will be have delegated authority within his/her role and will be the organisational senior manager in respect of the services under his/her remit. He/she will be responsible for the teaching and/or design and/or delivery of training and development programmes for the services under their remit. He/she will manage staff, resources and associated budgets.

KEY DUTIES / RESPONSIBILITIES

A. Service Delivery

1. Lead in the development and implementation of strategies for clinical audit and clinical effectiveness, ensuring that these are forward thinking and challenging, consulting with the Medical Director and Trust Clinical Audit Leads where appropriate and ensuring communication to staff and other stakeholders.

2. Interpret national clinical audit and effectiveness policy and develop this locally.

3. In conjunction with the Head of Improvement, contribute to a strategy for quality improvement for the Trust, building on current initiatives and promote the development of quality improvement skills for teams and individuals.

4. Act on any relevant published reports in terms of quality improvement, clinical audit and effectiveness that may impact on services or provide useful learning for the Trust.

5. Acting as the expert opinion on clinical audit and effectiveness, produce and implement a clear annual business plan for the Clinical Audit and Effectiveness within budgetary constraints, ensuring that this is integrated into the Business Planning processes of the Trust.

6. Work with internal auditors to ensure strategic alignment of the Trust's clinical audit and internal audit programmes.

7. With the Medical Director, ensure that the Clinical Audit Committee and its subgroups are a robust part of the Trust's committee structure.

8. Be responsible for undertaking specific projects on behalf of the Medical Director.

9. In conjunction with the Trust Clinical Audit Lead, effectively manage the Clinical Audit Committee and ensure each Service Line has an identified Clinical Audit and Improvement Facilitator and specialty Audit Lead.

10. Develop patient involvement in the clinical audit and effectiveness process.

11. In conjunction with the Head of Improvement, organise and host an annual sector wide Quality Improvement conference to showcase good practice and promote learning.

12. Represent the Trust as required at sector and external forums.

13. Lead in the development and management of the Trust's programme for clinical audit to ensure clinical practice and patient safety is effectively evaluated and maintained, prioritising this to ensure that topics of concern both at a national and Trust level are included, performance indicators are met, and that a register of audit projects is maintained.

14. Ensure that the Trust adheres to deadlines for the completion of all national clinical audits, national confidential enquiries and other mandatory work.

15. Support and contribute to the overall quality improvement work programme within the Trust, working in conjunction with the Head of Improvement and their team and utilising a variety of improvement methodologies.

16. With the Head of Improvement, ensure that quality improvement activities are coordinated, to ensure best use of Trust resources and to ensure best possible outcomes.

17. Highlight concerns resulting from clinical audit or other improvement work to Service Lines and at Trust board level as appropriate, ensuring that actions are in place and implemented to improve practice.

18. Ensure that audit and other quality improvement projects are soundly based, prioritised to meet the needs of the Trust and make most effective use of staffing and technical resources.

19. Ensure that all projects managed by the team have clear aims and objectives, meet confidentiality and data protection guidelines, are completed, reported, implemented and have outcomes monitored

20. Provide Directors, Clinicians and Managers with information and analysis resulting from clinical audit and other projects, taking into consideration issues that are of a potential sensitive or contentious nature.

21. Support the dissemination of outcomes from clinical audit and other improvement projects, to encourage further roll out or scaling of improvements.

22. Work with clinical, nursing and other colleagues, to develop and monitor key performance indicators.

23. Promote Clinical Audit outcomes through training, specialty audit meetings, newsletters, website and seminars and by giving formal presentations.

24. Ensure that the Trust participates in all aspects of the National Confidential Enquiry programmes and acts on findings.

B. Quality and Governance

25. Be responsible for ensuring that clinical risks that are highlighted by clinical audit, improvement and effectiveness workstreams are escalated as necessary to Service

Lines and through the Audit and Clinical Effectiveness Committee to Trust board sub committees, utilising the incident reporting system where necessary.

26. Coordinate and supply clinical audit and effectiveness evidence required for the overall assurance process required by RQIA.

27. Work with governance colleagues to ensure improved triangulated reporting to provide greater understanding and learning of the risks to the quality of patient care.

C. Financial and Resource Management

28. As budget holder, manage the pay and non-pay Clinical Audit and Effectiveness budget, ensuring that the budget is used effectively, seek opportunities to generate additional income where possible and contribute to the Trust Cost Improvement Plan where necessary.

29. Where required, develop business cases for the improvement or development of services.

D. Leadership and People Management

30. Effectively manage the Clinical Audit and Effectiveness staff to ensure an efficient, effective and responsive service.

31. Be responsible for recruitment, retention, and ongoing development, ensuring that all staff have an annual appraisal, current objectives and Personal Development Plan and that identified training needs are met.

32. Ensure that appropriate clinical audit and effectiveness resources and training are developed and available to all staff.

33. Identify own training and development needs and undertake appropriate training/education as required.

34. Participate in an annual individual performance review process where objectives will be agreed, performance monitored and personal development needs discussed.

35. To attend all statutory and mandatory training as and when required to do so.

36. Act responsibly in respect of colleague's health, safety and welfare following safe work practices and complying with the Trust's Health and Safety Policies.

E. Collaborative Working / Key Working Relationships

37. Work collaboratively at a regional level with DOH, HSCB, PHA and other Trusts to identify and implement best practice in pursuit of enhanced performance and continuous improvement.

38. Work collaboratively with relevant internal departments to ensure a seamless approach to the implementation of corporately agreed workplans within the postholder's remit.

39. Develop and maintain productive working relationships with operational and professional leads within the Trust, ensuring the provision of accurate and timely information as required.

40. Work collaboratively with Assistant Directors and senior managers within the Trust and other external organisations, and represent the Trust on local and regional groups.

Communication and Information Management

41. Implement and maintain systems and procedures to inform and receive feedback on the services within the postholder's portfolio from stakeholders. Evaluate that feedback and take appropriate action for continuous improvement.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Trust supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.

2. Ensure access to skills and personal development through appropriate training and support.

3. Promote a culture of openness and honesty to enable shared learning.

4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.

5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

GENERAL MANAGEMENT RESPONSIBILITIES

1. The post holder will promote and support effective team working, fostering a culture of openness and transparency.

2. The post holder will ensure that they take all concerns raised with them seriously and act in accordance with the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and their professional code of conduct, where applicable.

3. The post holder will, in the event of a concern being raised with them, ensure that it is managed correctly under the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and ensure feedback/learning is communicated at individual, team and organisational level.

EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

4.To work proactively with the Trust's Emergency planner and other internal and external stakeholders to develop appropriate emergency response and business continuity plans to ensure the service can maintain a state of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption.

PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

5. Lead on and be responsible for the co-ordination of the Trust's PPI Strategy within the Division or other sphere of responsibility. This will include supporting active engagement with user groups and the voluntary and independent sectors in the design and delivery of services.

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

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

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

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand. *<July 2021*

Southern Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE AND BAND

DEPARTMENT / DIRECTORATE

SALARY

HOURS

Ref No: <to be inserted by HR> **<Month & Year>**

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA

SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Qualifications / Registration And Experience	1. University Degree or a relevant1 professional qualification **AND** 4 years' experience as a Band 7 or above OR 2 years' experience as a Band 8A or above	Shortlisting by Application Form

	2. 2 years' experience in demonstrating personal responsibility for achieving measurable improvements in outcomes for services 3. 2 years' experience working with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes, 5. A minimum of 2 years' experience in staff management 6. 2 years' experience in demonstrating personal responsibility for achieving measurable improvements in outcomes for services	
Other	7. Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.*	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Knowledge / Skills and Abilities	1. Knowledge of assurance, clinical audit, improvement and governance systems, processes and outcomes. 2. Have an ability to provide effective leadership 3. Have high level interpersonal, verbal and written communication skills 4. Demonstrate evidence of improvement in service outcomes 5. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.	Interview / Test

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model. Particular attention will be given to the following dimensions:

- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results.

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
Successful applicants may be required to attend for a Health Assessment

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HSC Value	What does this mean?	What does this look like in practice? - Behaviours
W **Working Together**	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
Openness & Honesty	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

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#bettertogether

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Acute Directorate Clinical & Social Care Governance (CSCG) Co-ordinator

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JOB DESCRIPTION

JOB TITLE	**Acute Directorate Clinical & Social Care Governance (CSCG) Co-ordinator**
BAND	8B
DIRECTORATE	ACUTE
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Director of Acute Services
ACCOUNTABLE TO	Director of Acute Services

JOB SUMMARY

The post holder will have responsibility for driving forward and coordinating all aspects of the Trust CSCG agenda within the Acute Directorate with and on behalf of, the Service Director and the Assistant Director with responsibility for Governance. They will provide an internal and external Directorate focus for the prioritisation, linking, implementation and review and monitoring of both the operational and professional governance agenda for the Directorate.

The post holder will, on behalf of the Director, provide a key challenge function to the service teams within the Directorate to ensure that areas where performance improvement in relation to CSCG is required are identified and addressed. They will contribute to developing corporate and operational strategy, policy and decision making within the Trust with respect to the CSCG agenda within the Directorate and as an integral part of the Trust CSCG Working Body and through close collaboration with the Trust's Corporate Assistant Director for CSCG. They will be responsible for advising on and actively participating in planning, delivering, reviewing and monitoring both Directorate and Corporate CSCG plans and will act as a focal point for the Director of Acute Services and the Trust's Corporate Assistant Director for CSCG in respect of any issues relating to the development, implementation, performance management and assurance of CSCG plans, systems and procedures and their associated improvement plans.

The post holder will provide enhanced CSCG support and performance improvement expertise and intervention in this area to their Directorate and to corporate CSCG projects where required. He/She will provide their Directorate and the organisation with a suite of intelligent information analyses which demonstrate real time performance in relation to all areas of CSCG, including Incidents, Complaints, Risk, Litigation, Audit, Clinical Indicators and Patient Safety. The post holder will also be required in collaboration with the Trust Senior Management Team and the Trust CSCG Senior Manager, to develop the organisation's capacity for continuous improvement in the area of CSCG and to facilitate a culture of openness and learning from experience using dynamic leadership and facilitation skills.

KEY DUTIES / RESPONSIBILITIES

Directorate Responsibilities

1. On behalf of the Director of Acute Services, to take the lead within the Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and are providing timely assurance and alerts to both the Service Director and the organisation.

2. Lead on ensuring that at each level of the Directorate, staff have access to timely, high quality and appropriate information in relation to incidents, complaints, audit, clinical indicators, litigation and risk and that with in each service team this information is being acted on appropriately in order to mitigate risk, improve quality of care and patient and client safety.

3. In particular to coordinate via the Directorate governance team the timely and appropriate responses to both incidents and complaints on behalf of the Directorate and to ensure standards of response times and patient / client satisfaction is the complaints process is maintained.

4. To ensure that strong links are maintained between Directorates and corporate functions such as complaints, the management of SAI's and litigation.

5. Lead on the investigation of serious adverse incidents in the Acute Directorate, ensuring that a consistently high standard of investigation and report writing is maintained at all times.

6. Lead on patient/family engagement in relation to serious adverse incidents within the Acute Directorate.

7. Lead on the interpretation and implementation planning of all standards and guidelines in relation to patient and client care and service provision within the Directorate and facilitate service teams to ensure that these are implemented, monitored and reviewed in a timely manner.

8. Provide project management leadership when required in relation to implementation of standards and guidelines and / or the implementation of new Trust wide systems and processes related to CSCG. Identify any constraints, including resources, to implementation in a timely way and immediately report this to the Director and/or Assistant Director with responsibility for CSCG.

9. Use expert analytical skills to interpret the broad range of performance information and other data, including internal and external benchmarking, to identify service and Directorate trends, exceptions, risks and alerts in relation to CSCG issues and to present these in an appropriate format to service teams and the Director.

10. Lead on provision of specialist clinical governance and risk management knowledge and expertise to sensitively and constructively challenge and assist directorate teams in diagnosing and addressing the complex issues and factors which are preventing them maximizing their CSCG performance in relation to patient and client quality care and safety.

11. Lead on provision of specialist expertise to the Director and their senior managerial and clinical staff in relation to the management of incidents and complaints requiring detailed analysis and significant learning.

12. Provide expert advice and knowledge to the Directorate in relation to the concepts of risk management and mitigation and ensure that the Directorate proactively manages risk at all levels of service on a continuous basis.

13. Develop and foster excellent working relationships with service teams at all levels of the Directorate based on confidentiality and trust to enable and foster a Directorate and organizational culture of openness in relation to patient and client care.

14. Hold the other members of the governance team to account in relation to the successful delivery of all aspects of CSCG across the Divisions within the Directorate.

15. On behalf of the Director take the lead on ensuring good communication and clear lines of accountability relating to operational and professional CSCG. Coordinate the various Directorate Governance fora, assist the Director in prioritising new CSCG plans and projects, and be a focal reporting point for professional support and governance functions within the Directorate.

16. Lead on the provision of appropriate training in all aspects of CSCG for Directorate staff.

17. Develop and maintain strong networks with organisational, regional and national CSCG colleagues, keeping up to date with latest thinking and developments and bring this intelligence back to the organisation to inform and drive improvement.

Organisational Responsibilities

1. On behalf of the Service Director lead on the provision of key Directorate information and data in a timely and appropriate format to the organisation which provides corporate assurance that both the operational and professional aspects of CSCG are of a sufficiently high standard within the Directorate.

2. Lead the Directorate representation on the Trust CSCG working body and contribute to, and lead on as appropriate, the development, implementation and audit of organisational wide CSCG policies and procedures.

3. Be the lead within the Directorate in relation to sharing and learning from CSCG trends, exceptions, alerts and risk at an organisational wide level via the Trust CSCG working body. Disseminate this information throughout the Directorate and develop measures to evidence that learning has resulted in changes in practice.

4. Work collaboratively with the Trust's Corporate Assistant Director for CSCG to ensure that there is a clear, two way line of communication from Acute Directorate to SMT Governance and Trust Governance Committees.

5. Act as one of a small number of experts in CSCG who advise the Trust, via the CSCG working body, on organisational, regional and national policies, their organisational implications and potential implementation plans / methodologies.

6. Take the lead in planning and implementation of Trust wide policies and procedures as required via the CSCG working body and actively bring forward to the CSCG working body forum strategic plans for driving forward the CSCG

agenda within the Southern Trust and influencing and shaping this agenda regionally.

7. Ensure through providing robust monitoring arrangements, that at all times the Directorate is complying with and operating within the CSCG policies, procedures and standards that the Trust has agreed. Where monitoring indicates any exception or deviation this must first be brought to the attention of the Director of Acute Services. Where the issue remains unresolved the post holder must identify the deviation or exception to the SMT Governance via the appropriate Executive Director.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Trust supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.

2. Ensure access to skills and personal development through appropriate training and support.

3. Promote a culture of openness and honesty to enable shared learning.

4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.

5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

RAISING CONCERNS - RESPONSIBILITIES

1. The post holder will promote and support effective team working, fostering a culture of openness and transparency.

2. The post holder will ensure that they take all concerns raised with them seriously and act in accordance with the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and their professional code of conduct, where applicable.

3. The post holder will, in the event of a concern being raised with them, ensure that it is managed correctly under the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and ensure feedback/learning is communicated at individual, team and organisational level.

EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

- To work proactively with the Trust's Emergency planner and other internal and external stakeholders to develop appropriate emergency response and business continuity plans to ensure the service can maintain a state of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption.

PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

- To ensure effective communication with service users and families and to embed the role of Family Liaison as a key mechanism to involve and support families
- Lead on and be responsible for the co-ordination of the Trust's PPI Strategy within the Division or other sphere of responsibility. This will include supporting active engagement with user groups and the voluntary and independent sectors in the design and delivery of services.

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

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

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

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

<April 2021>

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE AND BAND	**Acute Clinical & Social Care Governance (CSCG) Co-ordinator Band 8B**
DEPARTMENT / DIRECTORATE	**Acute Services**
HOURS	**37.5**

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA

SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Experience	1. Have delivered against challenging performance management programmes for a minimum of 2 years meeting a full range of key targets and making significant improvements. 2. Have worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years. 3. Have successfully demonstrated high	Shortlisting by Application Form

	level strategic and people management, and organisational skills for a minimum of 2 years.	
Qualifications/ Registration	1. Have a relevant professional qualification at degree level of above, and worked for at least 2 years in a senior management role (band 7 or above) in a major complex organisation with responsibilities for aspects of risk management and governance.* Or 2. Have worked for at least 4 years in a senior management role in a major complex organisation with responsibilities for aspects of risk management and governance.*	Shortlisting by Application Form
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.*	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	***The following are essential criteria which will be measured during the interview stage.*** 1. Have good communication skills (written, oral, presentational and interpersonal) with the ability to communicate effectively with all levels of staff. 2. Evidence of highly effective planning and organisational skills. 3. Demonstrate the ability to assess risk and problem-solve based on excellent analytical skills.	Interview

	4. A good level of computer literacy 5. Demonstrate the ability to write clear and concise reports related to complex subject matter.	

DESIRABLE CRITERIA		
SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted		
Factor	**Criteria**	**Method of Assessment**
Experience	Have 2 years' experience in Clinical and Social Care Governance setting.	Shortlisting by Application Form

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model. Particular attention will be given to the following dimensions:

- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results.

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants:

- *may be required to attend for a Health Assessment*
- *can expect to be placed at the minimum point of the pay scale, although a higher starting salary, within the range of the pay band may be available if the person appointed has experience relevant & equivalent to the post. If the successful candidate is an existing HSC employee moving to a higher band, AfC Pay on Promotion will apply.*

Southern Health and Social Care Trust

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HSC Value	What does this mean?	What does this look like in practice? - Behaviours
Working Together	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
Openness & Honesty	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

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Health and Social Care Board

Via Email Only

To: Chief Executives of each Health & Social Care Trust

From the Chief Executive

Health & Social Care Board
12-22 Linenhall Street
BELFAST
BT2 8BS

Tel: 0300 5550115
Web Site: www.hscboard.hscni.net

Email: [redacted]

+ Accompanying Paper to all AD's

Date: 8 December 2021

Dear Colleague

REVISED INTEGRATED ELECTIVE ACCESS PROTOCOL (IEAP)

You will be aware of that work had been undertaken to revise the 2008 IEAP which concluded in June 2020.

The Department has considered the revised document and notes the changes that have been made to reflect pathway developments and new ways of working. The changes will have a minor, yet positive impact on patients/service users as reflected in the equality screening.

It has been agreed that the Waiting List Management Unit will support performance managing the implementation of the protocol.

I would appreciate if you could circulate within your respective Trusts for implementation and to note the protocol will be uploaded to the Departmental website.

Yours sincerely

[redacted]

SHARON GALLAGHER
Chief Executive

Encs

cc: Jim Wilkinson
Lisa McWilliams

INTEGRATED ELECTIVE ACCESS PROTOCOL

June 2020

Integrated Elective Access Protocol

Protocol Summary -

The purpose of this protocol is to outline the approved procedures for managing elective referrals to first definitive treatment or discharge.

Version	**2.0** This guidance replaces the Integrated Elective Access Protocol, 30th April 2008.
Status	Approved
Date	30 June 2020

Integrated Elective Access Protocol

Version

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0	30th June 2020	Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

Integrated Elective Access Protocol Review Group

The Integrated Elective Access Protocol Review Group consisted of;

Marian Armstrong, BHSCT,
Roberta Gibney, BHSCT
Andrea Alcorn, NHSCT,
Christine Allam, SEHST,
Anita Carroll, SHSCT,
Paul Doherty, WHSCT,
Deborah Dunlop, WHSCT,
Sorcha Dougan, WHSCT,
Donagh Mc Donagh, Integrated Care
Geraldine Teague, PHA
Linus Mc Laughlin, HSCB

Integrated Elective Access Protocol

Document control

The current and approved version of this document can be found on the Department of Health website https://www.health-ni.gov.uk and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	June 2022

Monitoring compliance with protocol

Monitoring compliance with the processes in this document should be part of Trusts internal audit processes.

Contents

Abbreviations

AHP	Allied Health Professional
CCG	Clinical Communication Gateway
CNA	Could Not Attend (appointment or admission)
DNA	Did Not Attend (appointment or admission)
DOH	Department of Health
CPD	Health and Social Care Commissioning Plan and Indicators of Performance Direction,
E Triage	An electronic triage system
GP	General Practitioner
HR	Human Resources (Trusts)
ICU	Intensive Care Unit
IEAP	Integrated Elective Access Protocol
IS	Independent Sector (provider)
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IT	Information Technology
LOS	Length of Stay
MDT	Multidisciplinary Team
NI	Northern Ireland
PAS	Patient Administration System, which in this context refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting.
PTL	Primary Targeting List
SBA	Service and Budget Agreement
TCI	To Come In (date for patients)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied help professional (AHP) bookings, including cancer pathways and waiting list management.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.

1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

- Reduce waiting times for treatment and ensure patients are treated in accordance with agreed targets.
- Allow patients to maximise their right to patient choice in the care and treatment that they need.
- Increase the number of patients with a booked outpatient or in-patient / daycase appointment, thereby minimising Did Not Attends (DNAs), cancellations (CNAs), and improving the patient experience.
- Reduce the number of cancelled operations for non-clinical reasons.

1.1.5 This protocol aims to ensure that a consistent approach is taken across all Trusts. The principles can be applied to primary and community settings, however it is recommended that separate guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.6 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic, inpatient and AHP waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for treatment.

1.1.7 This protocol will be reviewed regularly to ensure that Trusts' policies and procedures remain up to date and that the guidance is consistent with good practice and changes in clinical practice, locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.2 METHODOLOGY

1.2.1 The Department of Health (DOH) has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.2.4 For the purposes of this protocol, the term;

- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtual,
- elective admissions refer to inpatient and daycase admissions,
- inpatient refers to inpatient and daycase elective treatment,
- diagnostic refers to patients who attend for a scan / test or investigation,
- AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
- partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment,
- fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment,
- virtual appointment refers to any appointment that does not involve the physical presence of a patient at a clinic, (see also 1.5 Virtual Activity).
- PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an electronic system (PAS). Manual patient information systems should not be maintained.

1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.

1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.

1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.

1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be "fit, ready, and able" to come in (TCI).

1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.

1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.

1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.

1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.

1.3.9 For the purposes of booking/arranging appointments, all patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient's information.

1.3.10 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language.** It is essential that patients who are considered at risk for whatever reason have their needs identified

and prioritised at the point of referral and appropriate arrangements made. Trusts must have mechanisms in place to identify such cases.

1.3.11 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 BOOKING PRINCIPLES

1.4.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.4.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

1.4.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.4.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

1.4.5 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.4.6 The definition of a booked appointment is:

a) The patient is given the choice of when to attend or have a virtual appointment.

b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.4.7 Principles for booking Cancer Pathway patients:

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral.
b) Dedicated registration functions for red flag (suspect cancer) referrals should be in place within centralised booking teams.
c) Clinical teams must ensure triage, where required, is undertaken daily, irrespective of leave, in order to initiate booking patients.
d) Patients will be contacted by telephone twice (morning and afternoon).
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of three days of receipt of referral.
f) Systems should be established to ensure the Patient Tracker / Multidisciplinary Team (MDT) Co-coordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient.

1.4.8 Principles for booking Urgent Pathway patients:

a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.
c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.

d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.

e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.

b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.

c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.

d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).

e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

a) Patients who need to be reviewed within 6 weeks will agree their appointment (including virtual appointment) before they leave the clinic, where possible.

b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.

c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.

d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

1.4.11 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey.

1.5 VIRTUAL ACTIVITY

1.5.1 Virtual Activity relates to any planned contact by the Trust with a patient (or their proxy) for healthcare delivery purposes i.e. clinical consultation, advice, review and treatment planning. It may be in the form of a telephone contact, video link, telemedicine or telecommunication, e.g. email.

1.5.2 The contact is in lieu of a face-to-face contact of a patient/client, i.e. a face-to-face contact would have been necessary if the telephone/video link/etc. had not taken place.

1.5.3 The call/contact should be prearranged with the patient and /or their proxy. Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.

1.5.4 The contact must be auditable with a written note detailing the date and substance of the contact is made following the consultation and retained in the patient's records.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.

1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

1.6.3 The protocol should require a **minimum** of **six** weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes **six** weeks in advance.

1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

1.7 VALIDATION

1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

1.7.2 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

1.7.3 A New Technical Guidance has been drafted to facilitate Trusts in the recording of the validation work which can be found on the Data Standards Share Point site. Clinical Coding & Information Standards - StandardsandGuidance (hscni.net)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

2.1 INTRODUCTION

2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.

2.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.3 There will be dedicated booking offices within Trusts to receive, register and process all outpatient referrals.

2.1.4 Fixed appointments should only be used in exceptional circumstances.

2.1.5 In all aspects of the outpatient booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

2.2 KEY PRINCIPLES

2.2.1 Referrals into Trusts should be pooled where possible within specialties.

2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.

1. Red flag (suspect cancer),
2. urgent and
3. routine.

No other clinical priority categories should be used for outpatient services.

2.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

2.2.4 Patient appointments for new and review should be **partially booked.**

2.2.5 The regional target for a maximum outpatient waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

2.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.

2.2.7 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

2.2.8 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

2.2.9 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

2.2.10 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

2.2.11 Trusts should **not** use manual administration systems to record and report patients who have been booked.

2.2.12 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

2.3 NEW REFERRALS

2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.

2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

2.4.1 The starting point for the waiting time of an outpatient new referral is the date the referral is received by the booking office/department.

2.4.2 In exceptional cases where referrals bypass the booking office (e.g. sent directly to a consultant) the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office and registered at the date on the date stamp.

2.5 REASONABLE OFFERS

2.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

2.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

2.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

2.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

2.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

2.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

2.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

2.6 REVIEW APPOINTMENTS

2.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

2.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

2.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

2.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

2.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

2.7 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

2.7.1 DNAs – New Outpatient

If a patient DNAs their new outpatient appointment the following process must be followed:

2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they