Form 1 – Background Details	Yes	No	Partial	Comments (attached document or written statement)
Details of registration/licence to practice				
Brief details of employment in the previous year				
Supplementary Information e.g. membership of medical and specialist societies				

Form 2 – Current Medical Activities	Yes	No	Partial	Comments (attached document or written statement)
Job Plan – Fully Signed Off				
Summary of Clinical Activities inc. Private Practice both inside and outside the Trust				
Evidence of MPS / MDU Membership				
Information on non-clinical work – such as teaching or management responsibilities (to include Educational Appraisal form and Appraiser Structured Reflective Template if individual is an Appraiser (see link at end for all templates)				
Location of all current practices				
Evidence of any resource shortfalls which may have compromised outcomes				

NB: Evidence must be held in your folder against all of these domains

Form 3 – Supporting Information and Summary of Appraisal Discussion	Yes	No	Partial	Comments (attached document or written statement)
DOMAIN 1: Knowledge, Skills and Performance				
Workload Records - with reflection				
Evidence of CPD improving the quality of your practice				
Evidence of Teaching and Training Activities – Proof of Completing Required Competencies (if applicable)				
Evidence of Audit Activity – with reflection				
Evidence of Research Activity (if applicable) - with reflection				
Evidence that CPD follows the recognised best practice in your field or specialty as set out by the Colleges - with reflection				
Evidence of Published Articles and/or Presentations to Peers				
Additional information on formal management commitments – with reflection				
HPSS regional or national management involvement – with reflection				

DOMAIN 2: Safety and Quality	Yes	No	Partial	Comments (attached document or written statement)
Up to date audit data including information on audit methodology and a record of how results of audit have resulted in changes to practice (if applicable) – with reflection				
Reflection on significant events/critical incidents/near misses (personal or departmental)				
Reflection of how relevant medical guidelines have been reviewed by you and your team and how these have changed practice				
Evidence of involvement in Quality Improvement initiatives – with reflection				
Accounted for 100% of attendance at, and participation in, governance / patient safety / M&M or equivalent activity relevant to practice				
Up to date Mandatory Training Passport				
Statement of satisfactory research practice and evidence of Good Clinical Practice Training (if applicable)				
DOMAIN 3: Communication, Partnership and Teamwork	**Yes**	**No**	**Partial**	**Comments (attached document or written statement)**
Evidence of any team development activity				
Description of the team you work within (medical and/or multidisciplinary)				
Description of all activities in which you interact with other healthcare workers e.g. multidisciplinary meetings, working groups and committee work.				
Reflection on trainee/medical student feedback (if appropriate)				
Evidence of participation in multi-professional team meetings				
Evidence of Patient Feedback – with reflection				
Evidence of Colleague Feedback – with reflection				

DOMAIN 4: Maintaining Trust	Yes	No	Partial	Comments (attached document or written statement)
Reflection of funding arrangements (if applicable)				
Complaints with reflection				
Compliments with reflection				
Summary of Form 3	**Yes**	**No**	**Partial**	**Comments (attached document or written statement)**
Knowledge, Skills and Performance – discussion/action				
Safety and Quality – discussion/action				
Communication, Partnership and Teamwork – discussion/action				
Maintaining Trust – discussion/action				

FORM 4 - Personal Development Plan				
Fully Completed				
Evidence of reflection/discussion on achieving PDP				
Evidence of Two Years Current and Past PDPs				
Evidence of, for example:- • Patient / Safety Project • CME / Course Plan • Research or Audit • Service Development				

Form 5 – Health and Probity	Yes	No	Partial	Comments (attached document or written statement)
Probity statement – signed				
Health Declaration – Signed				
Registered with a GP				
Indemnity Section - signed				

Form 6 – Sign Off	Yes	No	Partial	Comments(attached document or written statement)
Signed Forms				

Form 7 – Revalidation Progress (GMC Minimum Requirements)	Yes	No	Partial	Comments (attached document or written statement)
Evidence of Continuing Professional Development and use of structured reflective template				
Quality Improvement Activity – should be relevant to current scope of practice				
Significant Events – evidence of review of significant events and use of structured reflective template				
Feedback From Colleagues Undertaken and use of structured reflective template				
Feedback From Patients Undertaken and use of structured reflective template				
Review of Complaints and Compliments and use of structured reflective template / Declaration of Absence of Complaints				
Mandatory Training Matrix in Appendix 1 Completed or up to date Training Passport included and Appendix 1 signed.				

Southern Health and Social Care Trust

Update to DOH Urology Assurance Group 18 December 2020

(Progress/updates from 12-18 December 2020)

Serious Adverse Incidents (SAI) Update (9)

Mid report of early identification of learning was shared with HSCB on 17 December 2020 and full reports x 10 (9 + 1 overarching) due end January 2021.

Summary of Activity for Patient Facing Information Line (17/12/20)

Calls up to 17th December 2020

- 144 calls to information line. (increase of 11 calls from last week)
- 8 email to the inquiry email address (increase of 2 emails from last week)
- 1 inquiry via complaints team (no more received since last week)
- 3 GP calls (one of these related to a private patient and medication – already escalated) (same as last week)
- 21 patients who have either contacted the information line/come via MLA/MP enquiry or from the GP query have been seen at clinic to date one of these patients need to be further investigate (same as last week – as Mr Haynes has been operating this week and no capacity for additional clinics)

Professor Sethia, Urology Subject Matter Expertise has agreed to look at all the patients that have contacted the Information Line and determine whether can advise them that they are not part of the Inquiry or whether they need to be follow-up. As this will take some time an acknowledgement letter is being sent out to all the patients/relative who have phoned in advising them that their case is being looked into and that they will be contacted as soon as the review is complete.

Independent Sector Clinics

- **194 management plans** have been received back from Independent Sector
  - **121** of these have been referred back to the care of their GP
  - **32** have been sent back to Trust for further care/follow-up.
  - **38** to be reviewed at Trust's Urology MDT (Professor Sethia has agreed to be the independent Consultant on these MDT's and these are commencing

on 14 January and will be every fortnight, and he has agreed to start reviewing the cases over the Christmas holidays).

- **3** referral to Oncologist for Urgent reassessment of treatment

Royal College of Surgeons Invited Review Service

Draft Terms of Reference has been drawn up for the Invited Review Service by the RCS – for agreement, tabled at HSCB meeting on 17th and attached as appendix 1.

General Medical Council

On the 15th December the GMC interim orders panel suspended Mr O'Brien from the medical register for a period of 18 months.

Structured Judgement Review (SJR)

The Trust met last week with the Royal College of Physicians to discuss the use of SJR methodology to support patient reviews. The Royal College of Physicians were supportive and felt it was an appropriate framework to use to conduct the described patient safety reviews in the absence of a full SAI process. The Trust is agreeing a core virtual training programme with the Royal College of Physicians team for a core group of reviewers.

Consultant's Private Practice

Internal Audit has commenced a review of Mr O'Brien's patients transferring into SHSCT as HSC patients. The review will also consider any Trust involvement with the Craigavon Urological Research & Education organisation.

Staff Engagement

Recognising the 'second victims' in this process, the Trust continues to work at ways to ensure all staff involved are and will be supported through this process. Fortnightly Team meetings are continuing with the Clinical Teams and the Chief Executive, Medical Director and Director of Acute Services.

Royal College of Surgeons of England

TERMS OF REFERENCE FOR CLINICAL RECORDS REVIEW

Review of Urology clinical records at Southern Health and Social Care Trust under the Invited Review Mechanism.

Background

The review team will consider the standard of care provided to patients in a sample of clinical records provided by Southern Health and Social Care Trust for patients that had been under the care of Mr O'Brien, Consultant Urologist.

Review

The review will involve:

- A clinical record review of up to 100 cases from period January 2015 – December 2015 of put forward by the Southern Health and Social Care Trust

Terms of Reference

In conducting the review, the review team will consider the standard of care demonstrated in the clinical records provided by the Southern Health and Social Care Trust including with specific reference to:

- Assessment including history taking, examination and diagnosis;
- Investigations and imaging undertaken;
- Treatment including clinical decision-making, case-selection, operation or procedures;
- Communication with the patient, their family and the GP, and patient consent;
- Team working including communication with other members of the care team, MDT discussions and working with colleagues;
- Follow-up action on the patient care (for example, ordering diagnosis/onward referral to other specialties (oncology etc).
- Actions taken as a result of Multidisciplinary Meeting recommendations
- Administration in connection to the patients episode

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard of care provided and whether there is a basis for concern in light of the findings of the review.

- May make recommendations for the consideration to the Medical Director of Southern Health and Social Care Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

The above terms of reference were agreed by the College, the healthcare organisation and the review team on [date].

Stinson, Emma M

From: Wallace, Stephen
Sent: 15 December 2020 12:55
To: Wallace, Stephen ([redacted])
Subject: MNOTES - 15.12.2020 11:30am UHB Apprisal and Revalidation

Bill Tunnicliffe
Maria O'Kane
Stephen Wallace

BT - AMD for Revalidation, layered structure. RO is separate from the MD – soft intelligence. Takes my information and recommendations, hard intelligence. In house – 8 years ago. Trust went through structural changes. Had to make appraisal processes uniform across four legacy organisations. Issues of self-declaration, requiring the doctor to declare if they have any other licensed activities. It is entirely reliant on the honesty of the doctor. This is set by the GMC requirements. Private providers are now more concerned with practitioners information being included in appraisal and revalidation processes. ISPs are asking for sharing of information, the doctor owns the appraisal not the organisation. BT – the process is for the doctor, GMC state that appraisal is not a performance management tool. Bringing on board an **Annual Professional Review**, job planning, performance, organisational processes around the doctor. This process belongs to the organisation. The doctor will be subject to performance management via this route. MOK – will CSCG be part of professional review, BT – yes this will be included in this. Designated bodies should not burden the A&R with local processes. MOK – private sector providers – take a view that doctor is renting a room rather than responsible for their practice. Letters of good standing require doctor to assure that the outcomes are in line with what their substantive roles are. The exceptions are limited in terms of doctors who's private practice differs from their substantive role. Doctors choose their own appraiser in UHB. Ian Paterson did not declare. The coding system is not reliable to identify deviations in practice. Every appraisal summary is signed off by the AMD A&R for quality purposes. MOK do you audit your appraisals, BT – rather work on a better appraisal than deeper audit of appraisal. BT – I am an appraiser, usually difficult doctors are handled.

Stinson, Emma M

From: OKane, Maria
Sent: 09 December 2020 11:01
To: Wallace, Stephen
Subject: FW: IPR's

Can we discuss???

From: Gibson, Simon
Sent: 09 December 2020 08:44
To: Reid, Trudy; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

See below

Individual Performance Review

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI (DHH)

From: Reid, Trudy
Sent: 09 December 2020 08:44
To: Gibson, Simon; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

Simon I have a mental block, what is it?
Trudy

From: Gibson, Simon
Sent: 09 December 2020 08:28
To: OKane, Maria; Wallace, Stephen; Reid, Trudy
Subject: RE: IPR's

P>S – If you don't have one, I'm sure we could all help you put one together as a baseline document

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust

Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI (DHH)

From: OKane, Maria
Sent: 09 December 2020 08:26
To: Wallace, Stephen; Reid, Trudy; Gibson, Simon
Subject: FW: IPR's

What are iprs?

From: Devlin, Shane
Sent: 08 December 2020 11:07
To: Beattie, Brian; Magwood, Aldrina; McClements, Melanie; McNeany, Barney; OKane, Maria; O'Neill, Helen; Morgan, Paul; Toal, Vivienne; Trouton, Heather
Cc: Alexander, Ruth; Campbell, Emma; Stinson, Emma M; Gilmore, Sandra; Griffin, Tracy; Mallagh-Cassells, Heather; Livingston, Laura; PADirectorofP&RSHSCT; Willis, Lisa
Subject: IPR's

Dear All

At our next 1:1 meetings we will be discussing IPR's for 2019/20 and 2020/21. Can I ask that you do two things in advance of the meeting.

1. Please review your 2019/20 IPR noting achievements (up until 31st March 2020) and forward to me.
2. Based on 2019/20 IPR produce for 2020/21 a roll forward of those items not achieved in 2019/20. I would then suggest a general statement, which I will prepare, to go into all IPR's with regards to managing the organisation through the COVID-19 pandemic

Given the year of COVID we have had, I think this is a fair approach to IPRs for 2020/21.

We will for 2021/22 have a modified approach and I will discuss this further.

Many thanks, Shane

Stinson, Emma M

From: Wallace, Stephen
Sent: 13 October 2020 10:53
To: Devlin, Shane
Cc: OKane, Maria; Trouton, Heather
Subject: Hyponatraemia Oversight - Updated ToR and Lead Role
Attachments: Terms of Reference - Hyponataemia Oversight Group Updated 05102020 (3).docx; Hyponatreamia Lead 8B.DOCX

Hi Shane,

As requested and per discussions with Maria and Heather please find attached revised terms of reference for the Hyponatraemia Oversight Group and proposed time limited lead role to coordinate the project. We are in agreement that the role as specified will serve to pull together all elements of the project and provide the oversight and assurances sought by both SMT and Trust Board.

We would be grateful if you can confirm this is something that you are willing to support for 9 months and within which service area you / SMT feel the lead role should rest.

Thanks
Stephen

Terms of Reference

Trust Oversight Group into the Inquiry into Hyponatraemia Related Deaths – October 2020

Terms of Reference of Oversight Group

The Trust Oversight Group into the Inquiry into Hyponatraemia Related Deaths is responsible for providing direction, support and oversight of improvement and systems strengthening work to implement the 96 recommendations contained in the Inquiry into Hyponatraemia Related Deaths (2018).

The oversight group will provide clarity and transparency of function; drive quality and safety and provide assurance to Trust Senior Management Team and Trust Board, as well as the public, pertaining to the recommendations made from the Inquiry into Hyponatraemia Related Deaths.

The function of the oversight group is to:

- Perform a baseline gap analysis with regard to all 96 Report recommendations of report
- Create an action plan complete with named action leads and time scales for targeted improvements to address recommendations
- Establish sub-groups as required to progress specific elements of work relating to implementation of recommendations
- To provide monitoring and oversight of progress towards implementation actions relating to recommendations
- Ensure that there is an improved overall compliance to the recommendations through the including the review and monitoring of the Public Health Agency Staff Training Competency Framework
- Provide oversight of audits relating to recommendations and their findings to provide assurance
- Support and encourage incident reporting processes among all staff of all directorates
- Escalate and identify any barriers, concerns or risks to improvement identified to Trust Senior Management Team

- Work collaboratively across multidisciplinary stakeholders to ensure the best and safest outcomes for service users

Membership of Oversight Group

Membership of the Oversight Group is as follows:

- Dr Maria O'Kane, Acting Medical Director – Joint Chair
- Heather Trouton, Executive Director or Nursing – Joint Chair
- Melanie McClements, Director of Acute Services
- Vivienne Toal, Director Human Resources and Organisational Development
- Dr Tracey Boyce, Director of Pharmacy
- Dr Bassam Aljarad, Consultant Paediatrician
- Ronan Carroll, Assistant Director, Acute Services Surgery
- Grace Hamilton, Assistant Director Nursing Governance
- Dawn Ferguson, Assistant Director Nursing and AHP Workforce
- Anne McVey, Assistant Director Acute Services MUSC
- Bernie McGibbon, Head of Service CYPS
- Dr Phillip Murphy, Associate Medical Director, MUSC
- Dr Mark Haynes, Associate Medical Director, Surgery
- Lynn Woolsey, Assistant Director, Nursing Workforce Development
- Stephen Wallace, Assistant Director Clinical Social Care Governance
- Marita Magennis, CYPS Governance Coordinator
- Paul Morgan, Director, Children and Young People Services
- Eileen Mullan, Non-Executive Director
- Dr Damian Scullion, Associate Medical Director, ATICS
- Tony Black, Governance Coordinator, MHLD
- Claire McNally, Governance Coordinator, OPPC

Other staff may be co-opted in depending on information required. Members should aim to attend all meetings. Should a member be unavailable to attend, they may nominate a deputy to attend in their place subject to the agreement of the Chair.

Frequency of Meetings:

- The group is a task and finish group and the anticipated timescale for completion of this work is 12-18 months.
- Meetings will be held monthly, this will be reviewed as required
- It is proposed that each meeting should not last more than 2 hours

Risk Assessment

The Oversight Group will create a Risk Register when considering the Inquiry recommendations. Areas of risk will be communicated to SMT by the Oversight Group Chair. These, where appropriate, will be cross referenced with any findings made by Internal Audit to ensure that all risk is addressed and minimised.

The Oversight Group have identified a key risk for the Trust "as failure of the Trust to implement actions in response to the recommendations into the Inquiry into Hyponatraemia".

Authority/ Delegated Powers

- The Oversight group is authorised by Governance Committee

- To progress or investigate any activity within its terms of reference to satisfy SMT that effective assurances have been made to implement the 96 recommendations and that patient safety is upheld

Reporting and Communication

The Oversight Group will report to Trust SMT monthly and produce Progress Reports for Trust Board as requested.

The quorum for the meeting will be no less than 50% of the membership and must include as a minimum the Chair or a nominated deputy; at least 2 Nurses and two Doctors; and clinical representation appropriate to the agenda items.

Reporting Structure

The minutes of the group shall be formally recorded and distributed to the members of the group and circulated to the Senior Management Team for information and action where appropriate.

The oversight group will provide a report to Governance committee 6monthly.
A report will be provided to Trust Board as part of the Medical Director's report.

Revision Dates

The group Terms of Reference will be reviewed at least annually

Agenda items and Papers for Meetings

Agenda items should be submitted to the corporate clinical and social care governance team corporate.governance@southerntrust.hscni.net 10 days in advance of the meeting.

The content of the agenda will be approved by the chair. Agenda and papers for the meeting approximately 5 days in advance of the meeting, to enable the members to have the opportunity to read information in advance.

Southern Health and Social Care Trust

Quality Care - for you, with you

Job Description

Post **Hyponatraemia Lead for 9 months**

Grade **8B**

Department

Base

Reports to

Responsible to

Job Summary

Risks associated with suboptimal fluid management in children are well documented. As a result, reducing the risk of hospital acquired hyponatraemia has been the focus of significant efforts across the health service for some years. Following inspections RQIA made recommendations in 2008 and again in 2010 to improve HSC Trust arrangements to reduce risk in this area.

The O'Hara Inquiry into Hyponatraemia-related deaths (2018) raised serious concerns about the standard of healthcare delivered to five children who tragically died in Northern Ireland as a result of hyponatremia related illnesses between 1995-2001. The report also identified system failures in the investigation of the deaths and made 96 recommendations for HSC organisations in order to improve the safety and quality of care delivered.

The purpose of this post is to drive forward the actions required to achieve these recommendations within the SHSCT. Where the implementation of recommendations is the responsibility of operational directors, the post holder will work in collaboration with operational leads to ensure the Trust is fully compliant with these recommendations.

S/he will chair an implementation group comprising of the key stakeholders including operational leads, project manager and CSCG support staff to progress this work.

S/he will report on progress against these recommendations to the Trusts Hyponatraemia Oversight Group.

Key result areas / Main responsibilities

Setting direction

1. Convene, co-ordinate and chair the Hyponatraemia Implementation Group to ensure that the recommendations are actioned and progressed within the Trust.

2. Establish appropriate reporting structures and assist with the development of solutions to progress outcomes ensuring appropriate mechanisms for escalation where barriers to compliance exist

3. To provide support regarding the implementation of clinical recommendations where the responsibility for enactment and assurance is the responsibility of operational directorates

4. Report on progress against each recommendation to the Trust Hyponatraemia Oversight Group and Trust SMT.

5. Provide clear and concise direction to stakeholders in Acute, and Paediatric Clinical services in the Trust, around the expectations within the clinical recommendations 10 -30.

6. Support the strategic review and improvement of services, in particular making use of improvement methodologies. Resultant outcomes to include, improved service user and staff satisfaction, service effectiveness and value for money.

7. Contribute to development of a Trust-wide learning culture that supports the ethos of lessons learnt to facilitate expertise, knowledge and skills sharing to ensure overall improvement in safety and quality and outcomes for patients and services.

Service delivery

8. Co-ordinate the Implementation and Oversight Groups, ensuring there is appropriate reporting mechanisms in place. The post holder will establish and implement a project management structure to these groups, ensuring that progress is made to achieve successful outcomes.

9. Lead the development of programmes of work to ensure the achievement and maintenance of all recommendations regarding the reduction of risk from Hyponatraemia.

10. Support and progress action plans and audits, collaboratively and energetically working through barriers to identify achievable solutions.

11. Work with clinicians, senior managers and frontline staff to understand situations or information within their sphere of work and develop practical solutions to ensure

implementation of the recommendations.

12. Lead the development of monitoring reports and produce a regular suite of information and other management reports on progress on the Hyponatraemia recommendations, for Trust Board, the Executive Quality Improvement Steering Group, Associate Medical Director Forum, and other sub committees.

13. Drive improvement as well as identifying areas of good practice and excellence.

14. Provide specialist advice, enhanced support, performance improvement expertise and guidance to senior managers, clinicians and staff in respect of service/s under their remit to reduce the of risk of Hyponatraemia to CYP in the Southern Trust.

15. Monitor the implementation of the Southern Trust's Nursing and Midwifery competency framework for the prescription, administration, monitoring and review of intravenous fluids for children and young people, ensuring that there is progress in implementation and compliance.

16. Support the relevant Assistant Directors to implement the Internal Audit recommendations regarding the Management of Children in Adult Wards and Management of Intravenous Fluids to reduce the risk of harm.

17. Work closely with all stakeholders to identify and highlight areas of non-compliance/lack of progress, reviewing possible solutions for consistency and escalating as required.

18. Develop strategies, systems, policies and procedures to address the key areas of risk, which support achievement of the recommendations within the Trust.

19. Challenge the service teams, to ensure areas where performance is unsatisfactory and improvement is required are identified, addressed and implemented.

20. Prepare responses to regional and national reports and recommendations from regional statutory and other bodies as required.

21. Translate regional guidance and standards in relation to relevant services into the Trust's context. Identify the implications for processes and systems and ensure that the necessary changes are disseminated and implemented within designated timeframes.

22. Work with operational to develop and provide any general or specialist training and education programmes to ensure as high compliance as possible in this area.

23. Work with directorate leads to develop strategies to improve training deficits, and supporting them to target shortfalls if noted.

Collaborative Working

24. Work collaboratively with operational and corporate Assistant Directors and senior managers and external organisations, and represent the Trust on local and regional groups.
25. Work directly with relevant internal departments to ensure a seamless approach to the implementation of recommendations and agreed work plans, ensuring the provision of accurate and timely information as required..

26. 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 assurance.

27. Work with a range of multidisciplinary stakeholders to develop a Policy for Safeguarding children in an Adult care setting in the Southern Trust

Communication and Information Management

28. Implement and maintain systems and procedures to inform and receive feedback on the services from stakeholders. Evaluate that feedback and take appropriate action for continuous improvement and implementation of recommendations made.

29. Review and evaluate audit outcomes and support stakeholders to take forward any improvement strategies to increase compliance improving outcomes and developing a learning culture.

30. Provide and present quantitative and qualitative reports for Trust Board, SMT, and other appropriate groups, on the work ongoing, implementation of recommendations, audit findings and actions to give assurance of safe and effective patient care.

Quality

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

32. Benchmark performance against local, regional and national standards.

33. Support senior operational managers and staff to meeting hyponatraemia recommendations relevant to their areas of responsibility

34. Facilitate programmes to improve compliance with fluid management for CYP in order to improve quality and safety performance deploying appropriate improvement methodology, toolkits, training and coaching as required.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

35. 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.

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

37. 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.

38. 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.

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

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

General Management responsibilities

41. Adhere to the Code of Conduct for HPSS managers which states that managers will be expected to work with integrity, honesty and openness, probity, accountability and respect, available on www.dhsspsni.gov.uk.

42. Ensure the appropriate governance and risk management arrangements are in place for the services you are responsible for and take appropriate action to identify and manage risk and to maintain safety of users, staff and others in accordance with relevant regulations, policies and procedures;

43. It is essential to ensure that the highest standards of infection prevention and control are maintained to ensure patient and client safety and maintain confidence in the Trust. As a Manager, you must ensure that you implement all instructions/ policy in this area and that all staff are made aware of and fully comply with these.

44. Where the post holder has responsibility for managing a budget, ensure that services are managed and developed both in accordance with agreed and funded priorities as set out on a yearly basis and in accordance with Standing Financial Instructions, particularly ensuring your compliance with payroll documentation procedures and timescales;

45. Ensure the necessary arrangements are in place in regard to the 'Knowledge and Skills Framework' outlines, where this applies, for the posts for which you have management responsibility. Ensure that each member of staff has an annual development and performance review, a personal development plan and that arrangements are in place to ensure that staff have maximum opportunity to progress through gateways in their pay bands and to contribute effectively towards our objectives;

46. Promote a culture of continuous service improvement amongst your staff, encouraging their participation and that of service users in reviewing and modernising current services and in service development;

47. Make sure you are trained and competent in the relevant policies and procedures which apply to the management of staff and other resources and abide by these policies; seeking advice as necessary from senior management or specialist staff as necessary;

48. Communicate effectively with staff and maintain productive working relationships amongst your staff and with others;

49. Delegate appropriate responsibility and authority to staff in order to ensure optimum and effective service delivery and decision-making, whilst retaining overall accountability and responsibility for outcomes;

50. Promote a culture of learning and development and facilitate arrangements for and participate in training and development of staff as agreed for the performance of their duties. Where training is in accordance with relevant standards make sure you have the relevant competences in order to carry out this responsibility;

51. Promote equality of opportunity for all by personal action, both in the management of your staff and in the provision of care to service users in accordance with the Trust's Equality of Opportunity Policy and Equality Scheme;

52. Take responsibility for ensuring appropriate standards of environmental cleanliness and for encouraging staff to maintain standards in their work area. Have an awareness of environmental issues and take appropriate action, for example to ensure the efficient use of energy and other resources, recycling etc.;

53. Make sure that staff are aware of trust policies regarding the Data Protection Act 1998, the Freedom of Information Act 2000, the Environmental Information Regulations 2004

and Records Management and that they must not disclose, withhold, retain or dispose of any information unless legally authorised.

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/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

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. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.

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

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 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.

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

PERSONNEL SPECIFICATION

Title of Post: **Hyponatraemia Lead**

Band of Post: 8B

Salary: £46,626 - £57,640

Hours: 37.5 hrs 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.*
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.*
4. *Volunteering experience may be considered appropriate in particular for roles within the context of direct patient/client care.*

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/ Experience	1. University Degree or a relevant[1] 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, 4. 2 years' experience in demonstrating personal responsibility for achieving measurable improvements in outcomes for services	
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	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities/Knowledge	1. Knowledge of Hyponatraemia Inquiry and associated recommendations 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. 6. Demonstrate evidence of using own initiative in managing priorities to achieve successful outcomes. 7. Ability to extract, analyse, interpret	Interview

	and present complex statistical information from a range of HSC systems/sources.	

[1] Relevant will be defined as a nursing, social work or AHP degree

Essential Leadership Capabilities:

The successful candidate will need to provide evidence and demonstrate their Leadership capabilities against the required dimension on the NHS Leadership framework.

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified. An assessment centre may also be used as part of the short-listing process.

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The dimensions concerned are given in the Healthcare Leadership Model (see below link) http://www.leadershipacademy.nhs.uk/discover/leadershipmodel/leadership-dimensions/

Particular attention will be given to the following:

- 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

Stinson, Emma M

From: Hynds, Siobhan
Sent: 16 December 2020 16:05
To: Wallace, Stephen
Subject: LPP Information redacted by the USI

Attachments:

LPP Information redacted by the USI

[redacted]

[redacted]

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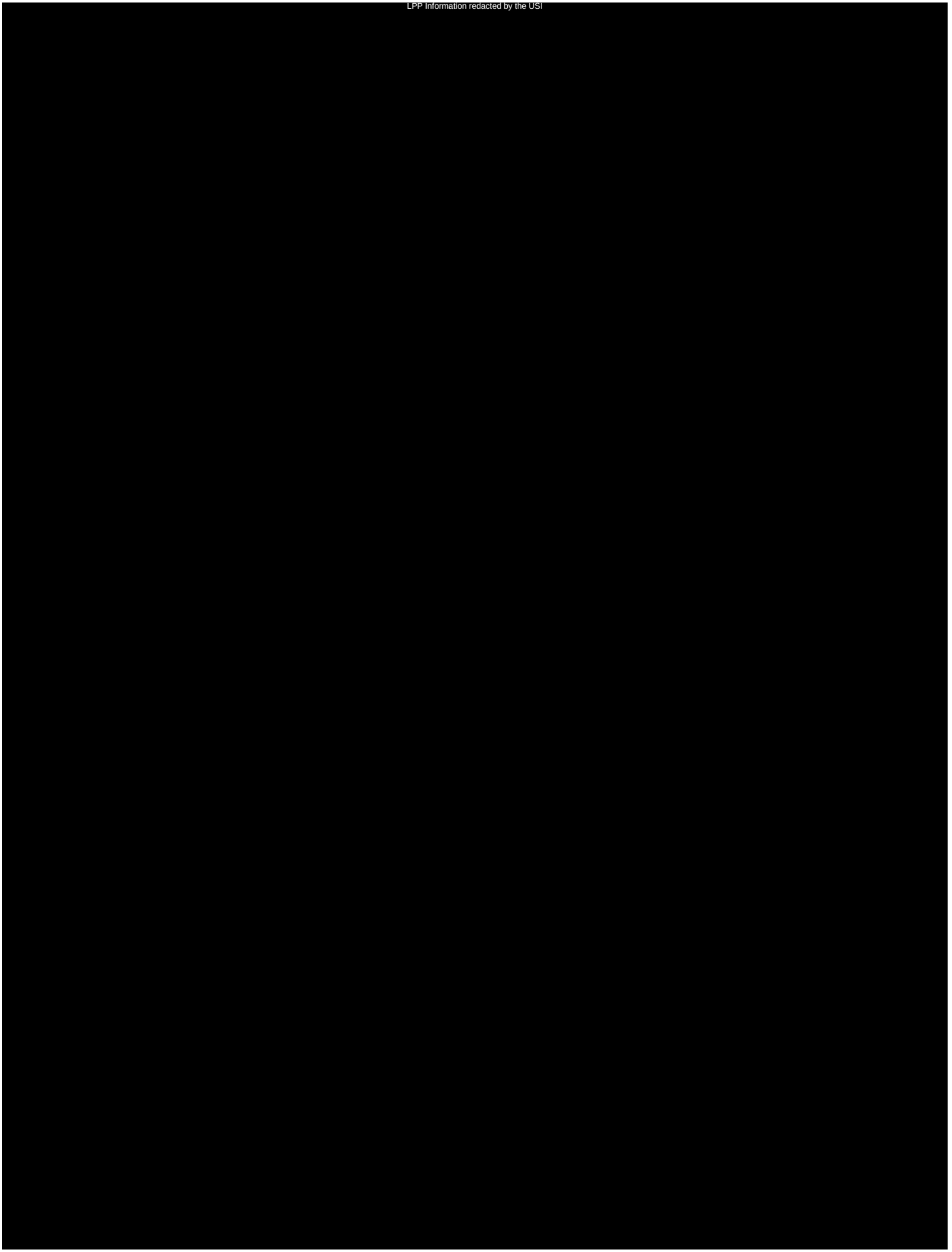

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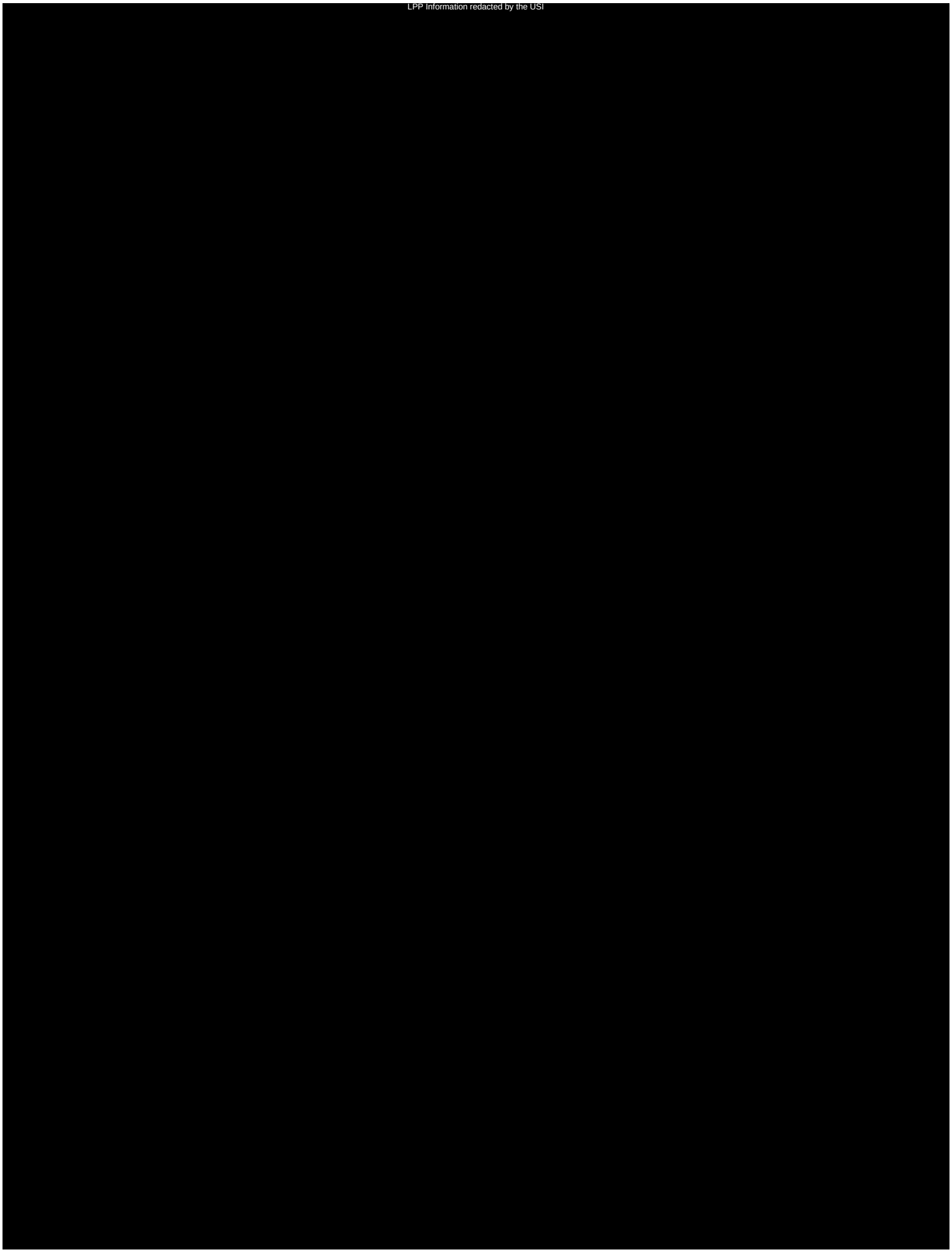

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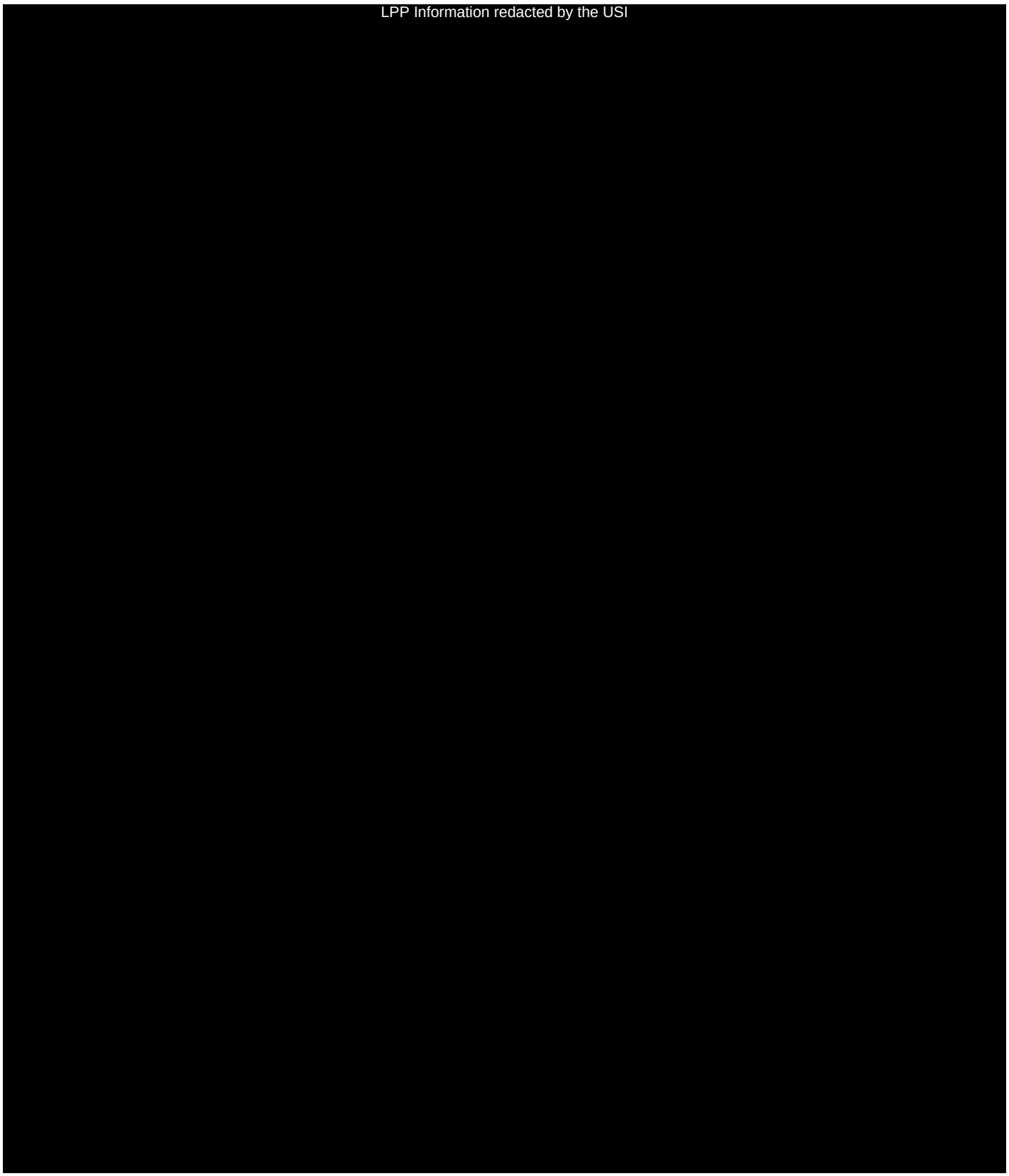
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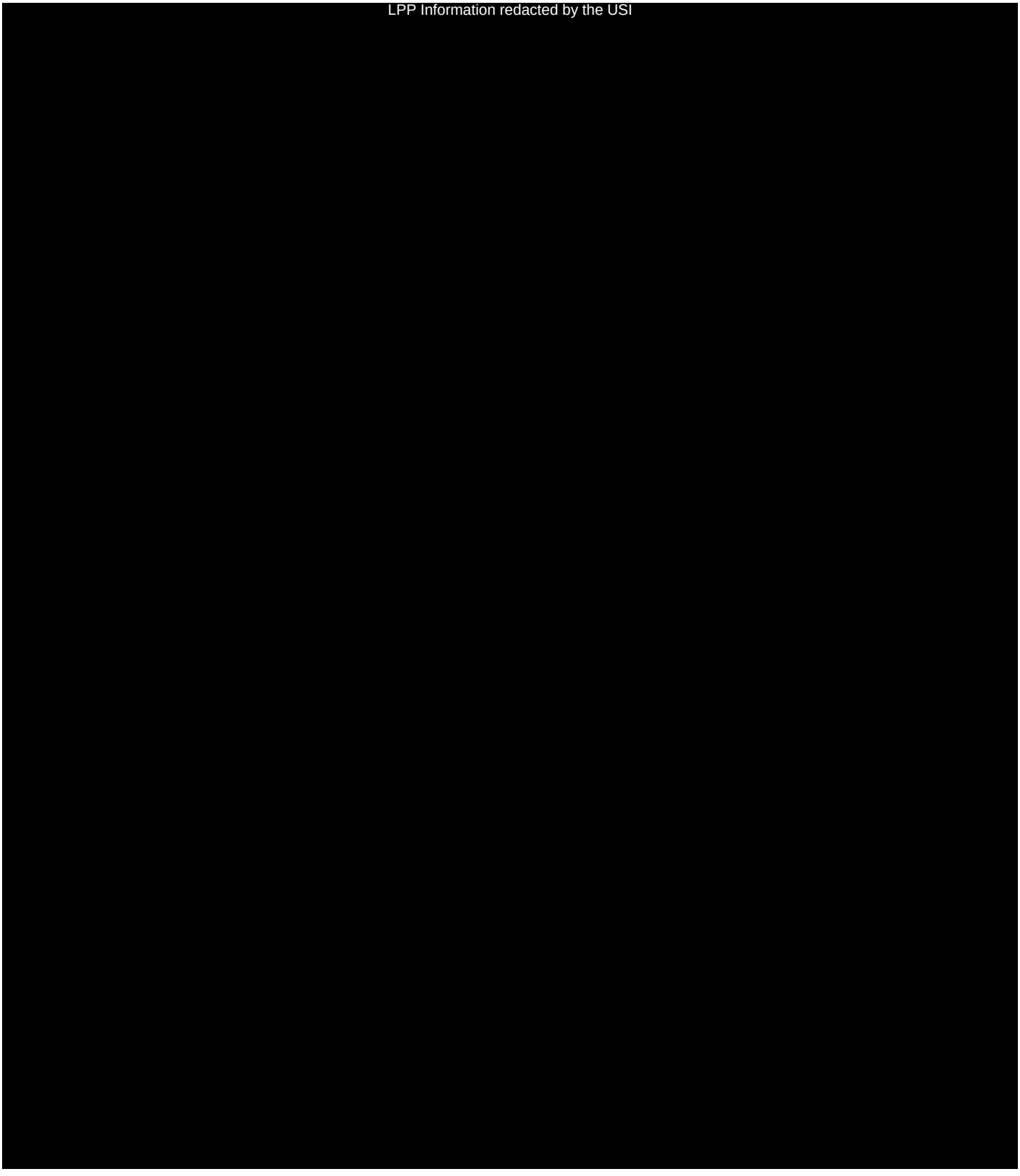
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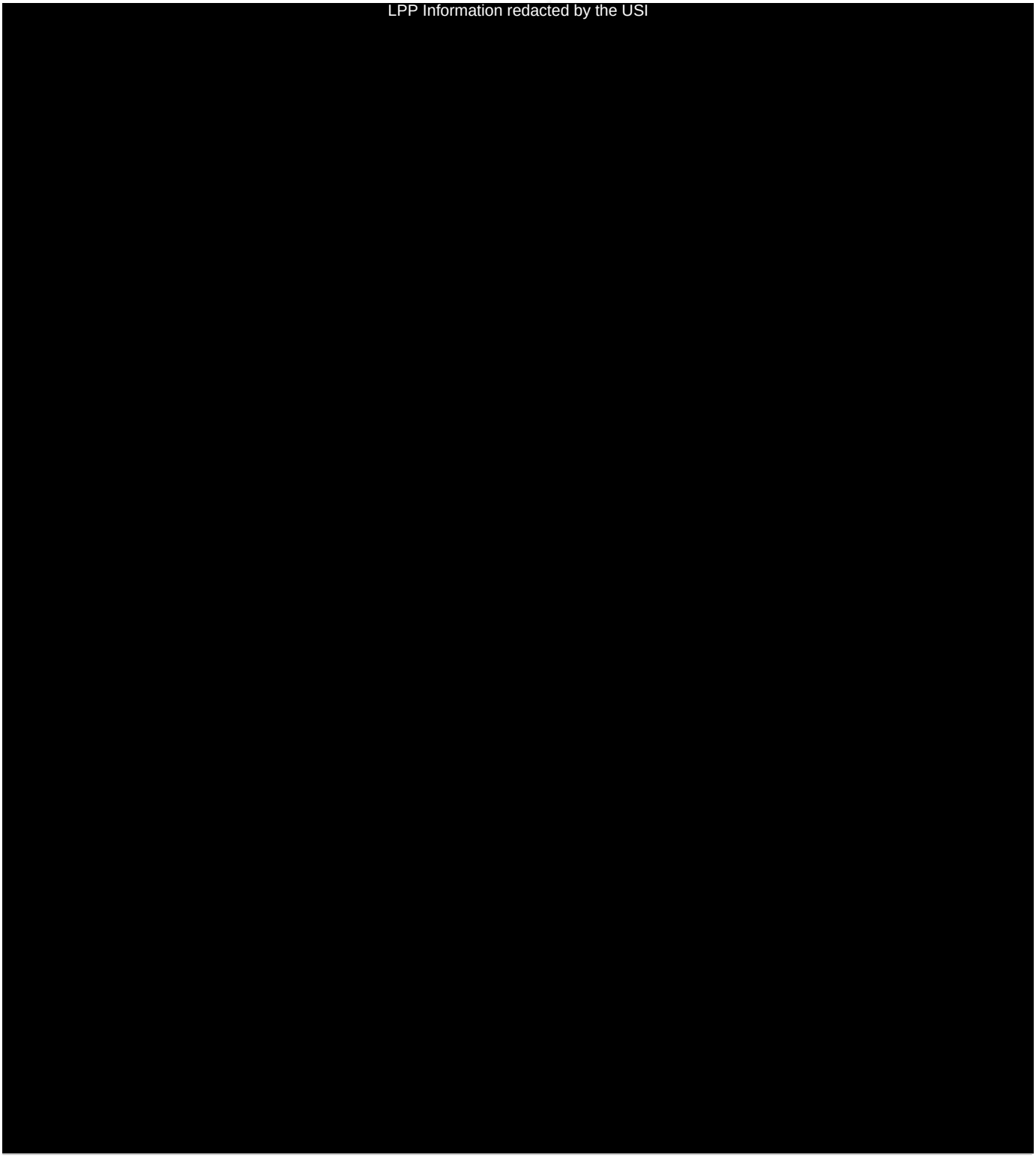
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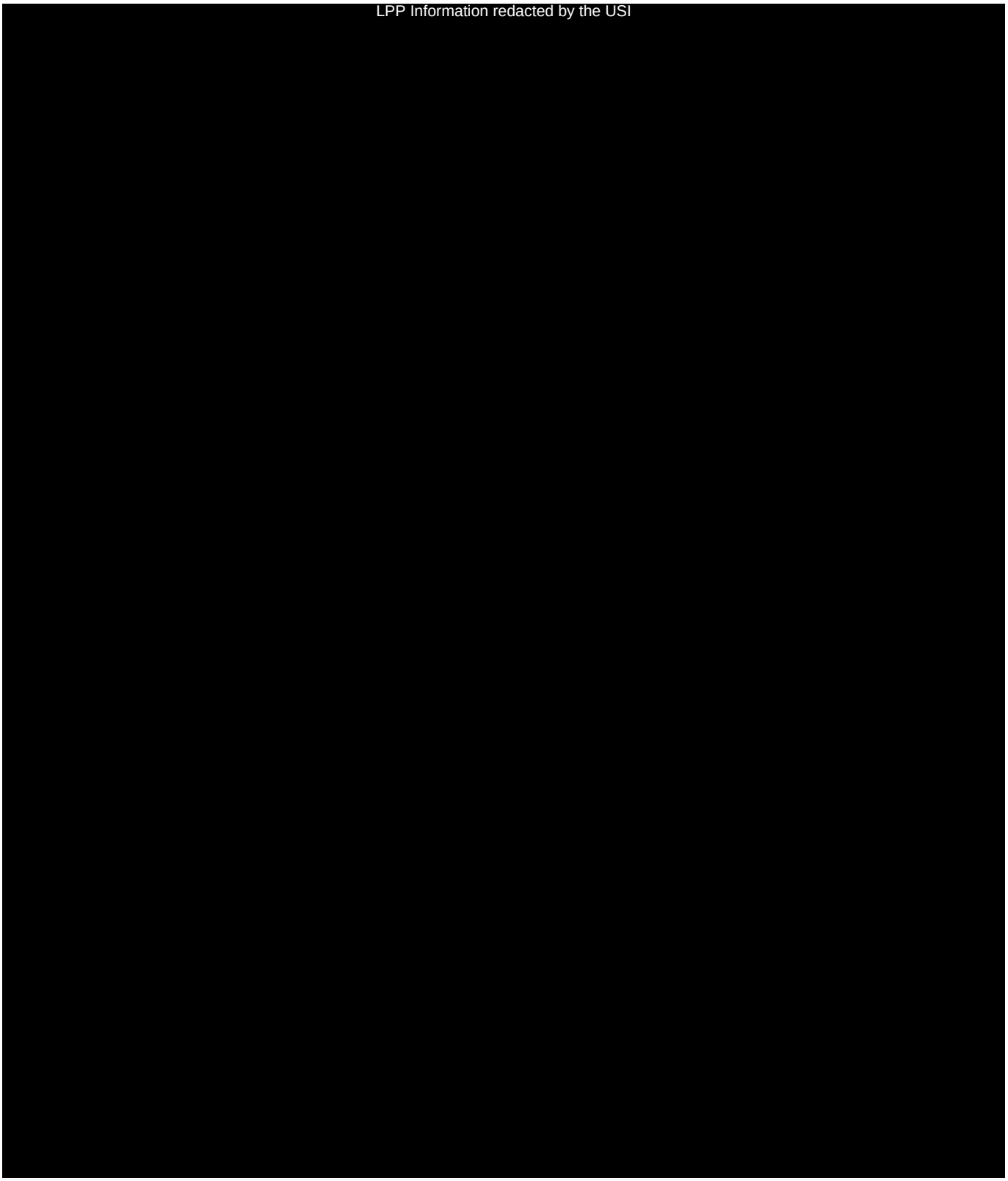
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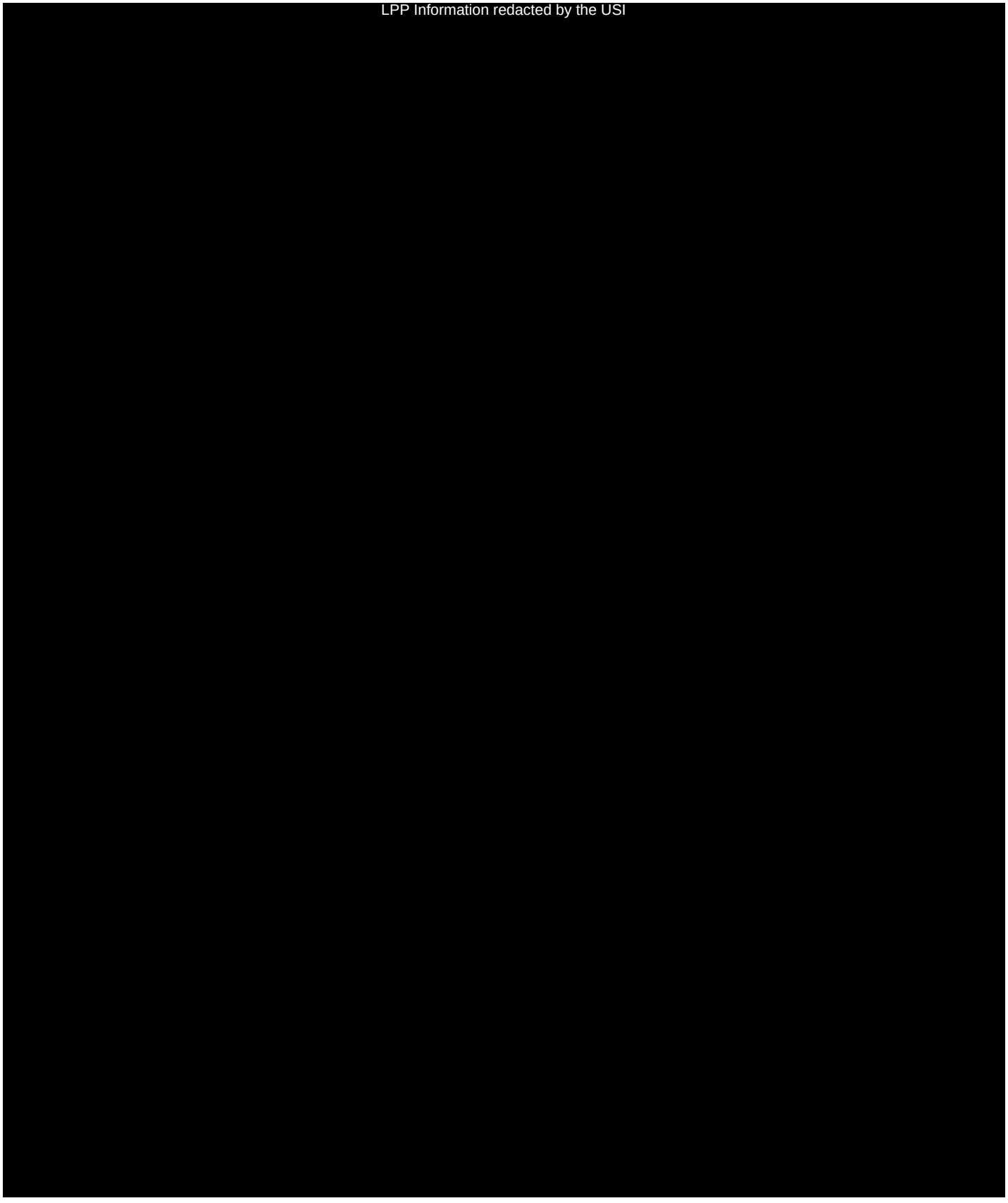
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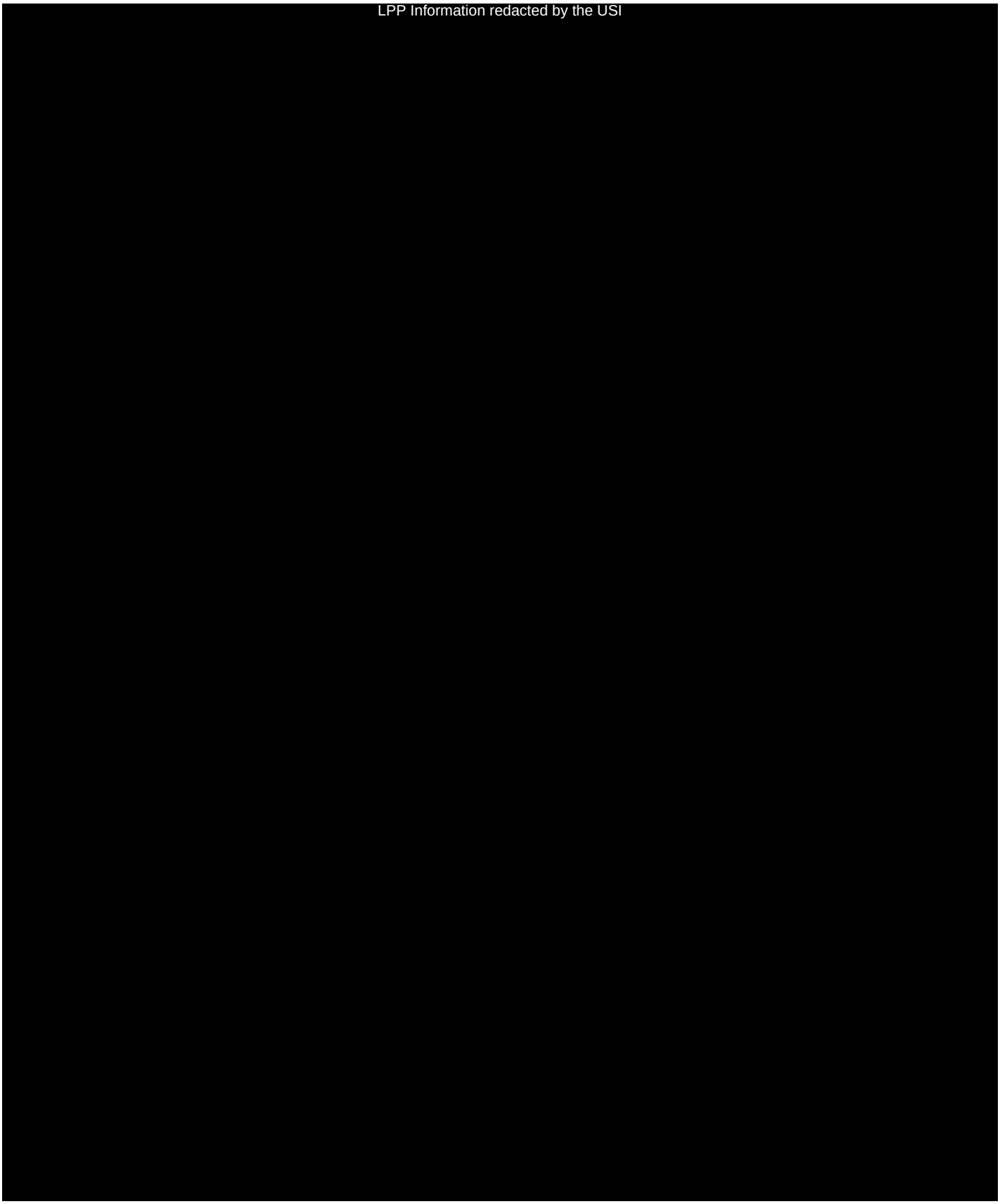
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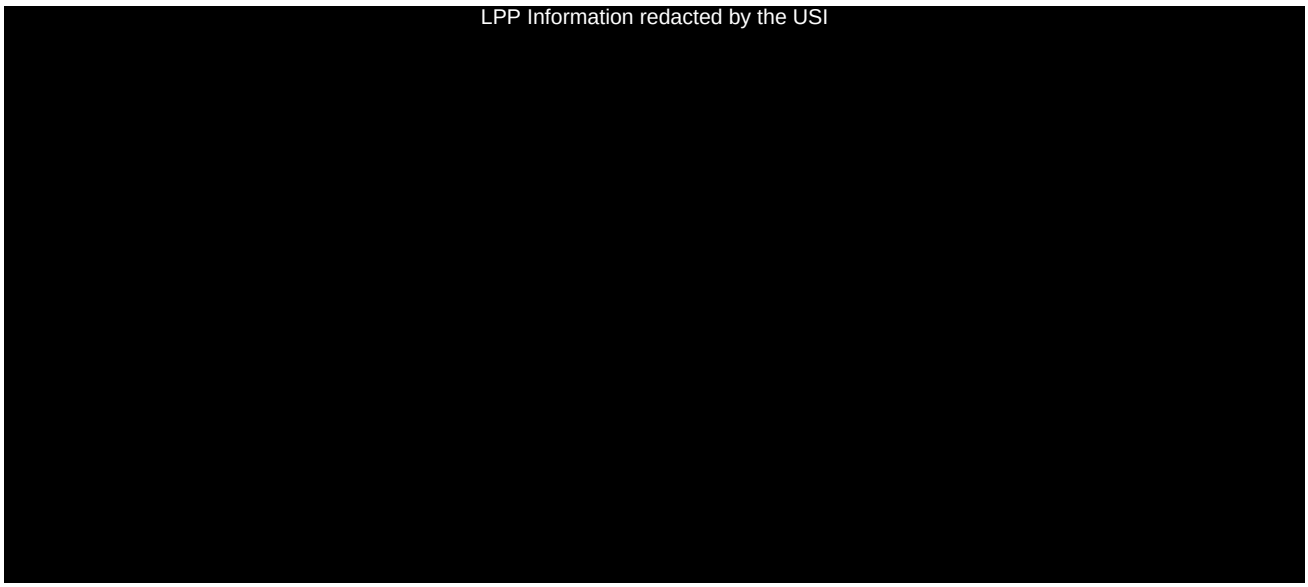
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Stinson, Emma M

From: Best, David <[redacted]>
Sent: 18 December 2020 09:21
To: OKane, Maria
Cc: Johnston, Julian; Wallace, Stephen
Subject: RE: Indepdendent Medical Examiner

Maria

Excellent news. Over the Christmas period we have decided to pause reviews and we will recommence in the first week of January. The IMEs are meeting on 4 January and we will consider how best to include the Southern Trust and from which date.

As a first step, could you confirm a lead doctor for both Craigavon and Daisy Hill. We will then liaise with them around the practicalities of what is required. We have developed an information sheet for dissemination to medical staff and essentially, we just need that to be distributed and for doctors to be aware that the process is starting. We will confirm a start date, following our meeting with the IMEs on 4 January.

Thanks

Davy

From: OKane, Maria [mailto:[redacted]]
Sent: 18 December 2020 00:12
To: Best, David <[redacted]>; Johnston, Julian <[redacted]>
Cc: Wallace, Stephen <[redacted]>
Subject: FW: Indepdendent Medical Examiner

Dear Julian / Davy,

Further to the meeting held with the Stephen and Damian last week regarding the newly established regional Independent Medical Examiner role the Southern Trust would be pleased to participate in the next phase of the project.

Can you advise what steps we need to take to commence this?

Regards
Maria

Dr Maria O'Kane
Medical Director

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Item	Attachment
Urology Update Papers for 12 to run through	2. SHSCT update for DOH Urology Assurarof Appendix 1 - Terms Reference CLINIC/
Appraisal, Revalidation and Annual Management Reviews for Doctors Update on the discussion with UHB – potential for Annual Management Reviews to complement A&R processes	MNOTES - 15 12 2020 11 30am UHB A
Individual Performance Review Shane to discuss what will be required for IPR re Medical Director	FW IPR's.msg
Hyponatraemia Revised terms of reference for Hyponatraemia and proposed 8B job – also lead directorate	Hyponatraemia Oversight - Updated
Judicial Review Correspondence from DLS re surgical patient – potential for future actions	FW URGENT FURTHER Litigation M
MLA Queries Currently the Trust has a 10 day response time set. This is from Mairead McAlindens time to improve MLA relationships. The rest of the regional Trusts have a 20 day response time Volumes now make this challenging (30 received in a single day alone) can this be realigned with the region – comms to be issued regarding this	
Independent Medical Examiner	RE Indepdendent Medical Examiner.msg
?? Colorectal Surgery	

Cancer Quality Surveillance Policy

Key Document code:	WAHT-KD-023	
Key Documents Owner:	Elaine Stratford	Cancer Quality Assurance Manager
Approved by:	Cancer Board	
Date of Approval:	23rd May 2019	
Date of review:	23rd May 2021	

Key Amendments

Date	Amendment	Approved by
9th March 2017	Revert to Original text in document in relation to referring to 'immediate risks' and 'serious concerns'	Cancer Board
23rd May 2019	Document approved	Cancer Board

Introduction

The National Quality Surveillance team was established in April 2015. It is a specialised commissioning directorate within NHS England and is responsible for all specialised services and all cancer services irrespective of how they are commissioned.

The purpose of the National Quality Surveillance programme is to measure both clinical outcomes and the implementation of the service specification by the clinical service against a number of set indicators. These focus on patient experience, clinical outcomes, structure and process. The programme will support the Quality Surveillance Team (QST) in the alignment of specialist services, building a quality profile for each specialised service and to provide a National and regional reporting function. The QST will also provide a responsive and flexible review visit programme in line with regional and National priorities.

The Quality Surveillance programme introduced a new information portal in July 2016 the Quality Surveillance Information System (QSIS). This portal enables each team to submit self-declarations (SD), against a number of specified indicators. It will act as a tool for commissioners to compare and benchmark across providers. Data will also be extracted from other sources such as National audits and surveys, acute and specialist Trust dashboards, CQC visit reports and local mechanisms of gaining feedback.

Data collection will also include sources such as patient experience feedback from the friends and family test, complaints, serious untoward incidents, service reviews, and previous peer review visits.

Self-declaration for cancer services

The Quality Surveillance programme for cancer services will require each team to submit an annual self-declaration. This will be sent out to the clinical teams for them to populate with the required information against the set quality indicators.

Within cancer services, the majority of teams and services will have an internal validation (IV) by an approved panel within the organisation. Information following the IV panel will be transferred onto the QSIS portal by the Cancer Quality Assurance Manager (who is QSIS lead/administrator for cancer services).

All self-declarations will need to be submitted by the deadline specified by the national team.

The National Quality Surveillance team as part of the NHS business plan will be organising external visits. These are in 3 categories:

1. Comprehensive visit

   These will be based on quality indicators and will be agreed nationally with the Specialised Commissioning Programmes Of Care (POC) boards based on national priorities. This will be for all organisations providing that particular service across the country. The schedule for the first of these comprehensive visits will be given by the end of November 2016 and will continue to be provided on an annual basis.

2. Targeted visit

   The National Quality Surveillance team may also request a targeted visit for a service. This would be a planned review to specific services/team informed by annual assessment and agreed with regional specialised commissioned teams, based on local priorities.

3. Rapid response visit

   At any point a rapid response visit may be requested by the National Quality Surveillance team which will be a short notice visit to a specific service/team in response to concerns raised in relation to patient safety.

The visit cycle will predominantly be from January to July, but may extend throughout the year.

Scope of the Policy

This policy is intended to cover all cancer and palliative care MDT's and services across the Trust for which indicators have been developed by the national quality surveillance team NHS England.

Definitions

- Self-declarations (SD): Every year each team/service will complete the self-declaration demonstrating compliance against the national indicators. In addition, the team/service will be required to provide an annual report, a work programme, an operational policy and appendix containing supporting evidence.

- Internal Validation (IV): a process of internal governance by the Trust. This includes a review of the selected teams/services' self-declaration, annual report, operational policy, work programme, and appendix. This will be by a panel with membership from the Trust, Clinical Commissioning Groups (CCG's) and user representation.

- External Reviews will take the form of comprehensive, targeted or rapid response as outlined above.

- 'Dummy run': prior to an announced comprehensive visit, targeted visit or rapid response visit from the national team, there will be a review of the evidence provided by the team/service. This review will take place at least 6 weeks prior to the planned visit, however the time frame may be less depending on the type of external visit requested. If the national team wish to undertake a rapid response visit when the Trust may have as little as 4 weeks' notice of the visit.

  The dummy run will be undertaken by the cancer team reviewing the available documentation to identify any potential areas of concern. The MDT team, directorate, divisional and executive teams will be informed immediately of any potential immediate risks or serious concerns identified at the 'dummy run'.

Responsibility and Duties

Cancer Management Team:

The cancer management team will lead on the IV process and will facilitate external reviews.

The team consists of:

- Associate Medical Director for Cancer Services
- Cancer Manager
- Macmillan Lead Cancer Nurse
- Cancer Quality Assurance Manager
- Cancer Data Information Manager
- Assistant Cancer Data Information Manager
- Macmillan Cancer Information and Support Service Lead
- Cancer services team secretary (for IV)

Associate Medical Director for Cancer Services:

- The Associate Medical Director for Cancer Services is Chair of the Trust Cancer Board, where any outcomes or actions from the Cancer Quality Surveillance process will be noted, discussed and monitored. Minutes from the Cancer Board will be forwarded to the executive team.

- To be responsible for reviewing the teams/services self-declarations and ensuring that any necessary changes are made. Any immediate risks and serious concerns at any stage will be reviewed and escalated to the Chief Executive Officer (CEO) or nominated deputy.

- To chair all IV panels where able (however if the Associate Medical Director for Cancer Services' own team is under review an alternative chair will be identified) and will agree and submit the subsequent report to the CEO or nominated deputy.

- To take part in the 'dummy run' of the team or service to be externally reviewed within a specified timeframe, (normally 6 weeks prior to the review but dependent of the type of review requested by the national team).

- To deliver a brief presentation introducing the selected team or service at any external review.

Cancer Services Manager and Macmillan Lead Cancer Nurse:

- To have overall responsibility for leading the Quality Surveillance programme.

- To be part of the IV panel and will Chair when required.

- To take part in the 'dummy run' of the team or service to be externally reviewed approximately six weeks prior to a visit requested by the National Quality Surveillance team, but this will be dependent of the type of review that has been requested.

Cancer Quality Assurance Manager:

- In discussion with the Associate Medical Director for Cancer Services and the Macmillan Lead Cancer Nurse and Cancer Services Manager develop the programme of internal validations and co-ordinate the external reviews ensuring all the relevant stakeholders have been informed. This will include the assembly of the internal panel, making room bookings and ensuring that the relevant documents have been circulated to panel members. Relevant IT equipment and facilities for use should also be made available.

- To support the teams in completion of the self-declaration documents, annual report, operational policy, work programme and supplementary evidence in the form of appendices, providing guidance regarding format and content.

- To maintain close communication with the national team.

- To be responsible for co-ordinating the internal programme of reviews and also any external reviews.

- Once the teams/services self-declarations have been completed, they will form part of the evidence for both IV and external review (taking the place of what was formerly the self-assessment document).

- To be a member of the IV panel.

- To fulfil the role of QSIS lead/administrator for cancer services, assisting MDT members to register on the portal with appropriate permissions.

- To disseminate all IV and external reports to executive members of the Trust board and the clinical governance department.

- To present the IV and external report findings at the Trust Cancer Board.

- At the national team's request for an external review, to organise and participate in a 'dummy run' and review the evidence provided by the MDT/service approximately 6 weeks before the external visit (or sooner if a rapid response visit is requested).

- To inform the Divisional Director of Operations, Clinical Director, Directorate Manager and MDT Lead immediately of any risks identified at the 'dummy run' and these will be noted, discussed and monitored by the Trust Cancer Board.

- To inform the following members of Trust staff immediately of any immediate risks or serious concerns identified at the IV or external review:

    - The Chief Executive Officer
    - Chief Medical Officer
    - Chief Nursing Officer
    - Chief Operating Officer
    - Deputy Chief Operating Officer
    - Relevant Divisional Medical Director,
    - Relevant Divisional Directors of Nursing,

- Relevant Divisional Director of Operations
- MDT Lead
- Directorate Manager
- Matron

To send the IV panel report to:

- The IV panel for factual accuracy for return of comments/clarification within 14 working days then
- The clinical team for factual accuracy for return of comments/clarification within 14 working days
- To oversee and facilitate the process identified in appendix one.
- To facilitate the Trust CEO response to any risks identified at any external visits.
- To ensure divisional teams are aware of any risks identified in either internal or external reviews and appropriate action plans are in place.
- To enter any immediate risk or serious concern onto the risk register (DATIX) system with the ownership of the risk being with the clinical and operational team. Cancer Board will monitor and review progression of the action plan in relation to the risk register on a regular basis.
- To liaise with divisional clinical governance teams in relation to the risk register.

The Cancer Data Information Manager and Assistant Cancer Data Information Manager:

- To be a member of the IV panel.
- To provide the specific cancer data information as required by Quality Surveillance indicators and to participate in the 'dummy run' of the team or service to be externally reviewed when available.

The MDT Coordinators:

- To use the Somerset Cancer Register live in the MDT meeting to assist in the collection of the specific cancer data information as required.
- To provide any specific information as requested by the cancer quality assurance manager.

Cancer Services Quality Improvement Nurse

- To be part of the "dummy run" of the team or service to be externally reviewed when available.
- To assist in the identification of patient representatives to form the IV panel when required.

Cancer Services Team Secretary:

- To provide administrative support to the cancer services team throughout the Quality Surveillance programme.

MDT Clinical leads:

- To ensure that the team/service has completed the self-declaration, annual report, operational policy, and work programme and that supporting evidence is available in the form of an appendix. These must be completed in the time frames that are specified either by the Trust or the national team.

- To facilitate the engagement of the clinical team in the Quality Surveillance programme.

- To be available for all internal and external validations of their team/service.

- To receive feedback from the IV panel or the national team and to inform the MDT team/service of the outcomes and take appropriate action as required.

- Following notification of any immediate risks or serious concerns the MDT lead working within the operational team is required to respond to cancer services within timeframes specified by the national team. (Responses are required within 10 working days for an immediate risk and 20 working days for serious concerns.)

- To attend the Trust Cancer Board at the request of the Chair.

- To take part in the 'dummy run' prior to any visits from the national team.

- To ensure an operational meeting is held yearly to discuss the Cancer Quality Surveillance programme and relevant evidence documents.

Chief Executive Officer:

- The CEO (or deputy) is responsible for the final approval of the self-declaration produced by the clinical team and ratified by the IV Panel to confirm that it is an accurate assessment of the selected team/services.

- The CEO (or deputy) will approve the self-declarations (following process as outlines in appendix one).

- Following an external visit from the national team, the CEO (or deputy) will be required to attend the High Level Feedback session.

- Following any external visits from the national team, it is the responsibility of the Trust's CEO (or deputy) to formally respond to the Quality Surveillance Team Director, within ten working days of notification of an immediate risk being identified and 20 working days after a serious concern being identified.

- Final approval of reports following internal validations.

Trust senior executives (Chief Medical Officer, Chief Nursing Officer and Chief and Deputy Operating Officer):

- To attend the high level feedback on the day following internal and external reviews.

- The Chief and deputy-chief operating officer will act as the QST leads for the organisation providing final sign off of self-declarations on the QSIS portal and acting as a point of contact for the organisation for communication with the Quality Surveillance team.

The Divisional Medical Directors, the Divisional Directors of Nursing, the Divisional Directors of Operations and Clinical Directors:

- To attend the high level feedback on the day of internal and external reviews when available.

Matrons:

- To participate in the 'dummy run' prior to any external reviews from the National Quality Surveillance Team.

- To attend the high level feedback session following internal or external reviews.

- To assist the MDT Lead and Directorate Manager to produce an action plan following notification of any risks and identified.

Directorate Managers:

- To take part in the 'dummy run' prior to any reviews from the national team

- To attend high level feedback sessions following IV and external reviews by the national team.

- To work with the MDT Clinical Lead to respond with an action plan following notification of any risks identified within timeframes specified by the national team. These are: within 10 working days for any immediate risks and 20 working days for any serious concerns.

- Any action plans developed will be monitored within the Division, and by Cancer Board and will be submitted to the national team as part of their annual assessment process.

- To attend the Cancer Board at the request of the Chair to update on the progress of actions in response to immediate risks or serious concerns.

Representative from Clinical Commissioning Groups:

- A representative from the Clinical Commissioning Groups and will be invited to take part in the Trust's IV as a member of the IV panel.

Table 1: Evidence for Quality Surveillance Review (annual)

Operational Policy	Annual Report	Work Programme
Describing how the team functions and how care is delivered across the patient pathway Outlining policies/processes that govern safe/high quality care Agreement to and demonstration of the clinical guidelines and treatment protocols for the team.	Summary assessment of achievements and challenges Demonstration that the team is using available information (including data) to assess its own service MDT Workload & Activity Data (activity by modality, surgical workload by surgeon, numbers discussed at MDT, MDT attendance) -National Audits -Local Audits -Patient Feedback -Trial Recruitment -Work Programme Update -Information relating to Clinical Lines of Enquiry	How the team is planning to address weaknesses and further develop its service. Outline of the team's plans for service improvement and development over the coming year -Audit Programme -Patient feedback -Trial Recruitment -Actions from previous reviews

Demonstration of agreement

Where agreement of strategic clinical network guidelines, policies, etc. is required, this should be stated clearly on the cover sheet of the relevant evidence documents, including agreement dates and versions. Similarly evidence of Trust guidelines, policies and all three core evidence documents require agreement of the MDT/service lead and the Associate Medical Director for Cancer Services dated and signed on the cover sheet. The agreement by a person representing the group or MDT (chair or lead ,etc.) implies that their agreement is not personal; they are representing the consensus opinion of the MDT.

Time scales for Self –Declaration

The Cancer quality assurance manager will produce an annual Trust Quality Surveillance programme timetable, once they have received notice from the national team of any planned external visits.

It is expected that the national team will inform the Trust by the end of November their timetable of comprehensive external visits for the forthcoming year ahead. In relation to other external visits from the national team, depending on the nature of the visit, the timeframe will be indicated by the national team on request of the visit.

All internal validations must be completed in time for the QSIS portal to be populated with self-declarations based on national indicators as specified by the national team.

Policy Detail

Self- Declaration process

Each team/service MDT Lead clinician will be expected to complete an annual self-declaration. The self-declaration from the QSIS portal will be downloaded and sent to the MDT Lead clinician to complete. Team members are also encouraged to register onto the QSIS portal on a 'read only' basis in order to familiarise themselves with the indicators set by the National Quality Surveillance Team.

Table 2: Key dates for Self -Declaration

Key Dates for teams/services to complete their self-declaration and supporting evidence for internal validation	
Self-declaration and supporting evidence documents from teams/services to be commenced by:	**1st December in the year**
Self-declaration and supporting evidence documents from teams/services to be completed by:	**By date specified by cancer services team**
Internal Validation to be completed by:	**End of 2nd week in June in the year**

Internal Validation

The Purpose of Internal Validation

NHS England stipulates that for all specialised commissioned services and all cancer services, however commissioned, an annual self-declaration is required. It is then for individual organisations to decide their governance processes to provide assurance of compliance to the national quality indicators. These are available on the QSIS portal.

WAHNHST have agreed that each team/service will have an internal validation on an annual basis unless there is a plan for an external visit from the National Quality Surveillance Team. This is to provide a robust clinical governance framework.

The only exception to this is if there are no national indicators for the team or service. This will then be discussed with the operational and clinical team.

By following this process, both clarity and assurances will be provided to the organisation in relation to the information provided from MDT/services against the nationally set indicators.

Process for IV

An IV panel will be selected from the following staff members:

- Trust Cancer Management team
- Patient/Carer Representative
- Nurse Representative
- Clinical Commissioning Groups Representative
- An expert colleague if required

The Internal Validation will be undertaken in one of two ways

- The IV panel will review all the submitted required documents with any points of clarification discussed with the MDT lead via telephone.

OR

- The IV panel will convene; review the submitted documents prior to meeting with representatives of the MDT and operational team to discuss any points of clarification. The representatives will be informed of the date of the IV by the Cancer Quality Assurance Manager a minimum of 6 weeks in advance to facilitate attendance

The IV Process will ensure

- The on-going quality assurance of cancer teams and services across the Trust
- Accountability for the Self-declaration is confirmed by agreement of CEO of the organisation.
- There is Commissioner and Patient/Carer involvement within the process
- The information from the self-declaration and the outcome of the internal validation is transferred onto the National Quality Surveillance (QSIS) web based portal within the timeframes specified by the national quality surveillance team.

The IV Self-declaration

The IV Self-declaration will be completed in real time by the panel and agreed by the panel members prior to the conclusion of the session.

Any risks identified

The MDT clinical team/service may identify following the IV process, three categories of concern relating to their team/service which are

- Immediate Risk
- Serious Concern
- Concern

Immediate Risk

An "Immediate Risk" is an issue that is likely to result in harm to the patient or staff, or have a direct impact on patient outcome and requires immediate action. Any immediate risk will be identified to the MDT/service lead and the CEO or deputy on the same day. A written response from the team/Trust identifying actions to resolve the issue(s) is required within 10 working days. Following IV the response will form part of the Internal Validation SD and will be agreed by the CEO or deputy.

Serious Concern

A "Serious Concern" is an issue, which although not an immediate risk to patients or staff could seriously compromise the quality or outcome of patient care and requires urgent action to resolve. Any serious concern will be identified to the MDT/service lead and CEO or deputy on the same day. A written response from the team/Trust identifying actions to resolve the issue(s) is expected within 20 working days. Following Internal Validation the response will form part of the national teams annual review process and will be agreed by the CEO or deputy.

Concern

A "concern" is an issue that is affecting the quality of the service. It does not require immediate action but can be addressed through the work programme of the MDT/service.

Following Internal Validation or external review, the CEO and senior members of the executive team will be notified of any immediate risk, serious concerns and concerns by the Cancer Quality Assurance Manager. The outcomes will be noted, discussed and monitored by the Trust Cancer Board.

External Visits
The Process

See Appendix 1 -Quick reference guide for External Peer Review visit.

Notification of Visits
It is anticipated that the National Quality Surveillance Team will provide the Organisation with sufficient notification of dates for planned comprehensive visits. The Cancer quality assurance manager will then notify individual teams/services of those dates if they have been selected for review.

Prior to External visits
For any external reviews the Cancer Quality Assurance Manager will organise a 'dummy run'. This is a review of the evidence provided by the MDT clinical team /service approximately 6 weeks before a planned comprehensive visit by the national team, but this could be a much shorter timeframe as dictated by the nature of the visit ie.targeted or rapid response.

This 'dummy run' will involve the cancer team, the relevant MDT lead and Clinical Nurse Specialist, Directorate Manager and Matron. The Divisional Director of Operations, and Clinical Director, will be informed immediately of any areas of concern identified at the 'dummy run' and these will be noted, discussed and monitored by the Trust Cancer Board.

Appendix One – Quality Surveillance – The process

Individual teams/services are made aware of the yearly timetable for their internal/external visit as soon as the cancer management team are aware

Team/service are sent PDF copy of self-declarations from QSIS portal. This must be returned to Cancer Quality Assurance Manager within 2 weeks of the date that the internal review is set for with a copy of annual report, operational policy and work programme.
For external visits, national timeframes will need to be strictly adhered to (this will depend on the type of visit requested)

Cancer Quality Assurance Manager and Macmillan Chemotherapy and Radiotherapy Project Nurse (as QSIS lead/administrators) enter information provided onto the QSIS portal. This information will form part of the review process.

Following the review the outcome of the review including any immediate risks and serious concerns identified are fed back to the MDT lead, executive team and senior members of the operational team.

Following IV the updated SD is generated including comments from the IV team. This is sent to the IV panel for factual accuracy check for response within 7 working days. This is then sent to the MDT/Service lead to disseminate to the team for factual accuracy. For return to the cancer management team within 7 working days.

Once any changes or amendments have been agreed the QSIS portal will be updated by the QSIS lead/administrators.

If any immediate risk and serious concerns are identified a response with an action plan is required within the nationally agreed timeframes i.e. immediate risk within 10 working days and serious concern within 20 working days. These action plans will be agreed at cancer board and monitored by both cancer board and the operational executive group

The agreed action plans will be added to the QSIS portal by the QSIS lead/administrators. The self-declarations will then be reviewed by the Associate Medical Director for Cancer Services. Any changes will be made on the portal by the QSIS lead/administrators

Once all the self-declarations have been approved by the Associate Medical Director for Cancer Services, the QSIS lead/administrators will send the self-declarations for approval.

The QST lead (or nominated deputy) will be notified that the self-declarations have been sent for approval and will review all the self-declarations and approve them. If any amendments are required at this stage they will be sent back to the QSIS lead/administrator to make the required changes.

Appendix Two- Quick Reference Guide: The External Quality Surveillance Team Visit

The Quality Surveillance Team Visit

Documentation
Two weeks before the visit from the Quality Surveillance Team, the visiting reviewers will be able to access, via the QSIS web based portal, the Trust teams/services self-declaration which will have been added, the operational policy, annual report, work programme and appendices which will be uploaded.

They will look for

- Compliance against the indicators
- Supporting evidence

One hard copy of the self-declaration and other submitted documents must be made available by the team/service under review

Timing
The visit will be designed around a sessional structure, as shown in the example below:

Activity	Approximate Time
Review team to review evidence in preparation for meeting	1.5 hours
Meeting with service	2 hours
Review team to write report	1 hour
Review team to give high level feedback to team/service lead	0.5 hour

Logistics

- A minimum of two rooms should be booked in the Trust for the visit, ensuring the room sizes are appropriate for the size of the MDT/Service being reviewed.

- Security passes, car parking and catering arrangements should be arranged ahead of the visit, and the Reviewers advised of the details

- Associate Medical Director for Cancer Services, Cancer Services Manager, Macmillan Lead Cancer Nurse, Cancer Quality Assurance Manager, and members of the Cancer management team to be available to meet the Quality Surveillance team at the start of the visit (if required).

- The Clinical Lead and all core members of the teams/services being reviewed should be available during the Quality Surveillance Team visit

- Members of Cancer Commissioning Services based in the Clinical Commissioning Groups will be made aware of the date of External Peer Review Visit and invited to attend if required.

The Cancer Quality Assurance Manager will assist and facilitate with this process.

Visit Reports

The Associate Medical Director for Cancer Services, Cancer Services Manager, Macmillan Lead Cancer Nurse, Cancer Quality Assurance Manager, MDT lead, senior members of the operational team and an executive of the organisation will receive high level feedback at the end of the day of any immediate risk and serious concerns identified.

The Cancer Quality Assurance Manager will inform via email the executive team, divisional and directorate teams and MDT lead of high level feedback of any immediate risks and serious concerns identified.

Draft reports will be written by the reviewers. The Trust will be given the opportunity to comment on the factual accuracy of the report before it is published.

Any comments relating to the draft report should be submitted in writing to the regional team within 10 working days of receipt of the draft. Any queries will be resolved locally with the regional team in the first instance. Any unresolved queries will be referred by the regional team to the national co-ordinating team.

The report will be received by the Cancer management team and notification sent to the operational team and senior members of the executive team for action within the Trust. Outcomes will be noted, discussed and monitored by the Trust Cancer Board.

Domain	Role		PA Required	PA Currently Funded	Investment Required	Comment
Operational Divisional Medical Director Posts	DMD Surgery and Elective Care		3	2.091	0.909	Previously Funded 3 PA's
	DMD ATICS		3	3	0	Current Incumbent DMD IMWH
	DMD Medicine and Unscheduled Care		4	4	0	
	DMD Integrated Maternity and Women's Health		3	3	0	Current Incumbent DMD ATICS
	DMD Cancer and Clinical Services		3	3	0	
	DMD Emergency Medicine & Unscheduled Care		3	3	0	Previously Funded Position
	DMD Children's and Young Peoples Services		3	3	0	
	DMD Mental Health and Learning Disability		3	2	1	Previously Funded 3-5 PA's
	DMD Older People		3	3	0	Being met with OPPC funds
Corporate Services	AMD Primary Care		4	4	0	
	AMD Infection Prevention and Control		3	3	0	Previously Funded Position
	AMD Research and Development		2	2	0	
	Medical Lead for Coroner Services		0.5	0	0.5	New Post currently unfunded
	Medical Lead for Standards and Guidelines		1	1	0	Previously Funded Position
	Medical Lead for Litigation		0.5	0	0.5	New Post currently unfunded
Clinical Director Structure	Surgery and Elective Care	CD General Surgery	1	1	0	
		CD T&O	1	1	0	
		CD Urology, ENT and	1	1	0	

Domain	Role		PA Required	PA Currently Funded	Investment Required	Comment
		Orthodontics				
	Emergency Medicine	CD CAH	1	1	0	
		CD DHH	1	1	0	
	ATICS	CD CAH	1	1	0	
		CD DHH	1	1	0	
		CD ICU	1	1	0	
	Medicine	CD CAH (Two Posts)	3	1	2	Additional Post (1.5PA per post)
		CD Cardiology	1	0	1	
		CD DHH	2	1	1	
	IMWH	CD CAH	1	1	0	
		CD DHH	1	1	0	
	CYPS	CD CAH	1	1	0	
		CD DHH	1	1	0	
		CD Comm Paeds	1	1	0	
		CD CAHMS	1	1	0	
	MHLD	CD Phys & Learning	1	1	0	
		CD Mental Health (Two Posts)	2	2	0	Being met with MHLD funds
		CD Psychiatry Old Age	1	1	0	

Domain	Role		PA Required	PA Currently Funded	Investment Required	Comment
	Cancer Services	CD Radiology	1	1	0	
		CD Laboratory	1	1	0	
		CD Cancer Services	1	1	0	
	Older People	CD Older People Community	1	1	0	
		CD Older People Stroke and Frailty	1	0	1	
Appraisal and 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*
	Appraiser Allocation (0.25PA per 8 appraisals per annum)		5	0	5	*Agreed as per LNC discussions 2019*
Patient Safety	Patient Safety Leads (M&M Chairs, 20 posts)		13.5	6	7.5	*Six posts Trustwide (7.5 new PA to include sub speciality and increase in support for CAH Medical M&M meetings)*
Total			**90.5**	**70.091**	**20.409**	

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director XXXXXXXXXXX

DIRECTORATE:

RESPONSIBLE TO: Service Director

ACCOUNTABLE TO: Medical Director

COMMITMENT: X PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DMD) will as a leader of the Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative, have an active role in contributing to the strategic direction and the ongoing provision of high quality services which are safe and effective.

The DMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. Trust is firmly committed to embedding the “right culture” where everyone is committed to 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 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 DMD has a lead responsibility within the Division on 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 DMD 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.

Main Duties / Responsibilities

1. To develop a culture of collective and compassionate leadership
2. To medically lead on all aspects of patient safety
3. To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control)	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement

4. To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
5. 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.
6. To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture
7. 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.

8. 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.
9. 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.
10. To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
11. To actively contribute to the development and delivery of the Trust strategy and business plan.
12. 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.

13. 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.
14. To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
15. 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.
16. To model the HSC values.
17. To act as an advocate for the Division.
18. To represent the Division at the relevant senior Trust meetings.
19. To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.

20. 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.
21. Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
22. Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options

General Responsibilities

The post holder will be required to:

- 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.
- 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.
- 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.

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
- Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
- Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
- 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.

- Take responsibility for his/her own ongoing learning and development.
- 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. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.
- 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.

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE: Associate Medical Director – Primary Care

DIRECTORATE: Older People & Primary Care

OPERATIONALLY RESPONSIBLE TO: Director of Older People & Primary Care

PROFESSIONALLY RESPONSIBLE TO: Medical Director

HOURS: 16 hours per week / 4 PAs

JOB SUMMARY

Be a member of the Directorate Senior Management team and play an active role in the provision of high quality services which are safe and effective. Provide a primary care perspective throughout the Southern Trust, working across all Directorates. Contribute to the development and implementation of services in line with the regional and Trust strategic direction.

- Provide expert advice to the Director of OPPC and Medical Director on matters relating to primary care provision.
- As part of the OPPC leadership team provide leadership and support on issues relating to primary care clinical and social care governance
- Design, develop and facilitate clinical governance interfaces between the Trust Southern Area General Practitioners that will facilitate timely information transfer regarding service provision, risk management and areas of concern
- To provide leadership to relevant medical staff in the Trust and promote the corporate values and culture of the Trust
- To provide leadership and professional support to the medical management team in the GP OOH service
- To take responsibility for performance management including appraisal of designated clinicians including completion of CP2A Forms where appropriate
- Enhance the relationship between primary and secondary care through partnership working to assist the Trust in the coproduction and redesign, modernisation and improvement of service delivery
- Promote effective communication between primary care and clinical/non clinical managers in the Trust to support team working
- Actively promote the development of clinical and professional networks between primary care and the Trust including GP Federations
- To provide leadership of GPs to enhance collaboration on Reform and Modernisation agenda

- Work with the Director of Older People and Primary Care to develop and maintain a regular forum or fora with GPs for discussion on strategic and operational issues and to be in a position to inform the Trust of primary care views on for example strategic change issues

As an Associate Medical Director – Primary Care, the jobholder will be a member of the directorate's senior management team and will contribute to policy development in all Trust directorates and support the achievement of overall objectives.

KEY RESPONSIBILITIES

Operational Leadership

Work with the wider Trust Management Teams to:

- Use the resources of the Directorate to deliver service improvement, in both quality and quantity, the activity, outcomes and targets agreed for the Directorate
- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated to maximise service provision and expand specific pathways of care
- Develop and maintain a regular forum or fora with GPs in order to discuss strategic and operational issues and to be in a position to inform the Trust of primary care views on strategic issues
- Actively promote the development of clinical and professional networks across primary, secondary and community care
- Develop systems to provide clinical information to staff to enable them to benchmark and audit their practice in order to develop innovative ways to deliver services and improve the patient experience.
- Be responsible for performance management, including appraisal and review of job plans, professional regulation for designated medical staff in the Directorate and to ensure that Personal Development Plans are in line with corporate objectives
- Provide clinical leadership in developing service improvement principles in response to specific access targets and ensure a focus on keeping the population well

Professional Leadership

- Develop and lead a team of primary care professionals to assist the Trust in redesign, modernisation and improvement of service delivery
- Identify and make provision for the training and development needs of designated medical staff in the Directorate and facilitate research activity in the Directorate

- To ensure the highest standards of clinical effectiveness in the Directorate, including the delivery of local and national recommendations including NICE guidelines, College guidelines or national reports

- Contribute as an effective member of Directorate Governance Committee

- Support the Trust to deliver on its quality and governance strategies through the promotion of a strong integrated governance approach in areas such as; professional regulation, dissemination of best evidence, data analytics and provision of information.

Strategic Leadership

- Function as a member of the Directorate Management Team with responsibility to contribute to strategic development as well as for operational excellence

- Advise the Management Team of Directorate priorities and pressures and be an active participant in Trust Delivery Plan negotiations.

- Provide advice in relation to postgraduate education within the service group.

- Support the Trust in planning a response to major incidents and outbreaks.

General Management Responsibilities

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

- Where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.

- Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.

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

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

- Promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Associate Medical Director – Primary Care works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Medical Director/ Director of Older People and Primary Care

General Requirements

The post holder will be required to:

- 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.

- 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.

- 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.

- Adhere at all times to all Trust policies including for example:

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

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

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

- 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.

- 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.

- 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.

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

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

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE: Associate Medical Director – Primary Care

DIRECTORATE: Older People & Primary Care

Ref No: **73818054**

Salary: Annual Salary will be remunerated in line with Consultant Terms & Conditions, based on years' service as a GP

Responsibility allowance: 20% of the appointee's basic annual salary

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

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

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

1. Hold a medical qualification, full GMC registration with licence to practice and must be on the GMC GP Register
2. Applicants must be on the NI GP Performers List
3. To have worked as a General Practitioner for a minimum of 3 years in the last 6 years
4. Demonstrate evidence of leadership within a team that led to successful service development and or quality improvement
5. Demonstrate evidence of having worked with a diverse range of stakeholders to achieve successful outcomes
6. Hold a full current driving license valid for use in the UK and have access to a car on appointment.[1]

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

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

7. Excellent communication skills, both orally and in writing
8. Knowledge of formal appraisal in general practice
9. Commitment to provide 2 days (4 PAs) per week

Southern Health and Social Care Trust

Quality Care - for you, with you

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

JOB DESCRIPTION

JOB TITLE: Medical Lead for Coroner Services (3 PA)
(1 Post, for 3 years in the first instance)

BASE:

DIRECTORATE:

RESPONSIBLE TO:

ACCOUNTABLE TO: Medical Director

JOB SUMMARY

The post-holder will work closely with the Trust's Litigation Manager and members of the Litigation Team to provide professional support and clinical input into the management of Coroner's cases.

The appointee will be professionally accountable to the Medical Director for medical professional regulation within this role.

The post-holder will be required to adhere to Department of Health protocol / standards governing the Preparation for Coroner's Investigations / Inquests.

KEY RESPONSIBILITIES

Coroner's Services

- Ensure, in conjunction with the Litigation Manager, that there is a direct and efficient method of communication between the Trust and the Coroner's Office.

- Support the Litigation Manager, as appropriate, in identifying involved staff to provide statements, as requested by the Coroner's Office.

- In conjunction with the Litigation Manager, provide support to involved staff to ensure that they are clear about the role of the Coroner and their responsibilities to the Coroner's processes.

- Support the Litigation Manager, when required and in line with the Escalation Process, to ensure that statements are obtained from involved staff and forwarded to the Coroner within the required time-scales.

- Support the Litigation Manager, as required to obtain any other information requested by the Coroner to ensure that this is provided within a timely manner.

- Review, where appropriate, any independent expert reports, provided from the Coroner's Office; consider whether the Trust requires an expert report and notify the Litigation Manager on nominations for same.

- Liaise directly, as required, with the Trust's Legal Advisors (DLS).

- Obtain detailed information from the Litigation Manager on Coroner's cases, and when required, advise the Medical Director and the Medical Director's Office on matters relating to the Coroner's processes.

- In conjunction with the Litigation Manager, provide support and guidance to Trust staff involved in the coroner's process, and particularly those who are required to attend an Inquest Hearing. This may require your attendance at consultations with legal representatives and at Inquest Hearings.

- In conjunction with the Litigation Manager, ensure the dissemination of lessons learned from Coroner's processes, for action to be taken within the service areas. Ensure that any corporate lessons are highlighted to the Medical Director's Office.

Professional Practice

- Where there are professional medical issues identified as part of the Coroner's process that need to be addressed, advise the Medical Director and the Medical Director's Office in relation to this.

General Responsibilities

The post holder will be required to:

- 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.

- 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.

- 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.

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

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

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

- 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.

- Take responsibility for his/her own ongoing learning and development.

- 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. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.

- 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.

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE Medical Lead for Coroners Services

DIRECTORATE

July 2019

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*

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

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

1. Applicants must be a permanent Consultant or SAS doctor within the Southern Health and Social Care Trust.

2. Hold a medical qualification, and GMC registration

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS/INTERVIEW PREPARATION:

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

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Leadership Framework. Candidates who are shortlisted for interview are therefore advised to familiarise themselves with this framework to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. For ease of reference a copy of the Summary document on the NHS Leadership Framework is available with this advertisement. Further information may be obtained from www.nhsleadershipqualities.nhs.uk

The successful candidate will be appointed for a period of 6 months in the first instance subject to satisfactory performance.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

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Southern Health and Social Care Trust

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THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

JOB DESCRIPTION

JOB TITLE: Medical Lead for Litigation Services (1 PA)
(1 Post, for 3 years in the first instance)

BASE:

DIRECTORATE:

RESPONSIBLE TO:

ACCOUNTABLE TO: Medical Director

JOB SUMMARY

The post-holder will provide professional support to the Trust's Litigation Team and work closely with the Litigation Manager, to ensure that clinical and social care claims are managed appropriately, and in accordance with the Trust's Procedure for the Management of Claims. Where required, the post-holder will also provide professional input to assist the Litigation Department's Medico-Legal Section in ensuring compliance with legislative time-scales associated with Subject Access Requests received from Solicitors, PSNI, Court Orders etc.

The appointee will be professionally accountable to the Medical Director for medical professional regulation within this role.

KEY RESPONSIBILITIES

Setting Direction

- Contribute to the development of a Litigation Services Operational Plan, in conjunction with the Litigation Manager
- Provide support and direction to consultants and other medical staff on issues pertaining to claims against the Trust

Management of Clinical & Social Care Claims

- Meet regularly with the Litigation Manager to review claims activity and agree action to be taken with regards:-

  -New Claims

  -Claims where there have been significant developments

  -Claims that require additional support to progress / settle / close (who will have responsibility for admitting liability and agreeing to settle claims (currently the Medical Director).

- Support the Litigation Manager, when required, in the investigation of claims by obtaining involvement reports and relevant information from involved medical staff. This will enable decisions to be made about liability at an early stage in accordance with Pre-Action Protocol for Clinical and Social Care Negligence

- Work with involved clinicians, when required, to identify to the Litigation Manager in a timely manner nominations for independent expert reports to assist in the defence of a claim.

- Support the Litigation Manager, when required, in the management of claims by obtaining comments from relevant involved medical staff on legal documentation/experts reports etc, to enable the Trust to prepare a defence to claims received.

- Participate in monthly meetings with the Trust's Legal Advisors (DLS) to review claims, and liaise directly with DLS on specific claims, as required.

- Assist the Litigation Manager with issues that are escalated, to ensure progression of claims management, in line with required time-scales.

- In conjunction with the Litigation Manager, ensure the dissemination of lessons learned from litigation claims, for action to be taken within the service areas. Ensure that any corporate lessons are highlighted to the Medical Director's Office.

- When required, advise the Medical Director and the Medical Director's Office on claims related activity.

Medico-Legal Subject Access Requests

- Assist the Litigation Manager with issues that are escalated, to ensure that subject access requests / Court Orders are complied with, in line with legislative requirements.

Professional Practice

- In conjunction with the Litigation Manager, provide support and guidance to Trust staff involved in the claims process, and particularly those who are required to attend Court. This may require your attendance at legal consultations and at Court.
- Where there are professional medical issues identified via the management of a claim that needs to be addressed, advise the Medical Director and the Medical Director's Office in relation to this.

Collaborative Working

- Work closely with Associate Medical Directors, Clinical Directors, and medical staffing in relation to claims management and identify areas of concern / areas for improvement

Service Development & Improvement

- Regularly review claims activity data in conjunction with the Medical Director/Medical Director's Office/Litigation Manager to identify areas in which the service could be developed and improved.

General Responsibilities

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Southern Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE Medical Lead for Litigation Services

DIRECTORATE

July 2019

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Stinson, Emma M

From: Wallace, Stephen
Sent: 15 December 2020 12:55
To: Wallace, Stephen ([redacted])
Subject: MNOTES - 15.12.2020 11:30am UHB Apprisal and Revalidation

Bill Tunnicliffe
Maria O'Kane
Stephen Wallace

BT - AMD for Revalidation, layered structure. RO is separate from the MD – soft intelligence. Takes my information and recommendations, hard intelligence. In house – 8 years ago. Trust went through structural changes. Had to make appraisal processes uniform across four legacy organisations. Issues of self-declaration, requiring the doctor to declare if they have any other licensed activities. It is entirely reliant on the honesty of the doctor. This is set by the GMC requirements. Private providers are now more concerned with practitioners information being included in appraisal and revalidation processes. ISPs are asking for sharing of information, the doctor owns the appraisal not the organisation. BT – the process is for the doctor, GMC state that appraisal is not a performance management tool. Bringing on board an **Annual Professional Review**, job planning, performance, organisational processes around the doctor. This process belongs to the organisation. The doctor will be subject to performance management via this route. MOK – will CSCG be part of professional review, BT – yes this will be included in this. Designated bodies should not burden the A&R with local processes. MOK – private sector providers – take a view that doctor is renting a room rather than responsible for their practice. Letters of good standing require doctor to assure that the outcomes are in line with what their substantive roles are. The exceptions are limited in terms of doctors who's private practice differs from their substantive role. Doctors choose their own appraiser in UHB. Ian Paterson did not declare. The coding system is not reliable to identify deviations in practice. Every appraisal summary is signed off by the AMD A&R for quality purposes. MOK do you audit your appraisals, BT – rather work on a better appraisal than deeper audit of appraisal. BT – I am an appraiser, usually difficult doctors are handled.

Stinson, Emma M

From: OKane, Maria
Sent: 09 December 2020 11:01
To: Wallace, Stephen
Subject: FW: IPR's

Can we discuss???

From: Gibson, Simon
Sent: 09 December 2020 08:44
To: Reid, Trudy; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

See below

Individual Performance Review

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI (DHH)

From: Reid, Trudy
Sent: 09 December 2020 08:44
To: Gibson, Simon; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

Simon I have a mental block, what is it?
Trudy

From: Gibson, Simon
Sent: 09 December 2020 08:28
To: OKane, Maria; Wallace, Stephen; Reid, Trudy
Subject: RE: IPR's

P>S – If you don't have one, I'm sure we could all help you put one together as a baseline document

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust

Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI (DHH)

From: OKane, Maria
Sent: 09 December 2020 08:26
To: Wallace, Stephen; Reid, Trudy; Gibson, Simon
Subject: FW: IPR's

What are iprs?

From: Devlin, Shane
Sent: 08 December 2020 11:07
To: Beattie, Brian; Magwood, Aldrina; McClements, Melanie; McNeany, Barney; OKane, Maria; O'Neill, Helen; Morgan, Paul; Toal, Vivienne; Trouton, Heather
Cc: Alexander, Ruth; Campbell, Emma; Stinson, Emma M; Gilmore, Sandra; Griffin, Tracy; Mallagh-Cassells, Heather; Livingston, Laura; PADirectorofP&RSHSCT; Willis, Lisa
Subject: IPR's

Dear All

At our next 1:1 meetings we will be discussing IPR's for 2019/20 and 2020/21. Can I ask that you do two things in advance of the meeting.

1. Please review your 2019/20 IPR noting achievements (up until 31st March 2020) and forward to me.
2. Based on 2019/20 IPR produce for 2020/21 a roll forward of those items not achieved in 2019/20. I would then suggest a general statement, which I will prepare, to go into all IPR's with regards to managing the organisation through the COVID-19 pandemic

Given the year of COVID we have had, I think this is a fair approach to IPRs for 2020/21.

We will for 2021/22 have a modified approach and I will discuss this further.

Many thanks, Shane

Better leadership for tomorrow

NHS Leadership Review

Lord Rose

June 2015

Contents

Foreword

Early in 2014 the Secretary of State for Health, the Rt Hon Jeremy Hunt MP, asked me to review what might be done to attract and develop talent from inside and outside the health sector into leading positions in the NHS; and to recommend how strong leadership in hospital Trusts might help transform the way things get done and to report my findings by the end of the calendar year, which I duly did. Early in 2015 the Secretary of State requested that I extend this report to consider how best to equip Clinical Commissioning Groups to deliver the *Five Year Forward View*, which had been published late 2014[1].

I started this Review in March 2014. I have met and listened to a wide range of stakeholders at meetings, briefings, visits and roundtables (details of this are contained at the end of this report). I have also read a significant amount of literature. I focused my attention on acute and secondary care (both NHS Trusts and Foundation Trusts, referred to together in this document as Trusts) as well as commissioning: there is no specific coverage here of primary care. There are specific recommendations for those in leadership positions within commissioning and provider organisations but in reality many of the recommendations are for the whole of the NHS.

I would make the following observations:

[1] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

- First, the NHS consistently delivers great service through a committed and passionate workforce of 1.38m staff in England[2]. During my Review I heard many great stories (only a few not so great). Mostly I found staff motivated and focused, often running on goodwill in a tough environment; some places felt more positive than others.
- Second, I saw and heard for myself the massive change that the NHS is embracing post 2012. This change needs to be allowed to settle down. There is genuine concern within the service that further restructuring will be imposed upon the system, which would be unhelpful. This is despite the current Government making no indication of wishing to do so. Through no fault of their own, people are often ill-prepared or ill-equipped to implement the changes asked of them.
- Third, the NHS performs an extraordinary service and is staffed by some extraordinary *people*, but the whole organisation could and should be made more effective by the application of some common-sense tactical and strategic thinking.

What I discovered and the evidence presented to me, would come as no surprise to anyone in any large organisation operating on the same scale. The NHS is not alone in facing the challenges highlighted in this Review.

There must be a shared vision; attention must be paid to its people, and those people must be helped, guided and assessed in their performance and delivery.

[2] NHS Choices, www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx

The recommendations of this Review are made in the areas of training, performance management, bureaucracy and management support.

In making them, I acknowledge that readers may feel review-fatigue; so I have kept this as succinct as possible. I also recognise that the NHS is immensely complex, and that one apparently straightforward recommendation will have many implications and perhaps unintended consequences; but because we are intimidated by complexity and scale there is equally a danger of doing nothing. The way to handle complex matters is to simplify them wherever possible. It is a risk we should take.

This Review is deliberately practical in its enquiry and recommendations. It builds on themes uncovered in the 2013 Mid-Staffordshire NHS Foundation Trust Inquiry[3] (Francis Report) and on other more recent reviews (Dalton 2014[4], King's Fund 2014 and 2015)[5] and the *Five Year Forward View* (NHS 2015); Simply put, this Review aims to make people better qualified to manage and to lead.

It is striking that the NHS has a central resource for quality but not for people, and these recommendations set out to address the fact that the people of the NHS are its main asset. What emerges is a range of recommendations (listed in

[3] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, Volume 3, Chapter 24- Leadership, page 1545, (6 February 2013), www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf
[4] *Dalton Review: options for providers of NHS care* (5 December 2014), www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care
[5] *System Leadership: Lessons and learning from AQuA's Integrated care discovery communities* (14 October 2014), The Kings Fund, www.kingsfund.org.uk/publications/system-leadership and http://www.kingsfund.org.uk/publications/leadership-and-leadership-development-health-care

the Executive Summary and in Recommendations), from the promotion of *one vision of the NHS* to an initiative to *cut bureaucracy*: simple enough ideas, tough to implement well on the scale required, and perhaps all the more important because of that.

Everyone should know what great leadership looks like; and even though not every job will require leadership qualities, some parts of every job will. We should not try to prescribe from any particular discipline. We should aim to develop, recognise and reward appropriately leadership qualities across the whole NHS workforce. Leadership qualities should be celebrated across all disciplines and job grades.

We should also recognise that we must work with what we have. A few simple things would make a huge difference: some centralised effort on training; or helping middle managers keep their confidence and focus; or knowing that the top leaders of tomorrow may be doctors, nurses or administrators. At the start of their NHS career, everyone should have adequate training; in mid-career they should have adequate support and clear pathways to progression as managers; and top leaders should have the appropriate support and experience to enable them to make correct decisions.

From my perspective of a manager from the private sector, these recommendations are simple remedies that could make the NHS more effective,