Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Sandra Judt
Board Assurance Manager
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

26 September 2022

Dear Madam,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant

information required to provide the witness statement required now or at any stage throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

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

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

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

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

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

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

in the Notice itself.

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

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

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 96 of 2022]

Pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO:

Sandra Judt
Board Assurance Manager
C/O Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 24th October 2022.**

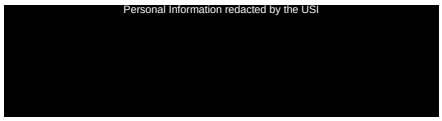
APPLICATION TO VARY OR REVOKE THE NOTICE

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

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 17th October 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 26th September 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE
[No 96 of 2022]

SECTION 1 – GENERAL NARRATIVE

General

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

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological format.

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.

5. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

6. If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.

7. What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?

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

9. Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?

Urology Services Inquiry

10. What performance indicators, if any, are used to measure performance for your role?

11. How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?

12. Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.

13. What systems of governance do you use in fulfilling your role?

14. Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

15. During your tenure, who did you understand was responsible for overseeing the quality of services in urology?

16. In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?

17. Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?

18. Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.

Urology Services Inquiry

Urology services

19. Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.

20. With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.

21. In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?

22. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?

23. Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?

24. Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:

    (i) Waiting times
    (ii) Triage/GP referral letters
    (iii) Letter and note dictation
    (iv) Patient care scheduling/Booking
    (v) Prescription of drugs

(vi) Administration of drugs
(vii) Private patient booking
(viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs
(ix) Following up on results/sign off of results
(x) Onward referral of patients for further care and treatment
(xi) Storage and management of health records
(xii) Operation of the Patient Administrative System (PAS)
(xiii) Staffing
(xiv) Clinical Nurse Specialists
(xv) Cancer Nurse Specialists
(xvi) Palliative Care Nurses
(xvii) Patient complaints/queries

Concerns

25. Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.

26. Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.

27. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.

Urology Services Inquiry

28. If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?

29. What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

30. Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?

31. Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.

32. In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?

33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?

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

35. What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?

Staff

36. As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?

37. In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.

Learning

38. Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.

39. Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?

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

41. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.

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

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

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

44. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

UROLOGY SERVICES INQUIRY

USI Ref: Notice 96 of 2022

Date of Notice: 26 September 2022

Witness Statement of: Sandra Judt

I, Sandra Judt, will say as follows: -

SECTION 1 – GENERAL NARRATIVE

General

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

1.1 I currently undertake the role of Board Assurance Manager, including the provision of a comprehensive Board secretariat, to the Trust Board and its six Committees (Audit; Governance; Endowments and Gifts; Remuneration; Performance and Patient and Client Experience) to ensure the effective and efficient administration of Board activity. I work proactively with the Chair and Chief Executive to ensure planned approaches to matters and issues requiring the consideration and /or action of the Board. This includes:

(a) Organisation of agendas and the co-ordination and timely distribution of papers and reports for the Board and its Committees;

(b) Co-ordination of the governance arrangements between the Board and Committees;

(c) Advise the Board on governance matters, ensuring that the Board operates in accordance with the Management Statement/Financial Memorandum and on processes contained within the Standing Orders;

(d) Planning the business of the Board and its Committees on an annual basis in conjunction with the Trust Chair and the Committee Chairs;

(e) Ensuring papers provided to the Board and Committees are fit for purpose and easily understood. This includes the accurate completion of a Report Cover Sheet for each paper being presented;

(f) Overseeing the production of accurate and concise minutes, ensuring that key issues, decisions taken and actions agreed are recorded;

(g) Developing clear and concise action logs and making sure that actions are implemented by those responsible within the timescales agreed.

1.2 I attend all Board and Committee meetings and service the confidential meetings of Trust Board. I am responsible for preparing accurate minutes of these confidential meetings and ensuring agreed actions are taken forward within the timescales set. I was responsible for taking and producing the minutes of the confidential Trust Board meeting on 27th January 2017 when

Board members were advised by Mrs V Toal, Director of Human Resources and Organisational Development, that under the Maintaining High Professional Standards Framework (MHPS), a Consultant Urologist had been excluded from practice from 30th December 2016 for a four- week period. At that meeting, Dr R Wright, Medical Director, confirmed that an Early Alert had been forwarded to the Department of Health and the GMC and NCAS had also been advised.

1.3 I attended a Directors' Workshop on 27th August 2020, when Dr Maria O'Kane, Medical Director, raised concerns about a recently retired Consultant Urologist's clinical practice. At that meeting, members agreed that this matter should be brought to Trust Board confidential section for further discussion immediately following the Workshop. I was responsible for ensuring that the issue was brought to the Trust Board confidential meeting on 27th August 2020. I was also responsible for taking and producing the minutes of this meeting.

I have attached the minutes of the Trust Board confidential meeting held on 27th August 2020.

1. *20200827 Confidential TB Minutes*

1.4 I have a lead role in the administration of governance and risk issues at Corporate level which includes ensuring the appropriate completion of the Board Assurance Framework (BAF), the Corporate Risk Register (CRR) and Controls Assurance process to support the embedding of active organisation wide risk management and providing assurance to the Board. For example, the Trust's Controls Assurance process is a fundamental process of governance which assists in identifying risks, determining unacceptable levels of risk and deciding where best to direct limited resources to eliminate or reduce those risks. The Trust process requires the completion of a baseline self-assessment on an annual basis across 22 central operations of the Trust. Where gaps are identified, action plans are put in place to control and monitor areas of control divergence and risk. I attach a briefing note on the Controls Assurance process and the outcome of the 2020-21 process, the existing

Board Assurance Framework and the mist up-to-date Corporate Risk Register.

2. Briefing note on Controls Assurance Standards

***3.* Report on outcome of Controls Assurance process 2020_21l al**

4. 20210617 Board Assurance Framework

5. 20220922 Corporate Risk Register

2. **Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.**

2.1 All documentation within my custody or under my control relating to the terms of reference of the Urology Services Inquiry has been previously submitted. All documents referenced in this statement are attached to this statement and can be found in S21 96 of 2022 – Attachments.

3. **Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological format.**

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. **Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.**

4.1 Board Assurance Manager (Band 7) from 16th May 2012 to present

4.2 Reporting directly to the Chair of the Southern Health & Social Care Trust, I manage and am responsible for the organisation and effective and efficient servicing of Trust Board and its six Committees. I work on my own initiative dealing with complex and competing deadlines. Please find attached my Job Description.

6. *Board Assurance Manager Job Description*

4.3 I am responsible for the development and co-ordination of the Board Development programme in conjunction with the Chair. I ensure that identified actions are monitored and taken forward and that training and development needs are met. To that end, I organise training sessions at Board workshops or stand alone training sessions as necessary to enhance Board members knowledge and skills. Please find attached some examples of training and development programmes.

8. 20220825 – Trust Board Development Programme

9. 20210820 email from Mrs Sandra Judt to Trust Board members re Official Reviews training

10. 20210820 Official Reviews training programme

4.4 I play an important role in supporting the Board and shaping its effectiveness. I lead on the completion of the Board Governance Self-Assessment Checklist on an annual basis. This tool supports the Board in assuring its governance arrangements and the identification of developmental needs. Department of Health require Boards to have their self-assessment ratings independently verified every 3 years.

11. 20220929 Board Governance Self-Assessment Tool

12. Internal Audit Report Board Effectiveness 2021-22

4.5 I have responsibility to ensure the Trust operates in accordance with agreed standards of corporate governance, to ethical standards appropriate to a public service organisation. To that end, I manage and maintain the corporate governance processes in relation to Gifts, Hospitality and Sponsorship and Declaration of Interests for both Board members and all Trust staff. I am responsible for ensuring their cascading throughout the Trust and issuing time reminders as regards returns. I have joint responsibility, along with the Trust's Fraud Liaison Officer, for review and update of two Trust wide policies; namely Gifts, Hospitality and Sponsorship and Declaration of Interests. Please see attached policies and reminder emails regarding completion of relevant forms

13. 20210801 Gifts, Hospitality and Sponsorship Policy

14. 20211104 letter from S. Judt to Board members re Declaration of Hospitality and Sponsorship

15. 20221001 Conflicts of Interests Policy

16. 20220314 Global email re Conflicts of Interest and Declaration of Interest form

4.6 In my role, I work closely with Trust Directors, both Executive and Non-

Executive and other senior staff inside and outside the Trust.

4.7 Board Support and Committee Services Manager Acting Band 6 from 1st April 2011 to 15th May 2012 and from 1st September 2009 to 26th September 2010

4.8 Acting Band 5 from 27th September 2010 to 31st March 2011 and from 12th January 2009 to 31st August 2009

4.9 Due to the secondment of the Board Secretary to the Northern Health and Social Care Trust, I had temporary moves to Acting Band 5 and Acting Band 6 on the dates outlined above.

4.10 Reporting to the Chair of the Southern Health and Social Care Trust, I had a lead role in managing the process of agenda setting for the Trust Board and standing Committees of the Board. I was responsible for the organisation and efficient servicing of Trust Board and its standing Committees to ensure that they were functioning effectively in line with Standing Orders. I provided a Secretariat to Trust Board, Governance Committee, Audit Committee, Remuneration Committee and Endowments and Gifts Committee. In this role, I worked proactively with the Chair and Chief Executive to secure a planned approach to matters of strategic interests and issues requiring Senior Management Team and Board action. I monitored the rhythm and pattern of meetings to ensure Trust objectives and development of the organisation and delivery of key objectives were met. The Board's role is strategic, so for example at that time, in line with the corporate objective of providing safe, high quality care, there was a strategic review undertaken into the Minor Injuries Service. Therefore, pre and post consultation, I monitored the pattern of meetings and set meeting dates to ensure that the Board was fully informed at key stages of the review and that key response times and deadlines were met in terms of decisions required/taken by the Board. Please see attached Schedule of Reporting to Trust Board 2012-13. Please see attached Board Support and Committee Services Manager Job Description.

17. Job Description Board Support and Committee Services Manager

18. 20122013 Schedule of Reporting to Board

4.11 Committee Secretary (Band 4) from 1st June 2007 to 11th January 2009

4.12 Reporting to the Board Secretary, I was responsible for the efficient and effective servicing of Trust Board and its standing Committees and the provision of administrative support to the Board Secretary. My principal duties included servicing all meetings including the preparation of agendas and papers, the production of minutes and the progression of business. I was responsible for the researching, collating and preparing of information and reports as necessary and developing and maintaining systems including an effective 'bring forward' system for matters relating to meetings to ensure the effective follow up of information and actions arising from meetings. Please see attached Committee Secretary Job Description.

19. Job Description Committee Secretary

5. **Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.**

Board Assurance Manager

5.1 I directly report and am accountable to Ms Eileen Mullan, Trust Chair, with effect from 1st December 2020 when she took up the position as Chair. Prior to this, I directly reported to and was accountable to Mrs Roberta Brownlee, Trust Chair from 16th May 2012 to 30th November 2020. I line

manage 2 Committee Secretaries (Band 4) - Personal Information redacted by the USI and Personal Information redacted by the USI in Chair/Chief Executive's office to deliver all responsibilities.

Board Support and Committee Services Manager

5.2 In this role, I directly reported to Mrs Roberta Brownlee, Chair and was responsible to Mrs Mairead McAlinden, Trust Chief Executive. I line managed a Project Support Officer (Band 4), Personal Information redacted by the USI, and Administrative Assistant (Band 3), Personal Information redacted by the USI, in Chair/Chief Executive's office to deliver all responsibilities. I allocated and supervised workload.

Committee Secretary

5.3 I directly reported and was responsible to Mrs Jennifer Holmes, Board Secretary. I line managed an Administrative Assistant, Personal Information redacted by the USI, from March 2009. I allocated and supervised workload.

6. **If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.**

6.1 I co-ordinate the secretarial provision across the key Committees of the Board to ensure that they are properly serviced and maintained to a high standard. This involves the line management of 2 Committee Secretaries (Band 4). I carry out this role by: -

(a) Regular meetings with both on an individual and group basis. The purpose of these are varied as follows: -

i. I provide advice and influence at agenda setting stage;
ii. Discussion on decisions taken and actions agreed at meetings to ensure these are accurately captured;
iii. I provide feedback on draft minutes;

iv. I bring to their attention Global emails, Departmental Circulars etc. which require action/response

(b) Personal Information redacted by the USI .

(c) I last completed appraisals for the two members of staff in 2016 and these are attached.

20. 20161219 Personal Information redacted by the USI

21. 20161219 Personal Information redacted by the USI

7. **What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?**

7.1 A Probationary Review meeting (3 Months) took place on 4th September 2012 with Mrs M McAlinden, Chief Executive. Please see:

22. Probationary Review (3 Month) Report

7.2 A Probationary Review meeting (6 Months) took place on 16th January 2013 with Mrs M McAlinden, Chief Executive. Please see:

23. Probationary Review (6 Month) Report

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

8.1 My role has been subject to 2 Knowledge and Skills Framework (KSF) Personal Development Review meetings as follows:

(a) The first of these meetings took place on 12th May 2009 between myself as Committee Services Manager and Mrs Jennifer Holmes, Board Secretary. Please find attached completed appraisal form.

24. 20090512 KSF appraisal form

(b) The second Personal Development Review meeting took place on 13th December 2016 between myself as Board Assurance Manager and Mr Francis Rice, Acting Chief Executive. Please find attached completed appraisal form.

25. 20161213 KSF appraisal form

9. **Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?**

9.1 Please see set out below relevant policy and guidelines governing my role: -

(a) Code of Conduct for HSC Employees
(b) Performance and Personal Development Review Policy
(c) Corporate Mandatory Training Policy
(d) Gifts, Hospitality and Sponsorship Policy
(e) Declaration of Interests Policy
(f) Anti-Fraud and Anti Bribery Policy
(g) Sickness Absence Policy
(h) Fraud Policy
(i) Whistleblowing Policy

Please find attached one example of relevant guidance.

26. Code of Conduct for HSC Employees

9.2 I am made aware of any updates on policy and guidance relevant to me by Global email circulars and accessing the Trust's Sharepoint site.

10. **What performance indicators, if any, are used to measure performance for your role?**

10.1 Whilst the KSF framework is designed to ensure I am supported to be effective in my job, I have not had a performance review meeting since 2016.

11. **How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?**

11.1 I assure myself that I adhere to the appropriate standards for my role by the completion of Corporate Mandatory Training. Please find attached a list of the Corporate Mandatory Training courses I have completed.

***27. 20212022 S Judt Completed Mandatory Training* courses**

12. **Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.**

12.1 I have no experience of these systems being by-passed.

13. **What systems of governance do you use in fulfilling your role?**

13.1 In the main, I use the corporate governance system '*the system by which organisations are directed and controlled*' in fulfilling my role. I support the Board to exercise strategic control over the Trust through this corporate governance system which includes: -

a) Management Statement and Financial Memorandum;

b) SHSCT Standing Orders, including schedule of matters reserved for Board decisions and a scheme of delegation, which delegates decision making authority within set parameters to Standing Committees and the Chief Executive and other officers;

c) Standing Financial Instructions;

d) An Audit Committee;

e) A Governance Committee;

f) An Endowments and Gifts Committee;

g) A Remuneration Committee;

h) A Patient and Client Experience Committee; and

i) A Performance Committee

Please see attached documents referenced above at a), b) and c):

28. 20170926 Final Financial Memorandum SHSCT
29. 20170926 SHSCT Management Statement
30. 20210225 Trust Standing Orders
31. 20180607 Trust SFIs

13.2 To ensure the Board's exercise of the various component parts of governance, the Trust has an Integrated Governance Framework in place which I had joint responsibility for producing. This aligns the requirements placed upon the organisation by the Department of Health (DoH), incorporates the risk management policy statement and defines the governance structures and arrangements through which assurances can be provided to the Trust Board. I have attached the Integrated Governance Framework.

32. 20170907 Integrated Governance Framework 2017_21

13.3 The Board Assurance Framework is a dynamic Board assurance tool underpinned by the Risk Management Strategy and the Corporate Risk Register. The Trust Board has a specific role in reviewing principal risks and significant gaps in control and assurance via the Board Assurance Framework and ensuring where gaps have been identified, corrective actions are taken. I have attached the Board Assurance Framework.

4. 20210617 Board Assurance Framework

13.4 A tenet of corporate governance is Risk Management. I use the Risk Management Strategy in my role and ensure that there is active risk management by the Senior Management Team to corporate risks and that the Corporate Risk Register is regularly reviewed and updated for approval by the Governance Committee.

14. **Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.**

14.1 I have been offered support for quality improvement initiatives during my tenure as outlined below: -

Certificate in Corporate Governance – CIPFA in 2012

14.2 Part of this course included an assessment which comprised completion of a work-based project within my organisation and the submission of a written report. I undertook a review of the Southern Health and Social Care Trust Board's effectiveness, focusing primarily on how it fulfils its function, what it does well, what challenges it faces and to identify areas for development and further improvement. Please find attached a copy of the Board Effectiveness project

34. 20120801 Certificate in Corporate Governance Board Effectiveness project

Paperless approach to Trust Board and Committees – Minute Pad

14.3 In 2015, I introduced a paperless approach to Trust Board and Committees. This was a quality improvement initiative working with Trust Board members to introduce a system for the storage and retrieval of Trust Board information.

***35. 20150416 Email from S. Judt to Trust Board* members re Minute Pad**

15. **During your tenure, who did you understand was responsible for overseeing the quality of services in urology?**

15.1 I understand that the Director of Acute Services was responsible for overseeing the quality of services in Urology and the Medical Director was responsible for overseeing the quality of the work of the professional medical workforce in Urology services.

16. **In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?**

16.1 In my experience, the Medical Director oversaw the clinical governance arrangements of Urology and did this by bringing clinical concerns related to a Consultant Urologist to the attention of Trust Board. Please see paragraph 31.1 for full details.

17. **Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?**

17.1 My role as Board Assurance Manager is to provide support to the Trust Board and provide a conduit for the information it receives. I am not a Board member, and feel that I was not able to provide sufficient support to Urology Services through the Board.

18. **Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.**

18.1 In carrying out my role as Board Assurance Manager, I work primarily with the Trust Chair, Chief Executive and Board members and would have had no contact with staff within Urology.

Urology services

19. **Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.**

19.1 I have responsibility for managing the flow of information to and from the Trust Board and its Committees. I ensure that the relevant information is brought to the Board's attention in a timely way in respect of the governance concerns aspect of Urology services. For example, at a meeting on 29th October 2020, the Chief Executive agreed to report on progress to Trust Board under confidential section so, I ensured that written update reports were timetabled in and provided at each meeting. Please see Section 34.5

20. **With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.**

20.1 I would liaise directly with the Acute Director, the Medical Director and the Systems Assurance Manager, to seek progress updates for each confidential Trust Board meeting. This would be via email. Please find attached one example email.

***36. 20201203 – Email from S. Judt to Dr O'Kane,* Mrs Melanie McClements and Mr Stephen Wallace**

21. **In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?**

21.1 I am responsible for ensuring that the relevant information is brought to the Board's attention in a timely way. I carry out this responsibility on a monthly basis by seeking progress update reports for the Trust Board's consideration.

22. **What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?**

22.1 As my role is at a corporate governance level, as opposed to a clinical governance level, I would have no knowledge of the efficiency and effectiveness of governance processes and procedures within a specific Directorate; Division or Service area. I therefore am not in a position to offer a view on the efficiency and effectiveness of the governance processes within Urology.

23. **Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?**

23.1 Through my role, which is at a corporate level, I did not inform or engage with performance metrics or have any other patient or system data input within Urology.

24. **Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:**

(i) **Waiting times**

(ii) **Triage/GP referral letters**

(iii) **Letter and note dictation**

(iv) **Patient care scheduling/Booking**

(v) **Prescription of drugs**

(vi) **Administration of drugs**

(vii) **Private patient booking**

(viii) **Multi-disciplinary meetings (MDMs)/Attendance at MDMs**

(ix) **Following up on results/sign off of results**

(x) **Onward referral of patients for further care and treatment**

(xi) **Storage and management of health records**

(xii) **Operation of the Patient Administrative System (PAS)**

(xiii) **Staffing**

(xiv) **Clinical Nurse Specialists (xv) Cancer Nurse Specialists**

(xvi) **Palliative Care Nurses**

(xvii) **Patient complaints/queries**

24.1 I do not have any specific responsibility or input into any of above areas within Urology.

Concerns

25. **Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.**

25.1 I am expected to follow the Southern Trust Your Right to Raise a Concern (Whistleblowing) Policy should I have a concern about an issue relevant to patient care and safety and governance. Please find policy attached.

37. 20180401 SHSCT Whistleblowing Policy

26. **Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next.**

You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.

26.1 I did not have any concerns arising from any of the issues set out at paragraph 24.1 above or any other matter regarding Urology services.

27. **Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.**

27.1 I was only made aware of concerns regarding the practice of a Practitioner in Urology at the same time as the Board were informed. From my perspective, whilst I had sight of reports to Trust Board regarding these concerns, I am not a Board member.

28. **If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?**

28.1 As explained in 27.1 above, I did not have concerns regarding the practice of any practitioner in Urology.

29. **What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?**

29.1 In line with the Trust's Risk Management Strategy, a risk assessment of the following risks was completed on 02.02.2022: -

a) Response to Statutory Public Inquiry into Urology Services in the Southern Health and Social Care Trust (USI):

b) Risk that due to capacity issues, the Trust may be unable to respond in a timely and complete way to Section 21 requests from the USI;

c) Further risk will be issues identified through the discovery process which may impact on the reputation and function of the Trust.

29.2 The Senior Management Team discussed the risk assessment on 25th January 2022. Risk Assessment presented and discussed by Governance Committee on 10th February 2022 as attached.

38. 20220202 Completed Risk Assessment

30. **Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?**

30.1 My role to provide support to the Board and ensure that they have the right information to enable them to effectively challenge and scrutinise issues being presented as opposed to being a Board member. Whilst I have access to reports and papers, I do not take actions as a Board member.

31. **Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.**

31.1 In my experience as Minute taker at confidential Trust Board meetings, once concerns were raised at Trust Board level, systems of oversight and monitoring were put in place. This is evidenced in the Trust Board confidential minutes of 27th January 2017 meeting when Mrs Toal, Director of

HROD, had advised the Board that concerns relating to Consultant A were being addressed under Maintaining High Professional Standards from December 2016. Please see 1.2 for the full details. In my experience as Committee Secretary, reporting to the Board Secretary, Dr Rankin, Director of Acute Services brought clinical issues in Urology to Trust Board confidential Meeting on 30th September 2010 and again on 25th November 2010.From the content of her briefings, I was not aware that there were triage issues with Mr O at that time. Whilst the briefing stated that data had indicated that something was amiss, there was no 'closing of the loop' and no specific actions requested by the Board, for example, a request for progress updates on the issues.

31.2 In my experience as Minute taker at confidential Trust Board meetings, once a second set of issues emerged about this Consultant Urologist's practice, the extent of which were such that from a Medical Director's perspective, warranted escalation to Trust Board, written progress updates were provided at each Trust Board confidential meeting from 24th September 2020 to date. These updates detailed the systems of oversight and monitoring put in place. I have attached some examples of these progress reports: -

39. Item 6. Confidential TB update – Urology

40. Confidential TB update - Urology

32. **In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?**

32.1 I have not been in a position to raise concerns, but if I had concerns to raise, I would do so under the Whistleblowing Policy

32.2 In my experience, through my attendance at Governance and Audit Committee meetings, if concerns are raised by others, the outcome and learning is shared as follows: -

a) A six-monthly Raising Concerns (Whistleblowing) report is presented to the Governance Committee on case activity and the work to share the lessons from cases across the Trust. This report includes a case study on one specific case. Please find attached an example of a Raising Concerns Report to Governance Committee.

41. 20221116 – Raising concerns report to Governance Committee

b) Learning from Experience Forum includes learning from Whistleblowing investigations. This Forum reports to Governance Committee on a six-monthly basis. Please find attached an example of an update report.

42. 20220512 Learning from Experience Update report to Governance Committee

c) Actual, suspected and potential frauds are reported to the Audit Committee as a standing agenda item. These reports detail learning outcomes as applicable. Please find attached an example of a Fraud report.

43. 20221013 - Fraud report to Audit Committee

33. **Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?**

33.1 In my role as Board Assurance Manager, other than having access to and sight of reports and papers to confidential Trust Board meetings, I was not aware that concerns with governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within Urology.

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

34.1 I did not raise or identify any concerns.

34.2 At a Trust Board Workshop on 27th August 2020, Dr Maria O'Kane, Medical Director, informed members of concerns about a recently retired Consultant Urologist's clinical practice. Members were agreed that this matter would be brought to Trust Board confidential section for further discussion immediately following the Workshop. Full detail is provided at 1.3.

34.3 Dr O'Kane verbally brought SAI investigation concerns to the attention of the confidential Trust Board meeting on 27th August 2020. Please see attached:

1. 20200827 Confidential TB Minutes

34.4 Dr O'Kane then provided a written report to the confidential section of the Trust Board meeting on 24th September 2020 outlining a summary of the clinical concerns relating to Consultant A, the actions taken to review aspects of his practice and the development of appropriate management plans to minimise risk or harm to patients. Please see attached:

44. Item 7. Urology – Summary for TB clinical concerns 24.9.2020 vt

34.5 As referenced in 31.2, written reports providing a summary of the clinical concerns relating to Consultant A were provided at each subsequent Trust Board confidential meeting. These concerns were and continue to be discussed by Trust Board as opposed to Governance Committee.

34.6 At confidential Audit Committee meeting on 14th October 2021, the Internal Audit Report Review of Mr A's private work in the Trust was discussed. It was the recommendation of the Audit Committee that this report also be considered by the Governance Committee. Please find attached a copy of this Internal Audit Report

45. IA Report – Review of Mr A's private work

34.7 At confidential Governance Committee meeting on 16th November 2021, under the feedback from Audit Committee, the Audit Committee Chair, the Medical Director and Director of Acute Services spoke to the IA Report Review of Mr A's private work in the Trust. Minutes of this meeting have been previously submitted.

34.8 At a confidential Governance Committee meeting on 10th February 2022, an update of progress on recommendations was provided.

46. *20220210 update on progress on IA recommendations*

Chief Executive meetings with Non-Executive Directors

34.1 On 29th October 2020, Mr Shane Devlin, Chief Executive, provided Non-Executive Directors with an update. At that meeting, Terms of Reference for the Assurance Group were discussed and the importance of assurance being provided to Trust Board was highlighted. The Chief Executive agreed to report on progress to Trust Board under the confidential section. Please find attached a copy of correspondence shared at that meeting.

47. 20201022 – L – 5593 From Permanent Secretary to Mr Shane Devlin

34.2 At these meetings, verbal updates were provided by Mr Shane Devlin, Chief Executive to the Non-Executive Directors. I have attached Notes of these meetings held on the following dates:

48. 20201008 Notes of Chief Executive meeting with Non Executive Directors
49. 20201015 Notes of Chief Executive meeting with Non Executive Directors
50. 20201029 Notes of Chief Executive meeting with Non Executive Directors
51. 20201105 Notes of Chief Executive meeting with Non Executive Directors
52. 20201119 Notes of Chief Executive meeting with Non Executive Directors
53. 20201126 Notes of Chief Executive meeting with Non Executive Directors
54. 20201203 Notes of Chief Executive meeting with Non Executive Directors
55. 20201217 Notes of Chief Executive meeting with Non Executive Directors
56. 20210107 Notes of Chief Executive meeting with Non Executive Directors
57. 20210114 Notes of Chief Executive meeting with Non Executive Directors
58. 20210121 Notes of Chief Executive meeting with Non Executive Directors
59. 20210204 Notes of Chief Executive meeting with Non Executive Directors
60. 20210211 Notes of Chief Executive meeting with Non Executive Directors

61. 20210304 Notes of Chief Executive meeting with Non Executive Directors
62. 20210311 Notes of Chief Executive meeting with Non Executive Directors
63. 20210318 Notes of Chief Executive meeting with Non Executive Directors
64. 20210517 Notes of Chief Executive meeting with Non Executive Directors
65. 20210607 Notes of Chief Executive meeting with Non Executive Directors

34.3 On 9th May 2022, Dr Maria O'Kane, Chief Executive, provided a verbal update. Please find attached notes of that meeting.

66. 20220509 Notes of meeting

35. **What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?**

35.1 A more joined up approach across the organisation between corporate and clinical and social care governance. Areas of improvement work should be progressed, for example, the potential for developing additional forums where information can be effectively triangulated and the right information brought to the right forum and/or Committee. As noted at 4.1.2, the Trust Board held a Development Day on 25th August 2022 when it reviewed the corporate, clinical, and social care governance systems and structures to ensure the ability for the Trust to provide assurance through the development of robust, new and improved structures and processes. In terms of corporate governance, members considered the following questions: -

a) Is Trust Board receiving the right reports and information?;
b) Is it focused on the right areas?;
c) Is it curious enough?

35.2 A plan for change was agreed and this will help to improve my effectiveness in carrying out my role. This work is being progressed and the new structures and processes will be aligned with the Board Assurance Framework. I have attached the agenda of Board Development Day in August 2022. Please see:

8. 20220825 – Trust Board Development Programme

Staff

36. **As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?**

36.1 As I did not work in Urology, I do not have a view as I do not/did not have an interaction with those staff within Urology.

37. **In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.**

37.1 I have no experience of whether medical (clinical) managers and non-medical (operational) managers work well together in Urology.

Learning

38. **Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category**

and state whether you could and should have been made aware of the issues at the time they arose and why.

38.1 I became aware of governance concerns arising out of the provision of Urology services at the time when the concerns were brought to Trust Board's attention on 27th August 2020.

39. **Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?**

39.1 I feel that I am not in a position to respond in a meaningful way as whilst I provide support and advice to the Board, I am not a member of the Board.

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

40.1 I feel that I am not in a position to respond in a meaningful way as whilst I was aware of concerns within Urology services as they were brought to the Board's attention, I am not a Board member.

41. **Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.**

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

41.1 In my view, there was not a failure to engage fully with the problems within Urology Services once Trust Board were informed of the issues on 27th August 2020. From that date, Trust Board has had oversight and has been provided with regular progress reports. Board minutes attest to the scrutiny and challenge of members.

41.2 Prior to 27th August 2020, in my view there was a failure to engage fully with the problems within Urology services. From a Board perspective, Dr Rankin's briefings to Trust Board on 30th September 2010 and 25th November 2020 (ten year's earlier) advised of clinical concerns, but lacked sufficient detail.

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

42.1 I consider that overall mistakes were made in that the information provided to Trust Board was not timely and lacked sufficient detail. In terms of what could have been done differently, the information could have been presented more regularly and in such detail to enable Board members to fulfil their role and responsibilities.

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

43.1 I think the clinical and social care governance arrangements were not fit for purpose in that more connection was required with the corporate governance arrangements. As referenced in 41.2, the only information that was escalated and shared with Trust Board about clinical concerns in Urology was from two briefing papers Dr Rankin provided on IV fluids and Antibiotics and Cystectomies in 2010. In my view, the relevance and depth of information that was escalated and shared with Trust Board members, did not provide them with robust assurance that concerns had been addressed nor enable them to make any informed decisions. I did not have any concerns specifically and therefore, would not have raised them.

44. **If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.**

44.1 I have nothing further to add.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

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

Signed [redacted]
Personal Information redacted by the USI

Date: 24th October 2022

Section 21 Notice Number 96 of 2022

Witness Statement: Sandra Judt

Index

Attachment	Document
1.	20200827 Confidential TB Minutes
2.	Briefing note - What is controls assurance
3.	Report on outcome of Controls Assurance process 2020_21
4.	20210617 Board Assurance Framework
5.	20220922 - Corporate Risk Register
6.	Board Assurance Manager Job Description
8.	20220825 Trust Board Development Day Programme
9.	20210820 - E - S. Judt to Trust Board members re Official Review training
10.	20210820 - Official Reviews Training Programme
11.	20220929 Board Governance self-assessment tool approved by Trust Board
12.	IA Final Report - Board Effectiveness 21-22
13.	20210801 Policy Gifts Hospitality and Sponsorship
14.	20211104 - L - From S. Judt to Board members re. Dec of Hospitality 21_22
15.	20221101 Policy Conflicts of Interest 2022-2024
16.	20220314 - Global email re Conflicts of Interest and Declaration of Interests Form
17.	Board Support and Committee Services Manager Job Description
18.	201223 Schedule of Reporting to Trust Board
19.	Committee Secretary Job Description
20.	20161219 Personal Information redacted by the USI
21.	20161219 Personal Information redacted by the USI
22.	20210904 S. Judt 3-Month Probationary Review
23.	20130116 S. Judt 6-Month Probationary report
24.	20091205 S. Judt KSF Appraisal Form
25.	20161213 S. Judt KSF Appraisal Form
26.	20160901 Code of Conduct for HSC Employees (Southern HSC Trust)
27.	20212022 Corporate Manadatory training completed S. Judt
28.	20170926 Final Financial Memorandum SHSCT
29.	20170926 SHSCT Management Statement
30.	20210225 Trust Standing Orders
31.	20180607 Trust SFIs
32.	20170907 Integrated Governance Framework 2017_21
34.	20120801 Certificate in Corporate Governance Project on Board Effectiveness
35.	20150416 - E - from S. Judt to Trust Board members re Minute Pad training
36.	20201203 - E - from S. Judt to Dr O'Kane, Melanie McClements and Stephen Wallace

37.	20180401 Your Right to Raise a Concern (Whistleblowing Policy)
38.	20220202 - Risk Assessment on Trust Response to USI
39.	Item 6. Confidential TB Update - Urology
40.	Confidential TB Update - Urology
41.	20211116 Raising Concerns (Whistleblowing).FINAL
42.	20220512 _Learning from Experience Update to Governance Committee
43.	20221013 - Fraud Report to Audit Committee
44.	Item 7. Urology - Summary for TB Clinical Concerns 24.92020 vt
45.	20211014 Internal Audit report - Review of Mr A's private work
46.	20220210 - Update on progress of IA recommendations
47.	20201022 RP5593 Letter to Shane Devlin - Urology Assurance Group
48.	20201008 Notes of Chief Executive meeting with Non Executive Directors
49.	20201015 Notes of Chief Executive meeting with Non Executive Directors
50.	20201029 Notes of Chief Executive meeting with Non Executive Directors
51.	20201105 Notes of Chief Executive meeting with Non Executive Directors
52.	20201119 Notes of Chief Executive meeting with Non Executive Directors
53.	20201126 Notes of Chief Executive meeting with Non Executive Directors
54.	20201203 Notes of Chief Executive meeting with Non Executive Directors
55.	20201217 Notes of Chief Executive meeting with Non Executive Directors
56.	20210107 Notes of Chief Executive meeting with Non Executive Directors
57.	20210114 Notes of Chief Executive meeting with Non Executive Directors
58.	20210121 Notes of Chief Executive meeting with Non Executive Directors
59.	20210204 Notes of Chief Executive meeting with Non Executive Directors
60.	20210211 Notes of Chief Executive meeting with Non Executive Directors
61.	20210304 Notes of Chief Executive meeting with Non Executive Directors
62.	20210311 Notes of Chief Executive meeting with Non Executive Directors
63.	20210318 Notes of Chief Executive meeting with Non Executive Directors
64.	20210517 Notes of Chief Executive meeting with Non Executive Directors
65.	20210607 Notes of Chief Executive meeting with Non Executive Directors
66.	20220509 Notes of Chief Executive update meeting with NEDs

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

Minutes of a Virtual Confidential Meeting of Trust Board held on, Thursday, 27th August 2020 at 12.10 p.m.

PRESENT

Mrs R Brownlee, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Dr M O'Kane, Medical Director
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Interim Director of Acute Services
Mr B McNeany, Director of Mental Health and Disability Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs J McKimm, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mr M McDonald, Non-Executive Director

1. CHAIR'S WELCOME

The Chair welcomed everyone to the virtual meeting.

2. INTERIM FINANCIAL STRATEGY – POST INDICATIVE ALLOCATIONS 2020/21

At the outset, the Chief Executive reminded members of the Trust's statutory duty to break-even, which will only be achieved by effective financial management. Ms O'Neill advised that the Trust has received notification of the indicative allocations for 2020/21. She referred members to the detail in the Interim Financial Strategy, which sets out the impact of these allocations on the financial position, the next steps required and to request Trust Board approval to set an unbalanced budget in the interim to facilitate appropriate stewardship and accountability of resources.

Ms O'Neill advised of an overall regional funding gap of £70m, £58m of which has to be addressed by Trusts. She further advised that the Trust has been allocated a medicines optimisation savings target of £1.04m. Ms O'Neill explained that for the fourth consecutive financial year, the Trust has been successful in negotiating out a significant share of the regional recurrent cash releasing efficiency target. For the last three financial years, the Trust secured full reduction of the target and for 2020/21, achieved a 50% reduction. This means that in 2020/21, the Trust is required to deliver general cash releasing savings of £4m. Recurrently however, the Trust has now avoided a total of £25m over the last 4 years.

Ms O'Neill stated that it was important to remember that before account is taken of the new savings/income generation targets, the Trust entered the new financial year with an opening recurrent gap of some £11.1m. Carried forward, cost pressures increased the deficit to £30m. However, the Trust was successful in achieving £0.4m of pharmacy savings in excess of plan, which reduces the deficit down to £29.6m. Ms O'Neill referred members to Table 3 on page 6 of the document, which summarises the total gap of £11.5m between committed expenditure and indicative income in 2020/21 before considering additional pressures.

Ms O'Neill reported total anticipated RRL 2020/21 of £717.2m and spoke of the significant elements. She confirmed that funding of £16.9m has now been received recurrently to support the 2019/20 pay settlement. She stated that given RRL anticipated income of £717.2m

and non RRL anticipated income of £42.8m, the Trust has a total maximum income of £760m available and hence the spending allowance for the Trust is currently £760m in 2020/21.

Ms O'Neill reported total forecasted expenditure 2020/21 of £774.3m as detailed in Table 7 of the document, leaving a forecasted gap of £14.3m. She advised that measures of £7m have been identified, these include pharmacy prescribing measures and natural slippage on some full year allocations, leaving at this stage an unresolved gap of a maximum of £7m.

Ms O'Neill stated that the financial plan will be further refined, with the Department of Health planning meetings to take place in September 2020. Directors will continue to review what additional savings measures are possible in the event that additional funding is not secured. Mrs McCartan asked if it was permissible to submit an Interim Financial Strategy without a balanced budget. Ms O'Neill stated that Directors of Finance were asked to submit a plan which identified the impact of the indicative allocations. This is merely the first stage and at present this shows an unresolved gap of £7m. The Interim Financial Strategy being discussed at Trust Board is to seek approval to set an unbalanced budget to support the appropriate stewardship and accountability of public funds. As discussions evolve with both the HSCB and DoH, the position may change, to include either potential additional unplanned expenditure benefits or some further funding support. Mrs McCartan noted the Trust's statutory duty to breakeven and stated that hopefully additional funding support would be secured.

Trust Board approved the setting of an unbalanced interim budget for 2020/21

3. **ANY OTHER BUSINESS**

i) SAI

Dr O'Kane brought to the Board's attention SAI investigations into concerns involving a recently retired Consultant Urologist. Members requested a written update for the next confidential Trust Board meeting.

ii) End of Non Executive Director Appointment Term

The Chair advised that Mrs Siobhan Rooney's term of office as a Non-Executive Director ends on 28th August 2020. On behalf of members, the Chair thanked Mrs Rooney for her enormous contribution to the Trust over the past nine years and wished her well for the future.

SIGNED: _____ DATED: _____

Controls assurance is a holistic concept based on best governance practice. It is a process designed to provide evidence that the Trust is doing its "reasonable best" to manage itself in order to meet its objectives, protect patients, staff, the public and other stakeholders against risks of all kinds.

It is a fundamental process of governance which assists in identifying risks, determining unacceptable levels of risk and deciding where best to direct limited resources to eliminate or reduce those risks.

The process in the HPSS is based on the use of twenty controls assurance standards which are designed to check that key controls across fundamental operations of the organisation are in place. Assessment against the key controls in each standard provides evidence of the organisation's control environment.

Therefore, controls assurance is also a means by which Chief Executives as Accountable Officers can discharge their responsibilities and enables them to provide assurances to the DHSS&PS, NI Assembly and the public.

Southern Health and Social Care Trust

Quality Care - for you, with you

REPORT ON OUTCOME OF CONTROLS ASSURANCE PROCESS 2020/21

CONTENTS

1. Introduction

The Controls Assurance process is a fundamental tenet of the Trust's governance arrangements. The Trust has a co-ordinated process in place designed to assess and provide evidence that key controls across central operations of the Trust are in place. It is also a means by which the Chief Executive, as Accounting Officer, discharges his responsibility of maintaining a sound system of internal governance.

The Trust's internal Controls Assurance process for 2020/21 has concluded. The lessons learned from the 2019/20 process were embedded and work continued during the year to build on the progress made to continually develop the governance arrangements and sources of assurance of the effectiveness of controls in operation in the Trust to manage risk.

2. Trust Internal Process for 2020/21

i) Controls Assurance Group

This group, chaired by the Director of Finance, Procurement and Estates, comprises Lead Assessors for each of the Controls Assurance areas. It met on three occasions during 2020/21 and agreed the work plan, accountability and reporting arrangements. Updates on progress were provided to the Group at each meeting.

ii) Baseline Self-Assessments

Baseline self-assessments were completed using an agreed RAG model for evidence lists (see below), together with a common scoring system.

Non-Compliant	0 – 44%
In Progress	45 – 74%
Compliant	75% +

The completed self-assessment templates and associated evidence are held electronically on SharePoint.

iii) Peer Review

For 2020/21, a peer review process was completed. This was undertaken in small groups comprising Lead Assessors with a checklist developed to assist in this work. This was a quality assurance exercise reviewing self-assessments and evidence provided.

iv) Assurance Statements

Lead Directors are required to sign off those areas of Controls Assurance for which they are responsible. The Trust introduced an Assurance Statement (see Appendix 1) for this purpose which states: "*In respect to the relevant standard, I confirm that my organisation has controls in place to enable it to meet the requirements of all extant statutory obligations upon it, that it complies with all standards, policies and strategies set by the Department and all applicable guidance set by other parts of government.*" Any significant control divergences are required to be reported together with actions to address.

Reporting of assurance is to both SMT and the Governance Committee. The overall position is then reported to Trust Board at year end via the Governance Statement.

3. Outcome of 2020-21 process

In accordance with the implementation programme (Appendix 2), baseline self-assessments together with evidence gathering were completed by end February/early March 2021. The outcome is summarized in Table A below. 18 areas achieved a green rating and 4 achieved an amber rating, the same outcome as was reported the previous year. However, notwithstanding the pressures associated with COVID19, considerable progress has been made in those areas rated amber at the end of 2019/20. As demonstrated in Table A below, the work concluded during 2020/21 now means that these standards are moving closer to achieving an overall RAG rating of green.

Table A

Standard	Overall RAG Rating	
	2020/21	2019/20
Emergency Planning		
Environmental Cleanliness		
Fleet & Transport Management		
Environmental Management		
Waste Management		
Buildings, Land and Plant		
Financial Management		
Food Hygiene and Safety		
Governance		
Health and Safety		
Human Resources		
ICT		
Information Management		

Standard	Overall RAG Rating	
	2020/21	2019/20
Non Pay Commissioning Cycle (Procurement)		
Decontamination of Reusable Medical Devices		
Medicines Management		
Research Governance		
Security Management		
Fire Safety		
Infection, Prevention and Control		
Medical Devices and Equipment Management		
Risk Management		

The Trust process requires that where gaps are identified in the baseline self-assessment, action plans are put in place to control and monitor areas of control divergence. Action plans are already in place for 2021/22 and progress will be monitored via various Fora within the Trust and reported to the Controls Assurance Group. An update on action plans will be sought in September 2021 to support the final sign off of the Mid-Year Assurance Statement.

4. Reporting to the Department of Health

ALBs are required to provide proportionate assurance to relevant Policy Leads in the Department of Health for some standards.

For 2020/21, the following standards require a return as follows:-

- Information Management (May 2021)
- Emergency Planning (24th September 2021)

The relevant Controls Assurance Group member is responsible for submission of relevant documentation to the Department.

Where applicable, assurance will be provided in the Governance Statement and Mid-Year Assurance Statement. The formal accountability process remains the vehicle for highlighting any exception issues.

5. Internal Audit

During the year, Internal Audit did not perform any compliance audits in the controls assurance areas.

6. Conclusion

The Trust continued to build on the progress made in the previous year, 18 standards maintained their overall green rating, with the remaining 4 areas progressively moving towards green, an overall improvement when compared to 2019/20

Ms H O'Neill
Chair
Controls Assurance Group

April 2021

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

APPENDIX 1

Controls Assurance – Assurance Statement

Assurance Statement

*In respect to **[insert name of standard]**[1], I confirm that my organisation has controls in place to enable it to meet the requirements of all extant statutory obligations upon it, that it complies with all standards, policies and strategies set by the Department and all applicable guidance set by other parts of government. Any significant control divergences are reported below together with an outline of actions in place to address these divergences.*

Supporting Evidence

In support of this assurance statement, I have submitted a completed self-assessment which is a true and fair reflection of the baseline assessment of the **[insert name of standard]** submitted to the Board Assurance Manager by the due date of **26th February 2021.**
A **red**/**amber**/**green** RAG rating has been achieved[2].

The evidence to support the baseline assessment is available on SharePoint, should it be required for the purposes of Internal Audit and/or other purposes.

Significant control divergences

Criteria	Action To Be Taken	By When	Responsible Officer

I can confirm that the above standard is/is not[3] required to be submitted to the named DoH Policy Lead **[insert name]** by **[insert date].** I am responsible for this submission and will copy this information to the Board Assurance Manager, for information.

Lead Assessor

Name/s:		
Designation/s:		
Date:		

Peer Reviewers

Name/s:		
Designation/s:		
Date:		

Approved by Lead Director/s for the named standard

Name/s:	
Designation/s:	
Date:	

[1] One assurance statement per individual standard
[2] Delete as appropriate
[3] Delete as appropriate

Southern Health and Social Care Trust

Quality Care - for you, with you

APPENDIX 2

CONTROLS ASSURANCE
IMPLEMENTATION PROGRAMME 2020/2021

Action	Responsibility	Timescales	Comment
Agree Internal Assessors and Peer Reviewers for each standard and accountability arrangements	Lead Directors/ Controls Assurance Group	September 2020	Completed. Agreed at Controls Assurance meeting 15th September 2021
Progress on action plans for 2020/21 (based on 2019/20 self-assessments)	Directors/Internal Assessors	September 2020	Completed. Agreed at Controls Assurance meeting 15th September 2021
Develop and agree Implementation Programme for 2020/2021	Board Assurance Manager/Controls Assurance Group	September 2020	Completed. Agreed at Controls Assurance meeting 15th September 2021
Cascade of information in relation to programme for controls assurance arrangements	Board Assurance Manager	September 2020	Completed.
Peer Review spot check on progress against recommendations	Peer Review Groups	End December 2020	Completed. Discussed at meeting 30th November 2020
Self-assessment documentation and evidence files to be completed and uploaded to SharePoint. Original self-assessments to be signed off by Lead Director.	Internal Assessors	By 26 February 2021	Completed: 26th February 2021
Peer Reviewers to quality assure evidence files and RAG ratings	Internal Assessors	By 26 March 2021	Completed: 26th March 2021.
Prepare draft Governance Statement	Assistant Director of Finance/Directors	Draft to be completed in early May 2021	Completed: Draft Statement to Audit Committee on 6th May and Governance Committee on 13th May 2021
Submit Assurance Statements to DoH Policy Leads (signed by Chief Executive)	Relevant Self-Assessor	May - September 2021	
Compilation of Controls Assurance Report to SMT and Governance Committee	Director of Finance/Board Assurance Manager	May 2021	Completed: Report to SMT on 4th May and Governance Committee on 13th May 2021
Progress on action plans for 2021/2022 (based on 2020/21 self-assessments)	Internal Assessors	September 2021	To inform Mid Year Assurance Statement

Southern Health and Social Care Trust

Quality care – for you, with you

BOARD ASSURANCE FRAMEWORK

June 2021

Contents

1. Introduction

The Board of the Southern Trust has a responsibility to ensure that safe, high quality care is provided and is underpinned by the public service values of accountability, probity and openness.

The Trust **vision** as articulated in its strapline ***'Quality Care – for you, with you'*****,** encompasses the Trust's core commitment to deliver safe, high quality care that is co-produced and co-designed in partnership with service users and staff who deliver services. The Trust's **objectives** reflect the priorities for the delivery of health and social care services to its local population to achieve this vision. The Corporate Plan 2017/18 – 2020/21 'Improving Together' outlines the Trust's objectives as follows:-

Source (Southern Trust Corporate Plan 2017/18-2020/21)

The Trust Board is responsible for ensuring it has effective governance systems in place to enable the achievement of the organisational objectives. Achieving these objectives and delivering safe, quality care and services which are accessible and responsive to patients and carers will remain the Trust's central focus.

An Integrated Governance Framework is in place which sets out the arrangements for integrated governance within the Southern Health and Social Care Trust for the four year period 2017/18 – 2020/21. This framework describes the high level integrated governance, risk management, performance management and financial control arrangements in place by which the Board will be assured that there is a comprehensive system for continuous quality improvement, controls assurance, risk management, clinical and social care governance; that objectives are being met and services are safe and of a high quality. The Trust's high level governance structure is outlined in **Appendix 1.**

2. Purpose

The purpose and design of the Board's Assurance Framework is to ensure that the Board can be effective in driving the delivery of the corporate objectives and that they are receiving sufficient and timely assurance information on the management of risks to deliver on these objectives.

3. Aim

The aim of this document is to provide a structured means of:-

- **identifying and mapping the main sources of assurance in the Trust** and **co-ordinating them to best effect.**
- effective and focused **management of the principal risks** to achieving the Trust's objectives.
- enabling the Board to **assure** itself that all significant risks are being managed effectively and appropriate **controls are in place and are effective**.
- **providing reliable evidence** to underpin the assessment of the internal control and risk management environment to inform the Annual Governance Statement

4. Organisational Context

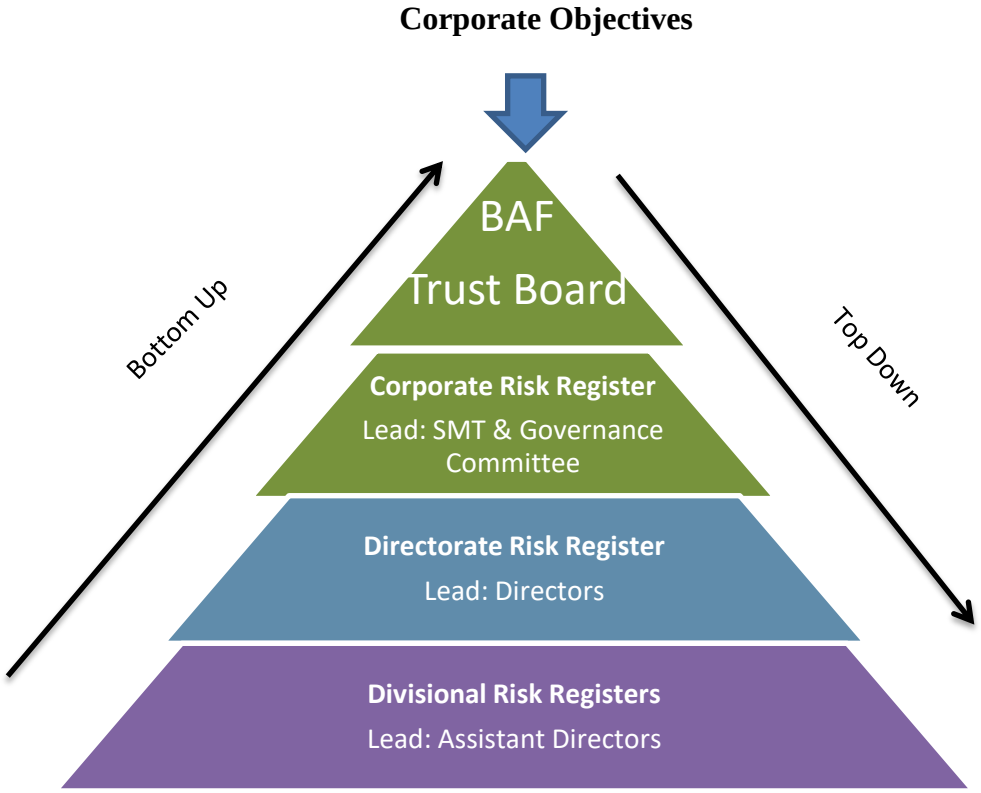
The strategic objectives, approved by the Trust Board in May 2017, form the basis of the Board Assurance Framework. Delivery of corporate objectives and action plans remain subject to the impact of the following four key organisational challenges:-

- Demographic factors
- Financial Constraints
- Workforce pressures
- Extraordinary circumstances, such as the Covid-19 pandemic, the impact of which will be profound and long lasting.

The Board Assurance Framework is an integral part of the governance arrangements for the Southern Trust and is underpinned by the **Risk Management Strategy,** the **Corporate Risk Register** and the **Controls Assurance** process and should be read in conjunction with the **Corporate Plan 2017/18 – 2020/21** and the **Integrated Governance Framework**.

5. Overview and Content of the Board Assurance Framework

To properly fulfil its responsibilities, the Trust Board must have a full grasp of the principal risks facing the organisation. Handling and managing risk is a combined 'top down' and 'bottom up' approach.



Assurance and Risk Assessment Pyramid

The **Board Assurance Framework** and the **Corporate Risk Register** contain many similarities, both report risk. Where necessary, there is cross-over from the Corporate Risk Register to the Board Assurance Framework and vice-versa.

The **Board Assurance Framework** works 'top down' from the Trust's strategic objectives determining proactively, the high level risks and what controls and assurance processes are in place. As part of the process, the Trust Board is committed to discussing and making the connections between the corporate objectives, the high level risks that could affect achievement of those objectives and the range and effectiveness of existing assurance reporting. The Trust Board own the Board Assurance Framework and review it on an annual basis.

All risks are graded in accordance with the regional risk matrix and entered on the appropriate risk register. The **Corporate Risk Register** works 'bottom up' and the Senior Management Team act as the filter for risk issues from Directorate Risk Registers for entry onto the Corporate Risk Register. Based on the knowledge of risks identified, the SMT will determine the level of assurance that should be available to them with regard to those risks. The SMT review the Corporate Risk Register on a monthly basis.

During 2020/21, SMT undertook a comprehensive review of the Corporate Risk Register in the context of the operational demands facing the Trust and agreed six principal risk areas on which to build a more agile Corporate Risk Register. This remains work in progress.

To ensure focused and effective management of these risks, the Governance Committee, on behalf of the Trust Board, review the Corporate Risk Register on a quarterly basis.

Given the inter-relationship between the Board Assurance Framework and the Corporate Risk Register, it is important that the Board is sighted on the key risks arising from the corporate risk environment therefore a high level summary of the Corporate Risk Register is provided in **Appendix 2.**

What is meant by Assurance?

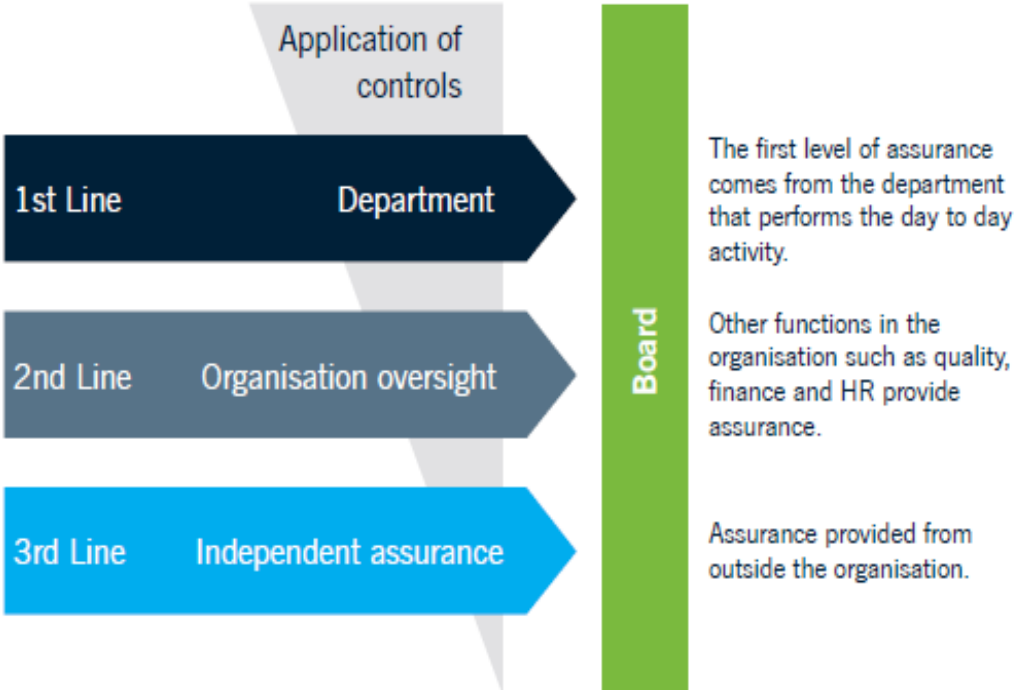
An objective examination of evidence for the purpose of providing an independent assessment on governance, risk management and control processes for the organisation.

Source (HM Treasury Guide on Assurance Frameworks 2012)

Trust Board receives assurances through a range of internal control frameworks including:

- reports from sub Committees to the Board;
- risk management process;
- monitoring of the Corporate Plan;
- Controls Assurance process;
- performance management framework;
- audit;
- mid year and annual governance statements etc.
- Executive Director governance frameworks

In addition, the Trust Board ensures objective assurance is also provided from independent reviewers including RQIA, Departmental reviews, Internal and External Audit. These assurances that the Board receives are broken down into the three lines of defence model in line with best practice as illustrated below:-



This June 2021 Board Assurance framework presents:

- the principal risks facing the Trust
- the key controls and processes relied on to manage risks
- the key sources of assurance
- where gaps in controls or assurance exist, what improvement actions are being taken to close the gaps.

6. Assessment

The Board Assurance Framework requires the Board to consider the effectiveness of each control through the process of obtaining assurances that the system/process is in place and is operating effectively.

A RAG rating on the effectiveness of controls from assurance work undertaken has been applied using the key below:-

GREEN: High: Controls in place assessed as adequate/effective and in proportion to the risks
AMBER: Medium: Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
RED: Low: Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks

HEAT MAP

Likelihood (frequency)	IMPACT (Consequence) Levels				
	Insignificant(1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)	Medium	Medium	High No. 1 Workforce capacity and capability No. 2 Staff engagement, morale and health & wellbeing No.8 Response to Major/Emergency Incidents	Extreme	Extreme
Likely (4)	Low	Medium	Medium No.5 Positive Risk taking	High No. 3 Access to Services	Extreme
Possible (3)	Low	Low	Medium No. 4 Early Intervention and Prevention No.6 Over-reliance on non-recurrent funding/inability to secure sufficient recurrent investment	High No. 7 Insufficient Capital	Extreme
Unlikely (2)	Low	Low	Medium	High	High
Rare (1)	Low	Low	Medium	High	High

TRUST OBJECTIVES 1 & 4 PROMOTING SAFE, HIGH QUALITY CARE & BEING A GREAT PLACE TO WORK – SUPPORTING, DEVELOPING AND VALUING OUR STAFF										
Lead Directors: Director of Human Resources and Organisational Development; Medical Director; Executive Director of Social Work; Executive Director of Nursing, Midwifery and AHPs			**Assurances** *Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective and that we are reasonably managing our risks and objectives are being delivered)*			**Assessment**			
Risk ***(What could prevent this objective being achieved)***	**Risk Level**	**Key Controls** ***(What systems/processes are in place to assist in delivery of objective)***	**Operational Management (First Line)**	**Corporate Oversight (Second Line)**	**Independent Assurance (Third Line)**	**Control RAG rating (See key)**	**Current gaps in controls/ assurance**	**Improvement actions**	**Due date for Improvement actions**
1. Achieving optimum workforce capacity and capability to meet demand.	Link to People Risk on Corporate Risk Register - High Risk	Bespoke recruitment campaigns for job groups and services International recruitment - Medical and Nursing Medical Engagement across both acute sites and regionally as required e.g. DHH Pathfinder Project and Regional Reform Programme Actions under Trust's Inspire, Attract, Recruit Strategy Attraction and Retention Workstreams under Nursing & Midwifery Workforce Strategy led by Steering Group. Midwifery workforce plan Theatres Workforce Plan Mandatory and profession specific training programmes in place. Sickness absence monitoring systems in place between HR and Directorates. Directors' Oversight Group in Mental Health Division.	Resourcing reports – internal / BSO Workforce data reports – Staff in Post, Turnover, flexible workforce etc. HR recruitment information KPIs Vacancy reports Management information reports on locum expenditure by speciality highlighting areas of increased spend and long term locum usage. Directorate specific mandatory training and KSF Development Review records are produced for Directors quarterly.	Workforce data is integrated into Trust Performance Committee reports on resourcing and other workforce pressures across medical and non-medical workforce Executive Directors of Nursing and Social Work reports to Trust Board (six monthly) HR Report to Trust Board (six monthly) Audit of compliance with normative staffing Mandatory training reports on compliance levels to SMT and Trust Board annually. Reporting of sickness absence levels to Trust Board via HR report.	DoH Regional Workforce Reviews Regional Workforce Strategy	Medium	Gaps in medical training rotas Inconsistent approach to medical staffing issues / rates regionally between Trusts. Gap in assurance that existing nursing workforce is fully optimised using e-roster system to full capacity. Off contract agency expenditure remains high	Paper highlighting Trust's position regarding trainees to remain on the agenda of DoH Trainee Workforce Group Establishment of Medical Resourcing Oversight Group Ongoing work to convert long term Agency Locum Doctors into vacant substantive posts Submit regionally agreed paper to DoH which sets out proposal for consistency in locum rates Ongoing Workstreams focusing on optimisation, recruitment and retention of nursing workforce Agency reduction taskforce group to be established for acute services in the first instance	DoH Group currently suspended due to Covid-19 June 2021 Linked to above – June 2021 - ongoing July 2021 Ongoing for duration of 2 year action plan June 2021

TRUST OBJECTIVES 1 & 4 PROMOTING SAFE, HIGH QUALITY CARE & BEING A GREAT PLACE TO WORK – SUPPORTING, DEVELOPING AND VALUING OUR STAFF									
Lead Directors: Director of Human Resources and Organisational Development; Medical Director; Executive Director of Social Work; Executive Director of Nursing, Midwifery and AHPs			**Assurances** *Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective and that we are reasonably managing our risks and objectives are being delivered)*			**Assessment**			
Risk *(What could prevent this objective being achieved)*	**Risk Level**	**Key Controls** *(What systems/processes are in place to assist in delivery of objective)*	**Operational Management (First Line)**	**Corporate Oversight (Second Line)**	**Independent Assurance (Third Line)**	**Control RAG rating (See key)**	**Current gaps in controls/ assurance**	**Improvement actions**	**Due date for Improvement actions**
							Action needs further progressed in HSC Workforce Strategy around achieving the optimum workforce model	Regional Safe Staffing meetings stood up following Industrial Action to be re-established following Covid-19	June/July 2021 – DoH establishing their safe staffing team currently

TRUST OBJECTIVES 1 & 4 PROMOTING SAFE, HIGH QUALITY CARE & BEING A GREAT PLACE TO WORK – SUPPORTING, DEVELOPING AND VALUING OUR STAFF									
Lead Directors: Director of Human Resources and Organisational Development; Medical Director; Executive Director of Social Work; Executive Director of Nursing, Midwifery and AHPs			**Assurances** *Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective and that we are reasonably managing our risks and objectives are being delivered)*			**Assessment**			
Risk ***(What could prevent this objective being achieved)***	**Risk Level**	**Key Controls** ***(What systems/processes are in place to assist in delivery of objective)***	**Operational Management (First Line)**	**Corporate Oversight (Second Line)**	**Independent Assurance (Third Line)**	**Control RAG rating (See key)**	**Current gaps in controls/ assurance**	**Improvement actions**	**Due date for Improvement actions**
2. Risk to staff engagement, morale and health and wellbeing due to workforce capacity / demand pressures	Link to People Risk on Corporate Risk Register – High Risk	Health and Wellbeing Strategy and Steering Group Clinical Psychology staff support and wellbeing service Occupational Health Service People management policies, systems, processes and training Ongoing recognition of staff and teams Raising Concerns Policy Management of organisational change policies & procedures Ongoing work of Psychological Wellbeing Sub group Chief Executive staff engagement sessions following Covid-19 first surge	Staff Health & Wellbeing supporting roll out of staff Health and Wellbeing Action Plan across teams Management information reports re turnover, sickness etc. JNCF and local JOF arrangements between management and TUs.	Action Plan from Health and Wellbeing Steering Group/Minutes of meetings Workforce KPIs and compliance reported to Trust Board monthly Performance Report to Performance Committee (Health and Wellbeing targets) HR Report to Trust Board (six monthly) Recognition at corporate level – staff e-brief, Trust Board leadership walks Raising concerns report to Governance Committee	Staff Survey and staff engagement score Non Executive Director lead for Raising Concerns	Medium	Workforce and Organisational Development Strategy is required	Development of a People Strategy for consultation and presentation to Trust Board Development of short and medium to long term psychological support plan post Covid-19 Development of a Health and Wellbeing Action Plan for 2021-2024 linked to the People Strategy Roll out of 'Creating a great place to work' initiative	August 2021 August 2021 August 2021 Ongoing

CORPORATE OBJECTIVE(S) 1 & 4: PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES									
Lead Director: Director of Performance & Reform and Operational Directors			**Assurances** *Where we can gain evidence that our controls/ systems are effective*			**Assessment**			
Risk	**Risk Level**	**Key Controls** ***(What systems/processes are in place to assist in delivery of objective)***	**Operational Management (First Line)**	**Corporate Oversight (Second Line)**	**Independent Assurance (Third Line)**	**Control RAG rating** ***(See key)***	**Current gaps in controls/ assurance**	**Improvement actions**	**Due date for Improvement actions**
3. If the demand for services continues to outstrip capacity, there is a risk of harm to the SH&SCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting	Link to Access to Services risk on the Corporate Risk Register – High risk	Service Re-Build Plans Strategic Accommodation Group Corporate Plan Service and Budget Agreement (SABA) with Commissioner HSC Performance Management Framework (Draft) Trust Performance Management Framework & Accountability arrangements Corporate support to Directorates - via nominated HR/Finance/ P&R business support	Directorate Management Action/Work Plans Divisional and Directorate Risk Registers	SMT Performance, workforce and finance - progress updates Finance Report to Trust Board Performance Report to Performance Committee HR Workforce Report to Trust Board	HSCB/Trust Performance Management meetings External Audit- Report to those Charged with Governance RQIA Reports/Audits	**Low**	Data evidencing growth in demand Unscheduled Care & elective waiting lists Regional workforce review reports that demonstrate capacity challenges in key specialties in SHSCT Impact and ability to maintain / sustain service in context of non-recurrent solutions for recurrent challenges (workforce and finance)	SMT review demography/ future funding sources and prioritise and/or stand down as appropriate. Regional transformation programme for elective - potential local impact Regional transformation programme for urgent/ emergency care - potential local impact Rebuild and reform of Trust services using the learning from Covid-19 and implementing decisions of the Regional Management Board	Ongoing Ongoing Ongoing Ongoing

CORPORATE OBJECTIVE(S) 1 & 2: PROMOTING SAFE, HIGH QUALITY CARE & SUPPORTING PEOPLE TO LIVE LONG, HEALTHY ACTIVE LIVES									
Lead Director: All			**Assurances** *Where we can gain evidence that our controls/ systems are effective*			**Assessment**			
Risk *(What could prevent this objective being achieved)*	**Risk Level**	**Key Controls** *(What systems/processes are in place to assist in delivery of objective)*	**Operational Management (First Line)**	**Corporate Oversight (Second Line)**	**Independent Assurance (Third Line)**	**Control RAG rating** *(See Key)*	**Current gaps in controls/ assurance**	**Improvement actions**	**Due date for improvement actions**
4. If there is not sufficient focus on early intervention and prevention (upstream activities), it will result in funding and workforce being incorrectly aligned to the HSC purpose of supporting people to live long, healthy active lives	Medium Risk	Trust Involvement and Leadership in a range of partnerships that promote health and social wellbeing, including Community Planning across 3 local Councils Cross-Directorate Community Planning and Making Life Better Steering Group PfG – focus on Supporting People to live long, healthy and active lives Commissioned annual Health Improvement plans from PHA Commissioned support for Community Development including Traveller and Ethnic Minority support, support for carers and for volunteering 'Making Life Better' – regional framework for Public Health. Trust is an active partner at regional level	Promoting Wellbeing Division supports the development and effectiveness of local multi-agency partnerships in achieving outcomes for health and social wellbeing Programme/service specific monitoring and evaluation measures are applied to inform future planning	Corporate Performance Scorecard to Trust Board (Health and Wellbeing targets) SMT oversight of embedding principles of 'Making Life Better' and Community Planning Patient and Client Experience Committee provides oversight of the PPI and Co-production/ partnership working impacts	Reporting framework to Health & Social Care Board and Public Health Agency External funding reporting to range of funding bodies e.g. CAWT Reporting framework to DfC for impact of Community Planning partnerships	Medium	Trust Corporate Strategy with a wellbeing focus is required	Development of a Corporate Strategy with a Wellbeing focus in line with Integrated Care Population Planning Framework Further development and implementation of Health and Wellbeing thematic plans within local Community Planning structures Refocus of investment into Community/ Voluntary sector aligned to health and social wellbeing outcomes	March 2022 March 2022 March 2022

CORPORATE OBJECTIVE 3: IMPROVING OUR SERVICES									
Lead Director: Medical Director supported by Operational Directors			**Assurances** *Where we can gain evidence that our controls/ systems are effective*			**Assessment**			
Risk *(What could prevent this objective being achieved)*	**Risk Level**	**Key Controls** *(What systems/processes are in place to assist in delivery of objective)*	**Operational Management (First Line)**	**Corporate Oversight (Second Line)**	**Independent Assurance (Third Line)**	**Control RAG rating** *(See key)*	**Current gaps in controls/ assurance**	**Improvement actions**	**Due date for improvement actions**
5. If the Trust does not promote positive risk taking and the appetite to pursue innovation and challenge working practices, this in turn will impact on the ability to improve and develop our services	Medium Risk	• Interim Risk Management Strategy • Controls Assurance process • Organisational learning • Delegation Frameworks for Nursing and Social Work/Social Care	Divisional and Directorate Risk Registers Annual self-assessment of compliance (including risk management) and associated action plans Reports of risk, adverse outcomes and performance against standards Lessons Learned programme in relation to Covid-19	Corporate Risk Register reviewed by SMT monthly and Governance Committee on a quarterly basis including a deep dive into individual risks Controls Assurance Group with reporting to SMT and Governance Committee Directorate Governance Fora Hot Governance Debrief to SMT Lesson Learned Forum Governance Committee	Corporate Risk Register shared with DoH as part of Accountability process Internal Audit on Risk Management (annually) Reporting on some standards to DoH Policy Leads	**Medium**	Gap in knowledge in terms of Risk Appetite/ level of risk that the Trust is prepared to accept seek and tolerate Training programme is required	Review of Risk Management Strategy following Clinical & Social Care Governance Review including Risk Appetite and associated operational delivery plan Risk Management General Awareness Training matrix Trust Board workshop on Risk Appetite Further develop reporting systems - Governance Assurance Strategy QI system aligned to Patient Safety Strategy	December 2021 December 2021 Autumn 2021 December 2021

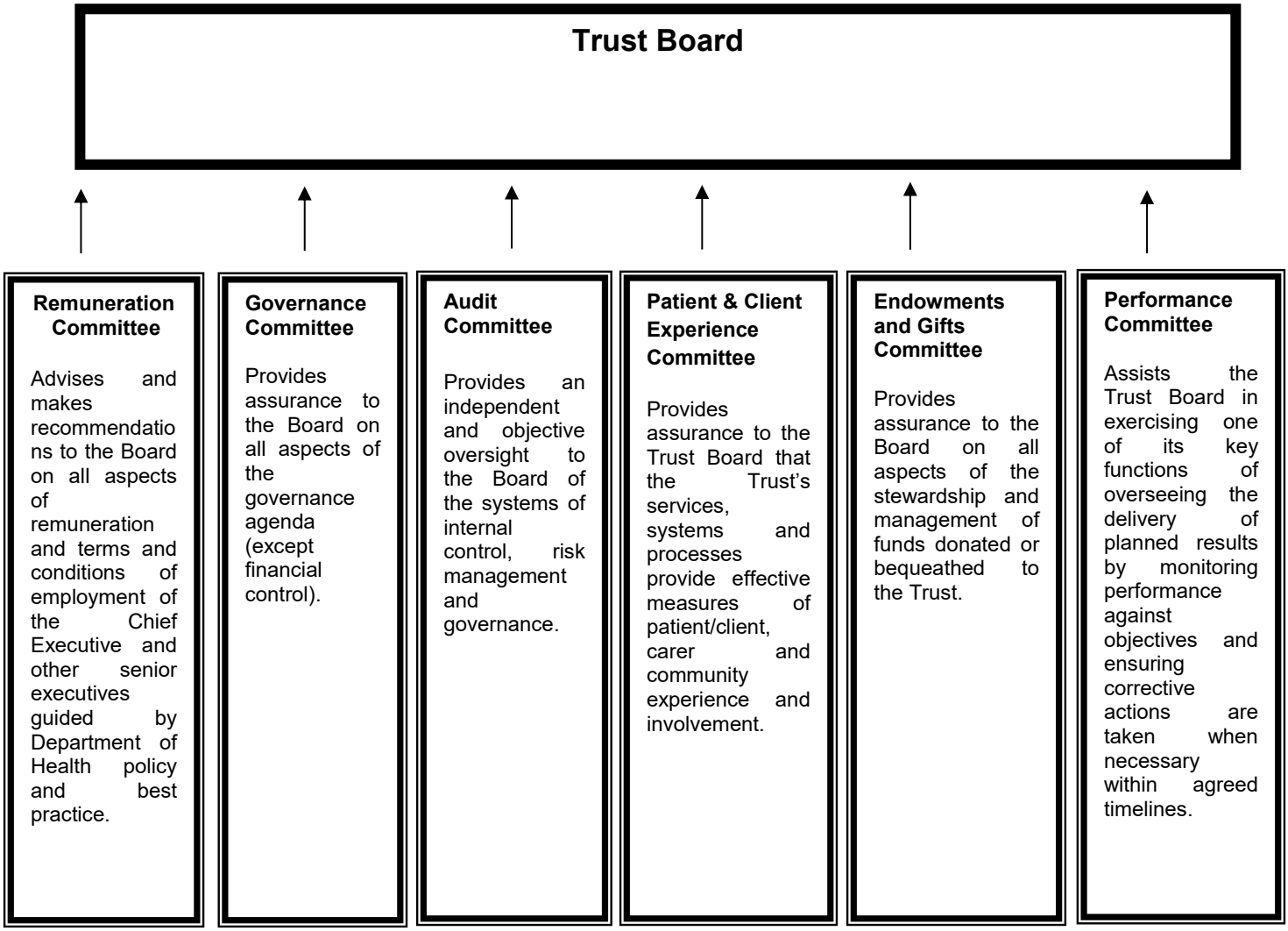
CORPORATE OBJECTIVE(S) 1& 4: PROMOTING SAFE, HIGH QUALITY CARE MAKING THE BEST USE OF OUR RESOURCES									
Lead Director: Director of Finance, Procurement and Estates			**Assurances** *Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective and that we are reasonably managing our risks and objectives are being delivered)*			**Assessment**			
Risk ***(What could prevent this objective being achieved)***	**Risk Level**	**Key Controls** ***((What systems/processes are in place to assist in delivery of objective)***	**Operational Management (First Line)**	**Corporate Oversight (Second Line)**	**Independent Assurance (Third Line)**	**Control RAG rating (See key)**	**Current gaps in controls/ assurance**	**Improvement actions**	**Due date for improvement actions**
6. Inability to secure a sustainable service due to over reliance upon non-recurrent funding, which in turn drives an inefficient use of all monetary and non-monetary resources and facilitates short term planning.	Link to Finance Risk on Corporate Risk Register - Medium risk	Continual update of the Trust's recurrent deficit and reporting of same to HSCB/ Department of Health Monthly meetings with HSCB re funding and quarterly meetings with DoH specifically in relation to securing a stable funding base. Ongoing work in relation to reducing the capitation gap Chief Executive Accountability meetings with Directors	Annual Financial Plan as informed by annual budget reported to DoH and HSCB. Monthly detailed expenditure and budget reports at head of service level, electronic and linked to all new allocations and details of flexible spend. Detailed variance analysis prepared with budgetholders required to confirm what remedial action is being taken as required. Summarised financial performance by Directorate with emerging pressures and themes detailed Detailed monitoring of all specific non-recurrent allocations eg ECR, Transformation Requests for investment are subjected to the business case process and must be presented at Investment Committee	Trust Delivery Plan to Trust Board Finance Report to Trust Board Annual Financial Plan to Trust Board Reported monthly to SMT Reported monthly to SMT Outcome of Investment Committee reported to SMT	External Audit Reported to HSCB and DoH Annual costing returns, specialty costs and HRGs to DoH and HSCB	Medium		To fully participate in the Regional Oversight Group for Sustainability to ensure that funds are available Work has commenced on the Financial Strategy 2021/ 22. Once clarity is received on the actual Trust budget, an updated briefing will be prepared for SMT and Trust Board. Mid-year "hard close" from a financial management perspective Director of Finance continues to work with HSCB & DoH on the capitation inequity gap.	December 2021 Ongoing Autumn 2021 Ongoing

CORPORATE OBJECTIVES 1&3 : PROMOTING SAFE, HIGH QUALITY CARE & IMPROVING OUR SERVICES										
Lead Director: Director of Finance, Procurement and Estates and Director of Performance and Reform			**Assurances** *Where we can gain evidence that our controls/ systems are effective*			**Assessment**			
Risk ***(What could prevent this objective being achieved)***	**Risk Level**	**Key Controls** ***(What systems/processes are in place to assist in delivery of objective)***	**Operational Management (First Line)**	**Corporate Oversight (Second Line)**	**Independent Assurance (Third Line)**	**Control RAG rating** ***(See key)***	**Current gaps in controls/ assurance**	**Improvement actions**	**Due date for improvement actions**
7. Insufficient capital to i) maintain and ii) develop Trust physical infrastructure (Estate/ facilities, Fleet, equipment, ICT etc) to effectively support service delivery and improvement This risk is paired with the IPC risk as the age, nature and condition of the Trust's infrastructure and overall Estate limits the ability to ensure robust infection control measures and social distancing.	Link to Estate and Infrastructure Risk on Corporate Risk Register – High Risk	Annual Capital Plan 10 Year Capital Priorities Capital Resource Limit management process Strategic development plans Fleet Replacement programme ICT Business Plan Minor Works process Property and Asset Management Plan Formal CAH fixed breaker emergency plan All side rooms constantly assessed to ensure patients are being appropriately placed in them.	Capital Monitoring group with key budgetholders Directorate process in place for identifying capital priorities	Strategic Investment Group 10 Year Capital Priorities as agreed by SMT Capital Allocation Group Estates Services Annual Report to Governance Committee Department of Health Condition of the Estate Review/ Report Independent auditing of critical systems (e.g. High Voltage, Water Safety, Ventilation)	Internal Audit RQIA Hygiene Inspection Reports CoPD	Medium	Insufficient funding to address backlog maintenance works as identified in Capital Works list	Prioritisation process for capital requirements including development of forward replacement programmes Development of Annual Capital Plans via Capital Allocation Group Ongoing submission to DoH to influence 10 Year Capital Strategy Develop Estate and implement improvement actions as a result of capital funding e.g. backlog maintenance	Ongoing Annually Ongoing Ongoing

CORPORATE OBJECTIVES 1&3 : PROMOTING SAFE, HIGH QUALITY CARE & IMPROVING OUR SERVICES									
Lead Director: Medical Director			**Assurances** *Where we can gain evidence that our controls/ systems are effective*			**Assessment**			
Risk *(What could prevent this objective being achieved)*	**Risk Level**	**Key Controls** *(What systems/processes are in place to assist in delivery of objective)*	**Operational Management (First Line)**	**Corporate Oversight (Second Line)**	**Independent Assurance (Third Line)**	**Control RAG rating** *(See key)*	**Current gaps in controls/ assurance**	**Improvement actions**	**Due date for improvement actions**
8. Ability to respond adequately to major/emergency incidents such as the COVID-19 pandemic	Link to Risk No.6 on Corporate Risk Register – High Risk	Corporate Emergency Management Plan Emergency Response Plans Acute Hospitals Major Incident Plan Business continuity and Pandemic Response plans including IT contingency plans. Ongoing risk assessments as part of incremental plans to resume service delivery Trust Re-Build Plans Chief Executive engagement process with front line staff on lessons learned from Covid-19	Bronze Pandemic operational group (Tactical) Directorate/Service Incident Coordination Teams Bronze senior management team Bronze operational group	SMT/Board Electronic update Bronze Incident Coordination Team for oversight of the Trust's response Emergency Preparedness Annual Report to Governance Committee Progress report on Covid-19 at each Trust Board meeting Re-build Plans to Trust Board Non Executive Director update meeting with the Chief Executive on Trust's response to Covid-19 Trust participation in development of regional Strategic Framework for Rebuilding HSC Services	Regional Silver command (HSCB, PHA, BSO) Regional Health Gold Command Health and Social Care Board Public Health Agency Department of Health	Medium	Identification of staff competencies and key knowledge and skills for emergency response.	Development and delivery of staff training and exercising programmes Ongoing risk assessment to identify emerging threats. On-going revision of plans in light of lessons learned from incident response and exercises. Agreement on competency requirements Preparation for next stage of the regional rebuilding plan for July, August and September 2021	Ongoing Ongoing Annually or as required March 2022 From June 2021

Appendix 1

High Level Governance Structure



As outlined above, assurance is provided through the Committee structure to Trust Board. The Senior Management Team is represented on each Committee and provides information to support decision-making and effective operation of the Trust at all levels.

Within the governance structure, there are sub-committees and groups; each with delegated responsibility. The reporting and accountability mechanisms are described in the Integrated Governance Framework.

Appendix 2

SUMMARY OF CORPORATE RISKS AS AT JUNE 2021

LOW	MEDIUM	HIGH	EXTREME	TOTAL
	1	5		6

Risk No.	Risk Area/Description	Corporate Objective	Current Risk Rating (Likelihood x Impact)	Target Risk Rating
1	**People** Risk to the delivery of safe, high quality and timely care as a direct consequence of significant workforce issues	1&4	**HIGH** **15 (5 x 3)**	**MEDIUM** **9 (3 x 3)**
2	**Estate and Infrastructure** Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate.	1&5	**HIGH** **16 (4 x 4)**	**MEDIUM** **9 (3 x 3)**
3	**Access to Services** Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.	1	**HIGH** **16 (4 x 4)**	**MEDIUM** **9 (3 x 3)**
4	**Technology Enablement** 1. Risk of significant business disruption as a result of a cyber and 3rd party security attacks. 2. Risk of achieving Regional Technology Programmes 3. Risk associated with reliance on Digital Technology	1,3 & 4	**HIGH** **16 (4 x 4)**	**MEDIUM** **9 (3 x 3)**
5	**Finance** Breach of statutory duty of break-even in-year and destabilisation of services due to over reliance upon non-recurrent funding and our inability to securre sufficient recurrent investment	5	**MEDIUM** **12 (4 x 3)**	**LOW** **6 (3 x 2)**
6	**Infection, Prevention and Control/Covid-19** Risk to patient safety due to the potential to develop a healthcare acquired infection. In particular, the Covid-19 poses unique challenges for IPC processes and there is a risk to the Trust's ability to respond adequately	1	**HIGH** **12 (3 x 4)**	**MEDIUM** **6 (2 x 3)**

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

September 2022

INTRODUCTION

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

Each risk on the Register has been linked to the relevant Corporate Objectives which remain unchanged for 2022/23 as detailed below:-

Corporate Objectives

1: Promoting safe, high quality care.
2: Supporting people to live long, healthy active lives
3. Improving our services
4. Making the best use of our resources
5. Being a great place to work – supporting, developing and valuing our staff
6. Working in partnership

Where relevant, risks have also been linked to the **3 Corporate priorities** contained within the Corporate Plan 2022/23 as detailed below:-

1. Stablishing, Rebuilding and Growing
2. Improving access to planned services for our patients
3. Supporting unplanned, urgent and emergency services

Risk scoring is based on likelihood and impact as summarized in the Risk Assessment Matrix below.

Risk Likelihood Scoring Table			
Likelihood **Scoring Descriptors**	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Risk Appetite: low (L); moderate (M); high (H) has also been included against each risk.

OVERVIEW OF CORPORATE RISKS AS AT SEPTEMBER 2022

The Corporate Risk Register remains a dynamic document which the Senior Management Team continually try and improve on. To that end, a deep dive into each corporate risk was undertaken by SMT during July and August 2022 with a view to populating a new streamlined Corporate Risk Register.

There are seven principal risk domains as follows:

1. People
2. Estates and Infrastructure
3. Access to Services
4. Technology Enablement
5. Finance
6. Infection, Prevention and Control
7. Urology Services Public Inquiry

Changes to the Register since August 2022

New risk

On 22nd September 2022, SMT agreed the inclusion of Risk No. 1.7 'Risk to the consistent provision of high quality, safe care to children, young people and families due to shortages and vacancies across the Health Visiting service' on the Corporate Risk Register.

There are currently 32 corporate risks, the risk ratings of which are outlined below.

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	8	24	0	32

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
1	**People**			
1.1	Risk to the consistent provision of high quality, safe medical care due to medical workforce shortages and vacancies within some specialties (exacerbated due to Covid-19)	1	**HIGH**	10
1.1a	Risk to the continuity of service provision within the Gillis Unit, St Luke's site, Armagh due to Consultant Psychiatry workforce shortages. Currently, there is only one permanent substantive Consultant Psychiatrist for the total Psychiatry of Old Age (POA) and Memory Service: three posts are vacant and one staff member remains on maternity leave until Autumn 2022	1	**HIGH**	13
1.2	Risk to safe, high quality care due to a high volume of medical locum engagements for different periods of time with varying levels of experience/training and often in hard to fill posts.	1	**HIGH**	14
1.3	Risk to the consistent provision of high quality, safe nursing care due to nursing and midwife shortages and vacancies across all Directorates and high nursing agency usage (exacerbated due to Covid-19)	1	**HIGH**	17
1.4	Risk to staff engagement, morale and health & wellbeing due to workforce capacity/demand pressures. (exacerbated due to Covid-19).	1 & 6	**HIGH**	19
1.5	Risk of potential harm to children due to Social Work vacancies impacting on the delivery of core Family Support & Safeguarding Services for children and families.	1	**HIGH**	21
1.6	Risk to the stability and effectiveness of Trust Board as a direct consequence of workforce vacancies at Senior Executive level and Non-Executive Director level.	1	**MEDIUM**	23
1.7	Risk to the consistent provision of high quality, safe care to children, young people and families due to shortages and vacancies across the Health Visiting service.	1	**HIGH**	24

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
2	**Estates and Infrastructure**			
2.1	Insufficient capital to maintain and develop Trust Estates works (works under £1.5m) and maintenance programme this year	3 & 4	**MEDIUM**	26
2.2	Inability to complete Estates project by year end during to delay in availability of materials, delay with contractors or internal Estates capacity	3 & 4	**MEDIUM**	27
2.3	Risk of harm to visitor, staff and patients safety resulting from legionella, fire hazards and poor maintenance	1, 3 & 4	**MEDIUM**	28
2.4	Lack of controls over Health and Safety	1 & 4	**MEDIUM**	29
2.5	Risk that Trust does not achieve Year 2 Sustainability plan due to lack of resources and staffing	3 & 4	**MEDIUM**	30
2.6	Servicing of medical equipment not carried out in timely manner due to items not being sent to Estates for servicing or due to resourcing issues	1, & 4	**HIGH**	31

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
3	**Access to Services**			
3.1	Risk to safe, high quality care due to delay in accessing elective services for assessment, diagnostics and treatment in accordance with clinical need due to a demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic	1	**HIGH**	32
3.2	If demand continues to outstrip supply and review appointments or planned assessment/ treatment are not completed in line with clinical timescales, due to demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic, then there is a risk of harm to individuals known to Trust services	1	**HIGH**	35
3.3	Clinical risk associated with delay in accessing inpatient beds in Acute, Mental Health, Beechcroft and Non Acute Hospitals	1	**HIGH**	37
3.4	Risk of deterioration of health and social functioning as a result of reduced access to a range of community services (examples include domiciliary care, day care centres, Carers Assessments etc.)	1	**HIGH**	40
3.5	Risk to the consistent provision of safe, high quality care due to reduced capacity in Out of Hours services (examples are GP OoH, Crisis Response and Emergency Department services)	1	**HIGH**	42
3.6	Risk to the ongoing supply of medicines due to EU Exit/NI Protocol when the grace period ends (currently extended), when NI will continue to follow EU rules and regulations for medicines and medical devices, whereas Great Britain will not, with implications for both the supply and regulation of medicines in N.I.	1	**HIGH**	44
3.7	Risk to the provision of food for patients and staff due to suppliers having difficulties sourcing and supplying some food produce.	1	**HIGH**	45
3.8	Risk to assuring compliance with agreed standards of care due to a reduced clinical audit capacity.	1	**MEDIUM**	46

4	**Technology Enablement**			
4.1	Risk to the HSC network availability in the event of a cyber attack on HSCNI or a supplier/partner organisation, resulting in the compromise of the HSC network and systems or the disablement of ICT connections and services to protect the HSC and its data. Risk associated with the reliance on digital technology to support service delivery, including information systems, clinical applications and data analysis tools such as Qlikview.	1	**HIGH**	47
4.2	Risk of achieving implementation of Regional Technology implementation due to the Trust not having the capacity to effect the change required to implement the digital initiatives.	1	**HIGH**	48

5.	**Finance**			
5.1	Risk of breach of statutory duty of break-even in year	4	**HIGH**	49
5.2	Risk of destabilization of services due to over reliance upon non-recurrent funding and the Trust's inability to secure sufficient recurrent investment	4	**MEDIUM**	51

6.	**Infection, Prevention and Control**			
6.1	Risk to patient, staff and visitor safety due to the potential to develop a healthcare acquired infection such as MRSA, C. difficile etc. In particular, the Covid-19 Pandemic with new and emerging variants poses unique challenges for IPC processes and there is a risk to the Trust's ability to respond adequately. (This risk is paired with the Trust's aging infrastructure risk and the People risk)	1	**HIGH**	52

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
7.	**Urology Services Public Inquiry (USI)**			
7.1	Organisational capacity to manage the range, and complexity of information required to support the USI. This includes general discovery requests, which are wide in their scope and cover significant areas of the Trust and the support required to comply with S21 requests. Moving forward to subsequent phases of the USI, organisational capacity and readiness in relation to preparations for the Public Hearing process will remain a challenge Capacity of legal team (DLS and Barristers) to support the USI, particularly with a number of concurrent Public Inquiries on-going	1	**HIGH**	55
7.2	Risk to service continuity as a result of Section 21 notices response times and Public Hearing preparations.	1	**HIGH**	56
7.3	Risk to health and wellbeing of staff	5	**HIGH**	57
7.4	Reputational risk exists in the process of the Public Inquiry – the public release of information and the Public Hearings which are likely to attract media attention.	1	**HIGH**	58
7.5	No funding stream identified	4	**HIGH**	59

1. PEOPLE

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-23 : Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.1 Risk to the consistent provision of high quality, safe medical care due to medical workforce shortages and vacancies within some specialties (exacerbated due to Covid-19)	Organisational risk in being able to continue to deliver services Potential impact on patient / client safety and quality of care delivery Reputational – loss of public confidence Impact on staff health and wellbeing in areas of high vacancy rates	**L**	Director of HROD Medical Director	Monitoring of vacancy position through Medical Staffing and Directorates International recruitment and targeted advertising Monthly medical recruitment report, fill rates, unfilled posts. Analysis and improvement of recruitment and advertising strategies Collaborative working with other Trusts, when required Independent Sector contracts	Score 15 (5 x 3)	Rating High	Score 9 (3 x 3)	**Rating** Medium	**Reports to Trust Board/Board Committees** Performance Committee deep dives per Division/ Service Medical Director reports **Reports Elsewhere** Monthly recruitment report to Medical Director, Chief Executive & Director HROD, copies to Divisional MDs JULY Monthly Recruitment Updat	Demand comes from more than vacant posts – but also need to identify what additional posts are necessary Updated and agile workforce planning is needed	Review of international recruitment progress to date on the contract by December 2022 Bids for recurrent funding for ED & Medicine submitted to Strategic Investment Group in June 2022. Has been tabled at SPPG for funding potential. May need to consider invest to save proposals where no funding available. Review in September 2022. Plan to review if appointment of specialist posts would help where we are unable to recruit consultants. Review by Oct 2022

				Greater use of alternative roles through advanced practitioners – nursing and AHPs and Physician Associates Escalation of pressures to DOH/ SPPG e.g. an early Alert was issued on 25.7.22 to DOH due to the risk with medical staffing in Haematology. Adverts now include a sentence asking for expression of interest from doctors who would wish to apply for Consultant posts, but are not yet eligible. A formal log is being kept. Appointment of overseas doctors via the Medical Training Initiative scheme.					Business cases for additional investment. Social Media advertising / BMJ advertising package Adverts	No E rostering system in place for medics	Work with DMDs and LNC to consider promotion of flexible job planning and other initiatives to retain staff and avoid further retirements. By Mar 2023 Explore E rostering solutions for medics by March 2023

				Consultant presence at Recruitment Fairs (e.g. Psychiatry Conference in Edinburgh June 22) Locum agencies to fill gaps.							

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.1a Risk to the continuity of service provision within the Gillis Unit, St Luke's site, Armagh due to consultant psychiatry workforce shortages. Currently, there is only one permanent substantive Consultant Psychiatrist for the total Psychiatry of Old Age (POA) and Memory Service: three posts are vacant and one staff member remains on maternity leave until Autumn 2022	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	**L**	Director of Mental Health and Disability	Co-location of Gillis and Willows Ward to allow the multi-disciplinary team to access on-site medical input and support. A review of Inpatient Memory Services is underway	Score 15 (5 x 3)	Rating High		Rating Medium	**Reports to Trust Board/Board Committees** Reported to Trust Board – May 2022 **Reports Elsewhere** SMT	Inpatient Memory Services review –what is optimum service for Southern Trust population?	Project Steering Group for Review of Inpatient Memory Services continues: public consultation planned for September/ October 2022 Recruitment campaign for Consultant Psychiatrist to be re-commenced September 2022.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.2 Risk to safe, high quality care due to a high volume of medical locum engagements for different periods of time with varying levels of experience/ training and often in hard to fill posts.	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	**L**	Director of HROD Medical Director	New Supporting Doctors in Difficulty Hub for Managers Monthly report of locum usage is issued to the service highlighting locum use, broken down in different data sets including expenditure. Centralised Medical Locum Team now part of Integrated Medical HR allows for streamlined oversight, identification of trends and consistent management of concerns.	Score 15 (5 x 3)	Rating High	Score 9	**Rating** Medium	https://view.pagetiger.com/Hub/doctors-in-difficulty-hub https://view.pagetiger.com/Medical-Staffing/shsct-locum-doctors Monthly locum reports issued to the service on their locum use and used for Monthly Oversight Committee.	Large volumes of Ad Hoc locums creates risk No Line managers for locums Locums have different RO's Induction of locums is not consistent	Development of the Page Tiger portal with videos to enhance induction materials available to locum doctors – **by Dec 22** Requirement for longer term locum doctors to have Job Plans – **by Mar 23** Engage with DOH for support and action in relation to regional paper relating to consistency in locum rates and enhancement of local medical banks. **Ongoing** ID Checks –To be reviewed with Deputy Medical Director to explore via Oversight Groups how this can be better managed. **By Mar 23** Formal Supervision arrangements for locums to be reviewed and strengthened **By Mar 23**

				Specific signposting page for Locum Doctors working in the SHSCT Deputy Medical Director for workforce now in post alongside a new SAS lead for Locum Governance Southern Trust has taken lead in finalising proposal to encourage development of local banks as alternative to agency and consistency in medical locum rates. Now with DOH for consideration. Specific Guidance for management of concerns with locum doctors. First Trust in NI to develop which has been shared with GMC and other Trusts for implementation elsewhere.							Identification of Locum Champions – to help mentor and support all locums – By Mar 23

				Protocol in place for engagement of Medical and Dental Agency Locums PALs oversight of current Medical and Dental Framework Monthly Oversight Committee for DMD to meet with AD for Service and AMD to review locum usage by specialty and identify plans for future.							

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.3 Risk to the consistent provision of high quality, safe nursing care due to nursing and midwife shortages and vacancies across all Directorates, and high nursing agency usage (exacerbated due to Covid-19)	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	**L**	Executive Director of Nursing, Midwifery and AHPs Director of HROD	Daily Senior Nurse oversight of staffing levels within Directorates at operational level supported by Safe Care to assess staffing levels on a daily basis in Acute Services. Directorate and other workforce analysis tools are in use for other Directorates to facilitate reporting status of Nursing and Midwifery Workforce Provision of Health roster workforce reports to operational teams to inform staff allocation.	Score 15 (5 x 3)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/ Board Committees** Quarterly recording Workforce report to Performance Committee. **Reports Elsewhere** Monthly Health roster reports to Operational Directors. Monthly Nursing workforce reports to SMT.	Improvement required in Trust data reporting to drive agency reduction locally. Lack of capacity in Nurse Bank / Agency management	Complete ward-by-ward agency workforce exit plans to reduce off contract agency staff and occurrence of Trust own staff through off contract agency - by end of September 2022 Completion of Invest to Save proposal for separate Band 8a Nurse Bank / Agency Business Manager. Commencement of data scientist in September 2022 with focus on agency expenditure and patient data to drive improvement in workforce decision making Commence secondary International Recruitment September 2022 and maintain International recruitment from the regional contract.

				Use of Bank and Agency and enhanced rates of pay for trust staff. Recruitment actions including local recruitment And regional and secondary International recruitment campaigns.							Alignment of QUB and OU nursing graduates to Band 5 posts. Open recruitment for Band 5 ongoing. Trust wide nursing and midwifery recruitment event November 22. The second year of the SRC pre nursing programme commences in Sept 2022 and the same programme being offered to Trust own staff. Launch and commence work against key actions within the Nursing and Midwifery workforce action plan 2022-2024. This includes recommendations from the Regional Retention Implementation report (DoH,2022). The focus continues on minimising all band 2/3 nursing assistant vacancies- ongoing

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.4 Risk to staff engagement, morale and health & wellbeing due to workforce capacity/ demand pressures (exacerbated due to Covid-19).	Human Resource impact – staff	**L**	Director of HROD	People Framework Health and Wellbeing Framework and Steering Group Clinical Psychology staff support and wellbeing service Inspire Contract Occupational Health Wellbeing Service Ongoing recognition of staff and teams People management policies, systems, processes and training	Score 15 (5 x 3)	Rating High	Score 9	**Rating** Medium	20220804 SHSCT 20220803 HWB HWB Notes 6 Jun 2022.docx OHWS - Managers Support Service OH Psychology overview New.pdf Occupational Heal and Well-Being ser 20220801 Dashboard Figures	People Framework requires to be launched. People & Culture Steering Group is required to drive People Framework Lack of support for staff with Long Covid New approach to appraisal needs rolled out. Lack of capacity for developing Raising Concerns programme	People Framework to be approved at September Trust Board 2022. People & Culture Steering Group to be established – October 2022. Long Covid Occupational Health Team recruitment ongoing. Team to be in place by mid October 2022. Roll out of new appraisal to be complete by March 2023. Development of F2SU Guardian roles and advertised in September. In place by November / December 2022.

				Raising Concerns Policy Management of organisational change policies and procedures Also – controls identified above in 1.1, 1.2. 1.3					20220315 ToR Trust Corporate Recognitio 22032022 Corp Recognition Steeri Flexible Working - All Documents Staff Conduct Your Appraisal Conversation - Pilo Appraisal Conversation - Guid CBH workshop slid - V5.ppt Creating a Great Place to Work 20220729 Your Right to Raise a Concern – \	Flexible working training / awareness for managers	Flexible working awareness raising for managers – by December 2022.
									Whistleblowing Management of Change 8b[redacted].pdf		

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.5 Risk of potential harm to children due to Social Work vacancies impacting on the delivery of core Family Support & Safeguarding Services for children and families.	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	**L**	Director of Children and Young People's Services	Prioritisation of child protection and LAC cases, in particular safeguarding visits Prioritisation of work across the Directorate in line with action plan Skill mix Regional recruitment initiatives 12 Band 4 Social Work Assistants are in the process of being offered posts within FSSG. Recruitment of additional 3 Band 4 Social Work Assistants within Corporate Parenting division to support transfer pathway.	Score 15 (5 x 3)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Executive Director of Social Work report to Trust Board – March 2022 Delegated Statutory Functions report to Trust Board **Reports Elsewhere** DSF Report to Strategic Planning & Performance Group (SPPG)	Regional recruitment initiatives remain ongoing however these are unlikely to bring about substantive social work recruitment within Gateway and FIT service, given the limited pool of social work new entrants regionally	Regional recruitment initiatives - ongoing Ongoing engagement with the SPPG and DoH on a regional basis

				CYPS have revised and approved the child's pathway and transfer procedure to include an earlier transfer of LAC children to Corporate Parenting Division. Regional Children's Leadership Improvement work streams have been implemented to review the Delegation Framework for Children's Services.							

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.6 Risk to the stability and effectiveness of Trust Board as a direct consequence of workforce vacancies at Senior Executive level and Non-Executive Director level.	Human Resource impact – staff Reputational risk Organisational risk Potential impact on patient / client safety and quality of care delivery	**M**	Director of HROD	Senior Executive restructuring Medical Director now appointed and due to take up post in November 2022 3 Operational Directors already advertised and to be appointed by end of September 22. Chair continues to raise Non Executive Director vacancies with Public Appointments Unit	Score 12 (4 x 3)	Rating Medium	Score 6	**Rating** Low (3 x 2)	**Reports to Trust Board/Board Committees** Senior Executive Restructuring updates to Trust Board Senior Executive Job Descriptions to Remuneration Committee **Reports Elsewhere** Report of Phase 1 restructuring – to TU Side, Trust staff.	Currently 4 of 11 Directors permanent. Director of Performance & Reform, Director of CYPS and Executive Director of Social Work to be advertised and appointed. 2 Non-Executive Director vacancies	All Director posts to be advertised and appointed by December 2022. Non Executive Director positions Competition programme, including SH&SCT vacancies – to be advertised by PAU in October 2022.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
1.7 Risk to the consistent provision of high quality, safe care to children, young people and families due to shortages and vacancies across the Health Visiting service.	Threat to compliance of the Regional Pre-School Child Health Promotion Programme (HCHF). Threat to compliance of pre-school vaccination programme. Reduced opportunities for early identification and intervention for infants/ children with underlying medical conditions or developmental delay. Threat to compliance with SBNI and Trust Safeguarding Children Policy & Procedure.	L	Director of CYPS Executive Director of Nursing	Implementation of step down model within the HV service, prioritising those families/children with the highest need. Systems in place to facilitate parents to be able to access the HV service when they have concerns. Within HV Service, a cross locality approach being undertaken to support HV teams with highest reduced staffing levels. Utilisation of Trust Bank and additional hours. Maintain referrals to Occupation Health in line with Trust policy and procedure.	Score 15 (5 x 3)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Monitoring and reporting of quarterly IoPs. Monthly staffing returns **Reports Elsewhere**	Regional lack of appropriately trained nurses available to recruit to undertake HV role. Regional gap in providing the number of HV training placement required to deliver full the Child Health Promotion Programme	Additional weekend clinics will be introduced. Communication Strategy will be developed. Influence the commissioning of additional regional HV training placements available. Avail of any regional opportunities to meet Normative Staffing levels within HV.

	Threat to compliance with Regional and Trust Health Visiting Policy & Procedures. Impact of long term deficits within HV on staff may contribute to further sick leave within the HV service and impact on morale			Proactive recruitment of additional HV. Maintain appropriate supports for staff including managerial and safeguarding children supervision. Recruitment of additional skill mix in the HV service. Escalation to PHA and DoH.							

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVES: Improving our services; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.1 Insufficient capital to maintain and develop Trust Estates works (works under £1.5m) and maintenance programme this year	Impact of physical safety to visitors/staff/ patients if Estates work is not undertaken. The Trust has a duty of care to protect those who use and enter its properties. Will lead to deterioration of Estate that if not adequately maintained, will further increase costs to public purse.	M	Director of Finance, Procurement and Estates	Capital funding of c£17m has been received for Estates work including invest to save in 22-23	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	**Rating** Low	**Reports to Trust Board/Board Committees** Estates Services Annual Report to Trust Board **Reports Elsewhere** Monthly Estates report to SMT Quarterly Governance meeting External audit check year end accruals	IPT for IV work at DHH with the DOH for approval. If not approved promptly, there is a risk that this work will not be carried out within the financial year Globally construction costs for building materials and contractors are increasing which could increase or delay projects	IPT with Permanent Secretary for approval and approval is imminent. Estates have contractors in place to commence work once approval is sought. PALS are monitoring the increased costs of construction and further funding will be bid for if costs increase.

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVES: Improving our Services; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.2 Inability to complete Estates project by year end due to delay in availability of materials, delay with contractors or internal Estates capacity.	Essential Estates work not being completed and consequently impacting on service and funding rescinded	M	Director of Finance, Procurement and Estates	Progress against projects is being monitored on monthly basis with report to SMT Action plan with timeframes in place for completion in place for all projects Experienced surveyors and architects employed in Trust to deliver projects PALS monitoring costs of building materials globally	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	**Rating** Low	**Reports to Trust Board/Board Committees** Estates Services Annual Report to Trust Board **Reports Elsewhere** Monthly reports to SMT Quarterly Estates Governance meetings	Globally construction costs for building materials and contractors are increasing which could increase or delay projects outside of Trust control	PALS continue to monitor the increased costs of construction and further funding will be bid for if costs increase.

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.3 Risk of harm to visitor, staff and patient safety resulting from legionella, fire hazards and poor maintenance	Safety of visitors/ patients/staff at risk	L	Director of Finance, Procurement and Estates	Cycle of water testing by trained staff in line with national policy and guidance Fire safety audits carried out by experienced fire officers in line with national policy and guidance	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	Rating Low	**Reports to Trust Board/ Board Committees** Estates Services Report to Trust Board **Reports Elsewhere** Independent external annual assessment of water testing with report provided detailing areas for improvement NIFRS carry out annual review of fire procedures Internal audit review	Recommendations from external assessments being implemented (All low risk rating)	Actions plan in place to address recommendation with timeframes

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVE: Promoting safe, high quality care; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.4 Lack of controls over Health and Safety	Risk of physical harm to staff/ patients and visitors	L	Director of Finance, Procurement and Estates	H&S Committee meeting quarterly H&S quarterly updates to DoFPE	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	**Rating** Low	**Reports to Trust Board/ Board Committees** Annual H&S report to Governance Committee **Reports Elsewhere** Quarterly H&S Committee with Unions in attendance	Limited Assurance Audit in 2021-22 with 13 recommendations H&S Team are under resourced, staff off on Long Term Sick Leave/Maternity and not sufficient staff to appropriately carry out H&S function in organisation	Actions plan in place to address internal audit recommendations with expected implementation by 31 March 2023. H&S Committee oversight and monthly meetings with A/D and DoFPE oversight at quarterly Estates Governance meetings Two Agency staff in post and a review of staff is being undertaken.31/12/ 2022

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVE: Improving our Services; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.5 Risk that Trust does not achieve Year 2 Sustainability plan due to lack of resources and staffing	Trust is not being as sustainable as it should be nor increases carbon footprint	M	Director of Finance, Procurement and Estates	5 Yr sustainability strategy commenced 21/22 Estates on target to achieve actions from plan Plans in place to install renewable energy (solar panels) in 2022-23 Programme of works in place to install LV DHH and electric car charging points Tree planting programme on target c£2m received from SIB in 22-23 for sustainability invest to save schemes.	Score 8 (4 x 2)	Rating Medium	Score 6 (3 x 2)	Rating Low	**Reports to Trust Board/ Board Committees** Annual sustainability report to Trust Board **Reports Elsewhere** Monitored at monthly sustainability meetings Monitored by DFPE at Quarterly Governance Meetings	Increased waste due to covid Further improvements to reduce energy consumption in hospital buildings is required	Revisit the Sustainability strategy to ensure that Trust is working towards reducing carbon footprint. Rolling out renewable energy schemes across Trust.31/3/2023 Keeping abreast of evolving renewable energy option for hospitals, more efficient boiler scheme 31/3/20223

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVE: Promoting safe, high quality care; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.6 Servicing of medical equipment not carried out in timely manner due to items not being sent to Estates for servicing or due to resourcing issues	Medical equipment fails to operate correctly posing harm to patients	L	Director of Finance, Procurement and Estates	Servicing schedule in place Red risk items are given priority 3 additional service engineers appointed Monitored on weekly basis by DoFPE Global emails sent to trust staff as reminder to not use equipment unless it has been serviced Internal audit recommendation have been implemented with number of o/s items been reduced to those that are misplaced	Score 16 (4 x 4)	Rating High	Score 6 (3 X 2)	Rating Low	**Reports to Trust Board/ Board Committees** Internal Audit Report to Audit Committee **Reports Elsewhere** Monitored by Assistant Director, Estates and DoFPE on weekly basis through weekly servicing report Monitored by DFPE at Quarterly Governance Meetings Internal audit follow up	Many items cannot be found Staff still not sending in items in advance of servicing date Actions implemented following limited internal audit recommendation to be reviewed	Tracking system being explored 31/3/2023 Global reminders will continue with support from Directors (ongoing) Actions to be cleared by 30/9/2022

3. ACCESS T O SERVICES

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Improving Access to Planned Services for our patients

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
3.1 Risk to safe, high quality care due to delay in accessing elective services for assessment, diagnostics and treatment in accordance with clinical need due to demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic	There is a risk of secondary harm to the SHSCT population/ patients/ Service users and potential fatalities as a consequence of delays accessing safe, timely and appropriate care and treatment Unsatisfactory patient experience Loss of service user and stakeholder confidence	**L**	Director of Surgery and Elective Care	Regional clinical prioritisation of operative/ theatre capacity directed to those most in need on an equitable basis Mechanism in place to review service waiting lists to ensure those with greatest need are allocated capacity and routine users are offered access to available capacity on a chronological basis. Virtual consultations	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Monthly Acute cross Divisional Performance meeting for identification of risk Monthly Acute Directorate SMT Performance	Staffing constraints to maximise capacity including theatre capacity	Recruitment strategy and recruitment campaign to ensure staffing levels to provide timely, safe effective care Review of Nursing workforce etc. Review of Consultant Job Plans

				Effective booking of patients (IEAP guidance) Proactive pre appointment procedure triage/testing for Covid 19 to minimise cancellations Pre-operative assessment Effective discharge planning/ Enhanced recovery to reduce length of stay and ensure safe and effective discharge to maximise bed capacity Regular performance meetings Monitoring of outpatient clinics and elective procedures capacity Red flags reviewed weekly; other referrals reviewed monthly					and Governance meeting Monthly report on Rebuild/ Service Delivery Plan to SMT	Data on OPD and theatre utilisation is limited Data on e.g. triage, dictation, OPD outcomes etc. is limited Impact of emergency admissions and delayed discharges on bed availability risks cancelled activity	Review IT solutions to the management of PTLs and effective booking Review waiting list manager roles for consideration of implementation Review IT solutions to provide real time data to enable review of and maximisation of capacity Action plan including no more silos recommendations Given correlating delay within Cancer Pathways, there will be an increase in monitoring of sharing of reports to support improved compliance with 31/62 day targets

				Independent Sector contracts to deliver OPD, diagnostic and treatment capacity							Opportunities continue to be identified to seek to increase capacity via sourcing of additional capacity, both internally & externally via Independent Sector Continue to scope innovative approaches/new ways of working to service delivery Development of Service Delivery Plans for core services

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Improving Access to Planned Services for our patients

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
3.2 If demand continues to outstrip supply and review appointments or planned assessment/ treatment are not are not completed in line with clinical timescales, due to demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic, then there is a risk of harm to individuals known to Trust services	There is a risk of secondary harm to the SH&SCT population/ patients and potential fatalities as a consequence of delays accessing safe, timely and appropriate care and treatment Unsatisfactory patient experience Loss of service user and stakeholder confidence	**L**	Director of Surgery and Elective Care	Mechanisms are in place to categorise planned procedures and reviews into urgent and non urgent for assignment to appropriate waiting lists and to review service waiting lists to ensure those with greatest need are allocated capacity Effective booking of patients (IEAP guidance) Virtual consultations	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Monthly Monitoring information to assist with oversight and identify and escalate those requiring prioritisation	Staffing constraints to maximise capacity including theatre capacity Data on OPD and theatre utilisation is limited	Recruitment strategy and recruitment campaign to ensure staffing levels to provide timely, safe effective care Review of consultant job plans currently being undertaken to drive consistency Review IT solutions to the management of PTLs and effective booking Review waiting list manager roles

				Proactive pre appointment procedure triage/testing for Covid 19 to minimise cancellations Mechanisms in place for GPs to escalate change/ deterioration in condition						Data on e.g. triage, dictation, OPD outcomes etc. is limited Impact of emergency admissions and delayed discharges on bed availability risks cancelled activity	Review IT solutions to provide real time data to enable review of and maximisation of capacity Action plan including no more silos recommendations
			Director of Mental Health and Disability	Mechanisms in place for individuals to contact duty system for urgent review should there be a significant deterioration in clinical condition							
			Director of Older People and Primary Care	AHP Community Outpatient Services managed in keeping with IEAP requirements. Clinical triage and prioritisation in place					Active monitoring of AHP output activity including monthly reporting against Rebuild/ Service Delivery Plan		Ongoing work by AHP Services to deliver increased levels of activity

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
3.3 Clinical risk associated with delay in accessing inpatient beds in Acute, Mental Health, Beechcroft and Non Acute Hospitals	Patient safety risk	**L**	Director of Surgery & Elective Care Director of Medicine and Unscheduled Care Director of OPPC	Acute and OPPC No More Silos Implementation Group Surgery contingency plan. Emergency & General Surgery on single site(CAH) Joint Directorate (Acute, MHD and OPPC) meeting up to three times daily to review inpatient delays and promote effective flow through both Acute and Non Acute Hospitals Care Home Information Hub plus Community Discharge Hub in place	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Activity levels reported through NMS	Staffing constraints to maximise capacity	Recruitment Strategy and recruitment campaign to ensure staffing levels to provide timely, safe effective care Review of Nursing workforce within Acute Wards – October 2022 Work ongoing to improve performance and increase the robustness of Winter Plans/Contingency

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
3.3 continued	Patient safety risk	**L**	Director of Mental Health and Disability	**Mental Health** Mental Health / Learning Disability Home Treatment/Crisis Response Teams Dorsy - fortnightly delayed discharge meeting. Bluestone Bed coordinator Daily Bluestone/Dorsy Ward rounds	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Mental Health & Disability - Early Alerts / RQIA updates	Inpatient beds levels impacted by frequent requests for out of Trust admissions due to regional bed pressures (Dorsy & Bluestone). Facilitation of early discharge for these admissions.	Ongoing Regional discussions. Early Alerts submitted. Clinical assessment.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
3.3 continued	Patient safety risk	**L**	Director of Children & Young People's Services	Regional AD CAMHS Forum Community teams provide extensive on-site support to acute medical ward Admission Request Meeting (ARM) facility in place to request admission. Robust communication methods in place across CAMHS and appropriate stakeholders	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/ Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Weekly status report from Beechcroft reported to Director/ Assistant Director/ Head of Service	Beechcroft's current inability to accept admissions. Waiting list currently (regionally). No contingency plan identified by Beechcroft Ongoing difficulties with access to acute assessment beds	Beechcroft are working to address capacity issues by expediting discharges where possible, where additional supports are being put in place in the community. CAMHS reviewing how they can increase the crisis response service to avoid admission to Beechcroft through intensive community support. DoH has commissioned a regional CAMHS workforce review, which will include Beechcroft. Report expected Autumn 2022.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Improving Access to Planned Services for our patients

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
3.4 Risk of deterioration of health and social functioning as a result of reduced access to a range of community services (examples include domiciliary care, day care centres, Carers Assessments etc.)	Patient safety risk	**L**	Director of Mental Health and Disability/ Director of Older People & Primary Care Services	Day Care and Short Breaks Local re-mobilisation pathways developed to support increased day care /short breaks attendances. Increase in offers of direct payments/SDS Mental Health Strategies for early intervention and prevention Implementation of IAPT (Improving access to psychological therapies) model of care	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Day Care remobilisation report to SPPG	The Trust is heavily dependent on the Independent Sector for provision of short break beds provision. This provision is impacted by covid rates as are Trust day care facilities.	The Trust continues to focus on care assessments and care planning to ensure needs are identified and met. Seek to increase capacity in IS for day centres Developing and strengthening partnerships for improving health and well being.

				Domiciliary Care Care Bureau working with Commissioning Teams to ensure outstanding Domiciliary Care list updated and outstanding packages highlighted to Providers daily Carers Assessments – Active monitoring of activity levels (Assessments offered and completed)					Active monitoring of outstanding Domiciliary Care cases Weekly Community Information reports	The Trust and Independent Sector Providers deliver domiciliary care through a partnership approach, however there are recruitment difficulties	Work ongoing to increase domiciliary care capacity by frequent review and potential downturn of existing packages, plus active recruitment of domiciliary care workers. Work ongoing to increase Carers Assessment levels by active championing of this activity against regionally agreed targets

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
3.5 Risk to the consistent provision of safe, high quality care due to reduced capacity in Out of Hours services (examples are GP OoH, Crisis Response and Emergency Department services)	Patient safety risk	**L**	Director of Medicine and Unscheduled Care Services Director of OPPC	GP Out of Hours Temporary measures in place to increase the resilience of the service, including temporary consolidation of the model from 5 sites to 2 ED Phone First and Urgent Care Centres established to improve the provision of advice, guidance and triage of patients to ensure patients are dealt with in the right place Escalation and ED capacity plan	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	**Reports to Trust Board/Board Committees** Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee **Reports Elsewhere** Active monitoring of GP OoHs, Phone First and Urgent Care Centres NMS Performance Report		Review of current GP OoH provision with temporary consolidation of current bases to reflect current available resources, improving the ability of the services to recruit to vacant posts Development of Phone First, Urgent Care Centres and ambulatory services to reduce attendance/capacity within EDs

			Director of Mental Health and Disability	"Well Mind Hub" and Crisis Café development with PiPs Mental Health Integrated Liaison Service Operates 24/7 LD Crisis Response Service operates from 9am to 1am						Learning Disability – Development of Community Assessment and Rehabilitation Service (CARS) – proposed implementation March 2023.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ Assurance**	**Mitigating Actions with due dates**
3.6 Risk to the ongoing supply of medicines due to EU Exit/NI Protocol when the grace period ends (currently extended), when NI will continue to follow EU rules and regulations for medicines and medical devices, whereas Great Britain will not, with implications for both the supply and regulation of medicines in NI. Key issues include: Medicines licensing Medicines supply chain Medical Devices	Patient safety risk Organisational risk Reputational – loss of public confidence	**L**	Head of Pharmacy & Medicines Management	DoH led EU/ Northern Ireland Programme Board	Score 12 (3 x 4)	Rating High	Score 9	Rating Medium	**Reports to Trust Board/ Board Committees** Medicines Governance Report to Governance Committee **Reports Elsewhere** Updates from EU Exit/ Northern Ireland Protocol Programme Board Meeting	Medicines with a marketing authorisation valid only in GB (England, Wales and Scotland) labelled as PLGB, do not require a Unique Identifier and must not be supplied to Northern Ireland unless specifically approved by MHRA. Medicines Supply Pharmacist to be recruited to assist procurement team manage issues in relation to EU Exit/NI protocol	From 1st January 2022, a statutory instrument titled the Human Medicines (Amendment) (Supply to Northern Ireland) Regulations 2021 established the Northern Ireland MHRA Authorised Route (NIMAR). NIMAR provides a route for the lawful supply of prescription only medicines that are unlicensed in NI, where no licensed alternative is available. Pharmacist recruited on temporary secondment from 1st Aug 2022 to 31st March 2023. Approval now received to recruit permanently- post will be advertised at the end of this year.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
3.7 Risk to the provision of food for patients and staff due to suppliers having difficulties sourcing and supplying some food produce. Risk factors include: Procurement risks and need to increase frozen and storage space. Issues with the meats contracts due to EU Brexit standards and procedures. The same supplier supplied both raw and cooked meats leading to an increased reliance on one supplier. Other issues with contracts include minimum order values and minimum quantities and the bakery items contract ending before its expiry date.	Reputational risk – food supply issues impact on menu planning and there is the potential for increased complaints from service users due to limited menu choices Organisational risk in being able to continue to source and supply some food produce and impact on patients and staff	**L**	Executive Director of Nursing	Food procurement is managed by BSO PaLS either through EMM or E-Procurement. BSO PaLS have business contingency plans. The Trust has a Catering Contingency Plan in place which includes menu alterations as appropriate dependent on food availability. The Trust has a contact in place for the maintenance of refrigeration.	Score 12 (3 x 4)	Rating High	Score 9	Rating Medium	**Reports to Trust Board/ Board Committees** Functional Support Services Report to Governance Committee **Reports Elsewhere** SMT	BSO in conjunction with HSC Trusts need to develop a Food Procurement Strategy which is fit for purpose and meets the needs of all HSC customers.	Senior Managers have attended attend a workshop regarding Food Procurement Strategy and this was meant to be followed up with BSO completing a scoping exercise to assist in the development of a strategy but this has been delayed.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care											
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
3.8 Risk to assuring compliance with agreed standards of care due to a reduced clinical audit capacity	Clinical / Reputational risk – failure to assure compliance with relevant local, regional or National Audit Recommendations Organisational risk in being able to fully deliver the Trust's clinical audit programme HR impact – staff capacity and morale	**M**	Medical Director	On-going support and delivery of limited clinical audit function, both locally at clinical lead level and corporately at facilitated support and assurance levels. Clinical Audit Strategy 2022 – 2024 sets out 9 key objectives to strengthen delivery and assurance over the next 3 year period.	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	Rating Low	**Reports to Trust Board/Board Committees** National Audit Assurance Report to Governance Committee annually. This includes participation in annual audit programmes, key outcomes and progress on plans for improvement **Reports Elsewhere** Weekly SMT Governance paper	Whilst partial in year funds were approved by SMT on 14.7.2022 as the first phase to strengthen the assurance function in Q2/3 2022, resource implications to strengthen and improve the clinical audit function remain.	Critical Post paper 2022/23 approved July 2022 Funding paper for clinical lead and remaining corporate posts to be submitted during 22/23 for 23/24

4. TECHNOLOGY ENABLEMENT

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
					Score	Rating	Score	Rating			
*4.*1 Risk to the HSC network availability in the event of a cyber attack on HSCNI or a supplier/ partner organisation, resulting in the compromise of the HSC network and systems or the disablement of ICT connections and services to protect the HSC and its data. Risk associated with the reliance on digital technology to support service delivery, including information systems, clinical applications and data analysis tools such as Qlikview.	Organisational risk in being able to continue to deliver services and impact to service users associated with delays in care and treatment. Loss of personal and organisational information Reputational – loss of public confidence Service user safety risk in the event of digital records being unavailable	**M**	Director of Performance and Reform	Regional Cyber Security Programme Board (Director of P&R) Regional and Local Incident Management & Reporting Policies and Procedures Regional Cyber Incident Response Plan Trust level controls to Defend, Respond and Recover Trust Cyber Security Oversight Group Vulnerabilities software management (Tenable) Regional Cyber Security Policy Continued promotion of Operational Business Continuity Plans at Cyber Oversight Group and reference on Team Risk Registers	16 (4 x 4)	High	9 (3 x3)	**Medium**	**Reports to Trust Board/Board Committees** Internal audits Regional cyber security programme papers, minutes Monthly cyber dashboard and cyber oversight group (including KPI for cyber awareness training) Monthly desktop message Monthly staff update Range of monitoring software and monthly meetings Individual Directorate/Divisional/Team Business Continuity Plans with ICT preparedness reviewed	Regional delays continue. Regional security group has not yet been established. Whilst the Trust has made good progress in local cyber security Internal Audit recommendations, the regional recommendations remain outstanding. Cyber Awareness Training KPI Individual Directorate /Divisional/ Team Business Continuity Plans with ICT preparedness are in place in some services, but not all. Need for assimilated cyber event to test plans and apply learning	Deloitte has been commissioned to review ICT Business Continuity Plans and test Disaster Recovery Plans - Report March 2023 Advice will be sought from Deloitte as part of the commission on testing BCPs – March 2023 Consideration of ward based simulation for multiple-system downtime to be discussed at next Local Cyber Security Group – December 2022

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
4.2 Risk of achieving implementation of Regional Technology implementation. There are a range of complex high risk Regional programmes including: • Encompass (Single care record) • Labs (Pathology Blueprint), • HRPTS replacement EQUIP • NI Picture Archiving system NIPACS upgrade • Digital shared services. The agenda is very large and diverse with limited additional resources in either the IT team or to help front line services with the business change. The risk is fundamentally that the Trust will not have the capacity to effect the change required to implement the digital initiatives. Ongoing risk associated with multi-system implementation ongoing in parallel	Delay in implementation of new digital improvements with ongoing reliance on systems with limited lifespan; reduced resilience to cyber attack; inability to perform functions Staff morale and impact on sickness & absenteeism in the event that they don't feel supported and trained on use of new technology will impact on the ability to deliver services	**M**	Director of Performance & Reform	Encompass Strategic Assurance Group (regional) Encompass Readiness Group (Internal) Transformational Board with SMT monthly for escalations & updates Encompass programme board at Chief Executive level EQUIP Programme Group (Regional) Pathology Blueprint Programme Group (Regional)	Score 16 (4 x 4)	Rating High	Score 9	**Rating** Medium	Reports to Transformational Board (Encompass) Regional Digital (DHCNI) Programme Board DHCNI Portfolio Programme Board	Gaps in resources, both operational and IT, to lead and implement digital transformation across the Trust associated with workforce challenges and funding	Transformation Programme Board has highlighted resource risks to Encompass Regional SRO. Paper outlining gaps and risks prepared by DOP's and presented to Encompass SRO Resource Challenges with Regional portfolio shared by DOP's at DHCNI Programme Board Internal Shared Services Readiness Group to be established – December 2022

5. FINANCE

CORPORATE OBJECTIVE: Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
5.1 Risk of breach of statutory duty of break-even in year	Failure to meet DOH target Breach of Accounting Officer responsibilities Risk of qualification of Annual Accounts by external audit	**M**	Director of Finance, Procurement and Estates	Budgets have been allocated to budget holders and regular scheduled monthly reporting to all budget managers in Trust Regular scheduled budget meetings with all budget managers when deviations to budget are addressed to ensure breakeven	Score 15 (5 x 3)	Rating High	Score 6 (3 x 2)	Rating Low	**Reports to Trust Board/Board Committees** Monthly Financial Position report to SMT/Trust Board Reporting to Chief Executive Accountability Meetings **Reports Elsewhere** Monthly monitoring returns to SPPG/DoH	Current agreed Budget for 2022/23 remains outstanding Trust in a deficit position with risk of funding not being secured, particularly in absence of a functioning NI Executive Significant turnover of senior personnel in Trust has potential to lead to some instability in budget management Significant pressures remain across all services, with managers having many operational challenges to oversee, reducing capacity to keep close control on finances	• Indicative allocations for the financial year 2022/23 have been released to Trusts, however, work continues with SPPG and DoH to understand the potential implications of the budget settlement on Trusts, in particular due to political landscape. Once further clarity is received in relation to the final agreed budget for the Trust, DoF will prepare an updated briefing for SMT and Trust Board. It is expected that this will be in September/ October 2022.

				Continual support to budget managers on use of Collaborative Planning Budget and Reporting system including targeted one on one training for new budget managers and regular monthly refresher training via zoom Trust works closely with SPPG and DoH to secure funding to address deficits and pressures to enable the Trust to breakeven at year end					**Reports Elsewhere (cont'd)** Report to those charged with Governance by NIAO following year end audit. Internal Audit of Budgetary Control on regular cycle		Finance will complete a mid-year hard close, the purpose of which is to inform the finance strategy for the remaining months of the financial year. This is good practice. The hard close will be as at September 2022. Results from this will be known in November 2022 and findings from this will inform forecasts for the remainder of the financial year.

CORPORATE OBJECTIVE: Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
5.2 Risk of destabilisation of services due to over reliance upon non-recurrent funding and the Trust's inability to secure sufficient recurrent investment.	Risk to medium to longer term planning of Trust Services to meet Corporate Objectives Risk of committing recurrent resources on the back of non-recurrent funding therefore with potential to increasing future financial deficit	**L**	Director of Finance, Procurement & Estates	Review and approval of Revenue IPTs and Capital Business Cases at Strategic Investment Committee Regular meetings with SPPG on financial plan and equity gap and early alerts to SPPG on pressures via Performance meetings with Commissioners	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	**Rating** Low	**Reports to Trust Board/Board Committees** Monthly Financial Position report to SMT/Trust Board Reporting to Chief Executive Accountability Meetings **Reports Elsewhere** Monthly monitoring returns to SPPG/ Reporting on Equity Gap to SPPG	There is still a significant element of the Trust budget provided on a non-recurrent basis each year. The impact of the current political instability is impacting on the DoH ability to agree budgets, particularly on a recurrent basis	Director of Finance is continuing to closely work with SPPG and Department of Health in relation to the capitation inequity gap. To date this work has been successful in ensuring that an element of budget previously non-recurrent has been made recurrent and SHSCT savings are less than that of other Trusts. There is now a full acceptance and recognition of the gap at commissioner level.

6. INFECTION, PREVENTION AND CONTROL

CORPORATE OBJECTIVE: Promoting safe, high quality care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
					Score 12 (3 x 4)	Rating High	Score 6 (2 x 3)	**Rating** Medium			
6.1 Risk to patient, staff and visitor safety due to the potential to develop a healthcare acquired infection such as MRSA, C. difficile etc. In particular, the Covid-19 Pandemic with new and emerging variants poses unique challenges for IPC processes and there is a risk to the Trust's ability to respond adequately. (This risk is paired with the Trust's aging infrastructure risk and the People risk)	May result in serious harm or death to a patient, prolonged Length of Stay, unsatisfactory patient experience Risk of HCAI for visitors Organisational risk in being able to fully deliver Trust services HR impact – staff capacity and morale Reputational risk – loss of public and stakeholder confidence Significant financial loss	**L**	Medical Director	IPC and microbiologist team IPC Strategy and IPC guidance including HH, PPE etc. Staff training Bronze SMT Bronze Operational Group Strategic and Clinical Forum meetings Augmented care group Laboratory testing and Surveillance and monitoring					**Reports to Trust Board/ Board Committees** Progress update report to Performance Committee **Reports Elsewhere** Reports to strategic forum Reports to AMS oversight committee Reports to the ventilation, water, environmental and decontamination committees	Increased workload of the IPC/ microbiology/ clinical/ Functional support services staff with the management of Covid-19 surges and outbreaks- limited ability to comply with the full remit of the IPC team, including outbreak report writing, updating strategy and GNB work streams	Develop a case to further develop an Multi-Disciplinary Team infection service Develop audit team to provide assurance on all aspects of IPC

				Patient and risk assessment for placement for both emergency, elective admission and OPD Isolation of patients with transmittable infections and those who are immuno-compromised Outbreak management groups Post infection reviews for learning and action Environmental Controls: Environmental decontamination programme and standards, segregation and safe disposal of waste process, programme of water safety and IPC design incorporated into refurbishments and new builds.						IPC strategy needs updated Absence of Regional IPC Strategy Compliance with mandatory training Limited face to face training due to pandemic Laboratory testing capacity for respiratory viruses is limited locally The IPC/ microbiology team have no access to IPC management /surveillance and epidemiology IT systems	Review and update of IPC/AMS Strategy Improve staff update of mandatory training Further develop videos to support on line mandatory training Further develop diagnostic capacity to facilitate early diagnosis to facilitate isolation and timely appropriate treatment to prevent AMR Continue to influence regionally for IPC management/ surveillance and epidemiology IT systems

				Antimicrobial Stewardship: Policies and Standards, and ward round						The aged Trust estates does not comply with HTM & HBN. Lack of ensuite isolation facilities, storage and ventilation. Poor finishes that inhibit the ability to clean	Continue to bid for funding to improve trust facilities including ensuite side room provision, ventilation, ED and ICU facilities. Improved environmental provision for day care etc. CAH and DHH site wide redevelopment Case for VHP and annual deep clean programme

7. UROLOGY SERVICES PUBLIC INQUIRY

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
7.1 Organisational capacity to manage the range, and complexity of information required to support the USI. This includes general discovery requests, which are wide in their scope and cover significant areas of the Trust and the support required to comply with S21 requests. Moving forward to subsequent phases of the USI, organisational capacity and readiness in relation to preparations for the Public Hearing process will remain a challenge Capacity of legal team (DLS and Barristers) to support the USI, particularly with a number of concurrent Public Inquiries on-going	Reputational Organisational HR impact	**L**	Programme Director of the Public Inquiry	Trust Public Inquiry Team Regular liaison with Trust legal advisors Lookback Group Quality Assurance Group DOH Urology Assurance Group SPPG/formerly HSCB Urology oversight group	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	**Reports to Trust Board/ Board Committees** Progress updates at each confidential Trust Board meeting **Reports Elsewhere** SMT Chief Executive regular reporting to Department of Health	Programme Board co-chaired by Chief Executive and Independent member has not yet met Clarity around the Public Hearing schedule awaited - Early clarity will assist in planning and preparing the Trust. Resource implications	First meeting of Programme Board scheduled for October 2022 The Trust will continue to use the experience gained by the UPI during the discovery and S21 response process which will add to its ability to deliver on USI requests. Identification of key resource requirements informed by experience of UPI to date. Staff recruitment in key support functions underway Completion mid-September. Additional legal cover to be sourced – completion September 2022

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
7.2 Risk to service continuity as a result of Section 21 notices response times and Public Hearing preparations.	Organisational risk – service delivery Reputational risk – loss of public confidence	**L**	Programme Director of the Public Inquiry	Liaison with USI in respect of projected timeframes for hearings Information shared with SMT to allow for service planning to accommodate S21 response timeframes	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	**Reports to Trust Board/ Board Committees** Progress updates at each confidential Trust Board meeting **Reports Elsewhere** SMT	Lack of confirmed timetable around schedule of Public Hearings limits Trust's ability to manage staff workloads accordingly. Uncertainly in relation to time that staff may be unavailable; witness may be required to give evidence more than once; need to identify level of preparation/ debrief required likely to vary between staff	The Trust continues to liaise with the USI to achieve a workable timeframe for response of S21s, and has highlighted the operational impact of the on-going discovery process -- managing on a case-by-case basis in conjunction with legal team Ongoing proactive engagement with USI continues in relation to S21 response deadlines and has been generally positively received Proactive identification of staffing impact and preparation of business contingency plans..

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
7.3 Risk to health and wellbeing of staff	HR impact – staff capacity and morale. Potential impact on staff sickness Impact on family life for staff involved in the UPI	**L**	Programme Director of the Public Inquiry	Occupational Health Support Psychologist is available for staff support Proactive regular check in sessions for PI Team and others as required is available Information in relation to psychological support is made available to all staff Inspire Line management support	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	**Reports to Trust Board/ Board Committees** Progress updates at each confidential Trust Board meeting **Reports Elsewhere** SMT	Lack of clarity around timeframe for public hearings limits timely engagement of key staff.	Consider need to allocate defined psychological support for public hearing process. Develop plans to pro-actively support staff engaged in public hearing process. This includes: Timing information; Briefing on what to expect ie attendance of observers; live-streaming; media coverage potential; website coverage. Arrangements to de-brief and follow up

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
7.4 Reputational risk exists in the process of the Public Inquiry – the public release of information and the Public Hearings which are likely to attract media attention.	Reputational – loss of public confidence	**L**	Programme Director of the Public Inquiry	Lookback Group Quality Assurance Group DOH Urology Assurance Group SPPG/formerly HSCB oversight group	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	**Reports to Trust Board/ Board Committees** Progress updates at each confidential Trust Board meeting **Reports Elsewhere** SMT Department of Health	Not all discovery process complete, therefore not all issues surfaced. Discovery relating to other participants not yet available to the Trust.	Consultations with staff and review of discovery information Full open and transparent discovery to ensure the Trust is aware of issues prior to publication. Ongoing process of assurance and learning

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care										
Risk Description linked to strategic objective alignment	**Impact of the Risk (implications)**	**Risk Appetite**	**Executive Risk Owner**	**Existing Controls (reflecting current risk rating)**	**Current Risk Score and Rating**		**Target Risk Score and Rating**		**Assurance from What? (papers/ metrics) Summary of reports**	**Current gaps in controls/ assurance**	**Mitigating Actions with due dates**
7.5 No funding stream identified	Potential Trust wide impact	**M**	Programme Director of the Public Inquiry	Monthly financial reporting	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	**Reports to Trust Board/ Board Committees** Progress updates at each confidential Trust Board meeting **Reports Elsewhere** SMT		Funding requirements shared with DoH.

Southern Health and Social Care Trust

JOB DESCRIPTION

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

JOB SUMMARY:

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

KEY DUTIES / RESPONSIBILITIES

1. Analyse all relevant information and propose an agenda to Trust Board and its Standing Committees. Working closely with the Chairman, Chief Executive, Trust Directors and Non-Executive Directors.

2. Work proactively with the Chairman and Chief Executive to secure a planned approach to matters of Board interest and issues requiring Board and SMT action.

3. Supervise logistics of the organisation of meetings ensuring board members are provided with all relevant information and ensuring papers are issued within exact timescales.

4. Supervise the taking and approval of minutes taking appropriate follow up action and ensuring tasks with action are followed up and reported at subsequent meetings. Ensuring that information is channelled to and from Committees and to from individuals involved in Board and executive business.

5. Attend Trust Board meetings and take accurate and concise formal minutes which are published to a wide audience.

6. Monitor the rhythm and pattern of meetings to ensure Trust objectives and development of the organisation and delivery of key objectives are met. Develop a schedule of reporting to Trust Board to enable the Board to meets its legal and statutory requirements and clinical, social care, quality and financial objectives within set timescales.

7. Review Terms of Reference of Committees of the Board and ensure that these are up-to-date in relation to best practice and revisions approved by relevant Committee and the Board.

8. Ensuring annual reviews of Committees are undertaken.

9. Ensure Standing Orders are updated as required and advice provided to the Chairman on processes as contained within the Standing Orders.

10. Ensure the regular provision of information for the Trust website in accordance with the Trust's Publication Scheme.

11. Ensure the Trust operates in accordance with agreed standards of integrated governance, to ethical standards appropriate to a public service organisation.

12. Initiate correspondence and other action at the request of the Chairman and Committee Chairs arising from the Board or its Standing Committees.

13. Line manage Committee Secretary in Chair/Chief Executive's office to deliver all responsibilities. Allocate and supervise workload.

14. Line manage Administrative Assistant (Band 3) in Chair/Chief Executive's office to deliver all responsibilities. Allocate and supervise workload.

15. Co-ordinate Trust wide process for management, monitoring and reporting Controls Assurance standards to assist the organisation to improve its governance and risk management procedures.

16. Co-ordinate risk information and present Board Assurance Framework to SMT and Board of Directors on bi-annual basis.

17. Co-ordinate risk information and present Corporate Risk Register to SMT on a monthly basis and Governance Committee on a quarterly basis.

18. Supervise the development and maintenance of database for Gifts and Hospitality register Trust wide. Provide quarterly report to SMT.

19. Supervise the process of Declaration of Interests and Declaration of Hospitality of Board members. Ensuring up to date register available in the Chief Executive's office.

20. Co-ordinate documentation to ensure the regular provision of information to the DHSSPS.

21. Development and co-ordination of Board Development programme. Responsible for taking forward identified actions within Board Development Plan.

22. Review of Board meetings on an ongoing basis (through facilitation of questionnaire) and analysis of same

GENERAL MANAGEMENT RESPONSIBILITIES

1 Review the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

2 Ensure that the review of performance identified in 1 above is performed for all levels of staff for which he/she has management authority.

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

4 Review the organisation plan and establish the level of service for which he/she is responsible to ensure that it is consistent with achieving objectives and recommends change where appropriate.

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

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

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

GENERAL REQUIREMENTS

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

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

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

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

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

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

7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

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

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

Southern Health and Social Care Trust
Board Development Day

Thursday, 25th August 2022

Aim: **To ensure the ability for the Trust to provide assurance through the development and agreement of robust, new and improved structures, systems and processes for Corporate, Clinical and Social Care Governance in Southern Health and Social Care Trust**

Desired Outcomes

- **To understand the drivers for improved governance and assurance within the Trust**
- **To critically evaluate the current structure and process and explore a proposed new approach**
- **To identify what needs done to mobilise the implementation of new ways of working**
- **To develop an action plan for progress by November 2022 and for longer term culture change with a focus on outcomes**

Programme

8.30am	**Welcome and Breakfast**	
9.00am	**Introductions and Setting the Context**	Eileen Mullan, Chair Dr Maria O'Kane, Chief Executive
Session 1	**Understanding the Need for Change** • What do we currently have? • What is being proposed? • How will it make a difference and how will we know?	Dr Maria O'Kane, Chief Executive Stephen Wallace, Assistant Director, Systems Assurance
10.45am	**Tea/Coffee**	
Session 2	**Agreeing the New Structure** o Critical evaluation	All Members
12.45pm	**Lunch**	
Session 3	**Implementing the New Agreed Structure**	All Members
Session 4	**Action Plan and Next Steps** • What do we need to do before November? • What is our longer-term project plan? o Who? o What and when? o How will we measure success?	All Members
3.20pm	**Review and next steps**	Eileen Mullan, Chair Dr Maria O'Kane, Chief Executive
3.30pm	**Board Governance Self-Assessment**	Eileen Mullan, Chair Sandra Judt, Board Assurance Manager
4.20pm	**Reflections and close**	

Judt, Sandra

From: Judt, Sandra [redacted]
Sent: 20 August 2021 10:09
To: Mullan, Eileen; Devlin, Shane; Wilkinson, John; McDonald, Martin; Donaghy, Geraldine; McCartan, Hilary; Leeson, Pauline; OKane, Maria; Trouton, Heather; Morgan, Paul; Magwood, Aldrina; Toal, Vivienne; McClements, Melanie; Beattie, Brian
Cc: Diamond, Aisling; Wright, Elaine; Comac, Jennifer; Campbell, Emma; Willis, Lisa; PADirectorofP&RSHSCT; Mallagh-Cassells, Heather; Stinson, Emma M; Gilmore, Sandra; Livingston, Laura; Alexander, Ruth
Subject: RE: Programme for Training (Official Reviews)
Attachments: Programme for Training (Official Reviews).docx

Thank you for responding regarding your availability for the Official Reviews Training.

Please find attached the final programme with the dates that suit the majority of Trust Board members and the trainer.

Grateful if you would confirm these dates in your diaries. Further information will follow regarding start times etc.

Many thanks

Sandra

Sandra Judt
Board Assurance Manager
SH&SCT
Trust Headquarters
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

Tel: [redacted]
Email: [redacted]

Programme for Training (Official Reviews)

Date	Topic	Duration	Time
Monday 4 October	Backdrop	1 day	11.00 a.m.
Thursday 7 October	Inquiry Process	½ day	p.m.
Monday 11 October	Issues Facing Inquiry	1 day	
Monday 18 October	Lessons Learned	½ day	a.m.
Thursday 21 October	Questioning Techniques	1 day	
Monday 25 October	Drafting Techniques	½ day	a.m.
Monday 8 November	Communication	½ day	p.m.

Department of Health
www.health-ni.gov.uk

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by Department of Health Sponsored Arms Length Bodies

Trust Board 29th September 2022

Contents

Introduction

This self-assessment tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice.

The public need to be confident that ALBs are efficient and delivering high quality services. The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department rests with the ALB's board. The board is the most senior group in the ALB and provides important oversight of how public money is spent.

It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise.

Good governance best practice requires Boards to carry out a board effectiveness evaluation annually, and with independent input at least once every three years.

This checklist has been developed by reviewing various governance tools already in use across the UK and the structure and format is based primarily on Department of Health governance tools. The checklist does not impose any new governance requirements on Department of Health sponsored ALBs.

The document sets out the structure, content and process for completing and independently validating a Board Governance Self-Assessment (the self-assessment) for Arms Length Bodies of the Department of Health.

The Self-Assessment should be completed by all ALB Boards and requires them to self-assess their current Board capacity and capability supported by appropriate evidence which may then be externally validated.

Application of the Board Governance Self-Assessment
It is recommended that all Board members of ALBs familiarise themselves with the structure, content and process for completing the self-assessment.

The self-assessment process is designed to provide assurance in relation to various leading indicators of Board governance and covers 4 key stages:

1. Complete the self-assessment
2. Approval of the self-assessment by the ALB Board and sign-off by the ALB Chair;
3. Report produced; and
4. Independent verification.

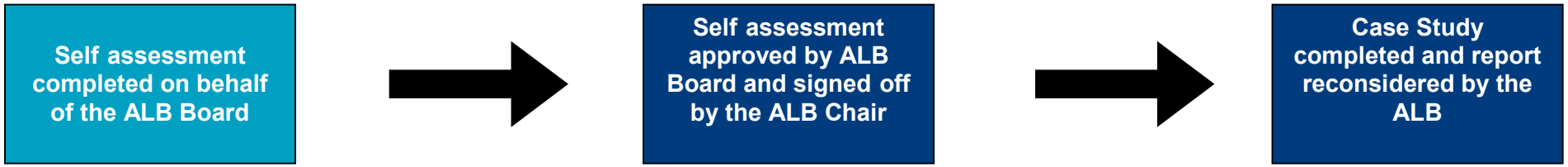
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach a consensus on the ratings. The Chair of the Board will act as moderator. A submission document is attached for the Board to record its responses and evidence, and to capture its self-assessment rating.

Refer to the scoring criteria identified on page 7 to apply self assessment ratings.

Approval of the self-assessment by ALB Board and sign off by the Chair: The ALB Board's RAG ratings should be debated and agreed at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and ultimately signed off by the ALB Chair on behalf of the Board.

Independent verification: The Board's ratings should be independently verified on average every three years. The views of the verifier should be provided in a report back to the Board. This report will include their independent view on the accuracy of the Board's ratings and where necessary, provide recommendations for improvement.

Overview



The Board Governance self-assessment is designed to provide assurance in relation to various leading indicators of effective Board governance. These indicators are:

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);

2. Board evaluation, development and learning (e.g. The Board has a development programme in place);

3. Board insight and foresight (e.g. Performance Reporting);

4. Board engagement and involvement (e.g. Communicating priorities and expectations);

5. Board impact case studies (e.g. A case study that describes how the Board has responded to a recent financial issue).

Each indicator is divided into various sections. Each section contains Board governance good practice statements and risks.

There are three steps to the completion of the Board Governance self-assessment tool.

Step 1

The Board is required to complete sections 1 to 4 of the self-assessment using the electronic Template. The Board should RAG rate each section based on the criteria outlined below. In addition, the Board should provide as much evidence and/or explanation as is required to support their rating. Evidence can be in the form of documentation that demonstrates that they comply with the good practice or Action Plans that describe how and when they will comply with the good practice. In a small number of instances, it is possible that a Board either cannot or may have decided not to adopt a particular practice. In cases like these the Board should explain why they have not adopted the practice or

cannot adopt the practice. The Board should also complete the Summary of Results template which includes identifying areas where additional training/guidance and/or assurance is required.

Step 2

In addition to the RAG rating and evidence described above, the Board is required to complete a minimum of 1 of 3 mini case studies on;

- A Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery; or
- Organisational culture change; or
- Organisational Strategy

The Board should use the electronic template provided and the case study should be kept concise and to the point. The case studies are described in further detail in the Board Impact section.

Step 3

Boards should revisit sections 1 to 4 after completing the case study. This will facilitate Boards in reconsidering if there are any additional reds flags they wish to record and allow the identification of any areas which require additional training/guidance and/or further assurance. Boards should ensure the overall summary table is updated as required.

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

- All good practices are in place unless the Board is able to reasonably explain why it is unable or has chosen not to adopt a particular good practice.
- No Red Flags identified.

Amber/ **Green** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved, there are either:
    - robust Action Plans in place that are on track to achieve good practice; or
    - the Board is able to reasonably explain why it is unable or has chosen not to adopt a good practice and is controlling the risks created by non-compliance.
- One Red Flag identified but a robust Action Plan is in place and is on track to remove the Red Flag or mitigate it.

Amber/ **Red** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved:
    - Action Plans are not in place, not robust or not on track;
    - the Board is not able to explain why it is unable or has chosen not to adopt a good practice; or
    - the Board is not controlling the risks created by non-compliance.

- Two or more Red Flags identified but robust Action Plans are in place to remove the Red Flags or mitigate them.

Red if the following applies:

- Action Plans to remove or mitigate the risk(s) presented by one or more Red Flags are either not in place, not robust or not on track

Please note: The various green flags (best practice) and red flags risks (governance risks/failures) are not exhaustive and organisations may identify other examples of best practice or risk/failure. Where Red Flags are indicated, the Board should describe the actions that are either in place to remove the Red Flags (e.g. a recruitment timetable where an ALB currently has an interim Chair) or mitigate the risk presented by the Red Flags (e.g. where Board members are new to the organisation there is evidence of robust induction programmes in place).

The ALB Board's RAG ratings on the self assessment should be debated and agreed by the Board at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and then signed-off by the Chair on behalf of the Board.

5. Board Governance Self- Assessment Submission

Name of ALB **Southern Health and Social Care Trust**

Approved by Eileen Mullan (ALB Chair)

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *September 2022*

1.1 Board positions and size

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The size of the Board (including voting and non-voting members of the Board) and Board committees is appropriate for the requirements of the business. All voting positions are substantively filled.* Size of the Board is in accordance with the Southern Health and Social Services (Establishment) Order (N Ireland) 2006, Health and Social Services Trusts (Membership and Procedure) Regulations (NI) 1994. Permanent recruitment into Chief Executive (May 2022) and 2 Director vacancies (Director of Finance, Procurement and Estates and Director of Mental Health & Disability Services during 2021/22 Permanent recruitment to Medical Director in July 2022, with commencement date of 7th November 2022. Interim Director of Children and Young People's Services/ Executive Director of Social Work in place from September 2021	In June 2022 approval was received from Department of Health to recruit a permanent Director of Medicine and Unscheduled Care Services; Director of Surgery and Elective Care, Maternity & Gynae and Cancer and Clinical Services; and Director of Adult Commuity Services. Recruitment process underway. Director of Performance and Reform recruitment in June 2022 – no appointment made. The post will be readvertised in October 2022. Chair has raised with Public Appointments Unit the 2 Non Executive Director vacancies – to be advertised by PAU in October 2022.	During the period, there have been significant changes with regard to the Executive (Voting) and (Non Voting) Director membership of the Board with two resignations and three retirements. 2 out of 7 Non Executive Director positions remain vacant. Therefore, all voting positions are not substantially filled. 4 out of 9 Non-voting positions are filled on an interim/acting basis	New Senior Management structure to be fully implemented in 2022-23

	Evidence Board Minutes Job Descriptions Biographical information on each Board member			
GP2	*The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge its responsibilities.* **Evidence** Standing Orders and Standing Financial Instructions Management Statement/ Financial Memorandum Board Development Programme Board Assurance Manager Attendance at subject specific events	None required	Not applicable	None identified
GP3	*It is clear who on the Board is entitled to vote.* **Evidence** Addressed in Standing Orders HSS Trusts (Membership Procedures) Regulations NI 1996	None required	Not applicable	None identified

GP4	*The composition of the Board and Board committees accords with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders.* **Evidence** Standing Orders	None required	Not applicable	None identified
GP5	*Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time*. **Evidence** NEDs appointments staggered – letters of appointment	Note: Whilst appointment term of NEDs is staggered, 2 NEDs will complete their term of office on 14.2.2024 and 3 NEDs will complete their term of office on 31.12.2024	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Chair and Chief Executive positions are filled.
RF2	None identified	More than 50% of the Board has remained constant in the previous two years.
RF3	None identified	All Trust Board meetings are quorate. Non attendance is by agreement with the Chair and a nominated Deputy attends in a Director's absence. Attendance at Board meetings is included in the Trust's Annual Governance Statement.

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *September 2022*

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan.* Trust Board considers the current balance of skills to be appropriate Allocation of NEDs to Sub Committees of the Board based on their skills, experience and knowledge **<u>Evidence</u>** Biographical information Committee membership Appraisals process Skills Matrix completed by Non Executive Directors in September 2022	None required	Not applicable	None identified

GP2	*The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors.* **Evidence** Biographical information Declaration/Register of Interests	Note: NEDs from private sector would be helpful – raised in Skills Matrix – September 2022	Not applicable	None identified
GP3	*The Board has had due regard under Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without.* **Evidence** Equality Scheme approved by Trust Board Board Minutes S75 Annual Progress Report to Trust Board	None required	Not applicable	None identified
GP4	*There is at least one NED with a background specific to the business of the ALB.* Yes **Evidence** Biographical information	None required	Not applicable	None identified

GP5	*Where appropriate, the Board includes people with relevant technical and professional expertise.* **Evidence** Biographical information Directors' Job Descriptions	None required	Not applicable	None identified
GP6	*There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer.* The majority of Board members (both Executive and NEDs) have served on the Board for longer than 18 months **Evidence** Board membership	None required	Not applicable	None identified
GP7	*The majority of the Board are experienced Board members* Yes – the majority of the Board are experienced Board members. **Evidence** Biographical information	None required	Not applicable	None identified
GP8	*Where appropriate, the Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment.* Yes	None required	Not applicable	None identified

	Evidence Biographical information			
GP9	*The Chair of the Board has previous non-executive experience.* Yes – the Chair has previous Non Executive experience **Evidence** Biographical information	None required	Not applicable	None identified
GP10	*At least one member of the Audit Committee has recent and relevant financial experience.* Yes – the Chair of the Audit Committee has recent and relevant financial experience **Evidence** Biographical information	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	NED Chair of Audit Committee has a recent and relevant financial background
RF2	None identified	NEDs with current or recent (within the previous 2 years) experience in the private/commercial sector
RF3	None identified	Majority of Board members are not in their first Board position
RF4	None identified	Majority of members have served on the Board > 18 months.
RF5	None identified	Balance of Directors/Non Executive Directors is correct
RF6	None identified	Non Executive Director membership on Committees strengthened

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *September 2022*

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The role and responsibilities of the Board have been clearly defined and communicated to all members.* **Evidence** Standing Orders Induction Programme Job Descriptions Code of Conduct and Code of Accountability Management Statement/Financial Memorandum	None required	Not applicable	None identified
GP2	*Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit.* Chair ensures Board members are clear on Ministerial priorities and direction **Evidence** Management Statement/Financial Memorandum Code of Accountability	None required	Not applicable	None identified

GP3	*There is a clear understanding of the roles of Executive officers and Non Executive Board members.* **Evidence** Job Descriptions Code of Conduct and Code of Accountability Management Statement/Financial Memorandum Standing Orders	None required	Not applicable	None identified
GP4	*The Board takes collective responsibility for the performance of the ALB.* **Evidence** Performance Framework Performance Committee reporting to Trust Board Code of Conduct and Code of Accountability Management Statement/Financial Memorandum Standing Orders Finance Report to Trust Board Board Assurance Framework Approval of Annual Report and Accounts	None required	Not applicable	None identified

GP5	*NEDs are independent of management.* Yes – NEDs are independent of management **Evidence** Job Descriptions Articulated in Codes of Conduct and Accountability Board Minutes to demonstrate challenge function	None required	Not applicable	None identified
GP6	*The Chair has a positive relationship with the Minister and sponsor Department.* Yes **Evidence** Minutes of Mid and Year End Accountability Review meetings (meetings stood down during Covid-19)	None required	Not applicable	None identified
GP7	*The Board holds management to account for its performance through purposeful, challenge and scrutiny.* **Evidence** Challenge and scrutiny function evident from Board Minutes Performance Committee Chair report to Trust Board	None required	Not applicable	None identified

	Monthly finance reports to Trust Board Scrutiny of Governance Statement, Annual Report and Accounts Trust Corporate Plan – annual progress updates to Trust Board Formal Scheme of Delegation			
GP8	*The Board operates as an effective team.* **Evidence** Board meeting reflection at end of each meeting Feedback from Board Development Programme Consensus approach to decision-making evidenced in Board minutes IA Report on Board Effectiveness – satisfactory level of assurance	None identified	Not applicable	None identified
GP9	*The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence.* **Evidence** Board Minutes	None identified	Not applicable	None identified

	Robust system of identifying matters arising and follow up (action log)			
GP10	*Board members respect confidentiality and sensitive information.* **Evidence** Trust Board confidential section for sensitive information Board Behaviours Information Governance training	None identified	Not applicable	None identified
GP11	*The Board governs, Executives manage.* Yes – The Board confirms that it governs the organisation and holds the Executive Team to account through purposeful challenge and scrutiny. **Evidence** Board Minutes and Action log	None identified	Not applicable	None identified
GP12	*Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function.* Board members contribute to Board discussions and challenge the Executive Team. **Evidence** Board Minutes	None identified	Not applicable	None identified

GP13	*The Chair is a useful source of advice and guidance for Board members on any aspect of the Board.* Yes – Chair well informed and provides updates on actions/activities/key developments at Board meetings **Evidence** Board Minutes Individual meetings with NEDs 1:1 appraisals Chair's Induction meeting with new members	None identified	Not applicable	None identified
GP14	*The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken.* The Chair allows open discussion before decisions are made. Board Minutes attest to this. **Evidence** Board Minutes IA Report on Board Effectiveness	None identified	Not applicable	None identified
GP15	*The Board considers the concerns and needs of all stakeholders and actively manages its relationships with them.* **Evidence** Trust Board meetings held in public	None identified	Not applicable	None identified

	Specific meetings with interested groups PPI Consultation Scheme Consultations on Trust Strategies engage stakeholders during development			
GP16	*The Board is aware of and annually approves a scheme of delegation to its committees*. **Evidence** Scheme of Delegation from Board to Committees approved by Board annually	None identified	Not applicable	None identified
GP17	*The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes*. Board delegated responsibility to the Audit Committee **Evidence** Annual summary report of PPEs completed on Capital and Revenue proposals > £300,000 to Audit Committee Audit Committee agenda and minutes	None identified	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Chair does not look constantly to the Chief Executive to speak or give a lead on issues – evidence via Trust Board Minutes
RF2	None identified	The Board does not tend to focus on details but on strategy and performance – evidence via Trust Board Minutes
RF3	None identified	The Board does not become involved in operational areas – evidence via Trust Board Agendas and Minutes
RF4	None identified	The Board is able to take a decision without the Chief Executive's recommendation – evidence via Trust Board Minutes
RF5	None identified	The Board does not allow the Chief Executive to dictate the Agenda – evidence via Trust Board Minutes and Agenda
RF6	None identified	Reguarly, one individual Board member does not dominate the debates or has an excessive influence on Board decision making – evidence via Trust Board Minutes

1. Board composition and commitment **ALB Name** ***Southern HSC Trust*** **Date** ***September 2022***

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board.* **Evidence** Clear Terms of Reference for each Committee in place and approved by Trust Board on an annual basis Board Minutes Scheme of Delegation	None required	Not applicable	None identified
GP2	*Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees.* **Evidence** The Board recognises that it carries responsibility for the actions of its Committees. Reflected in: – **Evidence** Scheme of Delegation Terms of Reference	None required	Not applicable	None identified

GP3	*Schemes of delegation from the Board to the Committees are in place.* **Evidence** Scheme of Delegation	None required	Not applicable	None identified
GP4	*There are clear lines of reporting and accountability in respect of each Committee back to the Board.* **Evidence** Scheme of Delegation Terms of Reference Committee Minutes to Trust Board Committee Chair Reports to Trust Board Committee Annual Reports to Trust Board Board Minutes Governance High Level Organisational Chart	None required	Not applicable	None identified
GP5	*The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle.* **Evidence** Board Assurance Framework Terms of Reference approved by Trust Board on an annual basis	None required	Not applicable	None identified

	Workplan/Schedule of Reporting in place for each Committee and agreed by Trust Board on an annual basis Trust Board Annual Cycle			
GP6	*The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made.* **Evidence** Committee Chair Reports to Trust Board Committee Minutes Board Minutes	None required	Not applicable	None identified
GP7	*The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees.* **Evidence** Annual Evaluation undertaken and reported via Committees' Annual Reports – Audit, Governance, E&G, Patient & Client Experience Audit Committee self-assessment in line with NAO guidance	None required	Not applicable	None identified

GP8	*It is clearly documented who is responsible for reporting back to the Board.* **Evidence** Responsibility of Committee Chairs as per Terms of Reference	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Minutes of Committee meetings are presented by relevant Chair as well as Committee Chair reports
RF2	None identified	Committee members do receive performance management appraisals in relation to their Committee role (appraisal template). NED appraisals include discussion on the Sub Committees they Chair
RF3	None identified	Terms of Reference in place for all Committees
RF4	None identified	Non Executive Directors fully aware of the differing roles between the Board and Committees. NED Induction programme.
RF5	None identified	Draft agendas for Committee meetings are drafted by the Board Assurance Manager/Committee Secretary with input from Directors, as required, prior to approval by the Committee Chair

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *September 2022*

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*Board members have a good attendance record at all formal Board and Committee meetings and at Board events.* Good attendance rates of Board members at virtual Trust Board and Committee meetings during 2021/22. **Evidence** Board attendance as evidenced in Board and Committee attendance records. These are presented to the Board for review on an annual basis as part of the Annual Reports from Committees. Board and Committee attendance evidenced in Governance Statement Board Development Programme attendance record Board and Committee Minutes Annual Performance Appraisal of NEDs identifies high attendance at events and meetings	None required	Not applicable	None identified

GP2	*The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time.* **Evidence** Board Behaviours Good Practice Principles for Board and Committees Reinforced by Chair at Board meetings – Board Minutes Induction Programme	None required	Not applicable	None identified
GP3	*Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair.* **Evidence** All Board members have received a copy of the Codes of Conduct and Accountability Compliance with the Codes included as part of NED annual appraisal – NED Annual Appraisal form	None required	Not applicable	None identified

GP4	*Board meetings and Committee meetings are scheduled at least 6 months in advance.* **Evidence** Schedule of Board and Sub Committee meetings prepared and issued in August each year Board Minutes	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	No record of Board or Committee meetings not being quorate.
RF2	None identified	All non-attendance at Board meetings is reviewed by the Chair and all non-attendance at Committee meetings is reviewed by the respective Committee Chair.
RF3	None identified	Non attendance is by agreement with the Chair and a nominated relevant Deputy attends in a Director's absence.
RF4	None identified	Board members behave consistently as per Code of Conduct and Code of Accountability
RF5	None identified	Attendance at Board and Sub Committees is reviewed annually and included in the Committee's Annual Report to Trust Board.

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *September 2022*

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*A formal Board Governance Self-Assessment has been conducted within the previous 12 months.* **Evidence** Board Governance Self-Assessment completed at Workshop on 26th August 2021 and formally approved by Trust Board at meeting on 30th September 2021 (Note – no requirement to submit to Department of Health)	None required	Not applicable	None identified
GP2	*The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken.* **Evidence** Board Self-Assessment Action Plan in place. Updated and reviewed each year. Action point from 2020/21 self-assessment has now been completed in that all Non Executive Director appraisals were completed at the end of 2021.	None required	Not applicable	None identified

GP3	*The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 3 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations.* **Evidence** Independent input required at least once every 3 years and this was included in the Internal Audit report on Board Effectiveness 2021/22	None required	Not applicable	None identified
GP4	*In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective.* **Evidence** Top down approach adopted to encourage engagement and attendance of staff at Trust Board meetings to share examples that epitomise what Trust business is about Attendance of staff and Assistant Directors at Trust Board meetings and their perspective sought at end of meeting Suggestions for improvements taken on Board to enhance	The Board continues to utilise the information gathered from these sources as a potential indicator of board effectiveness.		

	Board effectiveness. One example is that access to papers by public members and staff has been made available on Sharepoint prior to each meeting. Public attendance at Trust Board meetings Short period of reflection by members and attendees at end of Board meetings and poll completed.			
GP5	*The focus of the self assessment included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness.* **Evidence** Board Development Programme in place which includes time out for the Board to reflect on its effectiveness and focus for the future			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	
RF2	None identified	
RF3	None identified	
RF4	None identified	

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *September 2022*

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual self assessment and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements.* **Evidence** Self-assessment and findings to Board Workshop annually Board Development Programme – ongoing series of workshops on strategy, accountability and culture. The Board held eight informal workshops during the year to allow focused time to consider the following: • Review of Muckamore Abbey Hospital – Report of the Independent	None required	Not applicable	None identified

	Leadership and Governance Review; • Delegated Statutory Functions; • The Year Ahead, COVID-19 and Delivering Health and Social Care; • People Plan; • Consultation on Future Planning Model – Integrated Care System NI – draft Framework; • Independent Review into the circumstances of the RQIA Board member resignations; • Consultation on draft 3-Year Budget; and • General Surgical Model for the Southern HSC Trust IA Report on Board Effectiveness discussed at Board Workshop in May 2022 Board members Induction process			

GP2	*Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities.* **Evidence** Management Statement/Financial Memorandum Draft DoH Partnership Agreement template and Proportionate Autonomy for ALBs guidance Codes of Conduct and Accountability	None required	Not applicable	None identified
GP3	*Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues.* **Evidence** Governance arrangements – monitored by Governance Committee.	None required	Not applicable	None identified

GP4	*Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve.* **Evidence** Board Development Programme allows protected time for reflection and improvement. Board Workshop on 'The Year Ahead' took place on 26th August 2021 Board Development Day took place on 25th August 2022 to critically evaluate the current corporate and clinical and social care governance structure and process and explore a proposed new approach	None required	Not applicable	None identified
GP5	*Time is 'protected' for undertaking this programme and it is well attended.* **Evidence** Board Development Day is scheduled one year in advance and is well attended. Attendance record	None required	Not applicable	None identified

GP6	*The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges*. Board Workshops provide time out for members to think about the Board as a whole and its training and developmental needs. Involvement of the Board in planning/strategy was an area of development identified and work in this area continued during 2021/22. **Evidence** Workshop agendas focusing on vision, strategy and culture (see GP1 above)		Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Board Development Programme in place
RF2	None identified	None required

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *September 2022*

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB.* **Evidence** Induction process On Board programme	None required	Not applicable	None identified
GP2	*Induction for Board members is conducted on a timely basis.* **Evidence** Induction process	None required	Not applicable	None identified
GP3	*Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation's structure, ALB values and meetings with key leaders.* **Evidence** Induction process	None required	Not applicable	None identified

GP4	*Deputising arrangements for the Chair and CE have been formally documented.* **Evidence** Appropriate deputising arrangements in place for when the Chair and Chief Executive are not available	None required	Not applicable	None identified
GP5	*The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.* **Evidence** Senior Management Team Development Programme Attendance of Assistant Directors at Board Committee meetings to present and also at Board meetings to deputise or attend with Directorate staff colleagues	Stablilisation of the Senior Management Team is underway with all Senior Executive posts to be appointed by December 2022 Regional Aspiring Directors Succession Planning programme seeking nominees for 2022/23 programme and these are being identified within the Trust to complete future succession planning Further work required to develop succession plans for Board level positions into the future	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	New Board members attend the On Board training within 3 months of appointment
RF2	None identified	Documented arrangements in place for Chairing Board and Committee meetings if the Chair is unavailable.
RF3	None identified	Documented arrangements in place in respect of how the organisation is to be represented at a senior level at Board meetings if the Chief Executive is unavailable.
RF4	None identified	NED appointments are staggered.

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *September 2022*

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair* **Evidence** Annual Performance Appraisals of NEDs completed annually by the Chair	None required	Not applicable	None identified
GP2	*The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation.* **Evidence** Annual Performance Appraisals of Directors completed annually by the Chief Executive. New appraisal documentation includes Board member role	None required	Not applicable	None identified

GP3	*There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary).* **Evidence** Appraisal forms	None required	Department is responsible for co-ordinating the appraisal process.	None identified
GP4	*Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis.* **Evidence** Annual Appraisal form for NEDs Directors' Performance Appraisals which address personal development needs Objectives set for Directors by Chief Executive. In the case of the Chief Executive, this is undertaken by the Chair	None required	Not applicable	None identified
GP5	*Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role.* **Evidence** Assessment forms have an option for members to detail specific issues for the coming year	None required	Not applicable	None identified

GP6	*As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.* **Evidence** Board Minutes demonstrate challenge function Development of reporting to Trust Board	None required	Not applicable	None identified
GP7	*Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification*. **Evidence** All Board members subscribe to the Code of Conduct and, where appropriate, comply with the requirements of their respective professional bodies.	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Robust performance appraisal process in place.
RF2	None identified	Induction programme. Formal training and development and/or professional development is encouraged and in operation.
RF3	None identified	Time is set aside for appraisals and these are undertaken in a timely fashion for NEDs. Process to identify training needs of NEDs commences well in advance of appraisal meeting.
RF4	None identified	The Chair fully considers the differing roles of Board and Committee members.

3. Board insight and foresight ALB Name *Southern HSC Trust* Date *September 2022*

3.1 Board performance reporting

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept.* **Evidence** Monthly Board Performance Reports – Finance and Corporate CPD Performance Scorecard Board Minutes Performance Committee established by the Board with delegated responsibility for performance management which meets quarterly - Performance Committee Terms of Reference In the context of Covid19, updates on the Trust's Rebuild Plans were provided	None required	Not applicable	None identified

GP2	*The Board receives a performance report which is readily understandable for all members.* **Evidence** Monthly Corporate Performance Scorecard	None required	Not applicable	None identified
GP3	*The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made.* **Evidence** Committee Chair Report to Trust Board Board Agenda and Minutes highlighting Committee discussions	None required	Not applicable	None identified
GP4	*The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them.* **Evidence** Board Reports Board Minutes Board Assurance Framework and Corporate Risk Register	None required	Not applicable	None identified

GP5	*An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account*. **Evidence** Template in place for Board and Committee meetings where individuals and timescales are identified and progress actively monitored at subsequent meetings.	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Performance reports report significant unplanned variances and reasons for same
RF2	None identified	No performance failures were brought to the Board's attention by an external party
RF3	None identified	Finance and Patient, Safety and Quality reports considered together
RF4	None identified	Action log in place
RF5	None identified	Key risks reported/escalated to the Board as and when required

3. Board insight and foresight ALB Name *Southern HSC Trust* Date *September 2022*

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans.* **Evidence** Monthly Corporate Dashboard issued to Trust Board Minutes of Trust Board meetings and Directors' Workshop Notes on specific risks/projects Board Assurance Framework Progress reporting on Rebuild Plans post Covid for period 2020-2022	None required	Not applicable	None identified
GP2	*The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service.* **Evidence** Financial Plan	None required	Not applicable	None identified

GP3	*The Board receives information on all efficiency and productivity plans on a regular basis. Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated.* **Evidence** Financial Plan includes efficiency and productivity plans Issues reported to Trust Board on an exception basis	None required	Not applicable	None identified
GP4	*There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.* **Evidence** Accountability Review meetings PPEs to Audit Committee Board Assurance Framework	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Board receives regular performance information relating to progress against efficiency and productivity plans
RF2	None identified	Process in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans.
RF3	None identified	Financial Planning process considers where potential savings can be made with least impact on quality of care
RF4	None identified	Board Assurance Framework in place

3. Board insight and foresight ALB Name *Southern HSC Trust* Date *September 2022*

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF).* **Evidence** Chief Executive's key issues report is a standing item on the Trust Board agenda Board Minutes Directors' Workshops Board Assurance Framework	None required	Not applicable	None identified
GP2	*The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up.* **Evidence** Board agendas and minutes	None required	Not applicable	None identified

	Directors' Workshop agendas and notes Where further action/assurance is required, Trust Board remit to Governance Committee to monitor progress			
GP3	*The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan.* **Evidence** Annual progress against the Corporate Plan presented to Trust Board	None required	Not applicable	None identified
GP4	*The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis.* **Evidence** Corporate Objectives defined in Corporate Plan 2022/23 Compliance against the Corporate Plan is monitored throughout the year and reported to Trust Board.	None required	Not applicable	None identified

GP5	*The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).* Annual Board Cycle of Work Environmental and Strategic risks actively monitored through the Board Assurance Framework Directors Workshops for strategic planning	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Board has a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plans etc.
RF2	None identified	The Board has a programme of work in place. Workshops also regularly consider environmental and strategic risks.
RF3	None identified	The Board regularly reviews progress towards delivering its strategies.

3. Board insight and foresight ALB Name *Southern HSC Trust* Date September 2022

3.4 Quality of Board papers and timeliness of information

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time.* **Evidence** Schedule of Board and Committee meetings take account of month and year end procedures and key dates Annual Business Cycle Board meetings take place on last Thursday of the month to allow timely presentation of information	None required	Not applicable	None identified
GP2	*A timetable for sending out papers to members is in place and adhered to.* **Evidence** Board meeting timetable as per Standing Orders	None required	Not applicable	None identified

	Internal Timetable in place re issue of Sub Committee papers Paperless approach adopted via DecisionTime			
GP3	*Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion).* **Evidence** As outlined in Board Cover Sheet	None required	Not applicable	None identified
GP4	*Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal meetings.* **Evidence** Monthly Performance Dashboard Monthly Finance Report Progress update against the Corporate Plan objectives and outcomes presented to Board annually Process in place for access to reports to demonstrate performance outside of formal meetings.	None required	Not applicable	None identified

GP5	*Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through.* **Evidence** Each Board paper has an accompanying Board Cover Sheet ensuring that the paper is aligned to specific corporate objectives. Key areas /decisions required are drawn to members' attention as well as the areas of concern/risk/challenge to the proposal by the Senior Management Team	None required	Not applicable	None identified
GP6	*The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place.* **Evidence** Performance Reports Mortality Reports to Governance Committee Internal audit reports to Audit Committee	None required	Not applicable	None identified

	External Assurance Performance Reports to Performance Committee Monitoring of Controls Assurance Standards in place and available to Board members as required.			
GP7	*The Board can provide examples of where it has explored the underlying data quality of performance measures. This ensures that the data used to rate performance is of sufficient quality.* **<u>Evidence</u>** Annual internal audit of presentation of performance management to the Board and underlying data quality CHKS provides peer comparison which supports wider view of performance data Membership of NHS Benchmarking in place to enable to support rolling programme of review of Trust services. Implementation of Quality Improvement and Patient Safety Strategy to bring greater connectivity to a range of indicators including quality and safety and patient experience measures	None required	Not applicable	None identified

GP8	*The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should be collected and quality assured.* **Evidence** Trust Board Cycle of Reporting Board Assurance Framework	Evolving process	Not applicable	None identified
GP9	*Board members can demonstrate that they understand the information presented to them, including how that information was collected and quality assured, and any limitations that this may impose.* **Evidence** Understanding of information presented demonstrated through challenge function of members via Board minutes. Assurance to Board on performance of 'improvement trajectories' included in performance reporting on exception basis. Clinical and Social Care Governance Reporting to Governance Committee	None required	Not applicable	None identified

G10	*Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.* Documentation presented to the Board complies with Departmental guidance, circulars etc.	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Board papers issued via DecisionTime five working days in advance of the meeting
RF2	None identified	Board discussions focus on understanding of issues and providing clarity, where required, to ensure that decision making is well informed
RF3	None identified	Data quality is checked and validated prior to submission of papers to Board members
RF4	None identified	Board agenda and Board Report template specify the purpose of each paper.
RF5	None identified	Board Minutes attest to the challenge and scrutiny applied by members

3. Board insight and foresight ALB Name *Southern HSC Trust* Date *September 2022*

3.5 Assurance and risk management

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board.* **Evidence** Board Assurance Framework Risk Management Strategy Corporate and Directorate Risk Registers Board Minutes Governance Committee Terms of Reference	None required	Not applicable	None identified
GP2	*The Board has identified the assurance information they require, including assurance on the management of key risks, and how this information will be quality assured.* **Evidence** Board Assurance Framework The Senior Information Risk Officer (SIRO) is the Board member identified with lead	None required	Not applicable	None identified

	responsibility for providing assurance on the quality of data/information presented to the Board to support decision-making			
GP3	*The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc* **Evidence** A range of available sources of assurance are sought - RQIA, Internal/External, professional bodies etc. and reports to Governance Committee, Audit Committee, Performance Committee and Trust Board	None required	Not applicable	None identified
GP4	*The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services.* **Evidence** Completion of Board Governance Self-Assessment Tool on annual basis Annual Internal Audit on Risk Management Governance Controls Assurance Standard and compliance with same reported in Governance Statement	None required	Not applicable	None identified

	Review of Clinical and Social Care Governance undertaken Governance Committee Terms of Reference			
GP5	*The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate.* **Evidence** Risk Management Strategy Board Assurance Framework	None required	Not applicable	None identified
GP6	*An executive member of the Board has been delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff.* **Evidence** Executive Directors of Nursing, Midwifery and AHPs: Social Work and Medicine have responsibility for professional regulation and revalidation of all applicable staff	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Board Assurance Framework approved by Trust Board on an annual basis
RF2	None identified	Board assurance sources are identified via Risk Management process
RF3	None identified	Assurances are balanced across a range of sources
RF4	None identified	Board Governance Self-Assessments completed annually since 2013. Review of Clinical and Social Care Governance arrangements undertaken

4. Board engagement and involvement ALB Name *Southern HSC Trust* Date *September 2022*

4.1 External stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*Where relevant, the Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services.* **Evidence** PPI Consultation Scheme	None required	Not applicable	None identified
GP2	*A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.* **Evidence** PPI Corporate Action Plan - progress updates provided at each Patient and Client Experience Committee meeting Equality Scheme sets out how Trust will engage with a diverse range of groups/communities	None required	Not applicable	None identified

	Regional interpreting Service PPI Panel membership on Patient and Client Experience Committee			
GP3	*The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan.* **Evidence** The 2022/23 One Year Corporate Plan identifies that key stakeholders will be involved in the development of the next Corporate Plan for 2023-2028	None required	Not applicable	None identified
GP4	*The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan.* **Evidence** See GP3. The Trust was not required to submit a Trust Delivery Plan for2021-22. Public attendance at Board meetings	None required	Not applicable	None identified

GP5	*The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide* **Evidence** Clinical and Social Care Governance Report to Governance Committee Learning from Experience Forum	None required	Not applicable	
GP6	*The ALB has constructive and effective relationships with its key stakeholders.* **Evidence** Attendees list - actively encourage key stakeholders to attend Trust Board meetings All public consultations include communication/engagement plan External relationships are maintained on an ongoing basis with MLAs, local Councils Community Planning Social Media Policy – Facebook, Twitter and UTube page for development of digital media Proactive Media Planner to promote developments and news across the Trust DHH Pathfinder Group	None required	Not applicable	

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Corporate Plan is widely consulted on both internally and externally
RF2	None identified	The Trust continues to work on maintaining good relationships with external stakeholders, clients, client organisations etc.
RF3	None identified	Feedback from complaints, surveys and findings from regulatory and review reports is used to inform the Business Planning process
RF4	None identified	None
RF5	None identified	Developing format to incorporate implementation of learning from complaints through exisiting workstreams/quality improvement framework

4. Board engagement and involvement ALB Name *Southern HSC Trust* Date *September 2022*

4.2 Internal stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.* **Evidence** Regional Staff Survey (Trust specific results) Facebook, Twitter and U Tube Southern i Directors Visits U Matter Quality Improvement Strategy Quality Improvement Newsletter Consultation Engagment Plans Development of People Framework 2022-25 has been as a result of a range of staff engagement initiatives	None required	Not applicable	None identified

GP2	*The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have been included and not included.* **Evidence** Corporate objectives were developed via staff engagement process	None required	Not applicable	None identified
GP3	*The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities.* **Evidence** Leadership Walks Southern i	None required	Not applicable	None identified
GP4	*The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to service delivery and the running of the ALB.* **Evidence** Excellence Awards Good news stories reported via Chair's business at Trust Board meetings Southern i Proactive communication planner (Quarterly) highlighting	None required	Not applicable	None identified

	events/successes/developments across the Trust Service Improvement/Staff and Service User feedback at start of Trust Board meetings Annual Quality Improvement Event			
GP5	*The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these valves will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the ALB's stated values/behaviours.* **Evidence** HSC Values Code of Conduct Board Behaviours Monthly Case Management Report Working Well Together Policy Whistleblowing Policy People Management Framework GREATix	None required	Not applicable	None identified

GP6	*There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.* **Evidence** Corporate and Directorate Risk Registers communicated via cascaded engagement with Directorates	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	
RF2	None identified	There are no unresolved staff issues that are significant
RF3	None identified	There are no significant unresolved quality issues
	None identified	Workforce issues are included in HR Report to Trust Board.
	None identified	Best practice is shared within the Trust via a variety of means e.g. Trust Board, Committees. Southern i, Continuous Improvement etc.

4. Board engagement and involvement ALB Name *Southern HSC Trust* Date *September 2022*

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	*There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made.* **Evidence** Non Executive Directors Visits Report to Governance Committee Non Executive Director Children's Homes visits report to Governance Committee Active participation at events Trust Board meetings – attendance of staff and Assistant Directors	None required	Not applicable	None identified

GP2	*There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders.* **Evidence** The Chair and Chief Executive undertake and attend a variety of events, details of which are provided on a monthly basis in Chair and Chief Executive's business to Trust Board.	None required	Not applicable	None identified
GP3	*Board members attend and/or present at high profile events.* *Active participation at high profile events.* **Evidence** All events, seminars, workshops attended by NEDs are listed in the Chair and NED business to Trust Board on a monthly basis.	None required	Not applicable	None identified
GP4	*NEDs routinely meet stakeholders and service users.* Non Executive Director visits Children's Homes visits Trust Board Young People's Pledge Attendance at wide range of events	None required	Not applicable	None identified

GP5	*The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests.* **Evidence** Trust Board agenda and minutes and papers publically available on Trust website Record of Public attendance at Board meetings	None required	Not applicable	None identified
GP6	*As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.* **Evidence** Board Reports Board Minutes Annual Appraisals	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	See Good Practice GP1 – GP6 – there are a range of processes in place to raise the profile and visibility of the Board
RF2	None identified	High attendance by Board members at events/meetings

Summary Results **ALB Name** ***Southern HSC Trust*** **Date September 2022**

1.Board composition and commitment		
Area	Self Assessment Rating	Additional Notes
1.1 Board positions and size	Green	The Trust will ensure full implementation of the Senior Mangement structure in 2022-23. Department led Recruitment exercise for SH&SCT Non Executive Directors.
1.2 Balance and calibre of Board members	Green	
1.3 Role of the Board	Green	
1.4 Committees of the Board	Green	The focus of the Board Development Day on 25th August 2022 was to critically evaluate the current structure and process for corporate and clinical and social care governance and explore a proposed new approach.
1.5 Board member commitment	Green	

2.Board evaluation, development and learning		
Area	Self Assessment Rating	Additional Notes
2.1 Effective Board level evaluation	Green	
2.2 Whole Board development programme	Green	
2.3 Board induction, succession and contingency planning	Green	The Trust will further progress succession plans for key Board positions
2.4 Board member appraisal and personal development	Green	

3.Board insight and foresight		
Area	Self Assessment Rating	Additional Notes
3.1 Board performance reporting	Green	
3.2 Efficiency and Productivity	Green	
3.3 Environmental and strategic focus	Green	
3.4 Quality of Board papers and timeliness of information	Green	
3.5 Assurance and risk management	Green	

4. Board engagement and involvement		
Area	Self Assessment Rating	Additional Notes
4.1 External stakeholders	Green	
4.2 Internal stakeholders	Green	
4.3 Board profile and visibility	Green	

5. Board impact case studies		
Area	Self Assessment Rating	Additional Notes

HSC Business Services Organisation

Southern Health & Social Care Trust

Board Effectiveness 2021/22

nqa. ISO 9001 Registered Quality Management

Contents

Acknowledgement

Internal Audit wishes to thank management and staff at the Southern HSC Trust for their assistance and co-operation during the course of the audit engagement.

Control Log

Exit Meeting Held On:	14 March 2022
Working Draft Issued On:	22 February 2022
First Draft Issued On:	16 March 2022
Management Actions Due By:	**18 March 2022**
Management Actions Received:	24 March 2022
Final Report Issued On:	24 March 2022

Distribution List

Eileen Mullan	Chair
Dr Maria O'Kane	Interim Chief Executive
Sandra Judt	Board Assurance Manager
Catherine Teggart	Director of Finance, Procurement & Estates
Alison Rutherford	Assistant Director of Finance
Helen O'Hare	Acting Assistant Director of Finance

Introduction

In accordance with the 2021/22 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Board Effectiveness during December 2021 and January 2022. The last Internal Audit of this topic was performed during 2018/19 when satisfactory assurance was provided.

The Trust Board has the following key functions for which they are held accountable by the Department of Health on behalf of the Minister:

- To set the strategic direction of the organisation within the overall policies and priorities of the HPSS, define its annual and longer term objectives and agree plans to achieve them;
- To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;
- To ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;
- To appoint appraise and remunerate senior executives;
- To ensure that there is effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
- To ensure that the HSC body has robust and effective arrangements in place for clinical and social care governance and risk management.

To ensure that these functions are carried out effectively, the SHSCT's governance structure is underpinned by a number of key documents including the Management Statement and Financial Memorandum (MSFM), the Standing Orders (SOs), Standing Financial Instructions (SFIs), Corporate Plan, People Plan, Board Assurance Framework and Corporate Risk Register.

The SHSCT Board meets regularly (there were seven meetings in 2021), supplemented by Board Workshops and Development Days as required, and is supported by the following Committees:

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

The Board Governance Self-Assessment Tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice. Department of Health (DoH) require Boards to carry out a self-assessment of effectiveness annually and to have their self-assessment ratings independently verified on average every 3 years. This audit constitutes the independent verification.

Internal Audit attended the Trust Board Meeting on 27 January 2022. In attendance were a number of public and political representatives (cross party), journalists, and various groups of staff who joined for specific agenda items. After Board Members discussed agenda items, the Chair opened the floor which provided an opportunity for active public engagement and participation. A number of the political representatives commented and asked questions. This meeting was held by zoom; this virtual format has lent itself to increased involvement from public representatives at Trust Board.

Scope of Assignment

The scope of the review was to ensure that SHSCT has an appropriate, functioning and effective Board. Internal Audit reviewed the most recent DoH Self-Assessment completed by the SHSCT Board in August/September 2021. The NIAO Board Effectiveness Good Practice Guide and the Department of Health's Self-Assessment Tool were used as a basis on which to conduct this assignment through:

- Reviewing minutes and papers of Board/ Committee meetings;
- Reviewing key strategic and operational documents;
- Surveying Board members and senior executives regularly attending Board meetings;

- Meeting with the Chief Executive, Chair and three other Non-Executive Directors (NEDs) to discuss their views on board effectiveness; and
- Attendance at a Board Meeting in January 2022 to observe how it operates.

The audit was based on the risk that the SHSCT Board may not be operating effectively.
The objectives of this audit were to ensure that:

- The Trust has appropriate processes to build / establish the Board;
- There is an effective balance between strategy, accountability and culture at Board level;
- There are appropriate arrangements in place to develop the Board;
- There is clarity of roles, responsibilities and effective relationships among members;
- Board meetings are conducted effectively;
- Appropriate information is received by the Board to discharge its responsibilities, including monitoring service performance and quality;
- Board processes are effective;
- The Board communicates effectively;
- The Board conducts adequate, regular assessments of its own effectiveness.

Note: We report by exception only, and where no issues and recommendations are made, the result of our work indicates that the key objectives and risks are being managed and that procedures are being adequately adhered to.

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.

Executive Summary

Internal Audit can provide Satisfactory assurance in relation to Board Effectiveness. Satisfactory assurance has been provided on the basis that the Trust Board and its committees are meeting regularly; and adequate papers covering the key business areas are being presented. The Board is well attended, meets as required, with papers issued on a timely basis. There is regular and appropriate consideration of key aspects of Board business including accountability, strategy and culture. Board committees are meeting regularly with updates and annual reports being presented back to Trust Board. There was evidence that the Trust responded to and addressed learning from eg the outcomes of the Independent Review into the Circumstances of Board Member Resignations in the RQIA, and the Report of the Independent Leadership and Governance Review at Muckamore Abbey Hospital as both have been the subject of Board workshops over the last year.

Internal Audit issued a survey to all Board members and Directors who attend the Board to seek their views on the effectiveness of the Board; the survey was based on the NIAO good practice guide. In addition, Internal Audit had discussions with the Chief Executive, Chair and 3 Non-Executive board members. Feedback from members was, in general, very positive. Any issues raised support the findings noted below; e.g. Board succession. *The survey results are summarised in Appendix A of this report.*

A review of Board minutes evidenced that the information currently presented to the Board in relation to accountability, strategy and culture is appropriate, both in terms of content and frequency. Additionally, review of Board minutes and attendance at the January 2022 Board Meeting evidenced discussions around key areas together with evidence of appropriate challenge / questioning when appropriate.

The Department of Health has a requirement that Arm's Length Bodies are to have their Board Self-Assessments subject to independent verification every three years. As part of this assignment, Internal Audit reviewed the most recent Board governance self-assessment and resulting action plan and found that it was in line with the outcomes of this audit as established through surveys, interviews, attendance at a Board meeting and review of records. All Board members and Directors who attend the board were involved in the completion of the self-assessment, with feedback sought at a Board Workshop in August 2021 and a paper was presented at the Board meeting on 30 September 2021. All self-assessed ratings

were deemed satisfactory and in line with all audit findings and the approach to conduct the self-assessment was robust.

There are no significant findings impacting on the assurance in this audit.

The key findings of the audit are:

1. The Trust is undergoing a significant change at a Senior Management level and is progressing the appointment of a new Chief Executive. 3 of 9 Executive/Operational Directors posts are filled on an interim/acting basis. This proportion of interim posts could impact on Board Effectiveness and governance within the organisation if it continues for a prolonged period. There is a need to develop succession planning for the Board, with two NED posts vacant and the serving NEDs terms all due to expire in 2024. 80% of NEDs who responded to our survey indicated that they disagreed that the work of the Board and its Committees does not overburden any individual members.
2. Internal Audit note that some Board Papers are lengthy and contain a significant amount of complex information. On occasions coversheets accompanying reports can be four or more pages in length, resulting in key messages not being highlighted. Some Board members stated in the survey that Board Papers were still too long and detailed and that papers needed to be condensed.
3. The Management Statement and Financial Memorandum has not been updated since September 2017. It is appreciated that this is due to be replaced with a 'Partnership Agreement'. The MSFM needs to be clearer in terms of Chief Executive reporting responsibility to Board. The MSFM at paragraph 3.6.3 refers to the Chief Executive's responsibility to advise the Board as opposed to his/her accountability to the Board. The Trust SFI's have not been reviewed since June 2018.
4. The Trust has undertaken a review of its Clinical and Social Care Governance structures however implementation of this work has been delayed due to the ongoing COVID-19 pandemic.

Other findings include:

5. One Executive Director indicated in the survey that had not had an appraisal. This was identified as an area for improvement on the Board Self-Assessment.
6. Within the Trust area there are a diverse range of socio-economic, ethnic, and religious groups. The Trust acknowledge that the diversity of Trust Board could be further developed to more appropriately reflect the diverse community it serves.
7. Induction Training could be expanded to give new members a wider understanding of the work of the Trust, particularly for new members coming with no background in health and social care.
8. Internal Audit issued a board effectiveness survey to the Chief Executive, Chairperson, NEDs, Executive Directors and the Operational Directors that attend the Board. 12 out of 15 people responded to the survey. The results were largely very positive but included some areas for further consideration:
    - 50% of respondents disagreed that the work of the Board and its Committees does not overburden any individual members.
    - 33% of respondents disagreed that the size of the Board is right in terms of the number of non-executive members, given the complexity of HSC provider environment.
    - 33% of respondents disagreed that the appropriate level of induction was available on joining the Board.
    - 25% of respondents disagreed that Board membership is sufficiently diverse in terms of stakeholder representation.
    - 17% of respondents disagreed that the Board has an appropriate balance of professional expertise / functional skills, as well as strategic experience amongst its members.
    - 17% of respondents disagreed that the Board have a strong, and clear vision for SHSCT.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Stability of the Board and Senior Team	-	2	-
2.	Trust Board Meetings and Papers	-	1	-
3.	Corporate Documents	-	1	1
4.	Development of Clinical and Social Care Governance	-	1	-
5.	Appraisals for Executive and Operational Directors	-	1	-
6.	Stakeholder Representation on Trust Board	-	-	1
7.	Induction Training	-	-	1
8.	Board Survey Results	-	-	1
	TOTAL		**6**	**4**

Detailed Findings and Recommendations

1 Stability of the Board and Senior Team

Finding

The SHSCT has 6 Non-Executive Members (1 Chair and 5 NEDs) and 5 Executive members (Chief Executive, Director of Finance, Medical Director, Director of Nursing and Director of Social Work).

The DoH is responsible for the Chair and NEDs appointments to all HSC bodies and all appointments should be time limited. At the time of the audit two out of seven NED positions were vacant. The current serving NEDs are all scheduled to end their terms of office in 2024. The resulting pressure on NEDs in post is reflected in the survey results with 4 of 5 (80%) NEDs disagreeing that the work of the Board and its Committees does not overburden any individual members.

The Trust is undergoing a significant change at a Senior Management level and is progressing the appointment of a new Chief Executive. 3 of 9 Executive/Operational Directors posts are filled on an interim/acting basis. The Trust is planning to restructure a number of director roles.

75% of survey respondents believe that the Board is not sufficiently future proofed against sudden loss of members.

Implications

The knowledge and expertise on the SHSCT Board will be reduced where a significant number of Board members leave the organisation at the same time. This could impact on the effectiveness of the Board. Interim appointments could also impact on good governance.

Recommendation 1.1	The Trust should ensure all vacant and interim Executive posts are filled on a permanent basis, as soon as possible.
Priority	2
Management Action	**ACCEPTED** Permanent Director of Mental Health and Disability appointed and commenced on 14th March 2022. Interim Director of Performance & Reform appointed, pending permanent recruitment to the role.
Responsible Manager	Chair and Director Human Resources and Organisational Development
Implementation Date	December 2022

Recommendation 1.2	The Board should continue to engage with the DoH/NI Public Appointments to develop a succession plan to ensure the staggered replacement of NEDs in line with best practice.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Chair
Implementation Date	September 2022

2 Trust Board Meetings and Papers

Finding

Although Trust Board agendas were viewed as appropriate and members stated that the Chair did keep to the timings as per the agenda. Internal Audit noted Board Papers and some Reports being presented are long and contain a significant amount of complex information. There is a standardised coversheet for Board Reports which highlights key achievements, risks and concerns on occasions these summaries can be four or more pages in length, resulting in key messages not being highlighted. Some Board members in the additional comments section of the survey stated that Board Papers were still too long and detailed and that papers needed to be condensed.

At the Board meeting in January 2022, a NED commented on the length (approx. 120 pages) of the Executive Director of Nursing, Midwifery and AHPs report NEDs and noted that the report had six different authors. The NED asked if it would be possible for the Director to consider rationalising this report and focus on key risks, challenges and governance issues. In our Performance Management audit report 2021/22, Internal Audit have also recommended review of this particular report with a view to identifying key issues.

The Trust Board Development Day in November 2021 on Risk Appetite included discussion and presentation on using risk appetite to reduce the volume of papers. This may provide the Trust with an opportunity to review the length, quantity and volume of papers being presented at each Board meeting.

Implication(s)

If Board members receive too much information, their ability to recognise the risks and fulfil their duty to question and challenge is compromised.

Recommendation 2.1	Within the confines of the statutory requirements, the Trust Board should formally define their information needs and Management should review the quality and volume of board papers presented to Board. This should include streamlining (where possible and appropriate) the volume and content of papers ensuring that key highlights and risks are included in the coversheet/summary.
Priority	2
Management Action	**ACCEPTED** All reports presented to Trust Board will be reviewed to ensure that the report cover sheet is fully completed and that achievements as well as issues/risks/challenges are being appropriately highlighted.
Responsible Manager	SMT and Board Assurance Manager
Implementation Date	June 2022

Also see recommendation 2.1in the Performance Management audit report 2021/22

3 Corporate Documents

Finding

The Management Statement and Financial Memorandum (MSFM) have not been updated since September 2017. DoH intend to replace the MSFM with a 'Partnership Agreement' between SHSCT and the DoH. The 'Partnership Agreement' will outline the overall governance framework within which SHSCT operates, including the framework through which the necessary assurances are provided to stakeholders. Roles/responsibilities of partners within the overall governance framework will also be outlined.

The MSFM is required to be tabled, at a Board meeting at least annually, the MSFM is not on the Trust Board annual cycle of reporting nor is there evidence of this having been brought to a Board meeting during 2021/22.
The MSFM needs to be clearer in terms of Chief Executive reporting responsibility to Board. The MSFM at paragraph 3.6.3 refers to the Chief Executive's responsibility to advise the Board as opposed to his accountability to the Board.

The SHSCT Standing Financial Instructions (SFIs) have not been updated since June 2018 and there is no review date recorded on the SFIs.

Implications

Potential for lack of clarity over roles and responsibilities. There is a risk that key governance documents do not reflect current and best practice.

Recommendation 3.1	The Trust Standing Financial Instructions should be reviewed and updated.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Director of Finance, Procurement and Estates
Implementation Date	March 2023

Recommendation 3.2	SHSCT should raise the need for the Partnership Agreement to be developed and agreed as soon as possible, with the DoH.
Priority	3
Management Action	**ACCEPTED**
Responsible Manager	Chair
Implementation Date	March 2023

4 Development of Clinical and Social Care Governance (CSCG)

Finding

The Trust has undertaken a review of its Clinical and Social Care Governance structures however implementation of this work has been delayed due to the ongoing COVID-19 pandemic.

Implication

Poor Clinical and Social Care Governance structures could lead to gaps in oversight by the Board.

Recommendation 4.1	The outcomes of the review of Clinical and Social Care Governance need to be actioned and fully implemented
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Medical Director and Interim Assistant Director of C&SCG
Implementation Date	November 2022

5 Appraisals for Executive and Non Executive Board Members

Finding

All NEDs had an appraisal at the end of 2021 with the new Chair. However one Executive Director indicated that they had not had an appraisal of their performance in relation to their role as a Board member. There is currently no mechanism in place within the HSC to appraise all Trust Board members and all those who attend and present to Trust Board. In addition this was identified as an area for improvement on the Board Self-Assessment.

Implication

Trust appraisal process has not been consistently applied at this most senior level.

Recommendation 5.1	The Trust should continue to work with the DoH and other Trusts regionally to ensure that there is an appraisal process developed for use within the HSC for all Executive and Non Executive Board members in relation to their role on the Board.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Chair
Implementation Date	March 2023

6 Stakeholder Representation on the Trust Board

Finding

Within the Trust area, there are a diverse range of socio-economic, ethnic, and religious groups. The Trust acknowledge that the diversity of Trust Board could be further developed to more appropriately reflect the diverse community it serves.

The Chair has suggested that a consultative forum may be a way to improve diversity of the voices heard.

Implication

Failure to ensure diversity on the Board means that it is not fully representative of the SHSCT community.

Recommendation 6.1	As per CPANI Guidance on carrying out a skills and attributes audit on a public board, the need for Board diversity should be considered in a Skills and Attributes audit in consultation with DoH, before each public appointment round.
Priority	3
Management Action	**ACCEPTED** To be carried out in advance of next public appointment process for SHSCT Board.
Responsible Manager	Chair
Implementation Date	June 2022

7 Induction Training for Board Members

Finding

There were two new Board Members in the SHSCT during 2021. All board members must complete an induction process. Internal Audit noted:

- 3 of 4 (75%) Executive Directors who responded to the survey indicated that they had not had a satisfactory board induction.
- 80% of NEDs agreed that they had a satisfactory induction. However there is a sense amongst NEDs that the induction process could be further refined.

Implication

Gaps in induction could potentially reduce the effectiveness of the Board.

Recommendation 7.1	The Trust should review induction needs of new members – both executives and non executives.
Priority	3
Management Action	**ACCEPTED**
Responsible Manager	Chair and Board Assurance Manager
Implementation Date	June 2022

8 Board Survey Results

Finding

Internal Audit issued a board effectiveness survey to the Chief Executive, Chairperson, 5 NEDs, 4 Executive Directors and 4 Operational Directors that attend the Board. The survey covered 8 specific areas including Building the Board; Developing the Board; Roles and Responsibilities and Relationships; Board meetings; Board Information; Board processes, Communication and Values. Twelve out of a potential 15 responses were received. The results were largely very positive including for example:

- 100% of respondents agreed with all five statements relating to Board Information.
- 100% of respondents agreed with all four statements relating to Values and that these are evident in how the Board conducts its business.
- 100% of respondents agreed that the Board has the specific skills needed for oversight of SHSCT.
- 100% of respondents agreed that the Board is familiar with current best practice in risk management for identifying, assessing and managing risk.
- 100% of respondents agreed that the Board is underpinned by a spirit of trust and professional respect.
- 100% of respondents agreed that they were happy to challenge other members' views and instigate constructive debate on difficult issues.
- 100% of respondents agreed that they could raise concerns with the Chair and / or Chief Executive, and know they will be addressed.
- 100% of respondents agreed that the Board is always objective and collectively acts in the best interests of the organisation
- 100% of respondents agreed that there is positive interaction between board members, Chief Executive and Directors present.
- 100% of respondents agreed that the Chair effectively discharges her responsibilities.
- 100% of respondents agreed that a dedicated Board secretary with appropriate skills and experience is in place and that Board minutes are reflective of actual discussions including contribution of individual members, decisions made, actions agreed and responsibilities allocated
- 100% of respondents to the survey agreed that all Board members are personally engaged and interested in the SHSCT's activities.
- 100% of respondents agreed that the Board acknowledges instances where something went wrong and openly discusses how it should be addressed or missed opportunities and what should be done differently as a result.
- 100% of respondents agreed that they know the organisational / corporate risks and these are regularly discussed at Board meetings.
- 100% of respondents agreed that they receive appropriate information between meetings to keep abreast of significant issues, trends or developments.

In addition to the areas highlighted in the findings above other areas for potential future consideration relate to the following:

- 50% of respondents disagreed that the work of the Board and its Committees does not overburden any individual members.
- 33% of respondents disagreed that the size of the Board is right in terms of the number of non-executive members, given the complexity of HSC provider environment.
- 33% of respondents disagreed that the appropriate level of induction was available on joining the Board, including shadowing etc. of previous incumbents where necessary or mentoring provided (e.g. committee chairs etc.)
- 25% of respondents disagreed that Board membership is sufficiently diverse in terms of stakeholder representation.
- 17% of respondents disagreed that the Board has an appropriate balance of professional expertise / functional skills, as well as strategic experience amongst its members.
- 17% of respondents disagreed that the Board have a strong, and clear vision for SHSCT.

Implication

Survey results represent an opportunity for learning/development in some aspects.

Recommendation 8.1	The Board should consider any further learning coming from the audit survey results.
Priority	3
Management Action	**ACCEPTED**
Responsible Manager	Chair and Chief Executive
Implementation Date	June 2022

Appendix A – Table of Responses to Survey

Internal Audit issued a survey to the SHSCT Board and received 12 responses – 5 from Non-Executive Members, and 7 from Executive Directors and Directors who attend the Board. A comparison between Board members results and that of the senior executive team did not identify any material differences in opinions. Combined results have been included below (please note: these figures are rounded and not all questions were answered by all those surveyed)

No.	Question	Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree
1	**BUILDING THE BOARD**					
1b	The size of the Board is right in terms of the number of non-executive members, given the complexity of HSC provider environment.	17%	42%	8%	25%	8%
1c	The work of the Board and its Committees does not overburden any individual members.	8%	42%	-	42%	8%
1d	The Board has an appropriate balance of professional expertise / functional skills, as well as strategic experience amongst its members.	8%	75%	-	17%	-
1e	The Board has the specific skills needed for oversight of SHSCT.	17%	83%	-	-	-
1f	Board membership is sufficiently diverse in terms of stakeholder representation.	8%	58%	8%	25%	-
1g	All Board members are personally engaged and interested in the SHSCT's activities.	92%	8%	-	-	-
1h	Our Board is sufficiently future proofed against sudden loss of members.	8%	8%	8%	67%	8%
2	**DEVELOPING THE BOARD**					
2a	Appropriate level of induction was available on joining the Board, including shadowing etc. of previous incumbents where necessary or mentoring provided (e.g. committee chairs etc.)	25%	33%	8%	33%	-
2b	I had an initial meeting with the chairman on appointment and was briefed on the organisation / personal induction assessment performed	36%	45%	18%	-	-
2c	I receive regular updates on new developments / legislation etc. in order to keep Board members' skills and knowledge up-to-date	50%	33%	17%	-	-
2d	As part of my development I have visited departments in the organisation / directors & Heads of Service have presented work	75%	17%	8%	-	-
2e	After a couple of months, I had a personal follow up meeting with the chair.	45%	27%	18%	9%	-
2f	I have an opportunity to meet informally with other board members or directors	67%	33%	-	-	-
2g	I routinely attend mandatory training and updates on new / emerging issues	45%	55%	-	-	-

No.	Question	Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree
2h	I have had an annual assessment of my performance on the board	50%	30%	10%	10%	-
2i	The Board understands and has agreed the organisations risk appetite	30%	40%	30%	-	-
2j	The Board is familiar with current best practice in risk management for identifying, assessing and managing risk	45%	55%	-	-	-
3	**ROLES, RESPONSIBILITES AND RELATIONSHIPS**					
3a	There is clarity around roles of a board member, chairperson and chief executive and their respective responsibilities	45%	45%	9%	-	-
3b	The Management Statement and Standing Financial Instructions (SFIs) are accurate re roles and responsibilities	45%	36%	18%	-	-
3c	Our Board is underpinned by a spirit of trust and professional respect.	82%	18%	-	-	-
3d	I am happy to challenge other members views and instigate constructive debate on difficult issues	80%	20%	-	-	-
3e	I can raise concerns with the Chair and / or Chief Executive, and know they will be addressed	73%	27%	-	-	-
3f	I feel my views are valued by the Chair, Chief Executive and other Board Members	82%	18%	-	-	-
3g	The Board is always objective and collectively acts in the best interests of the organisation	82%	18%	-	-	-
3h	This organisation has strong leadership and appropriate culture	27%	64%	9%	-	-
3i	The Chief Executive values the views of the Board, and seeks our views on important decisions	64%	36%	-	-	-
3j	I am happy to contact the chair, Chief Executive or Directors outside of board meetings, if I have concerns or require further information.	73%	27%	-	-	-
3k	There is positive interaction between board members, Chief Executive and directors in meetings.	91%	9%	-	-	-
3l	Executives speak openly and engage in issues within their remit.	73%	27%	-	-	-
3m	The Board meets as often as necessary without the Chief Executive and Directors present.	27%	36%	36%	-	-
3n	The Board is a strong collaborative team.	55%	45%	-	-	-
3o	The Chair effectively discharges his/her responsibilities.	80%	20%	-	-	-
4	**BOARD MEETINGS**					
4a	A dedicated Board Secretary with appropriate skills and experience is in place.	92%	8%	-	-	-

No.	Question	Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree
4b	Sufficient time is made available to allow the Board to discharge its collective responsibility.	50%	50%	-	-	-
4c	The agenda for Board meetings is appropriate to ensure that all relevant items are brought to the Board's attention.	58%	42%	-	-	-
4d	Board decision making is effective, and collective responsibility for taking informed and transparent decisions within its scheme of delegation is exercised	64%	36%	-	-	-
4e	Board minutes are reflective of actual discussions including contribution of individual members, decisions made, actions agreed and responsibilities allocated	75%	25%	-	-	-
4f	Potential and actual Conflicts of interest are managed effectively.	75%	25%	-	-	-
4g	The Board makes effective use of technology to conduct its business.	83%	17%	-	-	-
4h	The Board undertakes realistic self-reflection / self-evaluation	33%	58%	8%	-	-
5	**BOARD INFORMATION**					
5a	Papers for Board meetings contain relevant and appropriate material and are received sufficiently in advance of the meeting.	25%	75%	-	-	-
5b	Information is available to Board members in a form and of a quality and quantity that enables the Board to discharge duties effectively.	25%	75%	-	-	-
5c	There is appropriate consideration at Board level to service quality, patient safety and client experience.	75%	25%	-	-	-
5d	There is appropriate consideration at Board level given to financial position.	83%	17%	-	-	-
5e	There is a sufficient balance of consideration at the Board of competing pressures of performance, financial position and quality/safety and there is appropriate integration between these three competing areas.	50%	50%	-	-	-
6	**BOARD PROCESSES**					
6a	The Board acknowledges instances where something went wrong and openly discusses how it should be addressed or missed opportunities and what should be done differently as a result.	64%	36%	-	-	-
6b	We have a strong, and clear vision for SHSCT.	42%	42%	-	17%	-
6c	We regularly consider what our long term objectives should be and how external factors may impact them.	25%	67%	8%	-	-

No.	Question	Strongly Agree	Tend to Agree	Neither Agree or Disagree	Tend to Disagree	Strongly Disagree
6d	I am familiar with and have contributed to developing our corporate plan, objectives and strategies to achieve these	45%	55%	-	-	-
6e	There is sufficient balance at Board level between looking back and strategic forward /future planning.	45%	55%	-	-	-
6f	I had an opportunity to challenge content of the annual business plan and I am happy with the content and targets set.	55%	45%	-	-	-
6g	The Board receives regular updates on issues impacting other Trusts both regionally and nationally.	73%	18%	9%	-	-
6h	The Board committee structure is clear and the Board is adequately informed of each committees' activities.	73%	27%	-	-	-
6i	I know the organisational / corporate risks and these are regularly discussed at Board meetings.	64%	36%	-	-	-
6j	I am content organisational / corporate risks are identified promptly by directors and escalated to the Board.	64%	36%	-	-	-
6k	Action plans to mitigate organisational / corporate risks are promptly implemented.	45%	45%	9%	-	-
6l	We have a good balance between strategic and operational issues on our agenda.	55%	45%	-	-	-
7	**COMMUNICATION**					
7a	I receive appropriate information between meetings to keep abreast of significant issues, trends or developments.	73%	27%	-	-	-
7b	I often hear significant issues for the first time on the media.	0%	9%	-	82%	9%
7c	The Board is doing a good job of communicating effectively with stakeholders including DoH, staff, health professionals, volunteers, local community officials and leaders, patients and the public generally?	20%	70%	10%	-	-
7d	The Board has strong networks with other HSC organisations.	64%	27%	9%	-	-
8	**VALUES**					
8a	The Board and its committees set the tone in relation to values and adhere to these?	82%	18%	-	-	-
8b	The Trust's values are displayed in the way business is conducted and how decisions are made at the Board.	45%	55%	-	-	-
8c	Trust values and expected behaviours are embedded in our Human Resources policies, processes and practices.	55%	45%	-	-	-
8d	At Board meetings we demonstrate that we listen to the ideas and concerns of others (including key stakeholders and staff).	55%	45%	-	-	-

Appendix B - Definition of Levels of Assurance and Priorities

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1 Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.

Priority 2 Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.

Priority 3 Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and other findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in in fulfilling their responsibilities.

Internal Audit Service – Ballymena Office
Greenmount House
Woodside Road Industrial Estate
BALLYMENA
BT42 4TP
TEL 028 9536 2540

Internal Audit Service – Londonderry Office
Lime Cabin
Gransha Park
Clooney Road
LONDONDERRY
BT47 6WJ
TEL 028 9536 1727

Internal Audit Service – Belfast Office
2 Franklin Street
BELFAST
BT2 8DQ
TEL 028 9536 3828

Internal Audit Service – Armagh Office
Pinewood Villa
73 Loughgall Road
ARMAGH
BT61 7PR
TEL 028 9536 1629

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

Gifts, Hospitality and Sponsorship Policy

Lead Policy Author & Job Title:	Fiona Jones, Corporate Financial Accountant/Fraud Liaison Officer Sandra Judt, Board Assurance Manager
Directorate responsible for document:	Finance & Procurement
Issue Date:	01 August 2021
Review Date:	01 August 2023

Working together Excellence Openness & Honesty Compassion

Policy Checklist

Policy name:	Gifts, Hospitality and Sponsorship Policy
Lead Policy Author & Job Title:	Corporate Financial Accountant/Fraud Liaison Officer Board Assurance Manager
Director responsible for Policy:	Director of Finance, Procurement and Estates
Directorate responsible for Policy:	Finance & Procurement
Equality Screened by:	**N/A – policy update**
Trade Union consultation?	Yes ☐ No ☒
Policy Implementation Plan included?	Yes ☐ No ☒
Date approved by Policy Scrutiny Committee:	01 August 2021
Date approved by SMT:	N/A – policy update
Policy circulated to:	Global email
Policy uploaded to:	Sharepoint, Trust website

Version Control

Version:	**V2_0**
Supersedes:	**Gifts, Hospitality & Sponsorship Policy V1_0**

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
Version 2_0	**Review and update in line with DoF Guidance 2/10 on the acceptance and provision of gifts and hospitality (amended as 10 July 2019)**	01/02/2021	**Fiona Jones, Fraud Liaison Officer S. Judt, Board Assurance Manager**
Version 1_0	**Gifts, Hospitality and Sponsorship Policy**	01/12/2015	**Vivienne Toal, Director of HROD**

Contents

1.0 Introduction

1.1 This policy is intended to provide advice to Trust staff who in the course of their day to day work or as a result of their employment, either receive offers of gifts, hospitality or sponsorship or provide gifts and hospitality to others on behalf of the Trust.

1.2 All decisions by Trust staff on the provision or acceptance of gifts and/or hospitality must be able to withstand both internal and external scrutiny. They must be defensible as being:

- in the direct interest of the organisation;
- proportionate to that interest;
- within limits that are acceptable to the Trust Board.

1.3 This policy reflects the 'Seven Principles of Public Life' known as the Nolan Principles:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

Appendix 1 outlines further details of the above Nolan Principles.

1.4 The Bribery Act 2010, introduced new statutory offences for activities in the public and private sectors including a new corporate offence. The Act also places specific responsibility on organisations to have in place sufficient and adequate procedures to prevent bribery and corruption taking place.

1.5 Under the Bribery Act 2010, it is an offence to:

- Pay bribes – to offer or give a financial or other advantage with the intention of inducing that person to perform a relevant function or activity improperly or to reward that person for doing so.
- Receive bribes – to receive a financial or other advantage intending that a relevant function or activity should be performed improperly as a result. 'Relevant function or activity' includes any function of a public nature and any activity connected with a business.
- Fail to prevent bribery – an organisation is guilty of an offence if Trust personnel or a third party connected to it bribes another person intending to obtain or retain business or a business advantage.

1.6 The prevention, detection and reporting of bribery and other forms of corruption are the responsibility of all those working for the Trust or under its control. The Trust expects all staff to perform their duties impartially, honestly, with integrity, and in good faith. All Trust staff are required to familiarise themselves and comply with the requirements of this Policy.

1.7 If a Trust employee is found to be in breach of the Gifts, Hospitality and Sponsorship Policy, he/she may be liable to disciplinary action under the Trust's Disciplinary Procedure, which may result in dismissal for gross misconduct. The Trust also reserves the right to terminate its contractual relationship with third parties if they breach this policy.

1.8 In addition to any disciplinary process and where the breach amounts to a criminal offence, this will be referred to the Police Service of Northern Ireland (PSNI). Conviction under the Bribery Act is punishable by imprisonment for a maximum term of 10 years for individuals and unlimited fines can be imposed on both individuals and the Trust.

2.0 Purpose and Aims

The purpose of this policy is to ensure that Trust employees are not placed in a position which raises or appears to raise, conflict in their progression of business activities.

It aims to:

- protect employees under the Bribery Act 2010 which makes it an offence to receive or offer a bribe (including certain levels of gifts and hospitality);

- promote high standards in public life, ensuring that staff and Board members follow the key characteristics of propriety as defined in the Nolan Principles.

3.0 Policy Statement

3.1 This policy has been compiled to ensure compliance with the 7 principles of Public Life drawn up by the Nolan Committee, contained in Appendix 1. All Trust staff must therefore apply the following principles in the conduct of their employment:

- they must not accept personal gifts, hospitality, sponsorship or benefits of any kind from a third party which might be perceived as compromising their personal judgement or integrity;

- they must not make use of their official position to further their private interests or those of others;

- they must report any knowledge or evidence of impropriety to a line manager;

- they must refer to their Head of Service when faced with a situation for which there is no adequate guidance;

- if in any doubt about accepting gifts, hospitality or sponsorship, they must seek advice from the appropriate Head of Service/Assistant Director, the Director with line management responsibility or Director of Finance, Procurement and Estates.

4.0 Scope of Policy

This policy must be adhered to by each member of the Trust Board, all staff and volunteers.

5.0 Responsibilities in relation to Gifts, Hospitality and Sponsorship

- Lead responsibility for policy monitoring and review lies with the Director of Finance, Procurement and Estates.

- Operational responsibility for implementation of the policy lies with managers under the leadership of their relevant director.

- The Board Assurance Manager is responsible for maintaining the Register of Gifts, Hospitality and Sponsorship.

5.1 Acceptance of gifts

5.1.1 Cash or Cash Equivalents

All offers of cash or cash equivalents e.g. lottery tickets, gift vouchers or gift cheques) made by suppliers, contractors, service users or their relatives to individual officers of the Trust, should be declined. Instead, the supplier, contractor, service user or relative should be made aware of the range of Charitable Trust Funds which are managed by the Trust to receive cash donations for general or specific purposes. Details of the current Charitable Trust Funds are available from the Director of Finance, Procurement and Estates.

5.1.2 Non-Cash Gifts

Personal gifts of a small or inexpensive nature such as calendars or diaries or other simple or inexpensive items such as flowers and chocolates which have a value less than £50 can be accepted by an individual.

This type of gift can be easily distinguishable from more expensive or substantial items where the value exceeds £50.00 which cannot on any account be accepted.

If there is any doubt as to whether the acceptance of such an item is appropriate, the matter should be referred to the Trust's Director of Finance, Procurement and Estates.

Non cash gifts of any value given for the benefit of patients and clients do not fall under this Policy, but are managed under the Charitable Trust Fund procedures and should be reported to **donations@southerntrust.hscni.net**

5.1.3 *Bequests*

Gifts, whether cash or non-cash, bequeathed to individual officers of the Trust through the provisions of a will, must also be declined. Instead, the service user or relative can be made aware of the range of Charitable Trust Funds which are managed by the Trust to receive cash donations for general or specific purposes.

5.1.4 *Exceptional Cases*

There may be exceptional cases where refusal of a gift will clearly offend a donor, cause embarrassment or appear discourteous. In these cases the donor should be advised that Trust Management will be notified of the offer. The appropriate form should be completed (Appendix 5) and the Trust's Director of Finance, Procurement and Estates will be asked to decide whether to:

- Return the gift to the donor with a suitably worded letter explaining why the gift cannot be accepted. A template is attached at Appendix 4 which should be tailored to each individual circumstance; or

- use the gift, if possible, in or by the Trust in accordance with the Charitable Trust Fund procedures.

Any acceptance or refusal of the gift should be recorded on the Trust's Gifts and Hospitality Register.

5.1.5 *Lectures, Conferences and Broadcasts*

Where gifts by the way of fees, ex gratia payments, vouchers or other gifts for lectures, broadcasts or similar occurrences are offered, their acceptance should be based on how much of the preparatory work for the event was done in the employee's own time, how much in official working time and the extent to which the Trust resources, other than for example, use of an officially issued laptop at home, were used in the preparation. The guiding principle is that the Trust will seek to recover the costs of publicly funded resources used for any non-HSC events. The following illustration is by way of example:

- if the preparation was carried out entirely in the individual's own time (for example outside fixed sessional commitments for medical or other clinical

staff) and the event took place in the employee's own time at no expense to the Trust, it would be acceptable for the individual officer to retain the whole fee, voucher or other gift.

If further guidance is needed in this area, the Director of Finance, Procurement and Estates should be consulted. In all instances, employees should be aware of the requirements of the Trust in respect of spare time activities and secondary employment.

5.1.6 Trade, Loyalty or Discount Cards

Staff should refuse any trade, loyalty or discount cards which are offered as a direct result of their position of employment within the Trust and are not available to all Trust employees.

Please refer to the Anti Bribery policy for matters pertaining to any form of gift or hospitality, including discounts, offered by a current or potential supplier to an employee involved in procurement of goods or services on behalf of the Trust or its patients and clients.

Please refer to the Anti Fraud policy for matters pertaining to the use of personal loyalty cards in the conduct of Trust business, including purchases by or on behalf of Trust patients and clients.

Frequent Flyer cards used by airlines can be used by staff to avail of special departure lounges and priority booking and check-in. Staff must not make private use of any flights/air miles, which derive from flights paid for from the public purse.

5.1.7 Staff involved in the procurement or monitoring of a contract

Apart from trivial/inexpensive gifts as referred to in section 5.1.2, no gifts or hospitality of ANY kind from any source should be accepted by anyone involved in the procurement or monitoring of a contract. This will ensure that no criticism can be made regarding bias to a particular company or supplier.

5.1.8 Hospitality received from third parties

The handling of offers of hospitality is recognised as being much more difficult to regulate, but it is an area in which staff must exercise careful judgment. It is recognised that it can be as embarrassing to refuse hospitality as it can be to refuse

a gift. There is also a need to distinguish between simple, low cost hospitality of a conventional type, for example, a working lunch or evening meal compared with more expensive and elaborate hospitality. There is clearly a need for a sense of balance. There is concern that acceptance of frequent, regular or annual invitations to events or functions, particularly from the same source and where a considerable degree of hospitality is involved, may severely test the principles stated earlier and should be refused. However, there may be instances where staff receive invitations to events run by voluntary organisations such as annual conferences or dinners. Attendance at such events is considered an integral element in building and maintaining relationships with these sectors and any hospitality received is likely to be reasonable and proportionate, and therefore acceptable.

The main point is that in accepting hospitality staff need to be aware of, and guard against, the dangers of misrepresentation or perception of favouritism by a competitor of the host. It is obviously easier to justify meetings which relate directly to the work of the Trust but where these happen outside working hours and on purely social occasions then they need to be justified as not being a personal gift or benefit. Where a contract is being negotiated, hospitality of any kind, including attendance of staff at seasonal events hosted by suppliers or contractors, should not be accepted.

As a general rule, invitations of hospitality which are extended to the Trust as a whole, can be accepted by a nominated officer and are less likely to attract criticism than personalised invitations to individual officers.

When in doubt about accepting hospitality or an invitation you should consult your Head of Service or the Director of Finance, Procurement and Estates. In all instances where anything beyond conventional hospitality is offered, the approval of the Head of Service or the Director of Finance, Procurement and Estates should be sought using the template at Appendix 5. It is particularly important to ensure that the Trust is not over represented at an event or function and care should be taken to ensure that this does not happen, for example, by enquiring from the host as to other staff who have received similar invitations.

5.1.9 Awards or Prizes

Staff should consult their Head of Service or the Director of Finance, Procurement and Estates if they are offered an award or prize in connection with their official duties. They will normally be allowed to keep it provided:

- there is no risk of public criticism;
- it is offered strictly in accordance with personal achievement;

- it is not in the nature of a gift nor can be construed as a gift, inducement of payment for publication or invention to which other rules apply.

5.1.10 Sponsorship for Attendance at Courses and Conferences

All offers of financial assistance or sponsorship by commercial or other organisations to attend **relevant** courses or conferences, involving an overall value in excess of £50, must be directed to the appropriate Director. The Director may accept such offers on behalf of the Trust provided that:

- the course or conference is one that the Trust would otherwise support
- the travel, accommodation and subsistence arrangements are in line with Trust guidance
- the sponsoring body does not nominate any particular individual (the Director will determine attendance in line with normal procedure)
- the sponsorship is not from a source that may be perceived to be in conflict with HSC aims and objectives, for example, from tobacco companies.

Travel paid for by third parties

All trips funded by a third party must be recorded on the Trust's Gifts, Hospitality and Sponsorship Register using the form included in Appendix 3.

5.1.11 Provision of Hospitality, Gifts and Awards

The paragraphs below outline the responsibilities on staff when considering the provision of hospitality, gifts or awards. Appendix 2 sets out maximum expenditure limits that have been prescribed by the Trust Board for such occurrences. The provision of hospitality, gifts and awards and/or the expenditure limits set out in Appendix 2 may be amended at any time in light of financial or other considerations. Such amendments will be issued by the Chief Executive's Office and will remain in force until formally further amended. If in doubt, the Director of Finance. Procurement and Estates should be consulted before any expenditure is committed.

a) Internal Hospitality

This should only be considered in clearly defined circumstances. For example, where meetings outside of normal working hours cannot be avoided (early morning or after normal working hours) or where staff are required to travel to attend meetings in circumstances where a lunch time break is not possible.

Where hospitality is to be extended for internal meetings, it should be limited to light refreshments and subject to the maximum limit set out in Appendix 2. In such cases written approval should be sought in advance from the appropriate Head of Service using the request form available from Facilities Managers in each locality.

In relation to residential training courses/conferences it is normal practice for meals and light refreshments to be provided for delegates. Alcoholic beverages are not to be included in the cost of evening meal provided under Trust hospitality arrangements.

In relation to non-residential events, lunch may be provided where it facilitates the running of the course or where alternative provision is not available. Written approval should be sought in advance from the appropriate Head of Service. Beverages provided with lunches should be restricted to tea, coffee, water or fruit juice.

As a policy rule, the Trust does not sponsor, or take up invitations to sponsor tables at charitable or other events organised by external bodies.

b) External Hospitality

The provision of hospitality by the Trust to representatives of other organisations should be modest and appropriate to the circumstances. In all instances, the expenditure involved must constitute good value for money.

Hospitality should not be offered solely as a return gesture or be automatically recurrent on a regular basis unless circumstances indicate that it is appropriate to do so. The use of public monies for hospitality purposes at conferences and seminars should be carefully considered. The Trust needs to be able to demonstrate good value in committing public funds.

5.1.12 Other Circumstances

If situations arise that are not covered by the foregoing guidance, prior approval should be sought from the Chief Executive or Director of Finance, Procurement and Estates before hospitality is provided and such approval should be formally documented.

It is recognised that there may be cases when, in the interests of the service, flexibility in interpretation of the rules may be necessary. Prior approval for such situations should be obtained in writing from the Chief Executive. Any request for approval of such instances should state why the request falls outside the boundaries of what is normally allowable and why it is considered necessary to provide such hospitality.

5.2 Authorisation and Approval of Hospitality

The purchase of gifts and hospitality should follow the Trust's normal procurement procedures and should comply with the requirements of the mini-code.

Notwithstanding those circumstances indicated above where specific approval is required from the Chief Executive or Director of Finance, Procurement and Estates, authorisation for, and approval of, hospitalit Notwithstanding those circumstances indicated above where specific approval is required from the Chief Executive or Director of Finance, Procurement and Estates, authorisation for, and approval of, hospitality expenditure should be obtained in accordance with the Trust's Schedule of Delegated Authority and associated procedures.

5.3 Provision of Gifts or Awards

Occasionally the Trust may wish to make a small presentation to speakers or other volunteers in acknowledgement of services provided to the Trust. Such gifts or awards should be of a token nature. Prior approval for the provision of gifts or awards is required from the appropriate Head of Service and such approval should be formally documented.

5.4 Register of Gifts, Hospitality and Sponsorship

In order to counter any possible accusations or suspicions of breach of the rules of conduct, a Register of Gifts, Hospitality and Sponsorship is maintained by the Board Assurance Manager in the Office of the Chair & Chief Executive. All offers of gifts, awards, sponsorship, prizes, invitations and substantial hospitality made to any member of the Trust Board and Trust staff **over the value of £50** must be reported using the form included in **Appendix 3**. Details should include: where the offer originated, to whom it was made, the amount and a note of the action taken, i.e.

accepted/refused/returned and the estimated value. It is the responsibility of the individual member/ officer to forward these details to the Board Assurance Manager

The Register will be published on the Trust's website. It will be subject to audit from time to time and can be viewed in Freedom of Information requests.

5.5 Recording of Hospitality provided by the Trust

All internal and external expenditure on hospitality should be allocated specific financial coding to assist in the collation of management information and to facilitate the monitoring and control of this facility.

6.0 Legislative Compliance, Relevant Policies, Procedures and Guidance

- The Bribery Act 2010
- SH&SCT Bribery Policy
- SH&SCT Anti Fraud Policy

7.0 Equality & Human Rights Considerations

This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The policy will therefore not be subject to an equality impact assessment.

Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

8.0 Sources of Advice & Further Information

Line-managers should be contacted in the first instance, in relation to any specific queries on the content of this policy. Managers / Heads of Service / Assistant Directors should then escalate queries which they are unable to address to their Director. Further advice for Directors is available from the Director of Finance, Procurement and Estates.

APPENDIX 1

THE SEVEN PRINCIPLES OF PUBLIC LIFE

Selflessness *- Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or their friends.*

Integrity - Holders of public office should not place themselves under any financial obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity - In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability - Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness - Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty - Holders of public office have a duty to declare any private interests relating to their public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership - Holders of public office should promote and support these principles by leadership and example.

APPENDIX 2

PRESCRIBED MAXIMUM EXPENDITURE LIMITS FOR THE PROVISION OF HOSPITALITY.

1. Hospitality for Internal Meetings:

Maximum Limit: £5 per head.

2. Residential or Non-Residential Events Organised by the Trust:

- Lunch - £10 per delegate
- Evening Meal - £20 per delegate
- Beverages supplied with meals - one third of cost of meal.

3. Extension of Hospitality to Individuals External to the Trust:

- Lunch - £20 per Head
- Evening Meal - £30 per Head
- Beverages - one third of cost of meal

4. Provision of Nominal Gifts to Guest Speakers, Volunteers etc:

Small gifts or gift tokens may be provided to a maximum value of £50.

APPENDIX 3

NOTIFICATION OF OFFERS OF GIFTS /HOSPITALITY/AWARDS / SPONSORSHIP OVER £50 IN VALUE

As per the Gifts and Hospitality and Sponsorship Policy, all offers of personal gifts, awards, prizes, invitations, hospitality, sponsorship of courses, conferences and meetings with an estimated value of over £50 must be reported on the proforma. Donations received via cash or cheque for the Charitable Trust Funds , do not need to be recorded.

DIRECTORATE: **MONTH :**

Date of event/gift offered	Offered to	Offered from	Description of offer and reason	Details of contracts current or potential	Est value of offer (£)	Action taken (Accepted/ refused/ returned)

This proforma must be completed and forwarded to Sandra Judt, Board Assurance Manager, via email @ [redacted] ***n the Chair and & Chief Executive's office to update the Trust wide Gifts, Hospitality and Sponsorship Register***

Personal Information redacted by the USI

APPENDIX 4

TEMPLATE FOR RETURN OF OFFER OF GIFT/HOSPITALITY

(The content of this template should be tailored to suit each circumstance)

Contact name

Contact details etc

Date

Dear

The Southern Health and Social Care Trust operates a Gift, Hospitality & Sponsorship Policy to ensure high standards of propriety in the conduct of its business.

On account of public confidence, perception is as important as reality and because of this I am obliged to return your offer of……..

This is not meant in any way to offend or imply that your [gift/hospitality] was offered in anything but the utmost of good faith, but is designed to protect both individual members of staff and the Southern Health and Social Care Trust. I hope you will accept our response in that spirit and that we can look forward to continued effective working relationships.

There are Charitable Trust Funds managed by the Trust to receive cash donations. Should you wish to make a donation, please contact [redacted]

Personal Information redacted by the USI

Yours …….

GIFT/HOSPITALITY APPROVAL FORM APPENDIX 5

PART 1 – To be completed by recipient of gift/hospitality

GIFT/HOSPITALITY AUTHORISATION FORM	
Name of person to whom offer made:	
Date of event or gift offered:	
Name of originator of offer:	
Description of offer and reason:	
Estimated/actual value of offer:	
State whether the offer was declined:	
Is there a current/potential contract with the donor? If yes, provide details:	
Signature of recipient:	Signed: Date:

PART 2 – To be completed by Director of Finance & Procurement/Head of Service

GIFT/HOSPITALITY AUTHORISATION FORM **(OUTCOME)**	
Decision: (Approved/Not Approved)	
Reason why approval has/has not been granted:	
Is gift being returned? (If so, letter as per Appendix 4 should be used)	
Has the gift been used or disposed of? If so, give details:	
Has the gift been donated to a nominated charity?	
Has the Gifts and Hospitality register been updated?	
Signature of Director of Finance & Procurement/Head of Service:	Signed: Date:

Southern Health and Social Care Trust

Quality Care - for you, with you

Chair
Eileen Mullan

Chief Executive
Shane Devlin

Our ref: SJ/smcc

4 November 2021

To: Trust Board Member

Dear Colleague

Re: Declaration of Hospitality and Sponsorship for the period 1 April 2021 – 31 March 2022

As you will be aware, the Codes of Conduct and Accountability for HSC Boards state that – 'Directors or employees of the Trust should declare hospitality which they have received from a third party'.

I should therefore be grateful if you would complete and return the attached questionnaire so that it can be recorded in the register which is held in the Chief Executive's office and which is subject to external audit. It would be useful if you could record a Nil return, where appropriate.

As there are a number of definitions of hospitality the following guidance is suggested.

"Hospitality may be defined as any benefit or service provided by a third party to an employee or a Director for which no payment is made by the Trust. The nature of the services or benefits envisaged could include accommodation, transport or travel, provision of meals, entry to sporting events, invitations to social events, or services of that nature. Sponsorship may also be included."

An example of an item which is unlikely to require disclosure would be the provision of a working lunch and it should normally be similar to the scale of hospitality that would be provided by the Trust. Alternatively, the provision of overnight accommodation would probably merit disclosure. It is recognised that levels of hospitality vary according to circumstances and if you are in doubt, please discuss with me.

Trust Headquarters, Craigavon Area Hospital site, 68 Lurgan Road, Portadown, Craigavon BT63 5QQ
Tel: Personal Information redacted by the USI E:mail: Personal Information redacted by the USI

If you have a declaration to make, please provide the following information on the attached form

- the nature of the hospitality;
- the provider's name and address;
- the date of receiving the hospitality;
- the estimated value of the hospitality received.

Please retain a blank copy of the form for future reference and ensure you advise of any hospitality you receive within 4 weeks of the event occurring.

Yours sincerely

Personal Information redacted by the USI

MRS SANDRA JUDT
BOARD ASSURANCE MANAGER

Enc

Trust Headquarters, Craigavon Area Hospital site, 68 Lurgan Road, Portadown, Craigavon BT63 5QQ
Tel: Personal Information redacted by the USI E:mail: Personal Information redacted by the USI

Southern Health and Social Care Trust

Quality Care - for you, with you

CONFLICTS OF INTEREST POLICY

Lead Policy Author & Job Title:	Fiona Jones, Corporate Financial Accountant/Fraud Liaison Officer Sandra Judt, Board Assurance Manager
Directorate responsible for document:	Directorate of Finance, Procurement and Estates
Issue Date:	01 November 2022
Review Date:	01 November 2024

Working together Excellence Openness & Honesty Compassion

Policy Checklist

Policy name:	Conflict of Interests Policy
Lead Policy Author & Job Title:	Fiona Jones, Corporate Financial Accountant/Fraud Liaison Officer Sandra Judt, Board Assurance Manager
Director responsible for Policy:	Catherine Teggart
Directorate responsible for Policy:	Finance & Procurement
Equality Screened by:	Sandra Judt, Board Assurance Manager
Trade Union consultation?	Yes ☐ No ☒
Policy Implementation Plan included?	Yes ☒ No ☐
Date approved by Policy Scrutiny Committee:	Click here to enter a date.
Date approved by SMT:	Click here to enter a date.
Policy circulated to:	SMT for cascading to Assistant Directors, Heads of Service for onward distribution to line managers, Global email, Sharepoint
Policy uploaded to:	Sharepoint and Global email

Version Control

Version:	**Version 2.0**		
Supersedes:	SHSCT Conflict of Interests Policy V1.0		
Version History			
Version	**Notes on revisions/modifications and who document was circulated or presented to**	**Date**	**Lead Policy Author**
Version	Click here to enter text	Click here to enter a date.	Click here to enter text
Eg Version 2_0	Click here to enter text	Click here to enter a date.	Click here to enter text

SHORT GUIDE TO THIS CONFLICT OF INTEREST POLICY

DO:

- Make sure **you** are aware of the Trust's Conflict of Interests Policy and follow it.
- Make sure if **you** are responsible for any staff that you understand the Policy, that your staff are made aware of this Policy and where to find it and apply it in your area.
- Make sure if you are a Board member, Assistant Director, Consultant, or work in finance, procurement, pharmacy, IT, Estates that **you** have a good working knowledge of the policy and follow it.
- Make sure **you** seek advice from your line manager in the first instance if you are not sure about the guidance in this Policy.
- Make sure that **you** (and your staff) are not put in a position where personal interests may come into conflict with Trust duties.
- Declare any relevant interests, and if in doubt, ask **yourself** the following questions:
    - Am I, or might I, be in a position where I or my family or friends could gain from the connection between my private interests and my employment or where it could be perceived by others that a gain could be made?
    - Do I have access to information, or contact with individuals, which could influence my decisions?
    - Could my outside interests be in any way detrimental to HSC, the Trust, or to patients' interests?
    - Do I have any reason to think I may be risking a conflict of interest?
    - If after asking these questions **you** are still unsure – **Declare it!**

- Inform **your** line manager if you take on new outside work and complete the 'additional employment section' of the Declaration of Interests Form.
- Raise any concern **you** may have in relation to fraud or potential bribery offences.

DON'T:

- Abuse your official position to obtain preferential rates for private gain.
- Interview a close personal friend or relative.
- Unfairly advantage one contractor over another.
- Undertake outside work that could compromise your Trust duties
- Show special favour in awarding contracts.

CONTENTS

1.0 INTRODUCTION

1.1 The primary responsibility of the Trust, as a public body, is to serve the public interest. Staff and Board members must therefore discharge their duties in a manner that is seen to be honest, fair and unbiased.

1.2 This policy reflects the 'Seven Principles of Public Life' known as the Nolan Principles which holders of public office need to uphold. Further details on these are provided in **Appendix 1.**

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

Of these, Integrity reflects that '*Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.'*

1.3 The Trust determines to ensure that it inspires confidence and trust amongst its staff, suppliers and the public by demonstrating integrity and avoiding any potential or real situations of undue bias or influence in decision making.

Consequently, the Trust must ensure that perceived and actual conflicts of interest are identified and managed in a way that

safeguards the integrity of staff and Board members and maximises public confidence in the Trust's ability to deliver public services properly.

1.4 This Policy covers the four main stages to work through in relation to conflicts of interest: -

- **Identifying** a conflict of interest – actual, potential or perceived
- **Declaring** conflicts of interest
- **Managing** conflicts of interest; and
- **Publishing** registers of interest.

2.0 PURPOSE AND AIMS

2.1 The purpose of this policy is to ensure that individuals covered by the scope of the policy are aware that they must take decisions free from any potential or real situations of undue bias or influence in the decision-making of the Trust.

2.2 The aims of this policy are to:

- promote high standards in public life, ensuring that staff and Board members follow the key characteristics of propriety as defined in the Nolan Principles;

- set out the standards of conduct expected of all staff where their private interests might conflict with their duties as an employee and the steps the Trust will take to safeguard itself against potential conflicts of interest;

- protect the Trust, its staff and Board members from any appearance of impropriety which may be a risk to its reputation or a breach of the Bribery Act 2010.

3.0 POLICY STATEMENT

The Trust wishes to ensure that staff and Board members discharge their duties in a manner that is seen to be honest, fair and unbiased, in line with HSC values and the seven Nolan Principles of Public Life. It is the expectation of the Trust that any conflict of interest (actual or perceived) that arises in the course of conducting HSC business is declared.

4.0 SCOPE OF POLICY

4.1 This policy must be adhered to by each member of the Trust Board and all staff.

5.0 CONFLICTS OF INTEREST – FOUR MAIN STAGES

5.1 Identifying a Conflict of Interest/Types of Conflict

Key Principle: It is important that conflicts of interest (including potential/perceived conflicts) are identified at the earliest opportunity.

5.1.1 Actual Conflict of Interest

Conflicts of interest may arise where an individual's personal, or a connected person's interests and/or loyalties conflict with those of the Trust.

5.1.2 Potential or Perceived Conflicts of Interest

A conflict of interest can also be potential or perceived. A perceived conflict of interest exists where it could be perceived, or appears, that private-capacity interests could improperly influence the

performance of a Trust member of staff or Board member's official duties and responsibilities. It may pose no actual risk to the conduct of public business, but it requires proper management in order to minimise the risk of reputational damage both to the Trust and the individual(s) concerned. A perception of a conflict of interest can be just as significant as an actual conflict of interest – both should be avoided. The key issue is whether there is a risk that a fair-minded outside observer, acting reasonably, would conclude that there is a real possibility of bias.

- The interest in question need not always be that of the Board member or member of staff themselves. It can also include the interests of close relatives or friends and associates who could benefit, or have the potential to influence the member of staff or Board member's behaviour.

  These individuals could include the following and any of their personal partners:

Close relatives – by blood or marriage	Grandchildren
Spouse/Partner	Brother
Parent	Sister
Grandparent	In-laws
Child	Cousins

  It can also include close friends or associates as someone with whom the individual has a longstanding and/or close relationship, socialises with regularly or has had dealings with which may create a conflict of interest.

  In order to identify and subsequently avoid real conflicts of interest or the perception of such, individuals must carefully consider whether an allegation of impropriety could be made against them, their family or friends and/or the Trust.

5.2 Declaring Conflicts of Interest

Key Principle: As soon as a member of staff or Board member identifies that they have any type of conflict of interest, it should be declared immediately to their manager. If in doubt, be over cautious and declare as it is better to be open and transparent.

5.2.1 Who should declare an interest?

- All staff on commencement are required to declare whether they have any interests by completing the Declaration of Interest Form **(Appendix 2)** and this declaration is held on their personal file in the HR Directorate. If a declaration of interest is declared, the form is also forwarded by the HR Directorate to the relevant manager and Board Assurance Manager. A similar process is applied for volunteers and held by the relevant Volunteer Coordinator.

- If an interest arises subsequent to the completion of the form when commencing, staff are required to declare their interests by using the Declaration of Interest Form and submit this to their manager.

- All existing staff will be reminded annually of this Conflict of Interest Policy and their responsibility to declare any new actual or perceived conflicts of interest by completing the Declaration of Interest Form.

- Staff are responsible for making sure that their registered interests are kept up to date at all times. Although the interest may be declared, this does not remove the member of staff's personal responsibilities for removing themselves from a position or situation which may result in a potential breach of this policy.

- Staff who have an interest in an organisation with which the Trust has a business relationship, for example in an equipment manufacturer or a pharmaceutical company, (or if they have previously worked for such an organisation) may be vulnerable to

allegations of impropriety. This also applies to partners, relatives and close associates of that member of staff.

- If staff have dealings or interests with external organisations which might influence or be seen by others to influence the Trust's business relationship with that organisation and where a conflict of interest could arise it must be declared using the Declaration of Interest Form.

- The Trust must be told of all cases where a member of staff, partner, close relative, personal friend or other close associate has a 'Relevant and Material' interest, including significant financial interests. This includes a private company, public sector organisation, other Trust employer or any other company that may compete for an HSC contract to supply goods or services to the Trust. A non-exhaustive list of interests which the Trust considers as 'relevant and material' is listed in **Appendix 3**.

- If in doubt about whether a declaration should be made, advice should be sought from your line manager. Board members, staff and managers are requested to err on the side of caution. The test is that an interest must be declared if it conflicts with your official duties, impairs your abilities to carry out your duties, and/or impacts on your work.

- There should be no conflict of interest between staff's duties and any other outside work. Any new outside work must be recorded on the 'additional employment section' of the Declaration of Interests form.

5.2.2 Specific responsibilities for annual returns

A greater duty applies to certain groups of staff due to their close involvement in the selection of suppliers and to purchasing decisions. Staff in these groups at **Band 6 and above**, are required to provide an annual declaration return - this includes a NIL return where there are no interests to declare.

Group	Named Co-ordinator*
Trust Board	Board Assurance Manager
Assistant Directors	Directors
Purchasing & Supplies	Director of Finance, Procurement and Estates
Pharmacy	Head of Pharmacy
Information Technology	Director of Performance & Reform
Planning	Director of Performance & Reform
Estates	Director of Finance, Procurement and Estates
Medical staff	Deputy Medical Director for Appraisal and Revalidation

The *named co-ordinator is required to arrange for the members of staff in these specific groups to complete an annual declaration form and ensure that these are completed and sent to the Board Assurance Manager.

- There is clear guidance on the procurement of goods and services for the public sector. Employees of the Trust are required to comply with 'PS06 PaLS Guide to Participation in the Tendering process'.

- Returns should be made to the Board Assurance Manager by the end of April each year.

5.2.3 Private Practice

- Any employee of the SHSCT must declare any private practice, which may give rise to any actual or perceived conflicts of interest, or which is otherwise relevant to the proper performance of their contractual duties using the Declaration of Interests Form.

- Any private work undertaken during Trust contracted hours or while on paid absence, may be considered as potentially fraudulent and dealt with in accordance with the Trust's Fraud Policy and Response Plan, and the Disciplinary Procedures.

- Medical staff undertaking private work within Trust premises and/ or utilising Trust facilities are required to obtain prior approval and ensure that the Trust's Private Patient Procedure is followed. Any departure from these requirements will be considered as a breach of duty to declare an interest and may also be investigated under the Trust's Fraud Response Plan and Disciplinary Procedures.

5.2.4 Board members' responsibilities

In addition to the main content of this policy, the following applies to Trust Board members.

Board members are required to declare interests which are relevant and material to the Trust. This is stated in 'The Code of Accountability and Code of Conduct for Board members of Health and Social Care Bodies (July 2012)'

'It is a basic requirement that Chairs and all Board members should declare any conflict of interest that arises in the course of conducting HSC business. Chairs and Board members must declare on appointment any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any

connection with a voluntary or other body contracting for HSC services'.

At the time Board members' interests are declared, they shall be recorded on the Register. Directorships and other significant interests held by members of HSC Boards must be declared on appointment, kept up to date, and set out in the annual report.

- A Register of all Board member interests will be kept and maintained by the Board Assurance Manager and will be reviewed by the Trust Board on an annual basis. Interests, however, should be declared as and when they arise, and not only as a result of this annual declaration.

- Further instructions regarding the duties and obligations of Board members are detailed in Section 7 of the Trust's Standing Orders.

- At the outset of a Board meeting and Committee meetings, the Chair shall invite members to declare an interest in any agenda item. If a conflict of interest is established, the member concerned shall, as soon as he/she is able after its commencement, disclose the fact and this is recorded in the minutes. It shall be disclosed in a manner that cannot be perceived to influence subsequent discussion or decision. Any action taken to manage any conflicts of interest e.g. the member leaves the meeting for a particular agenda item and plays no part in the relevant discussion or decision, should also be recorded in the minutes.

5.2.5 Gifts, Hospitality and other benefits

- A conflict of interest can arise where Board members or any member of staff accept the offer of gifts, hospitality or other benefits, for example from potential contractors/suppliers.

- The Trust's Gifts, Hospitality & Sponsorship Policy provides advice to all Trust staff on the expected standards of conduct and to those staff who, in the course of their day to day work or as a result of their employment, either receive offers of gifts, hospitality or considerations of any kind from contractors, agents, organisations, firms or individuals. The policy also provides advice on the provision of gifts and hospitality to others on behalf of the Trust.

5.3 Managing Conflicts of Interest

Key Principle: Conflicts of Interest (including potential/perceived conflicts) must be managed appropriately.

- When an employee reports an interest, management must consider how it should be dealt with ensure that all deliberations / actions are recorded on the Declaration of Interests form and register (including any decision to take no action).

  - Questions to be answered include:
  - Could the Board member / employee or their family or friends gain from his / her connection to the Trust?
  - How is the declared interest likely to be perceived externally?
  - Could the declared personal interest damage the reputation, impartiality or integrity of the Trust?
  - Is there a possibility that the declared interest might influence decision making by the Board member / employee or by others?

    The method of managing any conflicts of interest should be assessed on a case by case basis and will be determined after consideration of a number of factors such as the level of risk presented and what management is actually feasible

    In very low risk cases, it may be deemed sufficient to declare the interest so that it is known, but with no further action considered necessary.

In other more complex situations where the conflict is more serious and it is considered that it cannot be managed, it may be necessary for the member of staff/Board member to either relinquish the private interest that is creating the conflict with their public duties, or for them to resign from their position within the Trust.

In summary therefore, there are different options for managing conflicts of interest:

Restrict – where restrictions are placed on the staff member/ Board member's involvement in the matter
Recruit - where a disinterested third party is used to oversee part of all of the process that deals with the matter
Remove – where the staff member/Board member is removed from the matter
Relinquish – where the staff member/Board member relinquishes the private interest that is creating the conflict; and
Resign – where the staff member/Board member resigns from their position with the Trust.

The table contained in **Appendix 4** outlines possible management strategies and when they might be best used.

5.3.1 Failure to make a declaration

Should it be suspected that a member of staff has failed to appropriately declare an interest, or failed to demonstrate compliance with the conduct outlined in this policy, it may be deemed appropriate to take action in line with the Trust's Disciplinary Procedure and/or Fraud Policy.

5.4 Pubishing Registers of Interest

Key Principle: To ensure openness and transparency, Registers of Interest of Senior Officials and Individual Board members of public bodies should be made available/published.

- The Board Assurance Manager will hold the 'Registers of Interests'.

  - The Register of all Board member Interests will record all business and commercial interests declared by Board Members.

    It will be subject to an annual review and the outcome of that review will be reported to Trust Board and made publically available on the Trust's website.

  - The Register of Interests for staff will record all business and commercial interests declared by staff. It will be subject to annual review by the Director of Finance and the Director of HROD. The annual review should take into account any significant changes to contracts or suppliers which may have resulted from declarations of interests.

  - Where there is any doubt as to what an individual should or should not be registering, this should be discussed with Line Managers.

  - When publishing registers/making them publicly available, the Trust should take account of data protection legislation, and it should be remembered that only the individuals on the register making declarations should be identifiable. It is important that relationships when including family, friends and associates are not named – only their relationship and business/activity and interaction with the Trust needs to be considered for publication.

- The information provided will be processed in accordance with data protection principles as set out in the UK GDPR. Data will be processed only to ensure that Board members and staff act in the best interests of the Trust. The information provided will not be used for any other purpose.

- The above information will be incorporated into the two yearly review of the policy.

6.0 LEGISLATIVE COMPLIANCE, RELEVANT POLICIES, PROCEDURES AND GUIDANCE

- Circular HSC (F) 31-2021 - Guidance on Conflicts of Interest
- NIAO Conflicts of Interest: A Good Practice Guide, 2015
- Bribery Act 2010
- SHSCT Gifts, Hospitality & Sponsorship Policy, 2021
- SHSCT Anti-Fraud and Anti-Bribery Policy and Fraud Response Plan
- Department of Health, Code of Conduct for Board Members
- Department of Health, Code of Conduct for HSC Employees, 2016

7.0 REVIEWING THE POLICY

It will be the responsibility of the Director of Finance and Procurement to review this Policy.

8.0 EQUALITY AND HUMAN RIGHTS CONSIDERATIONS

8.1 This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Using the Equality Commission's screening criteria, no significant equality implications have been identified. The Policy is therefore not subject to equality impact assessment.

8.2 Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

9.0 ALTERNATIVE FORMATS

9.1 This is document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English.

10.0 RECORDS MANAGEMENT

The supply of information under the Freedom of Information does not give the recipient or organisation that receives it the automatic right to re-use it in any way that would infringe copyright. This includes, for example, making multiple copies, publishing and issuing copies to the public. Permission to re-use the information must be obtained in advance from the Trust.

11.0 SOURCES OF ADVICE AND FURTHER INFORMATION

11.1 Line-managers should be contacted in the first instance, in relation to any specific queries on the content of this policy. Line managers should then escalate queries which they are unable to address to their Director. Further advice for Directors is available from the Board Assurance Manager or Director of Finance & Procurement.

11.2 A useful guidance document to assist in dealing with an actual or potential conflict of interests is NIAO – Conflict of Interests – A Good Practice Guide, March 2015.

Appendix 1

The Nolan Principles
The Seven Principles of Public Life

- **Selflessness:** Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness:** Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.
- **Honesty:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership:** Holders of public office should promote and support these principles by leadership and example.

Appendix 2

Southern Health and Social Care Trust

Quality Care - for you, with you

DECLARATION OF INTERESTS FORM

Period:

Full Name (in Capitals)			
Staff Number		**Job Title**	
Department		**Directorate**	

Trust employees and Board members must declare interests they, or close family or friends have, which might improperly influence the performance of their duties and responsibilities as a Trust employee or which could be perceived to do so.

NATURE AND DETAIL OF INTEREST

Please complete any relevant detail below:

1	**Company interests:** Any relationship with a company or commercial organisation, Directorships, consultancy. (Please include name and business address)	
2	**Self-Employment**:	
3	**Charities:** Trusteeships, governorships or employment with any charities or voluntary organisations.	
4	**Public Appointments:** Remunerated or unremunerated	
5	**Memberships:** Including membership of professional or external bodies, or other associations	

6	**Close family links:** Any of the above interests held by a spouse, partner, close relative, other close associates or personal friends	
7	**Additional employment**: There should be no conflict of interest between your duties and any other job.	
8	**Any other relevant interests:** Held by you or your close family or friends	

Please tick that you have read and understood the Conflicts of Interest Policy ☐

DECLARATION:

I confirm that this declaration applies to me and anybody close to me as defined in the Policy. Please tick ***one*** box below.

	I confirm I have actual interests to declare to the best of my knowledge and belief. I declare that the interests above are those which the Southern HSC Trust should be aware of. I understand and accept that if any relevant and material interest changes it is my responsibility to keep the Trust informed of these changes.
	I confirm I have no actual interests to declare to the best of my knowledge and belief.
	I confirm I have interests to declare which could be potentially perceived by others as improperly influencing the performance of my duties and responsibilities as a Trust employee.

Signed: _____Date: _____

****

FOR ASSISTANT DIRECTOR / DIRECTOR TO COMPLETE

CONSIDERATION OF DECLARATION

I have read and discussed the above Declaration of Interest with the individual concerned and *feel that no further action is required at this time / need to take the following action. (* Delete as appropriate)

_____
_____
_____
_____

Signed: _____(minimum Assistant Director level)

Print name: _____ Job Title: _____ Date: _____

Appendix 3

CONFLICT OF INTERESTS POLICY

'RELEVANT AND MATERIAL' INTERESTS

An interest must be declared if it conflicts with your official duties, impairs your abilities to carry out your duties, and/or impacts on your work.

The following is a non-exhaustive list of interests which the Trust considers are relevant and material and must be declared:

- Where an employee works for another organisation, whether HSCNI related or not;
- Any directorships of companies likely to be engaged with the business of the Trust;
- Any role in an organisation which is a supplier or might be a future supplier of the Trust including:
  - A directorship including a non-executive directorship;
  - A majority or controlling share holding;
  - A prospect of future employment.

- Voluntary or remunerated positions, such as trusteeship, other public positions;
- Membership of professional bodies or mutual support organisations, including political parties;
- A position of authority in an organisation in the field of health care.
- Investments in unlisted companies, partnerships and other forms of business, major shareholdings and beneficial interests;
- Where a family member or close personal relationship exists with an external body or somewhere where you may be in a position to award services to;
- A controlling/or significant financial interest in a business which may compete for business at the Trust.
- A self beneficial interest in a private company that may treat patients of the Trust
- Any other perceived conflicts that are not covered by the above.

Appendix 4

Dealing with Conflicts of Interest (NIAO Good Practice Guide)

Management Strategy	When most suitable	When least suitable
Register Where details of the existence of a possible or potential conflict of interest are formally registered.	- For very low-risk and potential conflict of interest. - Where the act of transparency through recording the conflict of interest is sufficient.	- The conflict of interest is more significant or higher risk. - The potential or perceived effects of a conflict of interest on the proper performance of the public official/ Board member's duties require more proactive management.
Restrict Where restrictions are placed on the public official/Board member's involvement in the matter.	- The public official/Board member can be effectively separated from parts of the activity or process. - The conflict of interest is not likely to arise frequently.	- The conflict is likely to arise more frequently. - The public official/Board member is constantly unable to perform a number of their regular duties because of conflict of interest issues.
Recruit Where a disinterested third party is used to oversee part or all of the process that deals with the matter.	- It is not feasible or desirable for the public official/Board member to remove themselves from the decision-making process. - In small or isolated communities where the particular expertise of the public official/Board member is necessary and genuinely not easily replaced.	- The conflict is serious and ongoing, rendering ad hoc recruitment of others unworkable. - Recruitment of a third party is not appropriate for the proper handling of the matter. - A suitable third party is unable to be sourced.
Remove Where a public official/Board member chooses to be removed from the matter.	- For ongoing serious conflicts of interest where ad hoc restriction or recruitment of others is not appropriate.	- The conflict of interest and its perceived or potential effects are of low risk or low significance. - The public official/Board member is prepared to relinquish the relevant private interest rather than radically change their work responsibilities or environment.
Relinquish Where the public official/Board member relinquishes the private	- The public official/Board member's commitment to public duty outweighs their	- The public official/Board member is unable or unwilling, for various reasons,

interest that is creating the conflict.	attachment to their private interest.	to relinquish the relevant private interest.
Resign Where the public official/Board member resigns from their position with the organisation.	- No other options are workable. - The public official/Board member cannot or will not relinquish their conflicting private interest and changes to their work responsibilities or environment are not feasible. - The public official/Board member prefers this course as a matter of personal principle.	- The conflict of interest and its potential or perceived effects are of low risk or low significance. - Other options exist that are workable for the public official/ Board member and the organisation.

Source: NIAO Conflicts of Interest – A Good Practice Guide Page 23

Gribben, Laura

From: Global circular - [redacted]
Sent: 14 March 2022 17:57
To: DL_Global_Circular
Subject: Conflicts of Interest Policy and Declaration of Interest Form 2021_22

In accordance with the SHSCT Conflicts of Interest Policy, all staff are required to declare any conflict of interest (actual or perceived) that arises in the course of conducting HSC business.

While interests should be declared as and when they arise, the Trust's Senior Management Team has requested that an annual reminder is issued to all staff to ensure they are aware of their responsibility to declare any conflict of interest.

Please click here for a copy of the Conflict of Interests Policy. http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/SHSCTConflictofInterestsPolicyDECEMBER2015FINAL.pdf

If you have a conflict of interest to declare, please complete the attached form, by clicking here and return to Sandra Judt, Board Assurance Manager at the address below or email [redacted] **by 1st April 2022.**

The following questions are useful to ask, if you are in any doubt.

- Could the Board member / employee or their family or friends gain from his / her connection to the Trust?
- How is the declared interest likely to be perceived externally?
- Could the declared personal interest damage the reputation, impartiality or integrity of the Trust?
- Is there a possibility that the declared interest might influence decision making by the Board member / employee or by others?

I would draw your attention to the additional employment section of the form. There should be no conflict of interest between staff's duties and any other job. Any additional employment must be recorded on this form.

JOB DESCRIPTION

Title of post:	Board Support and Committee Services Manager
Band:	Band 6
Location:	Chairman and Chief Executive's office Trust Headquarters Craigavon
Reports to:	Chairman
Responsible to:	Chief Executive

Job Description

The post holder will take a lead role in managing the process of agenda setting for the Trust Board and standing committees of the Board. He/she will provide a secretariat to the Board of Directors, Governance Committee, Remuneration Committee, Audit Committee and Endowments and Gifts Committee. He/she will work proactively with the Chairman and Chief Executive to secure a planned approach to matters of strategic interest and issues requiring Senior Management Team and Board action. The post holder will be responsible for the co-ordination and management of meetings of the Trust Board, Senior Management Team and standing committees of the Board to ensure effective functioning in line with Standing Orders and Standing Financial Instructions. The role will require working closely with Trust directors, and other senior staff inside and outside the organisation including the Non Executive Directors.

Principal Duties

1. Analyse all relevant information and propose an agenda to the Chief Executive or Chairman (as appropriate) in respect of Trust Board and the standing committees of the Board. Supervise the logistics of the organisation of meetings; provide members with all information needed for the meeting, ensuring that papers are issued within exact timescales. Attend the meetings and take formal minutes which, in the case of Trust Board, are published to a wide audience. Arrange for the minutes to be approved and take appropriate follow up action to ensure that tasks with action are followed up and reported at subsequent meetings.

2. Ensure all the necessary arrangements are in place at venues for meetings, including room bookings, room layout, and provision of audio visual aids, preparation of material and equipments for presentations and arranging hospitality.

3. Monitor and review the rhythm and pattern of meetings to ensure Trust objectives and development of the organisation and delivery of key objectives are met. Ensure that a schedule of Board reports is approved each year and reflected in the agendas for each Board and committee meeting.

4. Provide a secretariat to:

- Trust Board
- Audit Committee
- Governance Committee
- Remuneration Committee
- Endowments and Gifts Committee

5. Review the Terms of Reference of Committees of the Board and ensure that these are up-to-date in relation to best practice and that revisions are approved by the relevant Committee and the Board.

6. Keep under review, information provided to Board members.

7. Ensure that the Trust operates in accordance with agreed standards of corporate governance, to ethical standards appropriate to a public sector organisation and with due regard to wider societal obligations.

8. Update Standing Orders as required and ensure that new versions of Standing Orders are available to staff and Board members.

9. Ensure the regular provision of information for the Trust website in accordance with the Trust's Publication scheme.

10. Develop and maintain systems to facilitate effective administrative support, management of information and effective communication channels in connection with the business of the Board of Directors.

11. Initiate correspondence and other action at the request of the Chairman, chair of committees or Board Secretary arising from the Board or standing committees of the Board.

12. Line manage Administrative assistant (band 3) and Project Support Officer (band 4) in Chair/Chief Executive's office to deliver all responsibilities. Allocate and supervise workload.

13. Develop and supervise the population of database for Assembly Questions. Produce monthly report to SMT, Chairman and Non Executive Directors.

14. Develop and supervise the maintenance of database for Gifts and Hospitalilty Register. Provide monthly report to Senior Management Team.

15. Develop and supervise the process of Declaration of Interests and Declaration of Hospitality of Board members. Issue correspondence to Board members in respect of same and ensure up to date register is available in Chief Executive's office.

16. Develop and co-ordinate Board Development programme in conjunction with the Chairman.

17. Encourage effective team working, communications and a focus on professional development and learning.

18. Work with the Communications Manager to ensure effective channels of communication between the Board the Trust and the public.

19. Work proactively to promote positive and effective working relationships within the Chairman and Chief Executive's office.

20. Maintain effective working relationships with key stakeholders both internal and external to the Trust maintaining appropriate communication networks and presenting a professional image at all times.

21. Produce reports using given facts and figures as determined by the Chairman or Chief Executive.

22. Provide administrative and secretarial support to the Chairman and Chief Executive as required.

This job description is subject to review in 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 by the Director.

Records Management

The jobholder will be responsible to the Board Secretary for all records held, created or used as part of their business including corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

General Responsibilities

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's No Smoking Policy.
- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- Adhere to equal opportunities policy throughout the course of their employment.

- Ensure the ongoing confidence of the public in service provision.

Southern Health & Social Care Trust

Personnel Specification

Job Title: **Board Support and Committee Services Manager – Band xx**

Hours: 37.5 per week

Location: Initially College of Nursing, Craigavon Area Hospital

Essential Criteria:

Applicants must provide evidence by the closing date for application that they are a permanent employee of the Southern Health and Social Care Trust and have:

- RSA Stage III or equivalent OCR qualification in typing or wordprocessing and a minimum of 2 years experience as a personal secretary/assistant;

OR

- RSA Stage II or equivalent OCR qualification in typing or wordprocessing and a minimum of 3 years experience as a personal secretary/assistant.

(NB. With regard to RSA/OCR Typing/Word Processing, applicants who have obtained these qualifications should clearly demonstrate that they have acquired parts 1 and 2 if they have received the qualification(s) after 1986.)

- Knowledge and understanding of Role of Board of Directors, the role of standing committees of the Board.
- Proven experience in the active development and management of information and office procedures.
- A shorthand qualification.
- Experience of Microsoft office packages to include wordprocessing, powerpoint and excel.
- Experience of preparing high quality presentations and compiling the graphical presentation of information and statistics.
- Experience of minute taking and servicing meetings.
- Experience of organising conferences or events.
- Have excellent communication, organisational and time management skills.
- **Have the ability to exercise good judgement, initiative and discretion**

PERSONNEL SPECIFICATION

Title of post:	Board support and Committee Services Manager
Grade:	Band xx
Location:	Chairman and Chief Executive's office Trust Headquarters Craigavon
Reports to:	Chairman
Responsible to:	Chief Executive

Essential criteria

(Applicants must clearly demonstrate in their application form how they meet the essential criteria – only information included in the application form will be considered at short-listing stage.)

A degree or equivalent recognised qualification and one years experience in an office/administrative environment to include previous experience of servicing committees, working to specified deadlines, working with people at various levels within an organisation, and management of systems and processes

or

Four years (within the last seven years) experience in an office/administrative environment to include previous experience of servicing committees, working to specified deadlines, working with people at various levels within an organisation, and management of systems and processes.

At least one year's experience of Microsoft Office to include Word, Excel, PowerPoint, Access and Outlook.

RSA Stage II word processing or equivalent.

A sound knowledge of corporate governance issues within health and social care in Northern Ireland.

A driving licence and/or* access to a form of transport, which allows the postholder to fulfil the duties of the post.

Good organisational and planning skills.

Ability to demonstrate effective communication and interpersonal skills.

Ability to work as part of a team.

Ability to meet tight deadlines.

A proven record of ability to maintain and improve services and systems to meet standards of quality and professionalism.

(*This relates to any candidate who has declared that they have a disability which debars them from driving.)

Desirable criteria

To undertake any other duties, which may be required to meet the exigencies of the service. The postholder may be required to work outside normal office hours.

Amended: 13 December 2007
Review Date: 13 December 2008

Updated 30.7.15

Schedule of Reporting to Trust Board 2012-2013

Strategic Issues

Report =overdue	Lead Director	Frequency	Date presented to TB	Date due to TB
Transforming Your Care	Mrs P Clarke	Monthly	26th April 2012 14th June 2012 30th August 2012 25th October 2012 29th November 2012 24th January 2013 28th March 2013	
Corporate Plan	Mrs P Clarke	6-monthly	26th April 2012 25th October 2012	
Trust Delivery Plan	Mrs P Clarke		15th May 2012 30th August 2012 28th March 2013	
Internal Capital and Revenue Business Cases in excess of £300,000	Mrs P Clarke		14th June 2012 30th August 2012 24th January 2013	

Updated 30.7.15

Proposal for Integrated Partnership	Mrs A McVeigh & Mrs P Clarke		26th April 2012	
Business Case for Implementation of Long Term Arrangements for Decontamination of Community Dental Instruments	Mr P Morgan		26th April 2012	
Update on Regional Action Plan to improve performance in Emergency Departments in Northern Ireland	Dr G Rankin		26th April 2012	
Strategic Review of Minor Injuries Units in SHSCT – Implementation Plan	Mrs A McVeigh & Dr G Rankin		30th August 2012 24th January 2013	
Minor Injuries Units Activity	Dr G Rankin		28th March 2013	
RQIA Radiology Review – SHSCT Phase II and Composite Action Plan for Phases I and III	Dr G Rankin		15th May 2012	

Updated 30.7.15

Proposal for the future of Addiction Services	Mr F. Rice		30th August 2012	
General Capital Allocation	Mrs P. Clarke		30th August 2012	
Daisy Hill Hospital (DHH) Additional Theatre Accommodation Project	Mrs P Clarke		28th March 2013	
"Who Cares? The Future of Adult Care and Support in Northern Ireland" – Trust Response	Mrs A McVeigh		24th January 2013 28th March 2013	
Community Information System	Mr F Rice		14th June 2012	
Business Case for Newry CCTC	Mrs P Clarke		24th January 2013	
"Hope, Confidence & Certainity" – Key Themes and Priorities for Action 2013-16 Report: SHSCT Response	Mrs A McVeigh		24th January 2013	
SHSCT Strategy "Changing for a Better Future" 2013-2015	Mrs P Clarke		28th March 2013	

Updated 30.7.15

Proposal to Cease Admissions to Statutory Residential homes for Older People	Mrs A McVeigh		28th March 2013	

Updated 30.7.15

Patient/Client Safety and Quality of Care

Report =overdue	Lead Director	Frequency	Date presented to TB	Date due to TB
Executive Director of Social Work Report	Mr P Morgan	Monthly	30th August 2012 25th October 2012 29th November 2012	
Unallocated Child Care Cases	Mr P Morgan	Monthly	26th April 2012 14th June 2012 30th August 2012 24th January 2013 28th March 2013	
Corporate Parenting Report 2010-11 and Action Plan** ** Action Plan at Governance Cttee on 4th December 2012	Mr P Morgan	6-Monthly	31st May 2012 29th November 2012	May 2013 November 2013
Annual Report on the Discharge of Delegated Statutory Functions	Mr P. Morgan	Annually	31st May 2012	May 2013

Updated 30.7.15

Progress Report on Protect Life and Lifeline	Mr F. Rice	Annually	25th October 2012	October 2013
Executive Director of Social Work – Progress on Family Support Hubs	Mr P Morgan		30th August 2012	
Executive Director of Social Work – Child Protection Panel Annual Report	Mr P Morgan	Annually	30th August 2012	
Medical Director's Report	Dr J Simpson	Monthly	26th April 2012 14th June 2012 30th August 2012 25th October 2012 29th November 2012 24th January 2013 28th March 2013	
HCAI Report	Dr J Simpson	Monthly	26th April 2012 14th June 2012 30th August 2012 25th October 2012 29th November 2012 24th January 2013 28th March 2013	

Updated 30.7.15

Organisation of Care Progress update	Mr F Rice & Dr G Rankin		26th April 2012 30th August 2012	
SHSCT Carer's Action Plan 2012/13	Mrs A McVeigh & Mr E Graham		24th January 2013	
Discharging Patients at Night	Dr G Rankin		30th August 2012	
Introduction of (NEWS) – National Early Warning System	Dr G Rankin		30th August 2012	
RQIA Report on Review of Mixed Gender Accommodation	Dr G Rankin		30th August 2012	
Update on Southern Outcomes Group	Mr P. Morgan			
Executive Director of Nursing Report	Mr F. Rice		14th June 2012 29th November 2012 28th March 2013	
Report on Compliance of the 7 AHP Disciplines with Core & Professional Specific AHP Quality Indicators	Mr F Rice		26th April 2013	

Updated 30.7.15

Water Safety Action Plan	Mrs P Clarke		25th October 2012	
DHSSPS Medicines Inspectorate – Findings of Annual Inspection	Dr G. Rankin	Annually		
Report of Aseptic Services Inspection	Dr G. Rankin	Annually		
Palliative Care Clinical Coding	Mrs P Clarke		28th March 2013	
NI Point Prevalence Survey, Preliminary Report 2012	Dr J Simpson & Dr Damani		24th January 2013	
Disability Action Plan	Mr K Donaghy		24th January 2013	
Disability Action Plan Outcomes Report	Mr K Donaghy		24th January 2013	

Updated 30.7.15

Operational Performance

Report =overdue	Lead Director	Frequency	Date presented to TB	Date due for TB
Performance Report	Mrs P. Clarke	Monthly	31st May 2012 *(2011/12)* 14th June 2012 *(D Sullivan)* 30th August 2012 25th October 2012 29th November 2012 24th January 2013 28th March 2013	
Finance Report	Mr S. McNally	Monthly	30th August 2012 25th October 2012 29th November 2012 24th January 2013 28th March 2013	
Human Resources Report	Mr K. Donaghy	Monthly	14th June 2012 30th August 2012 25th October 2012 29th November 2012 24th January 2013 28th March 2013	

Updated 30.7.15

Financial Resource Budget 2012/13	Mr S. McNally	Annually	14th June 2012	June 2013
Capital Resource Limit Performance Report	Mr S. McNally	Annually	14th June 2012	
Staff Pension Scheme Automatic Enrolment	Mr K Donaghy		28th March 2013	
DHSSPS Board Governance Self-Assessment Tool	Mrs R Brownlee	Annually	28th March 2013	March 2014
Southern Trust Management Statement	Mr S McNally		26th March 2012	

Updated 30.7.15

Board Reports

Report =overdue	Lead Director	Frequency	Date Presented to TB	Date due to TB
Board Assurance Framework	Mrs M McAlinden	6-Monthly	25th October 2012	October 2013
Draft Annual Report	Mr S McNally	Annually	14th June 2012	June 2013
Draft Annual Report and Accounts for the year ended 31 March 2012 – Trust Funds – For Sign Off	Mr S. McNally	Annually	30th August 2012	August 2013
Draft Report to those charged with Governance 2010/11 – Trust Funds	Mr S. McNally	Annually	25th October 2012	October 2013
Letters of Representation – Trust Funds Accounts – For Sign Off	Mr S. McNally	Annually	30th August 2012	August 2013
Report to Those charged with Governance – charitable Trust fund Accounts – year ended 31	Mr S McNally	Annually	24th January 2013	January 2014

Updated 30.7.15

March 2012 Approval of Write Off of Losses	Mr S McNally	Annually	14th June 2012 and 28th March 2013 !!!	
Controls Assurance Standards Report on Compliance 2011/12	Mrs M McAlinden		14th June 2012	June 2013
Decontamination of Reusable Medical Devices Annual Report 2011/12	Dr G Rankin	Annually	25th October 2012	October 2013
Emergency Planning and Business Continuity: Corporate Emergency Management Plan SHSCT Acute Hospital Major Incident Plan Business Continuity Management – Business Impact Analysis Report Multi-Agency Emergency Support Centre Plan – Southern	Dr J. Simpson		 24th January 2013 24th January 2013 24th January 2013 24th January 2013	 January 2014 January 2014 January 2014 January 2014

Updated 30.7.15

Area				
Emergency Preparedness Annual Report 2010/11	Dr J. Simpson	Annually	26th April 2012	April 2013
Emergency Preparedness Annual Report 2011/12	Dr J Simpson	Annually	14th June 2012	June 2013
Environmental Cleanliness Annual Report 10/11	Dr G. Rankin	Annually	26th April 2012	April 2013
Environmental Cleanliness Annual Report 11/12	Dr G. Rankin		25th October 2012	October 2013
Estates Annual Report	Mrs P Clarke	Annually	29th November 2012	November 2013
Fire Safety Management Annual Report 2011/12	Mrs P Clarke	Annually		
Food Hygiene Annual Report 2011/12	Dr G Rankin	Annually	25th October 2012	October 2013
Health and Safety Report	Mr K Donaghy	Annually		

Updated 30.7.15

ICT Business Plan 2011/12	Mrs P Clarke	Annually	25th October 2012	October 2013
Infection Prevention Control	Dr J. Simpson	Annually	29th November 2012	November 2013
Information Governance Annual Report 2011/12	Mrs P Clarke	Annually		
Information Technology Report	Mrs P. Clarke	Annually	26th April 2012	March 2013
Medical Devices and Equipment Management Annual Report 2011/12	Dr G Rankin	Annually	28th March 2013	March 2014
Medical Education and Training	Dr J Simpson	Annually		
Medical Staff Appraisal and Revalidation	Dr J Simpson	Annually		
Mid-Year Assurance Statement	Mr S McNally	Annually	25th October 2012	October 2013
Records Management and Information Governance Annual Report 2011/12	Mrs P Clarke	Annually		
Register of Interests 2012/13	Mrs R Brownlee	Annually	25th October 2012	October 2013

Updated 30.7.15

Research and Development Annual Report 2011/12	Dr J Simpson	Annually		
Risk Management Annual Report 2011/12	Dr P Loughran	Annually		
Section 75 New Equality Scheme and Action based Plan Section 75 Annual Progress Report 5-Year Review Equality Scheme Report	Mr K Donaghy Mr K Donaghy Mr K Donaghy	Annually Annually Annually	30th August 2012	August 2013
Security Management Annual Report 2011/12	Dr G Rankin	Annually	25th October 2012	October 2013
Statement of Internal Control	Mr S McNally	Annually		
Waste Management Annual Report 2011/12	Mrs P Clarke	Annually		

Updated 30.7.15

Board Committees

Report	Lead	Frequency	Date Presented to TB	Date Due for TB
Audit Committee Minutes of Meeting – 13.10.11 Feedback from meeting 1.2.12 Minutes of Meeting – 16.2.12 Feedback from meeting – 24.5.12 Minutes of Meetings on – 24.5.12 and 12.6.12 Feedback from meeting – 18.10.12 Revised Terms of Reference	Mrs E Mahood		 26th April 2012 26th April 2012 14th June 2012 14th June 2012 25th October 2012 25th October 2012 29th November 2012	

Updated 30.7.15

Minutes of Meeting – 18.10.12 Feedback from Meeting – 17.1.13 Feedback from Meeting on 7.3.13			24th January 2013 24th January 2013 28th March 2013	
<u>Governance Committee</u> Minutes of Meeting – 7.2.12 Feedback from Meeting – 15.5.12 Minutes of Meeting – 15.5.15 Feedback from Meeting – 11.9.15 Revised Terms of Reference	Dr R Mullan	Dr R Mullan	 14th June 2012 14th June 2012 25th October 2012 25th October 2012 29th November 2012	

Updated 30.7.15

Minutes of Meeting – 11.9.12 Feedback from meeting on 4.12.12 Minutes of Meeting – 4.12.12 Feedback from meeting on 5.2.13			24th January 2013 24th January 2013 28th March 2013 28th March 2013	
<u>Endowments &Gifts Committee</u> Minutes of meeting – 16.1.12 Feedback from meeting – 2.4.12 Minutes of meeting – 2.4.12 Feedback form meeting – 13.8.12 Minutes of Meeting – 13.8.12 Feedback from	 Dr R Mullan Mrs H Kelly		 26th April 2012 26th April 2012 13th August 2012 13th August 2012 25th October 2012	

Updated 30.7.15

meeting – 15.10.12 Revised Terms of Reference Minutes of Meeting – 15.10.12 Feedback from Meeting on 21.1.13			25th October 2012 29th November 2012 28th March 2013 28th March 2013	
<u>Patient Client Experience Committee</u> Minutes of Meeting – 1.12.11 Feedback from meeting – 8.3.12 Minutes of Meeting – 8.3.12 Feedback from Meeting – 20.9.12 Minutes of Meeting – 20.6.12 Feedback from	Mr E Graham		26th April 2012 26th April 2012 25th October 2012 25th October 2012 24th January 2012 24th January 2014	

Updated 30.7.15

meeting – 6.2.13 Revised Terms of Reference Minutes of Meeting – 6.12.12 Feedback from Meeting – 14.3.13			24th January 2014	
<u>Remuneration Committee</u> Revised Terms of Reference	Mrs R Brownlee		28th March 2013	

Updated 30.7.15

CONFIDENTIAL AGENDA – TRUST BOARD

2012 – 2013

Agenda item	Frequency of Presentation	Lead Director	Date presented to Board
Feedback from Remuneration Committee	As required	Mrs R. Brownlee	
SAIs	As required	Chief Executive	
RCAs	As required	Chief Executive	
RQIA Reviews	As required		
Child Protection Annual Report		Mr. P. Morgan	

Southern Health and Social Care Trust

JOB DESCRIPTION

JOB TITLE Committee Secretary

BAND 4

DIRECTORATE Chairman and Chief Executive Office

INITIAL LOCATION Trust Headquarters, Craigavon Area Hospital

REPORTS TO Board Secretary

ACCOUNTABLE TO Chairman

JOB SUMMARY

The post holder will be responsible for the efficient and effective servicing of committees of the Trust Board and the Senior Management Team and the provision of administrative support to the Board Secretary. The post holder will be responsible for the co-ordination of their workload to support the role of the Board Secretary and for ensuring that deadlines are met.

KEY DUTIES / RESPONSIBILITIES

- Ensuring the effective servicing of meetings of the Trust Board, sub committees of the Board e.g. Audit Committee, Governance Committee, Endowments and Gifts Committee.
- Maintain an effective bring forward system for matters relating to meetings and ensure the effective follow up of information and actions arising from meetings.
- Service all meetings including the preparation of agendas and papers: the management of arrangements for presentations, production of minutes and the progression of business.
- Research, collate and prepare information and reports as necessary.
- Make all the necessary arrangements at venues for meetings, including room bookings, provision of audio visual aids and hospitality.

- Ensure the necessary information is channelled to and from the committees and to and from individuals involved in Board and Executive business.

- Utilise an electronic document management system to support the information needs associated with the role of the Trust Board and its committees.

- Provide secretarial support to the Board Secretary – this will include diary management, mail management, file maintenance, effective messaging and the management of a 'bring forward' system.

- Make travel arrangements for attendance at conferences and meetings etc.

- Maintain effective working relationships with key stakeholders both internal and external to the Trust, maintaining appropriate communication networks and presenting a professional image appropriate to the offices of the Chairman, Chief executive and Board Secretary.

- As required provide secretarial and administrative support to other members of the senior management team.

This job description is subject to review in 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 by the Director.

RECORDS MANAGEMENT

The job holder will be responsible to the Board Secretary for all records held, created or used as part of their business including corporate and administrative records whether paper based or electronic and also including emails. All such records and public records are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

GENERAL RESPONSIBILITIES

Employees of the Trust will be required to promote the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.

- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's no smoking policy.

Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

JOB TITLE Committee Secretary

DIRECTORATE Chairman and Chief Executive Office

SALARY

HOURS

Ref No:

Essential Criteria:

Applicants must provide evidence by the closing date for application that they are a permanent employee of the Southern Health and Social Care Trust and have:

- RSA Stage III or equivalent OCR qualification in typing or word processing and a minimum of 2 years experience as a personal secretary/assistant

  OR

- RSA Stage II or equivalent OCR qualification in typing or word processing and a minimum of 3 years experience as a personal secretary/assistant

  (NB. With regard to RSA/OCR Typing/Word Processing, applicants who have obtained these qualifications should clearly demonstrate that they have acquired parts 1 and 2 if they have received the qualification(s) after 1986)

- Proven experience of effective minute taking

- Experience of Microsoft office packages to include word processing, powerpoint and excel.

- Experience of preparing high quality presentations and compiling the graphical presentation of information and statistics.

- Experience of minute taking and servicing minutes.
- Experience of organizing conferences or events.
- Have excellent communication, organizational and time management skills.
- Have the ability to exercise good judgment, initiative and discretion
- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- Adhere to equal opportunities policy throughout the course of their employment.
- Ensure the ongoing confidence of the public in service provision.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

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

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Committee Secretary Band 4

Staff Number: Personal Information redacted by the USI

Is Professional Registration up to date? N/A

KEY ISSUES & OUTCOMES	COMMENTS
Personal Information redacted by the USI	

Reviewee Staff Name (Print) Personal Information redacted by the USI

Signature Personal Information redacted by the USI

Date 19/12/16.

Reviewer Manager/Supervisor (Print) Personal Information redacted by the USI

Signature Personal Information redacted by the USI

Date 19/12/2016

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

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: Personal Information redacted by the USI

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	August 2006	
	Departmental Induction/Orientation	May 2016	
	Fire Safety	October 2016	
	Record Keeping/Data Protection	August 2014	(3 Yearly)
	Moving and Handling	August 2014	(3 Yearly)
Corporate Mandatory Training ROLE SPECIFIC	Infection Prevention Control	March 2015	(2 Yearly)
	Safeguarding People, Children & Vulnerable Adults	November 2015	(3 Yearly)
	Data Protection	August 2014	(3 Yearly)
	Waste Management	N/A	
	Right Patient, Right Blood (Theory/Competency)	N/A	
	Control of Substances Hazardous to Health (COSHH)	N/A	
	Food Safety	N/A	
	Basic ICT	N/A	
	MAPA (level 3 or 4)	N/A	
Essential for Post	Professional Registration	N/A	
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) Personal Information redacted by the USI Signature Personal Information redacted by the USI Date 19/12/16

Reviewer Manager/Supervisor (Print) Personal Information redacted by the USI Signature Personal Information redacted by the USI Date 19/12/2016

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: - Personal Information redacted by the USI

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

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: COMMITTEE SECRETARY – BAND 4 **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? _____

KEY ISSUES & OUTCOMES	COMMENTS
Personal Information redacted by the USI	

Reviewee Staff Name (Print Personal Information redacted by the USI Signatu Personal Information redacted by the USI Date 19/12/2016

Reviewer Manager/Supervisor (Print) Personal Information redacted by the USI Signature Personal Information redacted by the USI Date 19/12/2016

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

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: _____

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction		
	Departmental Induction/Orientation		
	Fire Safety	13th June 2016	
	Record Keeping/Data Protection	19th December 2016	
	Moving and Handling		
Corporate Mandatory Training ROLE SPECIFIC	Infection Prevention Control		
	Safeguarding People, Children & Vulnerable Adults		
	Waste Management		
	Right Patient, Right Blood (Theory/Competency)		
	Control of Substances Hazardous to Health (COSHH)		
	Food Safety		
	Basic ICT		
	MAPA (level 3 or 4)		
Essential for Post	Professional Registration		
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) Personal Information redacted by the USI Signatur Personal Information redacted by the USI Date 19/12/2016

Reviewer Manager/Supervisor (Print) Personal Information redacted by the USI Signature Personal Information redacted by the USI Date 19/12/2016

PLEASE SEND COMPLETED **PART B** TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: Personal Information redacted by the USI

Commenced: 16 May '12

PROBATIONARY REPORT (3 MONTHS)

Appendix 1

NAME: Personal Information redacted by the USI	**POST: Board Assurance Manager Band 7**
DEPT: Trust Headquarters, CAH site	**STAFF No:** Personal Information redacted by the USI

DATE OF APPOINTMENT	PERIOD COVERED BY REVIEW	ABSENCES DURING REVIEW PERIOD AND REASONS
		Personal Information redacted by the USI

TRAINING UNDERTAKEN DURING REVIEW PERIOD

Personal Information redacted by the USI

RESPONSE TO TRAINING

Personal Information redacted by the USI

PERFORMANCE DURING REVIEW PERIOD

MAIN TASKS UNDERTAKEN	ACHIEVEMENTS/COMMENTS RE: PERFORMANCE
Personal Information redacted by the USI	Personal Information redacted by the USI

ARE YOU SATISFIED WITH EMPLOYEE'S PROGRESS TO DATE: YES/~~NO~~

ADDITIONAL COMMENTS/ACTION TO BE TAKEN TO IMPROVE PERFORMANCE (3 MONTHS)

Personal Information redacted by the USI

Signed: Personal Information redacted by the USI **(Manager)** **Date:** 4/9/12

Signed: Personal Information redacted by the USI **(Probationer*)** **Date:** 4.9.2012

* **Signature confirms that the above review has been discussed with you.**

Copy to: Probationer and Employee Engagement and Relations – HR Department (along with completed 6 month report)

PROBATIONARY REPORT (6 MONTHS)

Commenced: 16 May '12

Appendix 2

NAME: Personal Information redacted by the USI	**POST:** Board Assurance Manager Band 7
DEPT: Trust Headquarters, CAH site	**STAFF No:** Personal Information redacted by the USI

DATE OF APPOINTMENT	PERIOD COVERED BY REVIEW	ABSENCES DURING REVIEW PERIOD AND REASONS
		Personal Information redacted by the USI

AINING UNDERTAKEN DURING REVIEW PERIOD

Personal Information redacted by the USI

RESPONSE TO TRAINING

Personal Information redacted by the USI

PERFORMANCE DURING REVIEW PERIOD

MAIN TASKS UNDERTAKEN	ACHIEVEMENTS/COMMENTS RE: PERFORMANCE
Personal Information redacted by the USI	Personal Information redacted by the USI

ARE YOU SATISFIED WITH EMPLOYEE'S PROGRESS TO DATE: YES/~~NO~~

RECOMMENDATION REGARDING CONFIRMATION OF APPOINTMENT (6 MONTHS)

Personal Information redacted by the USI

Signed: Personal Information redacted by the USI **(Manager)** **Date:** 16/1/13

Signed Personal Information redacted by the USI **(Probationer*)** **Date:** 16.1.2013

* **Signature confirms that the above review has been discussed with you.**

Copy to: Probationer and Employee Engagement and Relations – HR Department (along with completed 3 month report)

Southern Health and Social Care Trust

KSF APPRAISAL FORM

SECTION 1- BACKGROUND INFORMATION ON THE INDIVIDUAL, THEIR POST AND THE REVIEWER

Personal Information redacted by the USI

Southern Health and Social Care Trust

KSF APPRAISAL FORM

SECTION 2 (page 1) - RECORDING DEVELOPMENT REVIEW DECISIONS

NHS KSF dimensions and their level - CORE	Achieved	Areas for development	Evidence for decision	Comments
Personal Information redacted by the USI				

Southern Health and Social Care Trust

KSF APPRAISAL FORM

Personal Information redacted by the USI

[redacted]

Southern Health and Social Care Trust

KSF APPRAISAL FORM

Personal Information redacted by the USI

Southern Health and Social Care Trust

KSF APPRAISAL FORM

Personal Information redacted by the USI				

Southern Health and Social Care Trust

KSF APPRAISAL FORM

Personal Information redacted by the USI

[redacted]

Southern Health and Social Care Trust

KSF APPRAISAL FORM

Personal Information redacted by the USI

[redacted]

Southern Health and Social Care Trust

KSF APPRAISAL FORM

Personal Information redacted by the USI

Southern Health and Social Care Trust

KSF APPRAISAL FORM

Personal Information redacted by the USI

[redacted]

Southern Health and Social Care Trust

KSF APPRAISAL FORM

SECTION 2 (page 2) - RECORDING DEVELOPMENT REVIEW DECISIONS

NHS KSF dimensions and their level - SPECIFIC - add those agreed for post below	Achieved	Areas for development	Evidence for decision	Comments
[redacted]				

Personal Information redacted by the USI

Southern Health and Social Care Trust

KSF APPRAISAL FORM

Personal Information redacted by the USI

[redacted]

Trust/Directorate/Team Objectives	Achieved	Areas for development	Evidence for decision	Comments
Personal Information redacted by the USI [redacted]				

Southern Health and Social Care Trust

KSF APPRAISAL FORM

Personal Information redacted by the USI

[redacted]

Southern Health and Social Care Trust

KSF APPRAISAL FORM

SECTION 3 - RECORDING THE PERSONAL DEVELOPMENT PLAN (PDP)

(Remember development can include shadowing, reading, reflection, coaching, instruction)

Learning Objective linked to KSF/Trust Objective What do I need to do differently or know about to achieve my goals?	**Action Required** How will I achieve this?	**Resources** Method of learning? Who will arrange this? Timescale?	**Evaluation** Once completed what difference has this made? If not completed state reasons and onward plan	**Who could this learning be shared with?**
Personal Information redacted by the USI				

Southern Health and Social Care Trust

KSF APPRAISAL FORM

Signature of individual	Personal Information redacted by the USI	Date 12/5/09	Name of individual Personal Information redacted by the USI
Signature of reviewer		Date 12/5/09	Name of reviewer Personal Information redacted by the USI
Line Manager if Different from Reviewer		Date	Name of Line Manager

(please complete PDP and return to Education, Learning & Development, Lurgan HSSC, 100 Sloan Street, Lurgan BT66 8NT)

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

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Board Assurance Manager (7) **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? N/A

KEY ISSUES & OUTCOMES	COMMENTS
Personal Information redacted by the USI	

Reviewee Staff Name (Print) Personal Information redacted by the USI Signature Personal Information redacted by the USI Date 13/12/16

Reviewer Manager/Supervisor (Print) Personal Information redacted by the USI Signature Date 13/12/16

Southern Health and Social Care Trust

Quality Care - for you, with you

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

CODE OF CONDUCT FOR HSC EMPLOYEES

SEPTEMBER 2016

HSC Code of Conduct for Employees

This Code of Conduct is about the values for which we, as HSC staff, stand. The Code sets out the core standards of conduct expected of all HSC Staff. It has been written to complement existing professional codes of practice.

Professional staff are expected to follow the code of conduct for their own professions as well as this code.

The code aims:

- To guide staff, managers and employers in the work that they do and the decisions and choices they have to make; and
- To reassure the public that these important decisions are being made against a background of professional standards and accountability.

Adherence to the Code is mandatory for all employees, regardless of their status and breaches of the Code will be regarded as serious.

HSC staff are highly principled and value-driven people who will welcome this Code and exemplify the expected behaviours. All staff within HSC are responsible for, and have a duty of care, to ensure their conduct does not fall below the standards detailed in this Code and that no act or omission, within the sphere of their role, harms the safety and well-being of patients/clients and service users and their families. The Code is a set of values which should inform development programmes and training for all staff. It should make us all think exactly how we are going to work, how we make the care and safety of patients our first concern and how we respect the public, patients, clients, service users relatives and carers. If, however, the conduct and behaviours of staff falls short of the public's expectations this reflects poorly on the HSC as seriously as failures by clinical and care staff.

Breaches of the Code must be investigated fairly and employers should adopt a proportionate approach. Just as the Code sets out how all staff should behave and their responsibilities, you also have rights. You have the right to be treated with respect, evaluated consistently and fairly, encouraged to maintain and improve your knowledge and skills and to be helped to balance your work and home lives properly. HSC Employers must provide and promote an organisational culture which values and supports staff and teams.

This Code of Conduct applies to **all** HSC Staff, across all HSC Trusts and HSC Arms Length Bodies. This code incorporates the principles contained within the Code of Conduct for HPSS Managers 2003 and supersedes it.

This Code is also consistent with the 7 principles of public life, ('the Nolan Principles') which applies to everyone working as a public office-holder and therefore should govern the conduct of all health and social care staff.[1]

[1] https://www.gov.uk/government/publications/the-7-principles-of-public-life

1. INTRODUCTION

This Code of Conduct (the Code) sets out the standards of conduct expected of all staff in the Southern Health and Social Care Trust.

It presents the standards of conduct and behaviours required of all staff and informs employers, colleagues, patients/clients service users and the public about these.

The Code refers to “employees”, however, for the purposes of this document, this definition also applies to all workers (Agency & Bank), volunteers and work placements.

Adherence to the Code is an integral part of employees’ contractual responsibilities during their employment with the Southern HSC Trust.

- The behaviour of employees should reflect the organisation’s mission and values at all times.

- Employees must not use their privileged position to neglect, harm, abuse or exploit patients/clients/service users or their families.

- Employees should familiarise themselves with the contents of the Code and should act in accordance with the principles set out in it.

1.1 Overall principles & undertakings

As an HSC employee, I will observe the following principles:

- make the **care and safety of patients and clients** my first concern and act to protect them from risk;

- contribute to improving and protecting the health of the population as appropriate to my role;

- maintain **confidentiality,** respecting and protecting, at all times patients/clients, service users and their families’ right to confidentiality, privacy and dignity;

- **communicate openly and honestly** to promote the health and well-being of patients/clients, service users and their families.

- **respect** the public, patients, clients, relatives, carers, HSC employees and teams and partners in other agencies. I will also **show my commitment** to working constructively as a team member by working collaboratively with all my colleagues in the HSC and the wider community;

- **be accountable** and accept **responsibility** for my own work and be **honest and act with integrity**;

- sharing **responsibility for my own learning and development** in order to improve the quality of care to patients/ clients/service users and their families

Managers' Responsibilities

I will also endeavour to ensure that;

- HSC staff in my team are:
    - valued as individuals, colleagues and are treated with dignity and respect;
    - appropriately informed about the management of the HSC;
    - given appropriate opportunities to take part in continuous design, review and improvement of services;
    - have their ideas and realistic ambitions taken seriously;
    - given protection from harassment and bullying;
    - provided with a safe working environment;
    - helped to maintain and improve their knowledge and skills and developed to achieve their potential; and
    - helped to achieve a reasonable balance between their working and personal lives.

These principles are described in more detail in *Section **2*** below.

2. DESCRIPTION OF PRINCIPLES

2.1 Care & safety of patients & clients

I will;

- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public, patients and clients;
- be guided by the interests of patients and clients;
- ensure a safe working environment;
- act to protect patients and clients from risk by adhering to relevant legislation and putting into practice appropriate policies and procedures;
- work collaboratively with colleagues across all disciplines to support person-centred care/services.

2.2 Confidentiality

I will;

- respect patient, client and staff confidentiality;
- not, except in the performance my job role and duties with the organisation, divulge to any person in any manner whatsoever, any confidential information covering the business or transactions of the organisation and its activities and/or its patients, clients or employees[2], unless ordered to do so by a Court or Tribunal. I will make every effort to prevent disclosure of such information. I will not use social media to share information about the environment I work in or the patients/clients/service users for whom I care.
- comply with all relevant organisation policies in relation to the use of information associated with my role and in particular with reference to the personal use of social networking sites[3].

[2] Code of Practice on Protecting the Confidentiality of Service User Information
[3] Social Media Policy

- comply with my obligations under the Data Protection Act (1998) and Freedom of Information Act (2000) through the Organisation's information governance training. [4]

2.3 Respect for others & working as a team

I will;

- respect and treat with dignity and fairness, the public, patients and clients, relatives, carers, HSC employees and partners in other agencies. I will not unlawfully discriminate against, victimise or harass against anyone on grounds of their gender, marital/civil partnership status, sexual orientation, community background, political opinion, religious belief, race, age disability, family status, whether or not they have dependents or are persons who have undergone, are undergoing or intend to undergo gender reassignment.

- seek to ensure that anyone with a genuine concern is treated reasonably and fairly

- show my commitment to working as part of the department and Organisation team

I will show my commitment to team working by working constructively with all my colleagues across the HSC and in the wider community, contributing to an environment in which:

- teams of staff are able to work together in the best interests of service users; and

- leadership is encouraged and developed at all levels and in all staff groups

2.4 Accountability, Responsibility, Honesty & Integrity

I will;

- establish and maintain clear and appropriate boundaries at all times in my relationships with patients/clients/service users and their families, and with colleagues, always behaving in a professional manner;

[4] Data Protection Policy

- accept responsibility for my own work and ensure that I am responsible for answering any questions and complaints in an open, honest way.

- be honest and act with integrity and probity at all times and ensure that HSC resources are protected from fraud, bribery and other forms of corruption[5]

- not use my official position to receive, agree to accept or attempt to obtain any financial or other advantage for doing, or not doing, anything or showing favour, or disfavour, to any person[6].

- not receive benefits of any kind from a third party which might reasonably be seen to compromise my personal judgment and integrity.

- not deceive or mislead my employer, or any other organisation it deals with, or the public during the course of my employment with the HSC.

- abide by the rules adopted by my employer in relation to private interest and possible conflict with public duty, the disclosure of official information and in any political activities.

- not misuse my official position or information acquired in my official duties to further my private interests or those of others.

I will ensure proper management of the performance of my team and I will seek to ensure that those I manage accept that they are responsible for their actions to both;

- the public and their representatives; and

- service users, relatives and carers by answering questions and complaints in an open and honest manner.

I will also;

- accept responsibility for the management of the performance of the people I manage;

- seek to ensure that judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and include all information which

[5] Fraud Policy
[6] Gifts, Hospitality & Sponsorship Policy, Conflicts of Interest Policy, Fraud Policy, Bribery Policy

affects a colleague's performance, eligibility for advancement/reward and conduct; and

- play my part in making sure that no-one is unlawfully discriminated against and that policies on equality, diversity and human rights are promoted and adhered to at all times.

2.6. Responsibility for my own learning and development

I will seek to;

- Participate in training and personal development required by my employer and take responsibility for the achievement of the competence essential for your role, in line with KSF and organisational requirements

- Keep up to date with best practice and maintain an up-to-date record of your own learning and development

- Share my learning as appropriate and contribute to the learning and development of others

3. Employee concerns about improper conduct

If you believe you are being required to act in a way which:

- is illegal, improper, or unethical;
- is in breach of a professional code;
- may involve possible maladministration, fraud or misuse of public funds; or
- is otherwise inconsistent with this Code

you should either raise the matter through your line management or alternatively, approach in confidence, a nominated officer under the Trust's Whistleblowing Policy[7].

You should make yourself aware of the provisions of the Trust's Whistleblowing Policy.
The Chief Executive, who is the designated accounting officer for the Trust, has overall responsibility for propriety in a broad sense, including conduct and discipline.

[7] Whistleblowing Policy

I will;

- act to protect service users from harm, injury or loss by identifying and reducing risk by putting into practice the appropriate support, supervisory and disciplinary procedures for staff;

- seek to ensure that anyone with a concern is taken seriously and treated fairly in accordance with relevant procedures; and

- contribute to the creation of an open and learning organisation where concerns about individuals perceived to be breaking the Code of Conduct can be raised without fear

4. AFTER LEAVING EMPLOYMENT

You should continue to observe your duty of confidentiality after you have left your employment with the HSC.

Sandra Judt

My courses

Available courses | Courses in progress | **Completed courses**

SHSCT_Infection Prevention and Control Tier 1A

100% complete **Date completed** 13/07/2017 **(Valid until** 13/07/2019) **Final score - 83%**

SHSCT_Manual Handling Awareness (Regional)

100% complete **Date completed** 13/07/2017 **(Valid until** 12/07/2020) **Final score - 100%**

Download course certificate:

Information Governance Awareness

100% complete **Date completed** 05/10/2018 **(Valid until** 04/10/2021) **Final score - 87%**

Download course certificate:

SHSCT_Fire Awareness (Regional)

100% complete **Date completed** 05/10/2018 **(Valid until** 05/10/2019) **Final score - 100%**

Download course certificate:

Recruitment and Selection

100% complete **Date completed** 14/01/2019 **(Valid until** 13/01/2022) **Final score - 100%**

Download course certificate:

SHSCT_Infection Prevention and Control Tier 1A

100% complete **Date completed** 17/06/2019 **(Valid until** 16/06/2021) **Final score - 100%**

SHSCT_Fire Awareness (Regional)

100% complete **Date completed** 03/10/2019 **(Valid until** 02/10/2020) **Final score - 100%**

Download course certificate:

Cyber Security Awareness (Regional)

100% complete **Date completed** 10/10/2022 **(Valid until** 09/10/2025) **Final score - 100%**

Download course certificate:

Information Governance Awareness

100% complete **Date completed** 10/10/2022 **(Valid until** 09/10/2025) **Final score - 100%**

Download course certificate:

Infection Prevention and Control Tier 1

100% complete **Date completed** 10/10/2022 **(Valid until** 09/10/2024) **Final score - 100%**

Download course certificate:

Equality, Good Relations and Human Rights:Making a Difference (Regional)

100% complete **Date completed** 10/10/2022 **(Valid until** 09/10/2025) **Final score - 100%**

Download course certificate:

Download course certificate:

SHSCT_Manual Handling Awareness (Regional)

100% complete **Date completed** 10/10/2022 **(Valid until** 09/10/2025) **Final score - 100%**

Download course certificate:

You are logged in as [redacted] ([redacted])

APPENDIX 2

FINANCIAL MEMORANDUM

BETWEEN

The Department of Health

And

Southern Health & Social Care Trust

September 2017

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

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

Agreement of Terms

This Financial Memorandum sets out the strategic control framework within which Southern Health & Social Care Trust (SHSCT) is required to operate, including the conditions under which government funds are provided as detailed in Managing Public Money Northern Ireland (MPMNI). It aims to achieve prudent and effective management of resources by SHSCT, combined with a reasonable degree of day-to-day freedom for SHSCT to manage its operations.

The Memorandum has been drawn up by the Department of Health as the sponsor Department, in consultation with the SHSCT, which agrees to conduct its finances within the conditions contained herein. The contents of the Memorandum have been approved by the Department of Finance. It will remain in force and binding on the SHSCT until such time as it is reviewed and/or revised by the sponsor Department.

SIGNED ON BEHALF OF THE DEPARTMENT OF HEALTH

Personal Information redacted by the USI

PERMANENT SECRETARY

DATE: 13/10/17

SIGNED ON BEHALF OF SHSCT

Personal Information redacted by the USI

CHIEF EXECUTIVE

DATE: 26/9/17

FINANCIAL MEMORANDUM

BETWEEN

THE DEPARTMENT OF HEALTH (DOH)
AND
SHSCT

1. INTRODUCTION

1.1. This Financial Memorandum sets out certain aspects of the financial framework within which the SHSCT is required to operate.

1.2. The terms and conditions set out in the combined Management Statement and Financial Memorandum (MS/FM) may be supplemented by guidelines or directions issued by the sponsor Department/Minister in respect of the exercise of any individual functions, powers or duties of the SHSCT.

1.3. The Trust should follow the standards, rules, guidance and advice in MPMNI and satisfy the conditions and requirements set out in the combined MS/FM document, together with such other conditions as the sponsor Department/Minister may from time to time impose.

2. INCOME AND EXPENDITURE- GENERAL

2.1. The Departmental Expenditure Limit (DEL)

2.1.1. SHSCT's current and capital expenditure form part of the sponsor Department's Resource DEL and Capital DEL respectively.

2.2. Expenditure not proposed in the budget/Delegated Limits

2.2.1. SHSCT must not enter into any commitments or incur expenditure above pre-defined limits as set out in the delegated arrangements or which incur expenditure which is not provided for in the annual budget as approved by the sponsor Department. This reflects the general principles set out in MPMNI relating to the authority for expenditure, regularity, propriety and value for money which apply to all public expenditure.

2.2.2. SHSCT shall not, without prior sponsor Department approval, enter into any undertaking to incur any expenditure outside its remit or which may be likely to bring either SHSCT or the sponsor Department into disrepute

2.3. Novel, Contentious or Repercussive Proposals

2.3.1. SHSCT must obtain the approval of the sponsor Department and Department of Finance (DoF) for any transactions which set precedents, are novel, potentially contentious or could cause repercussions elsewhere

in the public sector. Sponsor Department and DoF approval must be obtained even where such transactions are within SHSCT's delegated limits which appear to offer value for money. Examples include:

- incurring expenditure for any purpose which is or might be considered novel or contentious, or which has or could have significant future cost implications;
- making any significant changes in the operation of funding of initiatives or particular schemes previously approved by the sponsor Department;
- unusual financing transactions, especially those with lasting commitments;
- making any change of policy or practice which has wider financial implications (e.g. because it might prove repercussive among other public sector bodies) or which might significantly affect the future level of the resources required. (The sponsor Department will advise on what constitutes 'significant' in this context).

2.3.2. SHSCT must identify any factors that might set precedents or make expenditure novel, contentious or repercussive to DoH when submitting such proposals for approval, whether capital, IT, Direct Award Contract (DAC), consultancy, gifting etc. and irrespective of any existing delegations.

2.4. Procurement

2.4.1. SHSCT's procurement policies shall reflect the public procurement policy adopted by the Northern Ireland Executive in May 2002 (refreshed May 2009); Procurement Guidance Notes and any other guidelines or guidance issued by DoH, Central Procurement Directorate (CPD) and the Procurement Board. SHSCT shall also ensure that it complies with any relevant UK and EU or other international procurement rules.

2.4.2. In particular, SHSCT shall reflect in its policies DoH and DoF guidance on procurement which addresses the appropriate market testing and evidence retention that should take place for all levels of purchase, irrespective of value, as small expenditures may not require Centre of Procurement Expertise (CoPE) involvement, but nonetheless require a form of market testing.

2.4.3. Periodically and wherever practicable, SHSCT's procurement policies shall be benchmarked against best practice elsewhere.

2.4.4. SHSCT's procurement activity should be carried out by means of a Service Level Agreement (SLA) with a recognised and approved CoPE. The relevant CoPEs are: the Business Services Organisation – Procurement and Logistics Service (BSO PaLS) for Goods and Services and Central Procurement Directorate – Health Projects (CPD HP) for Construction Works/Services. If another CoPE or equivalent is to be used for a specific

project, this should be consented to in advance by either BSO PaLS or CPD HP depending on the subject matter.

2.4.5. The Accounting Officer may decide on the level of internal delegation required for approval of purchases subject to delegated limits set by departmental or DoF guidance, and subject to any additional SLA requirements regarding, or formal guidance on, lowest acceptable delegations given by the relevant CoPE.

2.4.6. Delegations for the approval of purchases should be formally recorded within the organisation's scheme of delegation.

2.5. Competition

2.5.1. Competition promotes economy, efficiency and effectiveness in public expenditure. Works, goods and services should be acquired through public competition unless there are convincing reasons to the contrary, and where appropriate should comply with EU and domestic advertising rules and policy. The form of competition chosen should be appropriate to the value and complexity of the goods or services to be acquired.

2.5.2. Contracts shall be placed on a competitive basis and tenders accepted from suppliers who provide best value for money overall.

2.5.3. Where a contract is awarded to an economic operator (i.e. supplier, contractor) without competition, this is referred to as a Direct Award Contract (DAC). In light of their exceptional nature, all DACs should be dealt with in accordance with the advice, requirements and delegations set out in DoH and DoF guidance and in accordance with the SLA or any formal general guidance on direct awards given by the relevant CoPE (in addition to complying with any other applicable delegations not arising as a result of DAC status e.g. capital or IT delegations)

2.5.4. SHSCT shall send to the sponsor Department on a bi-annual basis (or on such other basis as shall be required by DoH) a report of contracts above the current de minimis limit for procurement expenditure in which competitive tendering was not employed.

2.6. Best Value for money

2.6.1. Procurement of work, supplies and services by SHSCT shall be based on best value for money. This is defined as the most advantageous combination of costs, quality and sustainability to meet customer and SHSCT requirements. In this context, cost means consideration of the whole life cost; quality means meeting a specification which is fit for purpose and sufficient to meet the customer's requirements; and sustainability means economic, social and environmental benefits. It is not about minimising up front prices. Whether in conventional procurement, market testing, private finance or some other form of public private

partnership, finding value for money involves an appropriate allocation of risk.

2.6.2. In accordance with MPMNI /NIGEAE, where appropriate a full options appraisal should be carried out before procurement decisions are taken.

Expenditure and Payments

2.7. Timeliness in paying bills

2.7.1. SHSCT shall collect receipts and pay all matured and properly authorised invoices in accordance with applicable terms, MPMNI and any guidance issued by the sponsor Department/ DoF.

2.8. Payments in advance / Deferred payments

2.8.1. SHSCT should control its commitments and expenditure to provide value for money. Payments made in advance of the delivery of a service are not value for money and should only be made in exceptional circumstances and require the approval of DoF. There are occasions where advance payments are acceptable and examples are listed in MPMNI.

2.8.2. Any proposal for deferred payments is considered novel and contentious and must have DoF approval.

2.9. Risk Management

2.9.1. SHSCT shall ensure that it has systems in place for identifying and managing risk and that the risks it faces are dealt with in an appropriate manner, in accordance with relevant aspects of best practice in corporate governance, and shall develop a risk management strategy, in accordance with the Treasury guidance *The Management of Risk: Principles and Concepts (the Orange Book)* and *MPMNI*.

2.9.2. SHSCT shall take proportionate and appropriate steps to assess the financial and economic standing of any organisation or other body with which it intends to enter into a contract or to which it intends to give grant or Grant in Aid (GIA).

2.10. Fraud

2.10.1 SHSCT shall adopt and implement policies and practices to safeguard itself against fraud, and ensure it has adequate controls to detect and deter fraud in accordance with MPMNI and Departmental and DoF guidance which includes DoF's guide *Managing the Risk of Fraud*. In line with this the SHSCT should develop a fraud policy statement and fraud response plan which should be updated every 5 years and sent to Counter Fraud and Probity Services at BSO for review. SHSCT shall notify the sponsor Department of any subsequent changes to the policy or response plan.

2.10.2 SHSCT should identify and assess how it might be vulnerable to fraud (including bribery), and evaluate the possible impact and likelihood of each fraud risk. Fraud should be always considered as a risk in the risk register.

2.10.3 All cases of attempted, suspected or proven fraud shall be reported to the BSO who shall report it to DoF and the C&AG (see section 4.8 in the Management Statement) as soon as they are discovered, irrespective of the amount involved.

2.11. Wider markets

2.11.1. In line with MPMNI, SHSCT shall seek to maximise receipts and seek out and implement wider market opportunities, provided that this is consistent with (a) SHSCT's main functions and core objectives; and (b) its corporate plan as agreed with the sponsor Department. All such proposals must be supported by a business case and subject to Departmental approval and DoF approval where appropriate.

2.11.2. SHSCT must ensure that services are priced fairly and competition law and the rules on state aid are considered. SHSCT must not however acquire assets just for the purpose of engaging in, or extending, commercial activity. If the wider markets activity demands further investment to keep it viable, SHSCT must ensure the activity is reappraised.

2.12. State Aid

2.12.1. Any funding favouring a particular company or sector or seen to distort competition could be subject to the European Union (EU) rules and, in certain circumstances, require notification to the European Commission. Article 107(1) of the EU Treaty prohibits in principle any form of preferential government assistance – state aid - to commercial undertakings. The purpose is to prevent distortion of competition within the EU. When designing policies, SHSCT should consider early whether state aids rules apply and seek advice from the sponsor Department.

2.13. Fees and Charges

2.13.1. Fees or charges for any services supplied by SHSCT, including services provided between bodies, shall be determined in accordance with MPMNI and should be based on a full cost recovery basis. Where it is decided to charge less than full costs, this will require DoH Ministerial and DoF approval and there should be an agreed plan to achieve full cost recovery within a reasonable period. If the subsidy is intended to last the decision should be documented and periodically reviewed.

2.13.2. All fees and charges should be disclosed in the annual accounts in line with MPMNI / FReM.

2.14. Commercial services

2.14.1. Charges for commercial services should be set at a commercial rate in line with market practice and reflect fair competition with private sector providers. The requirements of competition law and State Aid must be considered. Decisions to set rates at below market practice must have Ministerial and DoF approval.

2.15. Shared services

2.15.1. Active engagement should be undertaken with the BSO to continue improving, enhancing and extracting value from existing and new services with consideration to consolidating services through shared service provisioning.

2.15.2. SHSCT should always use BSO in the first instance where it can provide the relevant service. Where it is not possible to avail of BSO services then Enterprise Shared Services (ESS) should always be considered as a viable alternative and must be appraised in the business case.

2.15.3. All charges should be at cost in accordance with fees and charges guidance in MPMNI.

3. SHSCT INCOME

3.1 Grant-in-Aid (GIA)

3.1.1 GIA will be paid to SHSCT in regular instalments as agreed on the basis of a written application from SHSCT showing evidence of need. The application shall certify that the conditions applying to the use of grant-in-aid have been observed to date and that further GIA is now required for purposes appropriate to SHSCT's functions. The forecast GIA provided by SHSCT and included in the sponsor Department's spring supplementary estimates cannot be exceeded.

3.1.2 Where GIA is drawn by a service provider party on behalf of SHSCT, the Trust should seek assurances throughout the period about monies drawn on its behalf.

3.1.3 SHSCT should have regard to the general guidance and principles enshrined in MPMNI that it should seek GIA according to need. GIA should not be drawn down in advance of need.

3.1.4 Cash balances during the year shall be held at the minimum consistent with the efficient operation of the functions of SHSCT. GIA not drawn down by the end of the year shall lapse. However, where draw-down of GIA is delayed to avoid excess cash balances at year-end, the sponsor Department will make available in the next financial year (subject to

approval of the relevant Estimates provision by the Assembly) any such GIA required to meet any liabilities at year end, such as creditors.

3.2 Fines and Taxes as Receipts

3.2.1 Most fines and taxes (including levies and some licences) do not provide additional DEL spending power and should be surrendered to the sponsor Department.

3.3 Receipts from sale of goods or services

3.3.1 Receipts from the sale of goods and services (including certain licences), rent of land and dividends normally provide additional spending power. If SHSCT wishes to retain a receipt or utilise an increase in the level of receipts, it must gain the prior approval of the sponsor Department.

3.3.2 If there is any doubt about the correct classification of a receipt, SHSCT shall consult the sponsor Department, which may consult DoF as necessary.

3.4 Interest earned

3.4.1 Interest earned on cash balances cannot necessarily be retained by SHSCT without sponsor Department approval. Depending on the budgeting treatment of this receipt, and its impact on the SHSCT's cash requirement, it may lead to commensurate reduction of GIA or be required to be surrendered to the NI Consolidated Fund via the sponsor Department.

3.5 Unforecast changes in in-year income

3.5.1 If the negative DEL income realised or expected to be realised in-year is less than estimated, SHSCT shall, unless otherwise agreed with the sponsor Department, ensure a corresponding reduction in its gross expenditure so that the authorised provision is not exceeded. (**NOTE**: For example, if SHSCT is allocated £100 resource DEL provision by the sponsor Department and expects to receive £10 of negative DEL income, it may plan to spend a total of £110. If income (on an accruals basis) turns out to be only £5, SHSCT will need to reduce its expenditure to £105 to avoid breaching its budget. If the Trust still spends £110, the sponsor Department will need to find £5 of savings from elsewhere within its total DEL to offset this overspend.)

3.5.2 If the negative DEL income realised, or expected to be realised, in the year is more than estimated, SHSCT may apply to the sponsor Department to retain the excess income for specified additional expenditure within the current financial year without an offsetting reduction to GIA. The sponsor Department shall consider such applications, taking account of competing demands for resources, and will consult with DoF in relation to any significant amounts. If an application is refused, any GIA shall be

commensurately reduced or the excess receipts shall be required to be surrendered to the NI Consolidated Fund via the Department.

3.6 Build-up and draw-down of deposits

3.6.1 SHSCT shall comply with the rules that any DEL expenditure financed by the draw-down of deposits counts within DEL. SHSCT shall maintain and manage cash balances as working balances only. These shall be held at a minimum level throughout the year. Any interest earned on overnight deposits must be returned to the sponsor Department.

3.7 Proceeds from Disposal of Assets

3.7.1 Disposals of land and buildings are dealt with in Section 6 below.

3.8 Gifts and Bequests received

3.8.1 SHSCT is free to retain any gifts, bequests or similar donations subject to paragraph 3.8.2. These shall be capitalised at fair value on receipt and must be notified to the sponsor Department.

3.8.2 Before accepting a gift, bequest or similar donation, SHSCT shall consider if there are any costs associated in doing so or any conflicts of interest arising. The Trust shall not accept a gift, bequest or similar donation if there are conditions attached to its acceptance that would be inconsistent with its function.

3.8.3 SHSCT must keep a register detailing gifts received, their estimated value and what happened to them (whether they were retained, disposed of, etc). The Trust should liaise with sponsor Department as to whether the gifts received need to be noted in annual report and accounts.

3.8.4 Donations, sponsorship or contributions, e.g. from developers should also be treated as gifts and should be treated in line with guidance in Managing Public Money NI on Gifts and accounted for in accordance with FReM requirements.

3.9 Other Receipts

3.9.1 SHSCT should ensure that effective control is maintained, and records kept, of receipts from other sources (e.g. provision of fire certificates, reports etc).

3.10 Borrowing

3.10.1 *Normally* ALBs are not permitted to borrow funds. However if doing so, under exceptional circumstances, the ALB must observe the principles in MPMNI, seeking the approval of the Department and, where appropriate

DoF, to ensure it has the necessary authority and budget cover for borrowing or the expenditure to be financed for such borrowing.

4 EXPENDITURE ON STAFF

4.1 Staff Costs

4.1.1 Subject to its delegated limits of authority, SHSCT will ensure that the creation of any new/additional posts does not incur future commitments which will exceed its ability to pay for them.

4.2 Pay and Conditions of Service

4.2.1 Employees of SHSCT, whether on permanent or temporary contract, will be subject to levels of remuneration, and terms and conditions of service (including Superannuation) as agreed by DoH and DoF.

4.2.2 Annual pay increases of SHSCT staff must be in accordance with the annual Finance Director letter on Pay Remit Approval Process and Guidance issued by DoF. All proposed pay awards must have prior approval of the Ministers of both the sponsor Department and the DoF before implementation.

4.2.3 Payments shall be made to Board members in respect of travelling expenses, fees or other allowances in accordance with the relevant (Payment of Allowances to Members) Determination and Direction (Northern Ireland), which the sponsor Department may from time to time amend. SHSCT shall ensure that a comprehensive set of guidelines on all expenditure on travel and subsistence is in place.

4.2.4 Recruitment exercises to fill vacant or new senior positions in SHSCT should proceed only where there are exceptional circumstances which have been agreed by the Permanent Secretary of the sponsor Department in advance.

4.2.5 Any change to the remuneration of Senior Executives must have prior approval of the Permanent Secretary of the sponsor Department and the DoF Minister.

4.3 Pension Costs

4.3.1 SHSCT staff shall be eligible to join the Health and Social Care (HSC) Pension Scheme.

4.3.2 Staff may opt out of the HSC Pension Scheme provided by the Trust. However, the employer's contribution to any personal pension

arrangement, including a stakeholder pension, shall be limited to the national insurance rebate level.

4.3.3 Any proposal by the Trust to move from the existing pension arrangements, or to pay any redundancy, or compensation for loss of office, requires the approval of the sponsor Department and DoF. Proposals on severance payments must comply with MPMNI and any related DoF/ Departmental guidance.

5 NON-STAFF EXPENDITURE

5.1 Economic Appraisal

5.1.1 SHSCT is required to apply the principles of economic appraisal, with appropriate and proportionate effort, to all decisions and proposals concerning spending or saving public money, including EU funds, and any other decisions or proposals that involve changes in the use of public resources. For example, appraisal must be applied irrespective of whether the relevant public expenditure or resources:

- involve capital or current spending, or both;
- are large or small;
- are above or below delegated limits.

5.1.2 All business cases must be approved internally in line with the scheme of delegation. Those business cases above the delegated limits must be submitted for sponsor Departmental approval prior to any expenditure being committed. Business cases submitted to the sponsor Department for approval must be approved by SHSCT's Board and signed off by its Accounting Officer.

5.1.3 All business cases for external consultancy, including those below delegated limits, must be submitted to the sponsor Department in advance of any expenditure. All business cases for DACs should be advised on by the CoPE and appropriately approved in advance of expenditure.

5.1.4 Delegations do not remove the need for appraisal or evaluation. All expenditure, including that below delegation limits, must be appraised and evaluated with effort that is proportionate to the resources involved, with due regard to the specific nature of the case. NIGEAE provides more detailed guidance on the application of appropriate and proportionate effort.

5.1.5 Business cases and appraisals should be prepared in accordance with the following guidance, using the pro forma templates or full business case as required:

- The Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE);

- The HM Treasury Guide, The Green Book: Appraisal and Evaluation in Central Government; and

- Sponsor Department circulars.

5.1.6 Business cases below delegated limits will be subject to an annual test drilling exercise by the Department and DoF.

5.2 Capital Expenditure

5.2.1 Subject to being above an agreed capitalisation threshold, all expenditure on the acquisition or creation of fixed assets shall be capitalised on an accruals basis in accordance with relevant accounting standards.

5.2.2 Proposals for large scale capital projects or acquisitions will normally be considered within SHSCT's corporate and business planning process. Applications for approval within the Corporate/ Trust Delivery Plan by the sponsor Department, and DoF if necessary, shall be supported by formal notification that the proposed project or purchase has been examined and duly authorised by SHSCT's Board. Regular reports on the progress of projects shall be submitted to the sponsor Department in accordance with current instructions.

5.2.3 Approval of the corporate/Trust Delivery Plan does not obviate SHSCT's responsibility to abide by the economic appraisal process.

5.3 Capital Projects

5.3.1 The SHSCT Accounting Officer or appropriate officer as notified to the sponsor Department may authorise capital or IT expenditure on discreet capital projects of up to the agreed delegated limits. Capital or IT projects over this amount require the approval of the sponsor Department and where necessary DoF.

5.3.2 The principles of appraisal, evaluation and management apply equally to proposals supported by Information Communication Technology (ICT) as to all other areas of public expenditure. The appraisal of ICT projects should include the staffing and other resource implications.

5.3.3 Any novel and/or potentially contentious projects, regardless of the amount of expenditure, require the approvals of the sponsor Department and DoF.

5.3.4 Transfers of assets between government departments should generally be at full current market value; assets transferred under a transfer of functions order to implement a machinery of government change are generally made at no charge.

5.4 Transfer of Funds within Budgets

5.4.1 Unless financial provision is subject to specific sponsor Department or DoF controls (e.g. where provision is ring-fenced for specific purposes such as contractually committed projects) or delegated limits, transfers between budgets within the total capital budget, or between budgets within the total revenue budget, do not need sponsor Department approval. The one exception to this is that, due to HM Treasury controls, any movement into, or out of, depreciation and impairments within the resource budget will require sponsor Department and DoF approval.

5.4.2 Virement of funding from capital to resource budgets shall not be permitted without prior approval from the sponsor Department, DoF and the Executive.

5.5 Lending, Guarantees, Indemnities; Contingent Liabilities; Letters of Comfort

5.5.1 SHSCT shall not, without the prior written consent of the sponsor Department (and, where necessary, DoF), lend money, charge any asset or security, give any guarantees or indemnities or letters of comfort, or incur any other contingent liability (as defined in MPMNI), whether or not in a legally binding form.

5.6 Grants or loans by SHSCT

5.6.1 Unless covered by a delegated authority, all proposals to make a loan to a third party, whether one-off or under a scheme, together with the terms and conditions under which such a loan is made, shall be subject to prior approval by the sponsor Department and, where necessary, DoF. If loans are to be made under a continuing scheme, statutory authority is likely to be required.

5.6.2 The terms and conditions of such grants or loans shall include the requirement on the recipient organisation to prepare accounts and to ensure that its books and records in relation to the grant or loan are readily available for inspection by SHSCT, the sponsor Department and the C&AG.

5.7 Gifts Made

5.7.1 Departmental and DoF approval is needed for all gifts above delegated limits and those exceeding £250,000 (or subsequent updated limits) also require Estimate cover and notification to the Assembly. Gifts include transfers of assets or leases at below market value. Public money must not be used to provide for gifts to members of staff. This shall also apply to members of the SHSCT Board. Gifts by management to staff are subject to the requirements of DAO (DoF) 05/03.

5.7.2 Gifts should be noted in the annual report and accounts in line with MPMNI and the latest FReM requirements.

5.8 Write–offs, Losses and Other Special Payments

5.8.1 Proposals for write offs, losses or other special payments, including ex gratia and compensation payments outside the delegated limits, must have the prior approval of the sponsor Department and where necessary DoF. Furthermore it is important to consult with the sponsor Department if, irrespective of delegations, ssuch proposals:

- involve important questions of principle;
- raise doubts about the effectiveness of existing systems;
- contain lessons which might be of wider interest;
- might create a precedent for other departments; or
- arise because of obscure or ambiguous instructions issued centrally.

5.8.2 Losses shall not be written off until all reasonable attempts to make a recovery have been made and have proved unsuccessful and there is no feasible alternative.

5.8.3 SHSCT should always pursue recovery of overpayments, irrespective of how they came to be made.

5.8.4 Special payments should only be authorised after careful appraisal of the facts and when satisfied that the best course has been identified.

5.8.5 SHSCT should ensure that full justification for write-off, special payment or loss is provided together with the necessary legal advice where appropriate and lessons learned clearly identified.

5.8.6 Details of all losses and special payments should be recorded in a Losses and Special Payments Register, which will be available to auditors. The Register should be kept up-to-date and should show evidence of the approval by the appropriate officer as notified to the sponsor Department, for amounts below the delegated limit, and the sponsor Department, where appropriate.

5.8.7 Losses and special payments should be reported in the annual accounts in accordance with MPMNI and the latest FReM requirements.

5.9 Remedy

5.9.1 SHSCT should operate a clear accessible complaints process which should respond promptly and consistently and consider whether a remedy is appropriate in line with MPMNI

5.10 Leasing

5.10.1 Prior sponsor Department and DoF approval is required for all property and finance leases as delegated authority has been removed. SHSCT must have DEL provision for finance leases and other transactions that are, in substance, a form of borrowing.

5.10.2 Before acquiring a new lease or continuing with an existing lease term, SHSCT must, at expiry or break option dates, submit to the sponsor Department a proportionate business case at least 12 months before either the lease expiry date or landlord /tenant notice date, whichever is earlier. The Trust must ensure that the lease demonstrates value for money and that this is appropriately demonstrated in the business case through analysis of options including leasing of alternative property assets and purchase.

5.10.3 Business cases must be submitted for sponsor Department approval in the first instance. The sponsor Department will then seek approval from DoF before expenditure is committed.

5.11 Public Private Partnerships

5.11.1 SHSCT should seek opportunities to enter into public/private partnerships where this would be more affordable and offer better value for money than conventional procurement.

5.11.2 All such proposals require DoH / DoF approval. SHSCT must consult with the sponsor Department when considering any proposal to enter into such arrangements. Procurement by private finance is only considered suitable for capital projects of £50million and above, because less capital intensive projects seldom justify the relatively high procurement and management costs involved. For instance, Private Finance Initiative (PFI) solutions are not usually considered appropriate for ICT projects. Private finance should only be used after the rigorous scrutiny of all alternative procurement options, where:

- the use of private finance offers better value for money for the public sector compared with other forms of procurement; and
- the public sector partner is able to predict the nature and level of its long term service requirements with a reasonable degree of certainty.

5.11.3 SHSCT should ensure adherence to DoF guidance on value for money assessments of alternative procurement options.

5.11.4 SHSCT should consult with the Department over the accounting and budgeting treatment for any PFI arrangement. Where judgement over the level of control is difficult, the sponsor Department will consult DoF (which may need to consult with the Office of National Statistics over

national accounts treatment).

5.12 Subsidiary Companies and Joint Ventures

5.12.1 SHSCT shall not establish subsidiary companies or joint ventures without the express approval of the sponsor Department and DoF. In judging such proposals, the sponsor Department will have regard to its own wider strategic aims, objectives and those of the Government.

5.12.2 For public expenditure accounts purposes, any subsidiary company or joint venture controlled or owned by SHSCT shall be consolidated with it in accordance with guidance in the Financial Reporting Manual (FReM), subject to any particular treatment required by the FReM. Where the judgement over the level of control is difficult, the sponsor Department will consult DoF (which may need to consult with the Office of National Statistics over national accounts treatment). Unless specifically agreed with the sponsor Department and DoF, such subsidiary companies or joint ventures shall be subject to the controls and requirements set out in this MS/FM and to the further provisions set out in supporting documentation.

5.13 Financial Investments

5.13.1 SHSCT shall not make any financial investment without the prior written approval of the sponsor Department and, where appropriate, DoF, nor should it build up cash balances or net assets in excess of what is required for operational purposes. Funds held in bank accounts or as financial investments may be a factor for consideration when GIA is determined. Equity shares in ventures which further the objectives of SHSCT shall equally be subject to DoH and DoF approval unless covered by a specific delegation.

5.14 Unconventional Financing

5.14.1 SHSCT shall not enter into any unconventional financing arrangement without the approval of the sponsor Department and DoF. If the Trust is using a new or non-standard technique, it should ensure that it has the competence to manage, control and track its use and any resulting financial exposures, which may vary with time. In particular, SHSCT should consult the sponsor Department before using derivatives for the first time. SHSCT must evaluate any such financing techniques carefully, especially to assess value for money and any proposal must be assessed in line with MPMNI chapter on funding.

5.15 Commercial Insurance

5.15.1 SHSCT shall not take out any insurance without the prior approval of the sponsor Department and DoF, other than third party insurance required by the Road Traffic (NI) Order 1981 (as amended) and any other insurance which is a statutory obligation or which is permitted in MPMNI. Decisions on

whether to buy insurance should be based on objective cost-benefit analysis, using guidance in the *Northern Ireland Guide to Expenditure Appraisal and Evaluation (*NIGEAE) (supported by additional DoF guidance).

5.15.2 In the case of a major loss or third-party claim, the sponsor Department shall liaise with SHSCT about the circumstances in which an appropriate addition to budget out of the sponsor Department's funds and/or adjustment to the Trust's targets shall be considered. The sponsor Department will liaise with DoF Supply where required in such cases.

5.16 Employers Liability

5.16.1 SHSCT is listed in Exemption Regulations made by the Department of Enterprise, Trade and Investment (now the Department for the Economy), namely the Employer's Liability (Compulsory Insurance) Regulations (Northern Ireland) 1999, and therefore is not required to insure against liability for personal injury suffered by its employees.

5.17 Payment/Credit Cards

5.17.1 SHSCT, in consultation with the sponsor Department, shall ensure that procedures on the issue of payment cards (including credit cards) are in place. No payment/credit cards should be issued without the prior written approval of the Trust's Accounting Officer.

5.18 Hospitality

5.18.1 SHSCT shall ensure that a comprehensive set of guidelines on the provision of hospitality is in place. Reference should be made to sponsor Department guidance.

5.19 Use of consultants

5.19.1 SHSCT must notify the sponsor Department of any occasion when it intends to use consultants, for what purpose, and submit a consultancy business case in advance of any expenditure being committed. Prior DoH/ DoF approval must be sought in line with current delegated limits. SHSCT shall also comply with current DoH and DoF guidance on the Use of Consultants.

5.19.2 SHSCT will provide the sponsor Department with a quarterly statement on the status of all consultancies completed and/or started in each financial year.

5.19.3 Care should be taken to avoid actual, potential, or perceived conflicts of interest when employing consultants.

6 Management and Disposal of Fixed Assets

6.1 Asset Management Strategy

6.1.1 SHSCT should develop and operate an asset management strategy, underpinned by a reliable and up to date asset register, which should be reviewed annually by the SHSCT Accounting Officer as part of the corporate planning process.

6.1.2 SHSCT must ensure effective use, maintenance, acquisition and disposal of the public sector assets under its control.

6.1.3 SHSCT should keep an asset register of all the capital assets it owns and uses.

6.2 Asset transfer between public bodies

6.2.1 Public sector organisations may transfer property among themselves without placing the asset on the open market, provided they do so at market prices and in appropriate circumstances and this is accounted for in compliance with MPMNI and FReM.

6.3 Machinery of Government changes

6.3.1 Some assets transfer due to machinery of government changes. The relevant legislation (a Transfer Order) should prescribe the terms of any such transfer.

6.3.2 SHSCT should maintain information asset registers as part of their asset management strategy.

6.4 Register of Assets

6.4.1 SHSCT shall maintain an accurate and up to date register of fixed assets.

6.5 Disposal of Assets

6.5.1 SHSCT shall dispose of those assets that are surplus to its requirements in compliance with current policy. Assets should be sold for best price, as advised by Land & Property Services. Assets shall be sold by auction or competitive tender as advised by Land & Property Services (unless otherwise agreed by the sponsor Department) and in accordance with the principles of MPMNI provided SHSCT is satisfied that the articles are spent, redundant or surplus to requirements.

6.5.2 Other than at a public auction, no article shall pass into the possession of any member of staff of SHSCT or member of its Board without approval of the Department.

6.5.3 All receipts derived from the sale of assets (including grant financed assets, see 6.6 below) must be declared to the sponsor Department, which will consult with DoF on the appropriate treatment.

6.6 Recovery of Grant – Financed Assets

6.6.1 Where SHSCT has financed expenditure on capital assets by third parties, it shall set conditions and make appropriate arrangements to ensure that assets are not disposed of without the Trust's prior consent.

6.6.2 SHSCT shall ensure that any grants to third parties for the acquisition of assets should normally include a claw back condition under which the Trust can recoup the proceeds if the recipient of the grant later sells the asset.

6.6.3 SHSCT shall ensure that, if the assets created by grants made by the Board cease to be used by the recipient of the grant for the intended purpose, a proper proportion of the value of the asset shall be repaid to the Trust for surrender to the sponsor Department. The amount recoverable shall be calculated by reference to the best possible value of the asset and in proportion to the NI Consolidated Fund's original investment(s) in the asset.

7 BUDGETING PROCEDURES

7.1 Setting the Annual Budget

7.1.1 Each year, in the light of decisions by the sponsor Department on the SHSCT's updated draft corporate plan, the sponsor Department will send to the Trust:

- a formal statement of the annual budgetary provision allocated by the sponsor Department through the HSCB in the light of competing priorities across the Department and of any forecast income approved by the Department; and
- a statement of any planned change in policies affecting the Trust.

7.1.2 The SHSCT approved annual Trust Delivery Plan (TDP) will take account both of its approved funding provision and any forecast receipts, and will include a budget of estimated payments and receipts together with a profile of expected expenditure and of draw-down of any HSCB / Departmental funding and/or other income over the year. These elements will form part of the approved TDP for the year in question (Section 4.2 of the Management Statement).

7.1.3 Any GIA provided by the sponsor Department for the year in question will be voted in the sponsor Department's Estimate and will be subject to Assembly control.

7.2 General Conditions for the Authority to Spend

7.2.1 Once the budget has been allocated by the HSCB (and subject to any restrictions imposed by Statute/the Minister/this MS/FM or any other circulars, directives, and best practice guidance that may issue from, or by way of, the Department),) to SHSCT, the Trust shall have authority to incur expenditure approved in the budget without further reference to the HSCB or the sponsor Department, on the following conditions:

- The Trust shall comply with the delegations issued by the sponsor Department in HSC(F) 52-2016 (Appendix 1) or subsequent revisions. These delegations shall not be altered without the prior agreement of the sponsor Department and DoF;
- The Trust shall comply with the conditions set out in paragraph 2.3 above regarding novel, contentious or repercussive proposals;
- inclusion of any planned and approved expenditure in the SHSCT's budget shall not remove the need to seek formal DoH (and, where necessary, DoF) approval where such proposed expenditure is above the delegated limits, or is for new schemes not previously agreed;
- The Trust shall provide HSCB and the sponsor Department with such information about its operations, performance, individual projects or other expenditure as may reasonably be required (see paragraph 7.3 below); and
- The Trust shall comply with NI Procurement Policy and carry out procurement via a recognised and approved CoPE.

7.3 Providing Monitoring Information to the Sponsor Department

7.3.1 The SHSCT shall provide the sponsor Department with information on a regular basis which will enable the satisfactory monitoring by the Department of:

- the Trust's cash management;
- its draw-down of any GIA;
- the expenditure for that month;
- forecast outturn by resource headings; and

- other data required for the DoF Outturn and Forecast Outturn Return.

8 BANKING

8.1 Banking Arrangements

8.1.1 The SHSCT Accounting Officer is responsible for ensuring that the Trust's banking arrangements are in accordance with the requirements of Chapter 5 of *MPMNI*. In particular, the Accounting Officer shall ensure that the arrangements safeguard public funds and that their implementation ensures efficiency, economy and effectiveness. This responsibility remains even with the current banking pool arrangements. Accounting Officers are responsible for the credit risk to which public funds are exposed when held in commercial banks. It is important that they manage this risk actively, so that it is kept to a minimum. This means using the most efficient and cost effective money transmission methods and securing the best terms possible from banks. The Trust should seek the advice of the sponsor Department before opening new bank accounts.

8.1.2 The SHSCT Accounting Officer shall therefore ensure that:

- these arrangements are suitably structured and represent value-for-money, and are reviewed at least every two years, with a comprehensive review, usually leading to competitive tendering, at least every three to five years;

- sufficient information about banking arrangements is supplied to the sponsor Department's Accounting Officer to enable the latter to satisfy his/her own responsibilities;

- the Trust's banking arrangements shall be kept separate and distinct from those of any other person or organisation; and

- adequate records are maintained of payments and receipts and adequate facilities are available for the secure storage of cash.

9 COMPLIANCE WITH INSTRUCTIONS AND GUIDANCE

9.1 Relevant Documents

9.1.1 SHSCT shall comply with the following general guidance documents:

- This document (both the *Financial Memorandum* and the *Management Statement*);

- *Managing Public Money Northern Ireland (MPMNI);*
- *Public Bodies - a Guide for NI Departments* issued by DoF;
- *Government Internal Audit Standards*, issued by DoF;
- *Managing the Risk of Fraud* issued by DoF;
- *The Government Financial Reporting Manual (FReM)* (Treasury document) issued by DOF;
- Relevant DoF Dear Accounting Officer and Finance Director letters;
- Relevant Dear Consolidation Officer and Dear Consolidation Manager letters issued by DoF;
- *Regularity, Propriety and Value for Money*, issued by Treasury;
- The Consolidation Officer Letter of Appointment, issued by DoF;
- *PFI - Working Together in Financing our Future: Policy Framework for Public Private Partnerships in Northern Ireland" available at* http://webarchive.proni.gov.uk/20141007005953/http://www.ofmdfmni.gov.uk/maindoc.pdf
- Other relevant instructions and guidance issued by the central Departments (D0F/The Executive Office) including Procurement Board and CPD guidance.
- Specific instructions and guidance issued by the sponsor Department;
- Recommendations made by the Public Accounts Committee, or by another Assembly/Parliamentary authority, which have been accepted by the Government and which are relevant to SHSCT.

10 REVIEW OF FINANCIAL MEMORANDUM

10.1 This Financial Memorandum will normally be formally reviewed every five years, or following a review of SHSCT's functions as provided for in the Management Statement.

10.2 DoF will be consulted on any significant variation proposed to the Management Statement and Financial Memorandum.

APPENDIX 1

HSC(F) 52-2016 Revised HSC & NIFRS Delegated Limits and requirements for Departmental / DoF approval

1. DoF has updated some of the delegated limits per (DAO (DPF) 06/12) providing guidance on the revised arrangements for Departmental delegations, following the restructuring of the new nine Departments, and the associated requirements for DoF approval. The revised DAO can be found at: https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/daodfp0612_revised%20280716_0.pdf . The principles of DAO (DFP) 06/12 still remain and reminds organisations of the guidance contained in MPMNI relating to the authority for expenditure, regularity, propriety and value for money and the requirement to ensure that the principles of appraisals are applied when expending resources. The relevant extracts are included at **Annex A**.

2. This circular sets out the delegations between DoH and Health and Social Care bodies and NIFRS and conveys delegated authority to commit and incur expenditure subject to the restrictions set out at table A below and per **Annex B and Annex C.**

3. The main changes to delegated limits are:

    - Capital Projects
        - DoH delegated limit excluding hospital schemes has increased from £1m to £2m
        - Trusts delegated limit, excluding hospital schemes, has increased from £500k to £1.5m
        - New delegated limit introduced for PHA lead Research and development of £1.5m
        - Trusts delegated limit for hospital schemes has also increased from £500k to £1.5m
    - Gifts has increased from £100 to £250 for all bodies;
    - Ex-Gratia Financial Remedy Payments (i.e..those made to complainants through an organisation's internal complaints procedures/processes increased from £250 to £500;

- Overpayments - Foregoing the recoupment of overpayments of pay, pensions and allowances ; Pensions from £500 to £1,000;
- Clinical negligence – delegated limit increased from £500k to £1m;
- Delegated limit for all leases for Office / warehouse / storage accommodation is nil for all bodies;
- DoH Delegated limit for EU Peace IV and In VA Programmes has increased from £2m to £5m. Delegated limits for all bodies remains NIL.

4. The table below summarises the main financial delegated limits where the Department has given delegated authority to HSC and NIFRS to spend within those limits. This must be read in conjunction with **Annex B** and **Annex C which contains a full list of delegations for which HSC bodies and NIFRS have NO delegated authority other than those listed below.**

5. All proposed expenditure which is set to exceed the HSC/NIFRS delegated limit must receive the appropriate prior approval before commitment to spend.

TABLE A

Area of Delegation	HSC/NIFRS Delegated Limit	DoH Delegated Limit
Use of External Consultants	HSC Bodies - £10,000 NIFRS - £10,000	£75,000
Capital Expenditure (excluding hospital schemes)	HSC Board &Trusts - £1,500,000 BSO £250,000	£2,000,000
	PHA - £50,000	
	PHA R&D - £1,500,000	
	NIBTS - £200,000	
	Other HSC Bodies - £10,000	
	NIFRS - £250,000	
Hospital Schemes – New Build, Extension, Refurbishment and Equipment involving capital expenditure	HSC Board &Trusts - £1,500,000 BSO - £250,000 PHA - £50,000 NIBTS - £200,000 Other HSC Bodies - £10,000	£5,000,000
IT Projects	HSC Board; Trusts; BSO; PHA; £250,000	£1,000,000

Area of Delegation	HSC/NIFRS Delegated Limit	DoH Delegated Limit
	NIBTS - £200,000 NIMDTA - £20,000 Other HSC Bodies - £10,000 NIFRS - £250,000	
Gifts	£250	£250
Losses – write off of cash losses and cash equivalents, bookkeeping losses, exchange rate fluctuations, fruitless payments and constructive losses, property in stores or in use due to any deliberate act	HSC Bodies £10,000 NIFRS - £1,000	n/a*
Losses -. The write off of losses relating to pay, allowances, superannuation benefits, social security benefits, grants, subsidies and the failure to make adequate charges for use of public property or services and loans - as per guidance in MPMNI	All HSC Bodies and NIFRS - Nil**	Nil**
Losses - Waived of Abandoned claims	HSC Bodies £10,000 NIFRS - £1,000	£100,000
Special payments / Ex-Gratia Payments	All HSC Bodies - £10,000 NIFRS - £1,000	£100,000
Overpayments - Foregoing the recoupment of overpayments of pay, pensions and allowances	All HSC Bodies and NIFRS - £1,000 (pay & allowances) £1,000 (pensions)	£20,000
Overpayments - Foregoing the recoupment of overpayments of grants	All HSC Bodies and NIFRS - Nil**	Nil**
Special severance payments	All HSC Bodies and NIFRS - Nil**	Nil**
Ex-Gratia Financial Remedy Payments (i.e..those made to complainants through an organisation's internal complaints procedures/processes)	All HSC Bodies and NIFRS - £500	£500
Ex-Gratia Payments to be made as a result of a recommendation from the NI Public Services Ombudsman	All HSC Bodies - £10,000 NIFRS - £1,000	£50,000
Compensation payments for Clinical Negligence (to include interim payments if overall settlement is expected to exceed delegated limits) To include agreement of Periodic Payment Orders (PPOs)	HSC Bodies £1.000,000 NIFRS n/a	£2,000,000
Compensation payments following legal advice (This would include all personal injury and public liability claims)	HSC Bodies - £25,000 NIFRS - £1,000	£100,000
Compensation payments without legal advice	All HSC Bodies and NIFRS - Nil	£10,000
Extra-Statutory and Extra-Regulatory payments	All HSC Bodies and NIFRS - Nil	£100,000

Area of Delegation	HSC/NIFRS Delegated Limit	DoH Delegated Limit
Confidentiality Agreements	Nil	Nil
Grants: Revenue Capital	All HSC Bodies and NIFRS £500k per annum £200k in total	 £500k per annum £200k in total
Leases for office accommodation/ warehousing / storage	- All HSC Bodies and NIFRS Nil	Nil
Pay remits	All HSC Bodies and NIFRS Nil	Nil
Revenue Business cases	NIFRS - £250,000 All other HSC Bodies – fully delegated	Nil

* DoH has full delegated authority

** Prior DoH and DoF approval required in all cases

6. It is mandatory for HSC bodies and NIFRS to obtain prior Departmental approval for expenditure above those limits outlined above and per Annex B & C attached. Failure to obtain the required DoF approvals will result in regularity and propriety issues. Any expenditure which falls outside a Department's delegated authority and which has not been approved by DoF is deemed irregular and could result in qualified accounts and investigation by PAC.

7. Where expenditure proposals exceed the Department's delegated limits, DoF Supply will act as the approving authority.

8. All expenditure which is novel, contentious, repercussive or which could set a potentially expensive precedent, irrespective of size, even if it appears to offer value for money taken in isolation **must** have Departmental and DoF approval before expenditure is committed.

Further Guidance

9. For further details on these categories of expenditure, including approvals procedures, HSC Bodies and NIFRS should refer to Managing Public Money

Northern Ireland[1] and NIGEAE[2], as well as current Departmental finance guidance on:

- The use of professional services (including consultants)
- Losses and special payments
- Claims handling (including clinical negligence and personal injury litigation)
- Fraud
- Capital

Process for approval of expenditure

10. Any payments / expenditure that require Departmental approval must be submitted through Financial Policy and Accountability Unit, who will act as a single point of contact through whom all liaison with DoF on significant financial matters, including approvals, should be conducted. This is to ensure that appropriate Departmental approvals have been obtained and that regularity, propriety and VFM have been adhered to.

11. It has been agreed that the Infrastructure Investment Director will be the contact point for all such submissions concerning capital.

Should you have any queries please contact the following.

Paula Shearer Personal Information redacted by the USI
Sharon Allen (Capital) Personal Information redacted by the USI

Action Required

12. HSC Bodies and NIFRS to note the requirements to obtain prior Departmental approval before committing expenditure outside the delegations conveyed by this letter. This circular should therefore be circulated as appropriate throughout your organisation, and schemes of delegation revised and updated accordingly.

[1] https://www.finance-ni.gov.uk/articles/managing-public-money-ni-mpmni
[2] https://www.finance-ni.gov.uk/topics/finance/northern-ireland-guide-expenditure-appraisal-and-evaluation-nigeae

Yours sincerely

PAULA SHEARER

Financial Policy, Accountability and Counter Fraud Unit

Annex A

Extract from revised DAO (DFP) 06/2012

Expenditure Appraisal and Evaluation

1. FD(DFP) 20/09 draws departments' attention to the Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE), which contains DoF's core guidance on the appraisal, evaluation, approval and management of policies, programmes and projects. The principles of appraisal should be applied, with proportionate effort, to every proposal for spending or saving public money, or proportionate changes in the use of public sector resources. For example, appraisal must be applied irrespective of whether the relevant public expenditure or resources:

   - involve capital or current spending, or both;
   - are large or small;
   - are above or below delegated limits.

2. Appraisal is a systematic process for examining alternative uses of resources. It is designed to assist in defining problems and finding the solutions which offer the best value for money. It is a way of thinking expenditure proposals through, right from the emergence of the need for a project through its implementation, to post-project evaluation. It is the established vehicle for planning and approving projects and other expenditures. Good appraisal leads to better decisions and use of resources. It facilitates good project management and project evaluation. Appraisal is not optional; it is an essential part of good financial management, which is vital to decision-making and crucial to accountability. But it must also be proportionate.

3. It is important to begin applying appraisal early in the gestation of any proposal which has expenditure or resource implications. The justification for incurring any expenditure at all should be considered. Appraisal should be applied from the emergence of a need right through to the recommendation of the most

cost-effective course of action. It should not be regarded merely as the means to refine the details of a predetermined option.

4. It should be noted that delegations do not remove the need for appraisal or evaluation. All expenditure, including that below delegation limits, must be appraised and evaluated with effort that is proportionate to the resources involved, with due regard to the specific nature of the case. NIGEAE provides more detailed guidance on the application of appropriate and proportionate effort.

Implementation of delegated authority

5. This DAO restates a number of working arrangements which are intended to facilitate the efficient implementation of delegated authority and the achievement of accountability and value for money. They are part of the internal controls of a department and should facilitate an Accounting Officer in signing the Governance Statement.

Management Arrangements

i. Departments should nominate a senior official, preferably the Departmental Finance Director, to assist in the discharge of all aspects of the delegation arrangements within the department. This official should act as a single point of contact through whom all liaison with DoF on significant financial matters, including approvals, should be conducted, unless alternative arrangements are agreed with DoF. Departments should inform DoF of the name and job title of this point of contact and notify DoF of any subsequent change.

ii. Expenditure above delegated limits generally requires specific DoF approval. The normal procedure for seeking DoF approval is to submit a suitable business case to the appropriate DoF Supply Division in accordance with the guidance in NIGEAE.

iii. All cases presented to DoF for approval must confirm that the department is content with the regularity, propriety and value for money of the project and the project has the necessary approvals

within the departmental Accounting Officer's delegated arrangements. Where it is clear to DoF that a case has been submitted without proper departmental approval procedures being followed, the case will be returned without consideration.

iv. It should be noted that where DoF approval is required, expenditure should not be committed until DoF approval has been granted. Where DoF's approval has not been sought, DoF will not generally grant retrospective approval where the relevant expenditure has already been committed or the works have commenced.

v. The practice of consulting DoF informally during the course of development of a project is strongly encouraged, particularly where the project is deemed to be complicated, novel or contentious. However, such informed consultation does not remove the need for a department to formally submit the project for DoF approval if that is required. DoF will not confirm its formal view of any proposal unless the department has provided confirmation of its Accounting Officer's view (under the responsibility of the Accounting Officer) on the regularity, propriety and value for money of the relevant proposed expenditure.

Appraisals and Post Project Evaluations

vi. All departments should ensure that their operating procedures and guidance on conducting economic appraisals comply with NIGEAE, are recorded in a Finance Manual, that this Manual is kept updated regularly, and that those who are involved in the economic appraisal process have access to it.

vii. The Departmental Finance Director should ensure that commensurate Post Project Evaluations (PPEs) are completed in accordance with the principles set out in NIGEAE that lessons learnt are shared within the department (and, where appropriate, with other departments). A copy of the PPE should be forwarded to DoF Supply

if it formed a condition of the approval. Departmental Finance Manuals should ensure that appropriate procedures are established for PPEs.

Review of Processes

viii. Each department should carry out an annual review (independent of the spending areas) of the processes in relation to the appraisal of cases and PPEs that fall within its delegated limits, to ensure that the proper processes are being followed and the delegation limits set out in this DAO adhered to. If a department has evidence-based confidence in its internal controls, it may decide to implement a cycle of reviews, taking a different part of the department each year.

Review of Economic Appraisals/PPEs

ix. In addition to the annual review of processes described at (viii) above, departments should conduct ad hoc 'test drilling' of economic appraisals and PPEs that fall (a) within their delegated limits and (b) within the delegated limits given to their sponsored bodies, to ensure that the appropriate appraisal standards have been applied in accordance with NIGEAE guidance and that decisions have been taken on a proper basis. The review should be undertaken independent of the spending area. A department may undertake a cycle of reviews concentrating on the higher risk areas. A report of the findings of the examination of individual cases should be provided by departments to the Departmental Accounting Officer and to DoF Supply on an annual basis, by 30 June each year. This should provide further assurance to the Departmental Accounting Officer in signing off the Annual Governance Statement.

x. Departments should submit to DoF Supply a list of all appraisals above the level agreed with their Supply Officer. Supply may request a sample of those cases for review, to confirm the effectiveness of departments' control systems (in line with the criteria in MPMNI A.2.3.8). Any

necessary corrective action identified should be implemented within an agreed timescale.

ANNEX B

AREAS REQUIRING DoF APPROVAL FOR ALL DEPARTMENTS

	Details	Reference
Where DoF approval (in writing) is required:		
Use of Resources		
1	Public statements which might imply a willingness on the part of the Executive to commit resources or incur expenditure beyond agreed levels	MPMNI Box A.2.3.A
2	Guarantees, indemnities or general statements/ letters of comfort which could create a contingent liability	MPMNI Box A.2.3.A
3	All expenditure which is novel, contentious, repercussive or which could set a potentially expensive precedent, irrespective of size, even if it appears to offer value for money taken in isolation	MPMNI Box A.2.3.A Box 2.3
4	Expenditure that could create pressures which could lead to a breach of: 1. Departmental Expenditure Limits (DELs); 2. resource limits or capital limits; or 3. Estimates provision.	MPMNI Box A.2.3.B
5	Expenditure that would entail contractual commitments to significant levels of spending in future years for which plans have not been set	MPMNI Box A.2.3.B
6	Legislation with financial implications as per guidance in MPMNI	MPMNI A.2.2.1
7	New services under the sole authority of the Budget Act	MPMNI A.2.5.15
8	Loans – on borrowing from the Northern Ireland Consolidated Fund for Contingencies	MPMNI A.2.5.9 MPMNI A.2.5.11
Accounting Officers		
9	Appointment of the permanent head of each central government department to be its Accounting Officer	MPMNI 3.2.1
10	Appointment of an Accounting Officer for a Trading Fund (TF)	Financial Provisions NI Order 1993 and MPMNI 3.2.2
Internal Management		
11	Gifts – Giving any individual gift in excess of £250. **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.12.3
12	Insurance – Decision to purchase commercial insurance.	MPMNI 4.4.1 – 4.4.2

	Details	Reference
13	Losses – The write off of losses relating to pay, allowances, superannuation benefits, social security benefits, grants, subsidies and the failure to make adequate charges for use of public property or services and loans - as per guidance in MPMNI - **Refer to Table A for HSC and NIFRS Delegation**	MPMNI Annex A.4
14	Losses - Waived or Abandoned claims above £100,000 and Special payments e.g. ex gratia over £100,000. To include the foregoing the recoupment of overpayments of pay, pensions and allowances over £20,000 and the recoupment of overpayments of grants. **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.10.2 & Box A.4.10.A MPMNI A.4.11
15	Payments – Advance payments excluding those allowed under the guidance in MPMNI	MPMNI A.4.6.5
16	Payments – Deferred payments excluding those allowed under the guidance in MPMNI	MPMNI A.4.6.9
17	Payments - Special severance payments - **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.13.9
18	Payments – Financial Remedy Payments over £500 (ie payments made to complainants through an organisations internal complaints procedures/processes) and payments over £50,000 to be made as a result of a recommendation from the Northern Ireland Public Services Ombudsman	MPMNI A.4.14.8
Funding		
19	Banking – Proposals to open an account outside the pool or any proposed changes to Banking Pool arrangements	MPMNI 5.8.2 MPMNI A.5.7.3 MPMNI Box A.5.7.B
20	Banking – Requests for indemnities that commercial banks may seek to replace their normal arrangements	MPMNI Box A.5.7B
21	Borrowing from the Private Sector for all Arms Length Bodies (ALBs)	MPMNI 5.7.1
22	Borrowing on terms more costly than those usually available to government	MPMNI A.5.6.11
23	Borrowing – foreign borrowing	MPMNI A.5.6.12
24	Foreign Currency - Any proposals to negotiate contracts in foreign currencies other than the euro, yen or US dollar	MPMNI A.5.7.13
25	Income - Use of income and cash by departments to meet expenditure needs if there is no specific legislation	MPMNI A.5.3.1 MPMNI A.5.3.5
26	Income & Receipts - Increases to the amount that can be treated as an accruing resource	MPMNI A.5.3.8 MPMNI A.5.3.9

	Details	Reference
	during a financial year in order to finance a comparable increase in expenditure as per in-year monitoring/budgeting guidance	
27	Liabilities – Departments seeking statutory authority to accept liabilities	MPMNI A.5.5.5
28	Liabilities – Assuming statutory liabilities including the liabilities of any sponsored bodies in excess of £1 million for any single transaction	MPMNI A.5.5.14
29	Liabilities – Reporting non-statutory, where required, to the Assembly	MPMNI A.5.5.23
30	Liabilities – Reporting a contingent liability in confidence by writing to the Chair of the PAC	MPMNI A.5.5.28
31	Liabilities – Departments should consult DoF about reporting a liability during recess and outside Assembly sessions during a dissolution	MPMNI A.5.5.30 MPMNI A.5.5.34
32	Loans – proposals to make voted loans and premature repayment	MPMNI 5.6.1 MPMNI A.5.6.2
Fees, Charges and Levies		
33	Charges - Primary legislation to empower charging	MPMNI 6.2.1
34	Charges - Restructuring charges using the Fees and Charges (NI) Order 1988 No. 929 (N.I.8) in line with guidance in MPMNI	MPMNI Box 6.2
35	Charges - Public sector supplier moving away from full cost charging	MPMNI A.6.4.8
36	Interdepartmental Transactions – where the transaction may require legislative procedures or where DoF agreement is required under statute	MPMNI A.6.6.3
Working with Others		
37	Agency framework documents and the methods of financing an agency	MPMNI 7.4.2 & Box 7.2
38	All Management Statements and Financial Memorandums (MSFM) or other relationship documents	MPMNI 7.7.6
39	The establishment or termination of an NDPB	Public Bodies: A Guide for NI Departments
40	The establishment and operation of a Trading Fund including sources of capital	Financial Provisions NI Order 1993 and MPMNI A.6.6.3, MPMNI 7.5.2, 7.5.4 & Box 7.3
41	Provision of funding by way of an Endowment Fund	A.5.1.10
42	Grants to Councils under the Local Government (Finance) Act (NI) 2011	Local Government (Finance) Act (NI) 2011
Other Delegations		
43	Wider market projects where the full annual cost or aggregated annual income from such	MPMNI A.7.6.6

	Details	Reference
	services exceeds, or is expected to exceed thresholds agreed by DoF	
44	Assets - Transfer or disposal of assets at less than market value.	
45	Assets – to appropriate any sums realised as a result of selling an asset above the deminimis level in the DoF Budget/In-year Monitoring Guidance	
46	Assets – to allow an organisation to retain receipts arising from the sale of assets funded by grant or grant-in-aid above the deminimis level in the DoF Budget/In-year Monitoring Guidance	
47	Compensation payments without legal advice - Individual compensation claims settled out of court over £10,000. - **Refer to Table A for HSC and NIFRS Delegation**	
48	Compensation payments following legal advice - Individual compensation claims settled out of court over £100,000 where the legal advice is that the department will not win the case if contested in court. - **Refer to Table A for HSC and NIFRS Delegation**	
49	Consultants – Expenditure on external consultancy projects over £75,000 Expenditure on external consultancy assignments co-funded by the Strategic Investment Board over £150k – **Refer to Table A for HSC and NIFRS Delegation**	FD(DOF)07/12 Minute to Principal Finance Officers dated 19 April 2004
50	Estimates – form and content of Main and Supplementary Estimates.	Supply Estimates in Northern Ireland – A Guidance Manual
51	Virement	Supply Estimates in Northern Ireland – A Guidance Manual
52	Fraud – any departure from immediate reporting (not including National Fraud Initiative (NFI) for which separate arrangements have been agreed	FD(DFP) 02/13
53	IT projects over £1 million **Refer to Table A for HSC and NIFRS Delegation**	CONSIDER AGAINST AGILE
54	Capital Projects - All other expenditure on Capital Projects involving over £2million of Central Government expenditure unless other delegations specifically allow - **Refer to Table A for HSC and NIFRS Delegation**	
55	Projects - All PFI + 3PD projects at key stages as stipulated in NIGEAE	NI Guide to Expenditure Appraisal and Evaluation MPMNI A.7.5.4 FD(DFP) 20/09 FD(DFP) 17/11

	Details	Reference
56	Receipts – repayment of CFERs from the Northern Ireland Consolidated Fund	
57	Redundancy – All staff redundancy schemes not covered by existing regulations or which are more generous than existing NICS scheme.	
58	EU - All expenditure over £5 million under the EU Programmes for which the Special EU Programmes Body is responsible rather than with a threshold of £2 million.	Letter to Finance Directors & EUSG Members 2 March 2011
59	Pay Remits - **Refer to Table A for HSC and NIFRS Delegation**	FD Letter - Pay Remit Approval Process and Guidance
60	All leases for Office Accommodation (including supporting storage or warehousing) – both new and existing extension or renewal beyond break points. Excluding offices outside Northern Ireland - **Refer to Table A for HSC and NIFRS Delegation**	Letter to Accounting Officers 28 July 2014

Annex C

Specific DEPARTMENT OF HEALTH delegations

Ref number	Details	Reference
Where DoF approval (in writing) is required:		
1	Hospital Schemes – New Build, Extension, Refurbishment and Equipment involving capital expenditure over £5m. **Refer to Table A for HSC and NIFRS Delegation**	
2	Third Party Development schemes for health and social care/ service provision.	
3	All grants/awards to the Voluntary and Community Sector: Revenue Grants £500,000 per annum Capital Grants £200,000 - **Refer to Table A for HSC and NIFRS Delegation**	
4	Medical/Clinical Negligence settlements over £2m. - **Refer to Table A for HSC and NIFRS Delegation**	
5	Staff redundancy schemes.	
6	Provisions concerning appointment of officers.	Fire Services (NI) Order 1984
7	Doctors Qualifications.	HPSS Order 1972 Article 107(6)
8	Doctors Rights/Working Conditions.	HPSS Order 1972 Article 107(6)
9	Requirement to maintain list of Doctors/Dentists by Boards / Departments.	HPSS Order 1972 Article 107(6)
10	Terms of Service for Medical Professionals.	HPSS Order 1972 Article 107(6)
11	Prescription Charges.	HPSS Order 1972 Article 98 (2) Schedule 15
12	Optical Charges.	HPSS Order 1972 Article 98 (2) Schedule 15
13	Dental Charges.	HPSS Order 1972 Article 98 (2) Schedule 15

MANAGEMENT STATEMENT

BETWEEN

DEPARTMENT OF HEALTH FOR NORTHERN IRELAND

&

SOUTHERN HEALTH & SOCIAL CARE TRUST

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

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

Management Statement

Southern Health & Social Care Trust

1. INTRODUCTION

1.1 This document

1.1.1 This *Management Statement* and *Financial Memorandum* (MS/FM) has been drawn up by the sponsor Department, the Department of Health, in consultation with the Southern Health & Social Care Trust (referred to in this document as SHSCT or the Trust), Southern Trust Headquarters, 68 Lurgan Road, Portadown, BT63 5QQ. The document is based on a model prepared by the Department of Finance (DoF).

1.1.2 The terms and conditions set out in the combined M*anagement Statement* and *Financial Memorandum* may be supplemented by guidelines or directions issued by the sponsor Department/Minister in respect of the exercise of any individual functions, powers and duties of the SHSCT.

1.1.3 A copy of the MS/FM for the SHSCT should be given to all newly appointed Trust Board Members, senior Trust executive staff and departmental sponsor staff on appointment. Additionally the MS/FM should be tabled for the information of Trust Board Members at least annually at a full meeting of the Board. Amendments made to the MS/FM should also be brought to the attention of the full Board on a timely basis.

1.1.4 Subject to the legislation noted below, this *Management Statement* sets out the broad framework within which the Trust will operate, in particular:

- the Trust's overall aims, objectives and targets in support of the sponsor Department's wider strategic aims and the outcomes and targets contained in the Programme for Government (PfG) and in the Commissioning Plan Direction (CPD);
- the rules and guidelines relevant to the exercise of the Trust's functions, duties and powers;
- the conditions under which any public funds are paid to the Trust; and
- how the Trust is to be held to account for its performance.

1.1.5 The associated *Financial Memorandum* sets out in greater detail certain aspects of the financial provisions which the SHSCT shall observe. However, the *Management Statement* and *Financial Memorandum* do not convey any legal powers or responsibilities.

1.1.6 The document shall be reviewed periodically by the sponsor Department in line with the reviews referred to in Section 7 below.

1.1.7 SHSCT, the sponsor Department, or the Minister, may propose amendments to this document at any time. Any such proposals by the Trust shall be considered in the light of evolving departmental policy aims, operational factors and the track record of the Trust itself. The guiding principle shall be that the extent of flexibility and freedom given to the Trust shall reflect both the quality of its internal controls to achieve performance and its operational needs. The sponsor Department shall determine what changes, if any, are to be incorporated in the document. Legislative provisions shall take precedence over any part of the document. Significant variations to the document shall be cleared with DoF Supply after consultation with the Trust, as appropriate. (The definition of "significant" will be determined by the sponsor Department in consultation with DoF).

1.1.8 The *MS/FM* is approved by DoF Supply, and signed and dated by the sponsor Department and SHSCT's Chief Executive.

1.1.9 Any question regarding the interpretation of the document shall be resolved by the sponsor Department after consultation with the SHSCT and, as necessary, with DoF Supply.

1.1.10 SHSCT should provide the documents detailed in Append 1 to the sponsor Department with the frequency described therein.

1.1.11 Copies of this document and any subsequent substantive amendments shall be placed in the Library of the Assembly. (Copies shall also be made available to members of the public on SHSCT's website).

1.2 Founding legislation: status

1.2.1 SHSCT is established by means of an Establishment Order made under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 (the 1991 Order). The Establishment Order is the Southern Health & Social Services Trust (Establishment) Order (Northern Ireland) 2006. SHSCT does not carry out its functions on behalf of the Crown.

1.3 The functions, duties and powers of SHSCT

1.3.1 SHSCT is established for the purposes specified in Article 10(1) of the 1991 Order. http://www.legislation.gov.uk/nisi/1991/194/article/10 . These include any functions of the Department with respect to administration of health and social care that the Department may direct. The Trust's general powers are listed in the Schedule to the 2006 Establishment Order -

http://www.legislation.gov.uk/nisr/2006/294/schedule/made

1.4 Classification

1.4.1 For policy/administrative purposes SHSCT is classified as a health and social care body (akin to an executive non-departmental public body).

1.4.2 For national accounts purposes SHSCT is classified to the public corporations sector.

1.4.3 References to SHSCT include, where they exist, all its subsidiaries and joint ventures that are classified to the public sector for national accounts purposes. If such a subsidiary or joint venture is created, there shall be a document setting out the arrangements between it and SHSCT.

2. AIMS, OBJECTIVES AND TARGETS

2.1 Overall aim

2.1.1 The approved overall aim for SHSCT is to improve health and social well-being outcomes, through a reduction in preventable disease and ill-health, by providing effective, high quality, equitable and efficient health and social care.

2.2 Objectives and key targets

2.2.1 The Department determines SHSCT's performance framework in light of the Department's wider strategic aims, current PfG objectives and targets and the CPD.

3. RESPONSIBILITIES AND ACCOUNTABILITY

3.1 The Minister

3.1.1 The Minister is accountable to the NI Assembly for the activities and performance of SHSCT.

His/her responsibilities include:

- keeping the Assembly informed about the Trust's performance, as part of the HSC system;
- carrying out responsibilities specified in the founding legislation including appointments to the Trust Board (including its Chairman) and laying of the annual report and accounts before the Assembly; and

- approving the remuneration scheme for Non-Executive Board members and setting the annual pay settlement each year under these arrangements.

3.2 The Accounting Officer of the sponsor Department

3.2.1 The Permanent Secretary, as the sponsor Department's principal Accounting Officer (the 'Departmental Accounting Officer'), is responsible for the overall organisation, management and staffing of the sponsor Department and for ensuring that there is a high standard of financial management in the Department as a whole. The Departmental Accounting Officer is accountable to the Assembly for the issue of any grant-in-aid (GIA) to the SHSCT. The Departmental Accounting Officer designates the Chief Executive of the SHSCT as its Accounting Officer, and may withdraw the Accounting Officer designation if he/she believes that the incumbent is no longer suitable for the role.

3.2.2 In particular, the Departmental Accounting Officer of the sponsor Department shall ensure that:

- SHSCT's strategic aim(s) and objectives support the sponsor Department's wider strategic aims, current PfG objectives and targets and the CPD;

- the financial and other management controls applied by the sponsor Department to SHSCT are appropriate and sufficient to safeguard public funds and for ensuring that the Trust's compliance with those controls is effectively monitored ("public funds" include not only any funds granted to the Trust by the Assembly but also any other funds falling within the stewardship of the Trust);

- the internal controls applied by SHSCT conform to the requirements of regularity, propriety and good financial management; and

- any GIA to SHSCT is within the ambit and the amount of the Request for Resources and that Assembly authority has been sought and given.

3.2.3 The Departmental Accounting Officer is also responsible for ensuring that arrangements are in place to:

- continuously monitor SHSCT's activities to measure progress against approved targets, standards and actions, and to assess compliance with safety and quality, governance, risk management and other relevant requirements placed on the organisation;

- address significant problems in the Trust, making such interventions as he/she judges necessary to address such problems;